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The year 2011 was certainly not among the best for good memories. Instead of looking backwards, we in International Hospital Federation (IHF) believe that the future is always full of opportunities.

In the Chinese Calendar, 2012 is the Year of the Water Dragon. In China, the Dragon is a legendary animal. It is the symbol of both imperial power and the unexpected.

Looking back, 2012 marks the centenary anniversary of important events such as the establishment of the Republic of China (January 1, 1912); the creation of the African National Congress (January 8, 1912); the discovery of the South Pole by explorer Robert F. Scott, although Ronald Amundsen had got there before him (January 18, 1912), the sinking of the Titanic (April 15, 1912) and the declaration of war on Turkey by Montenegro, beginning the First Balkan War.

In health care, the legendary British National Health Insurance Act came into effect (July 15, 1912).

In the same spirit, 2012 is already shaping up to be equally action filled and unpredictable. Despite some guarded optimism about Europe’s latest attempts to stem the euro zone crisis, the mood is sombre, with many concerns about what lies ahead in 2012. The growing inequality between the planet’s haves and have-nots has reemerged as a central issue, thanks largely to the Arab Spring uprisings, the Occupy movement and other protests around the globe.

When gazing into the 2012 “crystal ball” what do we see as some of the main opportunities and challenges for the health sector?

Although globalization of care is still at an early stage, major changes are to come in the next decade but their pace and evolution are uncertain. Some large groups are developing a real international strategy, but most service provision is still national. E-Health presents an opportunity for accelerating globalization. This evolution needs to be closely monitored. Increasingly there is a need for effective global governance of the health care industry.

At the same time, complexity and diversity in health care are on the increase. All countries face challenges of providing effective, quality, and efficient care within the limited budget envelope provided by governments and by households’ willingness to pay. Although many countries pay increasing attention to patient safety and quality of care, both must continue to improve at a faster pace to meet the expectations of better-informed and more-empowered patients. Health care organizations and health professionals need to accelerate their changes to best respond to these trends.

There is increasing recognition of the limitations of both the public and the private sectors in providing for all the needs in the health sector. Increasingly a new public-private mix is evolving with strong role for both in health care. In emerging markets where the public sector is not yet well established, the private sector is stepping into the gap between patients’ expectations and the public sector’s ability to deliver quality care. Slowly, long entrenched historical barriers are eroding, and a new more open public-private mix is emerging in response to market pressures.

Finally, university hospitals are coming back into focus as centers of excellence, providers of essential care, and trainers of a future cadre of health care workers, instead of being seen as esoteric ivory towers, black holes in the health budget.

IHF is well placed to help its members address many of these challenges and to provide global leadership in the hospital and health sector more broadly.
They are real world settings in which many of the challenges in the health sector come together in one place.

IHF is well placed to help its members address many of these challenges and to provide global leadership in the hospital and health sector more broadly. The federation has its finger on the pulse of many of the upcoming challenges that face both organizations and managers in the health care industry. It will open an international discussion on core competencies for health care leaders. And it has set up a platform of dialogue for hospital manager associations. It is expected that the profession will set up international criteria for core competency assessment with the support of the IHF backing up international recognition.

World Hospitals and Health Services will deal with several of these issues in the coming year.

This issue of the journal begins with an article by Xiaohui Hou and Tao Dai, providing a fascinating glimpse into the rapidly transforming health care system in China, including the recent introduction of health insurance and expansion in coverage under this program (the Water Dragon of the Chinese Health System).

Tsuneo Sakai describes the establishment of new medical support systems and reconstruction schemes for the health care delivery system undertaken by Japan following the Great East Japan Earthquake of 2011.

Rob Haley provides an overview of trends, business opportunities, and policy challenges related to medical tourism in Egypt.

Keith Bolton describes some of the challenges faced in building and operating the new 250- to 300-bed Nelson Mandela Children’s Hospital (NMCH) in Johannesburg, South Africa, as a public-private partnership initiative.

Ngoy KZ Bukonda, Maruat Chand, and Tumba G Dzashi report the work of a survey they conducted in 2010 on private health care business models in Mbuji Mayi, the capital city of the Eastern Kasai Province (EKP), Democratic Republic of the Congo (DRC).

Yundendorj Gantugs, Ochir Chimedsuren, and Purevdorj Tseden describe the management challenges in a district hospital in Ulaanbaatar, Mongolia.

Ulrich Matern describes a new stepwise planning methodology to increase patient safety and hospital efficiency, including an early peer-review process, in hospital design and innovative training for hospital staff.

Jan De Maeseneer and Pauline Boockkostems stress the importance of a paradigmshift from “problem-oriented” towards “goal-oriented” care as noncommunicable diseases (NDCs) and multimorbidity becomes the rule rather than exception in health care.

Hugh MacLeod examines the connectivity and communication challenges faced by hospitals and health care providers that try to improve patient safety and quality of care.
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The evolution of the hospital system in China

ABSTRACT: The Chinese health care system has improved rapidly, especially in the areas of health insurance and the movement toward universal coverage. Public hospital reforms have been much slower, however, and have encountered significant challenges. The objective of this article is to describe the current challenges in public hospital reform in China through the lens of the evolution of the hospital system. The authors also draw general lessons that could be applied to other countries.

Hospitals are a vital part of the health care delivery system. In China from 1960 to 2010, the number of hospitals grew from 6,020 to 20,900, and the number of beds increased from 0.89 per 1,000 population to 2.17 during the same period of time. In addition to the scale increase, the hospital system in China has evolved from a community-based and government-financed system to a complex and semi-autonomous system with both public and private providers. This evolution coincided with market-oriented reforms in the health care system and rapid economic growth throughout the country.

The Chinese health care system has improved rapidly, especially in the areas of health insurance and the movement toward universal coverage. The public hospital reforms have been much slower, however, and have encountered significant challenges. The system is also increasingly being criticized by the public for being “too expensive and too difficult”. Under enormous pressure, in April 2009 the State Council unveiled a blueprint for health care over the next decade, launching a much-anticipated reform of the ailing medical system with the goal of ensuring fair and affordable health services for all of the nation’s 1.3 billion citizens (Xinhua News 2011).

The objective of this article is to describe the current challenges in public hospital reform in China through the lens of the evolution of the hospital system.

Era I: Establishing public hospitals before the market reform (before 1980)

In 1949, when China was newly established, the country faced famine, high mortality and morbidity rates, a high prevalence of infectious disease, and low life expectancy. In order to provide basic medical services to the population, control infectious diseases, and improve life expectancy, the government established a large, hierarchical public hospital system with three tiers in both urban and rural areas: street, district, and municipal hospitals in urban areas; and village station, township health centers, and county hospitals in rural areas. The medical staff were public employees and were paid a fixed salary.

Era II: Transferring fiscal burdens to public hospitals and the emergence of private medical facilities (1980–2009)

In 1949, when China was newly established, the country faced famine, high mortality and morbidity rates, a high prevalence of infectious disease, and low life expectancy. In order to provide basic medical services to the population, control infectious diseases, and improve life expectancy, the government established a large, hierarchical public hospital system with three tiers in both urban and rural areas: street, district, and municipal hospitals in urban areas; and village station, township health centers, and county hospitals in rural areas. The medical staff were public employees and were paid a fixed salary.

The system was quite effective. In two decades, it reduced the infant mortality rate to a level comparable to that in developed nations; it eradicated smallpox and nearly eradicated tuberculosis and schistosomiasis; the average life expectancy of Chinese rose from 35 years in 1949 to 68 years in 1979 (World Bank 1984).

While the system has conquered a number of challenges in a relatively short span, it became increasingly challenging for the government to fund this system. Smaller government subsidies and reimbursements for actual costs led to the slow adoption of new technologies; hospitals could not replace outdated medical equipment or refurbish the hospital infrastructure. The underlying payment incentives did not encourage providers to contain costs, and the efficiency and quality of services were quite low.

Era III: Transferring fiscal burdens to public hospitals and the emergence of private medical facilities (1980–2009)

In order to alleviate the financial burden on the central government and promote efficiency, the government changed its policy,

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devolving more power to localities and allowing hospitals to develop ways of generating revenue and to retain profits. This reform fell under the broad category of market reform starting in 1980, when many formerly state-owned enterprises (SOEs) were privatized. However, the public hospital reform was much slower than the privatization of the SOEs because of the ongoing debate over whether to let public hospitals, a major player in a vital social sector, enter the marketplace in a socialist country. As a consequence, the degree of privatization in health care was much weaker than in other sectors. In 1989, the State Council (China Government 1989) promoted a number of new contracting mechanisms for medical institutions, which allowed public hospitals to earn profits from specialty medical services and to charge more for higher-quality services, while the prices for basic medical care were still regulated by the government. This reform injected new funds into hospitals. For example, public hospitals were allowed to raise capital from medical staff and retirees, which could then be invested in private for-profit units within the public facilities. Public hospitals can also enter into joint ventures with companies in the private sector.

The decentralization of power and the incentives for hospitals to retain profits helped promote innovation by public hospitals and raised money through private funding and patient fees. The higher-tier public hospitals in metropolitan areas, with more highly trained medical staff, were particularly successful in bringing in revenue and earning higher returns; but the lower-tier smaller hospitals struggled to keep up, and the new policy failed to help them succeed in the market. There were also a number of other unintended consequences.

The sense of social responsibility by public hospitals grew weaker. When government financial contributions to public hospitals were reduced, public hospitals became responsible for their own profits and losses. Driven by profit seeking, they behaved more like private providers, selling medicines to make up for low revenues and providing unnecessary and elective medical services, which usually involved the use of modern technologies in diagnosis and treatment (Eggleston et al. 2008). The conflicts between hospitals’ need to generate self-funding and their social functions were pronounced, and their social role grew weaker. As a result, hospital-patient relationships grew increasingly tense, and trust between patients and medical institutions deteriorated.

At the institutional level, the incentives for public hospitals did not promote efficiency or competition. The government viewed public hospitals as public enterprises; but financial subsidies from the government were minimal, and hospitals were encouraged to seek profits from new technologies and new projects. Caught in the middle, hospital managers sometimes avoided governmental control and overinvested in medical technology. Human resources and wage and salary reforms also lagged behind. Performance indicators were neither clear nor aligned with better management, resulting in low efficiency and noncompetitive behavior.

A parallel development over the same period of time was the emergence of private hospitals. Before 1949, China had about 520 private hospitals (mostly mission hospitals operated by churches). However, with collectivization and nationalization in early 1950, almost all health facilities were converted to ownership by different levels of government or state-owned enterprises (Liu et al. 2006). Since the economic reforms in the 1980s, several private and semi-private organizational forms in the health care sector have emerged, first in the big metropolitan areas, such as Beijing and Shanghai. The emergence of private hospitals is driven by both market conditions and favorable policies (Hou and Coyne 2008). The increased and differentiated demand combined with inadequate supply created market niches for private hospitals.

With market reform deepening, public policy also began to favor private facilities. In 1980, the State Council approved the Ministry of Health’s request to permit doctors to establish private practices. This change has significantly affected rural areas, and private clinics began to flourish in the countryside. In 1989, the MOH issued “Regulations on Hospitals and Clinics for Foreigners and Overseas Chinese and the Practice in China of Foreign Doctors.” In 2000, the Chinese government issued regulations on nonprofit
and for-profit health care organizations. With these favorable policies and market conditions, the private hospital market has grown rapidly. From 2003 to 2009, the percentage of for-profit specialty hospitals grew from 27% to 41% of the total hospitals, while the percentage of for-profit general hospitals grew from 9% to nearly 20% (Figure 2). Although private hospitals still constituted a relatively small percentage of the market they grew quickly and became more important players in the hospital market. The limited empirical evidence shows no evidence that private for-profit hospitals have driven up average medical expenditures while serving their profit-maximization objectives. Rather, they help increase the market supply of health care, which in turn better serves the increasing demand (Liu et al. 2009).

Era III: Exploring options to address access and cost issues in the public hospital system (2009—present)

The start of this era is marked by the issuance of “Guidelines on Deepening the Reform of Health Care System” in 2009. In early 2010, the government issued “Guidance for the Public Hospital Reform Pilots” to provide direction for further improving quality and access. It designated 16 cities as the site for pilot where public hospitals could experiment with ways to better serve the public, improve operational efficiency, improve fairness and accessibility, and optimize the organizational structure, and promote innovation. It specifies four “separations”: the separation of regulation and operation, the separation of policy-making and management, the separation of medical and pharmaceutical services, and the separation of for-profit and not-for-profit hospitals. These guidelines have come under increasing public criticism for increasing public access to care and reducing costs. Although the government has authorized the 16 designated pilot cities to design their own public hospital reform agenda to “establish a reasonable, effective and optimized medical service system” (Xinhua News 2010). The reform initiatives are categorized below:

Public hospital governance reform. The main objective is to align the accountability and responsibility of different public bureaus on public hospital management. For example, some pilot cities have established a public hospital management committee as the highest decision-making authority. A mayor or deputy mayor usually serves as the head of the committee, and its main function is to coordinate strategic decision making and implementation of public hospital reform by the various bureaus.

Hospital conglomerations. The main objective is to increase economies of scale and improve operational efficiency. Although public hospitals are affiliated with governments at various levels (the military, higher education, business enterprises, and so forth), hospital group development is mostly led by the government. Spurred by market competition, medical institutions have been active in developing hospital groups—more than 120 in recent years (Li et al. 2006). Different models have been developed in the market, including cooperative hospital groups, hospital chains, merged hospital groups, and hospital groups with reorganized assets.

Provider-payment system reform. The main objective is to contain public and private out-of-pocket expenditures. The new payment methods use case-based payments adjusted for disease profiles, such as diagnosis-related groups (DRGs) or global budget caps, or a combination of the two approaches to replace the fee-for-service (FFS) methods. The limited empirical evidence shows that prepayment is associated with a slower rate of growth of overall expenditures, program spending, and patient copayment per inpatient admission compared with FFS (Yip and Eggston 2001).

Despite these initiatives, progress in public hospital reform has been much slower than in health insurance reform. The slow progress of the reform highlights the underlying structural and institutional weaknesses that lie at the heart of the conflict between public hospitals and public interests. The weak institutional setting provides powerful incentives for physicians and hospitals to exploit patients and third-party payers for financial gain.

Lessons learned from the evolution of the Chinese hospital system

The evolution of the Chinese hospital system offers several lessons. First, it is impossible to institute reforms beginning with a blank slate; change is always embedded in an existing socio-institutional context. Rather than imposing blueprint solutions, political and historical realities must be considered. A strategy for reform must be guided by careful analysis of the current situation, and consider available options, vested interests, potential costs and benefits, and potential allies and opposition.

Second, two critical issues are usually ignored in the rush to design and implement health reforms: governance and sequencing. Without both of these being properly addressed, the health care reform may encounter unintended consequences or even an undesirable regression (Rose et al. 2003). When China decentralized revenue generation and profit retention to the public hospitals in the 1980s, there was no appropriate governance mechanism to guarantee the public interest and provide external accountability. Introducing a governance reform later in the process is more difficult than doing it at the outset.

Third, the entrance and development of private hospitals may increase market competition and improve the efficiency of the health care delivery system, but their development and functions...
need to be closely monitored and evaluated.

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References
What have we learned from Japan’s major earthquake, tsunami and nuclear incident?

TSUNEO SAKAI
PRESIDENT, JAPAN HOSPITAL ASSOCIATION

ABSTRACT: Ten months have passed since the Great East Japan Earthquake struck on March 11, 2011. Although we have tried our best to support the affected areas for the last ten months, people and hospitals in these areas are still suffering from various calamities and these include damage from the earthquake, tsunami, nuclear incident, harmful rumors, and manmade disaster. In this article, various supportive efforts of the Japan Hospital Association (JHA) in the acute, mid-term, and long-term stages are described. Based on our experience, we propose to establish a new medical support system and reconstruction scheme for the health care delivery system in the affected areas.

JHA’s supportive efforts

The Japan Hospital Association (JHA) has tried to assist the affected areas and people from the beginning of the disaster. Our medical support can be divided into three stages: the acute stage, mid-term help and long-term help. Our support is focused in six main areas: manpower, materials, money, information, government, and the system. As for the system, JHA established a Special Disaster Committee on the day of the earthquake and we have worked in cooperation with the government from then. As for manpower, the Disaster Medical Assistance Teams (DMAT) – this is a well-trained medical team of at least one doctor, one nurse and other hospital staff – were immediately deployed after the earthquake (Figure 2).

The tsunami disaster was different from the Hanshin Awaji Earthquake which struck the western part of Japan in 1995. According to Professor Iwase of Chiba University who examined 126 casualties in the Iwate Prefecture district of 80-90% died of drowning from the tsunami compared to 80 percent who died in falling buildings in 1995. It was difficult to evacuate the affected areas and bring relief supplies because of the widespread destruction, and the remoteness of the affected coastal areas from the core cities. More than 400,000 people were evacuated to the safety evacuation areas. Prolonged lack of utilities such as electricity, water and gas combined with food and fuel shortages affected the people in these areas. Many people suffered from hypothermia and undernutrition. Considerable numbers of the elderly were reportedly to have died during the evacuation. Most of the coastal hospitals lost their medical supplies due to the tsunami; and they could not receive enough replacements due to the destruction of medical supply factories, and a malfunctioning delivery system caused by the destruction of main roads, and a shortage of manpower and fuel.

The JHA also raised money for the victims. The JHA has tried to collect all the necessary information but
It was possible to estimate the damage from the earthquake and tsunami, and then to show the geographic distribution of the damaged hospitals. We were hoping to use the information for transportation and evacuation plans. Actually it was very difficult to do so in the acute stage. We estimated that three hospitals in Iwate were completely destroyed by using the seismic polygon and without going to the affected areas themselves. Eventually we found out that four instead of three hospitals were completely destroyed. One hospital which we could not identify had been constructed more than 50 years ago and they did not have any anti-earthquake construction devices.

In the long-term support phase we decided to establish a new medical support system based on our experience. We are trying to organize an all-Japan support system asking many other organizations to join us. The main aim of this system is to get all the necessary information, then update and share the information efficiently. We divided Japan into eight to nine districts and have district centers which can function as a control point whenever necessary. We do not know which part of Japan will face the next disaster. So we should prepare for any part of Japan to function as the control point in case of a disaster. By integrating information from the affected and non-affected areas, we can make efficient logistic plans. The key concept would be information-loaded GIS. This system can function not only in a disaster but also in peace time. Even then we have a poor distribution of medical resources. This system can help ease these uneven conditions in normal times as well.

As for the nuclear incident, the Japanese Association for Acute Medicine (JAAM) took a key role in forming the Fukushima Nuclear Power Plant Accident Working Groups to help people. They consisted of an off-site center functioning as a regional headquarters based at Fukushima Medical University, and J-Village Medical Teams near the Fukushima I National Power Plant to help people there on a daily basis. They also received full support from National Institute for Radiological Science. Another organization involved in the nuclear disaster was the Fukushima...
The shortage of physicians and nurses was crucial for the affected areas. These areas had been faced with a shortage of physicians before the earthquake. JHA took a leading role in obtaining information regarding the demand and supply of physicians, then matching their needs. We tried to send young physicians for set periods, two to four weeks, to the areas concerned. Even ten months later these supports are welcomed because of the baseline physician shortage in the affected areas.

It remains important to send support teams to the affected areas continuously. However, it seems impossible to reconstruct health care delivery systems in the completely damaged areas in only a year or so. Nearby areas might be able to support them for a certain time but they also are in trouble themselves. JHA is proposing a completely different reconstruction scheme. It is to relocate the functions of the damaged area as a whole to the unaffected areas. It includes patients, their families, and medical personnel. We are now explaining this idea to the central and regional administrations, hospital organizations, and mass media. We are collecting the data needed for this proposal. The affected areas need sufficient time for them to reconstruct the health care delivery system. However, they would not be able to fulfill their function during this period. Then we might be able to arrange a substitute for them. Therefore, it is important to have knowledge regarding both the affected areas and the unaffected areas for this arrangement.

JHA is determined to try its best to reconstruct the health care delivery system in Japan and bring a bright future.

Conclusion

Disaster strikes when you least expect. It is essential to establish a new health care support system that could function in the disaster situations as well as in peace time. GIS is a very useful tool in constructing this kind of support system.

Dr. Sakai is President of Japan Hospital Association and President of Seirei Hamamatsu General Hospital in Hamamatsu, Japan. He specializes in neurosurgery. He graduated from Chiba University School of Medicine in 1970 and has had full neurosurgical training at State University of New York, Upstate Medical Center, Syracuse, USA.

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Prefectural Hospital Association and JHA worked very closely with them to help hospitals and hospital personnel in the area. The most striking thing is that many young people working in the district hospitals have been leaving the hospitals worrying about the nuclear damage. It is going to take some time for these areas and hospitals to regain their proper functions.

The shortage of physicians and nurses was crucial for the affected areas. These areas had been faced with a shortage of physicians before the earthquake. JHA took a leading role in obtaining information regarding the demand and supply of physicians, then matching their needs. We tried to send young physicians for set periods, two to four weeks, to the areas concerned. Even ten months later these supports are welcomed because of the baseline physician shortage in the affected areas.

It remains important to send support teams to the affected areas continuously. However, it seems impossible to reconstruct health care delivery systems in the completely damaged areas in only a year or so. Nearby areas might be able to support them for a certain time but they also are in trouble themselves. JHA is proposing a completely different reconstruction scheme. It is to relocate the functions of the damaged area as a whole to the unaffected areas. It includes patients, their families, and medical personnel. We are now explaining this idea to the central and regional administrations, hospital organizations, and mass media. We are collecting the data needed for this proposal. The affected areas need sufficient time for them to reconstruct the health care delivery system. However, they would not be able to fulfill their function during this period. Then we might be able to arrange a substitute for them. Therefore, it is important to have knowledge regarding both the affected areas and the unaffected areas for this arrangement.

JHA is determined to try its best to reconstruct the health care delivery system in Japan and bring a bright future.

Conclusion

Disaster strikes when you least expect. It is essential to establish a new health care support system that could function in the disaster situations as well as in peace time. GIS is a very useful tool in constructing this kind of support system.

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Public policy and medical tourism: Ethical implications for the Egyptian health care system

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ABSTRACT: Egypt’s medical tourism industry has been experiencing tremendous growth. However, Egypt continues to lack the necessary investment in its public health system to effectively care for its population. Current policy and the emergence of medical tourism have led to unequal health care access, resulting in high a prevalence of infectious diseases and lack of resources for its most vulnerable populations. As a new Egyptian government emerges, it is important for policymakers to understand the critical issues and ethical concerns of existing health policy. This understanding may be used to propose new policy that more effectively allocates resources to care for Egypt’s population.

In January 2011, Egyptians began demonstrating in Cairo’s Tahrir Square as part of a much broader movement called the “Arab Spring.” This movement served to communicate the population’s growing economic and political discontent and is resulting in unprecedented political change in the Middle East (The Economist 2011). Egyptians were particularly steadfast in demanding change despite the fact that Egypt’s economy had been experiencing tremendous growth over the past several decades. However, it continued to lack the necessary investment in its public health system to effectively care for its population (Haley and Bég 2010). This lack of priority and funding is best illustrated by Egypt’s overall spending on health care of just 3.7 percent of GDP, far lower than the 17.6 percent spent by the United States (Auerback and Kellermann 2011). More importantly, of this 3.7 percent, less than 43 percent was attributed to Egypt’s public health system while more than 57 percent was allocated to the relatively more affluent private health care sector (Fouad 2005). Egypt’s public policy tended to favor the private sector, particularly the sectors that supported its tourism industry and its emerging medical tourism market. This inequity is of significant concern because Egypt’s health indicators are among the lowest in the region (WHO 2004).

In February 2011, Egyptian President Hosni Mubarak resigned and a new government will likely face an extraordinary and persistent demand for fair and equitable public policies. Policy-makers will likely experience significant challenges as it attempts to create a new government and rebuild its tourism industry and medical tourism market. This article aims to inform Egyptian policymakers of the importance of identifying policy that results in an equitable and adequately resourced public health system. It also identifies ethical issues and concerns regarding current Egyptian public policy and identifies solutions for policymakers to consider when developing new public health policy.

Egypt’s tourism industry and public health

Egypt’s tourism industry produces approximately $4 billion per year and accounts for over 11 percent of its gross domestic product (GDP) (County Guide to Egypt 2011). Increasingly, public policy was developed that often favored the disproportionate investment and reallocation of health care resources away from the public health sector in order to fund policies that more directly supported Egypt’s tourism industry. These policies often had significant financial and ethical implications that negatively impacted the equity and distribution of Egypt’s public health resources. For example, health care services in Egypt’s urban and tourism dominant areas are far more accessible and more modern relative to the health care systems in Egypt’s lower income and rural regions. Egypt’s lower income and rural areas are typically non-tourism regions. These regions often have the highest prevalence of infectious disease and a significant lack of access and financing for its public health system (El Hadadi 2004). Furthermore, these areas typically lack the most basic public health services such as health care centers, family planning units, and hospitals (Handoussa 2008). In addition, studies indicate that more than 81 percent of Egypt’s total physician hours are provided within urban areas although they only represent less than half of Egypt’s total population (El Hadidi 2004).

While Egypt is typically known as a tourist destination, it has also positioned itself as an emerging medical tourism destination particularly for cosmetic surgery. The global economic recession and the exponential increase in medical costs in many developed countries have resulted in a growing number of patients from these countries trying to identify affordable health care options for their elective and acute procedures. Therefore, an increasing
Currently, a number of patients are travelling to third-world countries to obtain medical care at far more affordable prices (Haley et al. 2010). For example, it is estimated that more than six million Americans travel abroad for their healthcare treatment for services that may cost 20 to 80 percent less than what is charged in the United States (Herrick 2007). Prices for healthcare treatments typically include the medical procedure, follow-up care, airfare, accommodations, and food. Medical tourism destinations can offer far lower prices for healthcare treatments because of lower labor and administrative costs as well as a lower risk of malpractice litigation.

Improving standards of care within Egypt’s private health sector, relatively lower healthcare costs, and an already popular tourism destination have positively positioned Egypt for medical tourism; particularly in such destinations as the Red Sea, Cairo, Alexandria, and Giza (Egyptian Medical Services Co 2011). As a result, Egypt is experiencing an expansion of its traditional tourism industry into a rapidly growing and lucrative medical tourism market.

### Policy Implications

There are positive implications for the Egyptian population if the new Egyptian government furthers the development of policy that facilitates a growing tourism industry and medical tourism market. However, it is important for policymakers to clearly understand the potential negative health policy implications and ethical issues of policies that are developed to favor Egypt’s medical tourism market.

Medical tourists typically expect a quality of care that is at least at parity, if not higher, than the care that they would otherwise receive in their own country. These higher expectations may encourage and facilitate the adoption and diffusion of policies that assure a higher standard of care within all of Egypt’s healthcare facilities; perhaps through the utilization of such accrediting organizations as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). Accredited organizations are typically required to adopt a systematic approach to collect outcome data and to report on quality indicators to maintain their accreditation (Haley et al. 2010). This systematic collecting, measuring, and reporting of data can have a significant and positive impact on improving the quality of Egypt’s healthcare services.

Additional revenue from the medical tourism market could also fund needed public health resources, such as public health education programs that specifically target Egypt’s most prevalent infectious morbidities. Egypt has among the world’s highest prevalence of infectious diseases, including Schistosomiasis, Hepatitis C, Trachoma, Acute Diarrhea and Respiratory Infections (WHO 2004). However, only 14 percent of Egypt’s hospitals currently have infection control committees and even fewer have specialists in infection control or surveillance systems in place (Maha et al. 2006). The funding of adequate resources and a much greater investment in public health education that leads to an effective and measurable reduction in Egypt’s infectious disease rate could encourage more tourism and more revenue for the population.

However, policies that reassign resources to facilitate the growth of a tourism industry and a burgeoning medical tourism market have also resulted in negative consequences and ethical concerns. For example, the investment and reallocation of limited funds for a more affluent medical tourism market can further prejudice an already unequal access to quality healthcare for Egypt’s most vulnerable citizens. The unequal distribution of funds has resulted in approximately 50 percent of Egypt’s public health facilities having significant shortages of medical equipment and primary care (Nanadakumar et al. 1999). Any policy that further reallocates and decreases the funding to Egypt’s public health system will likely have a dramatic and negative impact on the health of the Egyptian population; particularly for those who are poor and most vulnerable. This negative impact should be of significant concern to policymakers since approximately one-fifth of Egypt’s 80 million people are considered impoverished and live on less than US$1 per day (Hany 2007). In addition, the Egyptian population is already characterized by having one of the lowest average life expectancies in the region at 59 years (WHO 2004).

Policymakers must also consider that clinicians and private healthcare facilities that market themselves to a wealthier clientele, such as medical tourists, will likely be unaffordable to Egypt’s general population.

As Egypt continues to experience unprecedented leadership and change, policymakers must develop policies that ensure fair and equitable healthcare access. While policies should be developed to further facilitate the growth of Egypt’s tourism industry and medical tourism market, policymakers must also...
consider the potential unintended consequences and ethical issues that emerge as decisions are made regarding Egypt's limited economic and health care resources. Therefore, policies must be developed that prevent the shift of limited resources from the public sector into the private sector. In addition, policies should also be considered that allocate and target adequate tourism and medical tourism revenues into the public health system.

While Egypt's policymakers may identify an immediate economic benefit of shifting limited resources to the tourism industry and medical tourism market, they must also focus on investing and developing a strong public health system. This investment will ultimately improve the quality of life, decrease the prevalence of infectious disease, and improve the productivity of Egypt's population. These improvements may lead to a more sustainable medical tourism market and may also help to significantly reduce Egypt's unequal access to needed public health services.

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Creators of private health care businesses in the Democratic Republic of the Congo: Profile and sources of start-up funds

ABSTRACT: A survey was conducted in July 2010 to explore the creation of private health care businesses in Mbuji Mayi, the capital city of the Eastern Kasai Province (EKP), Democratic Republic of the Congo (DRC). The survey yielded 68 responses. The results indicated that the entrepreneurs were predominantly Congolese men with backgrounds in the health services field who had raised their start-up capital mostly from personal savings or from friends and family. Their businesses, which were mostly in the form of sole proprietorships, were likely to be located in areas underserved by government-owned medical facilities.

The development of health care services that draw most of their financial resources from government tax revenues has been an area of great emphasis in health care policy in most developing countries (Benett 1992; Harding 2003; World Bank 1993). This has happened at the expense of the private health care sector for which data have been widely unavailable and generally anecdotal. The private health care sector was largely overlooked until household survey data on health care use and expenditure patterns came out in the 1990s, showing particularly that “the majority of health care contacts were with private providers on a fee for service basis” (Hanson and Berman 1998). This fact came as a real surprise given that public policies have been generally geared toward promoting universal access to subsidized public services.

Since then, efforts have been deployed to better understand the various dimensions of the private health care sector (Baker and van der Gaag 1993; Berman and Rose 1996; Harding 2003; Mustgrove 1996). Reviewing the literature, Hanson and Berman (1998) note, among many other things, the surprisingly large extent, composition, size and key factors affecting the size of the private health care sector; and they lament that “most developing countries devote a lot of policy attention to government roles in health care financing but little to the development of private provision in health sector planning” (p. 198). Contrary to this assessment, Harding (2003) sees and reports “more and more policymakers” as “attempting to incorporate private practitioners and facilities into overall sector policy in developing countries” (p. 7). Unfortunately, despite this recognition, it remains that the experiences of developing countries are rarely well documented. This lack of documentation prevents health care policy makers and analysts from having a clear picture of the socio-demographic profile and of the major sources of start-up funds for private health care entrepreneurs. This gap needs to be bridged, particularly in poor countries, not only where the governments are known to have assumed a significant role in the provision of health care services but also where a significant growth of the private health care sector has been noticed or encouraged in the context of structural adjustment programs.

There are a number of reasons why this study is important. First, this is the first study of its kind undertaken in sub-Saharan African countries. Second, people who live in these countries suffer higher disease burdens, die more prematurely, have lower per capita incomes, and experience higher unemployment rates than their counterparts in other regions of the world. Third, because of these crucial socio-economic challenges, these countries need to engage in and effectively promote health care entrepreneurship. If they are successful on this path, their private health care entrepreneurship is more likely to contribute to the mitigation of each of the aforementioned scourges. A fourth
public and private health facilities that have been established to address these problems. In Section 2 we explain the methodology of the survey. In Section 3, we present our survey results. In Section 4, we discuss the relevance of our findings in the context of health policy development in sub-Saharan African countries.

Section 1: Study setting

The emergence of the present-day DRC as a distinct political administrative unit is credited to the entrepreneurial spirit of a Belgian monarch whose vision, undertakings and shortcomings continue to stir both admiration and widespread condemnation. Regardless of how this monarch is appreciated, the fact remains that he was successful in making his case for the creation and recognition of the Congo Free State. This was formally achieved at the Berlin International Conference which in 1885, bestowed private title to the territory upon a private association headed by King Leopold II of Belgium (Hochschild 1999; Waldman 2006; Vansina 1984) and known as the “Association Internationale du Congo” (AIC). Under this leadership, AIC established and implemented a brutal system of exploitation which is estimated to have cost the lives of 10 million people (Waldman 2006). Following intensive denunciation of its human rights violations, the brutal regime of AIC became a case of real embarrassment to the Belgian government and people. The Belgian Parliament responded by converting the Congo Free State into a Belgian colony in 1908. The country which was then subdivided into six provinces remained a Belgian colony until June 30, 1960 when independence was expeditiously granted to the Congolese peoples. The number of these provinces increased from six to ten in a twist of social and political events. These events contributed to the creation of the present-day Eastern Kasai province (EKP). The EKP emerged in August 1960 as an autonomous state under the name of “État Autonome du Kasai.” At this inception, it was mostly the initiative of Luba political leaders who, because of the persecution that Luba people had endured elsewhere (particularly in the Katanga and Western Kasai provinces) wanted to create a political space under their own control and who thus elected to rebel against the established order of the newly emerging independent DRC. After a short period of the central government of Congo was able to subdue this rebellion and to create the EKP by enacting a law of August 14, 1962. After four years of operation under this later legislation, the province saw its territory expanded, under the Ordinance-law No. 60/205 of April 6, 1966, to reach its current size of 173,100 Km² (about 7 percent of the total area of the DRC) and its current configuration which includes two other former provinces (Lomami and Sankuru) and the City of Mbuji Mayi. As shown in the map (Figure 1), the territory of the EKP is located in the Congolese heartland and does not share borders with any foreign country, but is surrounded by other Congolese provinces. In line with the political organization of the country, the EKP contains two cities (Mbuji Mayi and Muene Ditu) and three districts: Kabinda, Sankuru and Tshilenge.

The EKP has about 10 million inhabitants; it is part of a country with an overall population of nearly 71 million, making it the fourth most populous nation in Africa. The average life expectancy is about 45 years (Waldman, 2006). The DRC suffers from a high disease burden. The under-five mortality (2002-06) was 148 per 1,000 live births, the prevalence of chronic malnutrition among under-five children is 45 percent and maternal mortality in 2001
was 1,289 per 100,000 live births. The DRC experiences a huge burden of malaria; it accounted for an estimated 11 percent of all estimated malaria cases in the WHO African Region in 2006 (World Health Organization, World Malaria Report 2009).

Over the many years of its existence, the Congolese government has pursued the provision of health care in partnership with non-governmental organizations including religious and philanthropic organizations, private employers and for-profit health providers.

Following the Alma Ata International Conference on the Primary Health Care Strategy in 1978, efforts were made to reorganize the delivery of health care services according to a hierarchical system with the professed aim of making a package of primary health care services (water, sanitation, treatment of most common ailments, maternal and infant health, family planning, essential medicines, etc) as geographically, financially, and culturally accessible as possible to the population (World Health Organization 2011). Under this strategy, the health system is organized on three levels: central, intermediate (province-level) and peripheral (zone de santé/health zone, the equivalent of the district-level in most countries). Each health zone (HZ) is intended to cover an average population of 110,000 and includes one central HZ office, the equivalent of the district (district-level in most countries). As is the case all over the territory of the DRC, each HZ office is responsible for providing a government-defined minimum services package. In addition, each HZ has a general referral hospital that offers a package of complementary services (Hardman 2006). Through its various health centers and its outpatient and inpatient departments based at the referral hospital, the HZ provides a range of medical care and health prevention programs that address the needs of the people living within the zone. As is the case all over the territory of the DRC, which contains 11 provinces, efforts aimed at addressing medical needs in the EKP have been considered and deployed at the HZ level with very poor results. In 2003, the EKP comprised 29 HZs, which were delimited in the context of the primary health care strategy implemented in the DRC in 1983. The province now has 51 HZs as a result of the last two redistricting exercises of 2004 and 2008. Ideally, within each of these 51 HZs of the EKP, one would expect to find a whole range and a sufficient number of health facilities erected by the various partners (government, private employers and private not-for profit and for-profit organizations), adequately distributed and staffed and operated to prevent and treat diseases and to promote the physical, mental and social well-being of the populations. This does not seem to be the case particularly in terms of the distribution of referral hospitals. The number and distribution of referral hospitals does not reflect at all compliance with the standards that have been defined for fully functional HZs. The province has only 30 referral hospitals for a total of 51 HZs. Assuming that each of these 30 hospitals is located in one specific HZ, this means that at least 21 additional referral hospitals are needed to equip each remaining HZ and hence to achieve compliance with the standards of the primary health care system regarding referral hospital deployment. In terms of ownership, two-thirds of the existing hospitals (n=20) have been erected by the government and the remaining one-third (n=10) by various religious organizations. When one examines the overall distribution of health facilities (hospitals, health centers, medical practices, maternities and pharmacies), the same pattern of uneven distribution emerges: A large portion of the government health facilities are located in one district; the district of Sankuru has about 48 percent of health facilities of the EKP. When one excludes from the analysis the district of Muene Ditu which has about the same number of government (n=150) and private for profit (n=150) health care facilities, it appears that the fewer government facilities a district had, the more it has attracted the establishment of private health care facilities. This would suggest that private for profit entrepreneurs have found it more appealing to establish their health care facilities where there are less government facilities.

Data in Table 1 shows that Mbuji Mayi is the district with the greatest number of private health care businesses (n= 529). This provides a logical justification of the selection of Mbuji Mayi as our study site: more than 90 percent of health facilities here are owned and operated by private for-profit entrepreneurs.

Section 2: Study questions and methods

Study questions: The aforementioned discussion points to some interesting opportunities for private health care businesses in the DRC and particularly in the EKP. However, this background has also uncovered many questions worthy of exploration in the context of Congolese private health care businesses. Two among these questions occupy a prominent place for this article. One unanswered question centers on the profile of the health care entrepreneurs. It is not clear who these entrepreneurs are in terms of professional background, chronological age, age at start of business, gender and other socio-demographic variables. It is important to explore some of the common characteristics of the founders of health care businesses in the DRC. A second question is the lack of knowledge about whether or not these health care entrepreneurs have received any support to launch their businesses and, if so, from what particular sources they have received any contribution.

Study methods: The study was a cross-sectional study, using

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<th>Table 1: Distribution of health facilities by health district in Eastern Kasai Province, September 2010</th>
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Source: Democratic Republic of the Congo. Provincial Medical Offices, Eastern Kasai Province, unpublished draft report, 2010
a structured questionnaire developed in French, the official language of the DRC. The survey questionnaire contained the following six sections: (a) data on the health care establishment; (b) demographic data on entrepreneur; (c) beliefs and attitude toward entrepreneurship; (d) launching and financing of business; (e) performance evaluation of the business; and (f) factors associated with a successful entrepreneurship career. The research protocols were reviewed and approved by the executive committee of the medical school, serving as an institutional review board for the protection of human subjects. One hundred and two (102) medical students were trained. Each student was assigned to one of the 34 teams. Each team was made of three students collectively entrusted with the responsibility of administering the survey to two different private health facilities in one or another HZ in Mbuji Mayi. Data were entered into a spreadsheet and then analyzed by means of SPSS, version 17, in order to address these study questions.

Section 3: Results
Common characteristics of founders of health care businesses: Sixty-eight private health care businesses were surveyed. Fifty-six (92.4%) were sole proprietorships. Twenty-three of the businesses were formed by older adults (>50y) as opposed to thirty-seven by middle-age adults (30-49y) and six by younger adults (<30y). Males represent 80 percent of entrepreneurs; and physicians and nurses are the most common professions of entrepreneurs, representing respectively 36 percent and 20 percent of the sample. The overall average age of entrepreneurs at start-up was 36.4 years.

Sources of start-up funds: Tables 2 and 3 display the distribution of entrepreneurs according to their sources of start-up funds. Most of the funds necessary for start-ups were generated from self, family or friends. Less than 15 percent of entrepreneurs used start-up funds that were mostly generated from banks or commercial lenders. Almost 88 percent of entrepreneurs got the majority of their start-up funds from their own savings or from family and friends.

Section 4: Discussion and conclusion
The results reveal that health care entrepreneurship in the DRC is overwhelmingly in the form of sole proprietorships which comprise about 85 percent of all start-ups. This is in line with previous research that shows that small businesses are the predominant form of business in sub-Saharan Africa (Khavul, Burton and Wood 2009). Complementary to this is the finding that most businesses raise money from family and friends, and not from the formal banking sector. This also illustrates the importance of social ties in the African culture, and the institutional weaknesses and voids that permeate the business environment there. These findings support the assertions of Khavul, Burton and Wood (2009) that small family businesses are the predominant form of business in Africa, and that these rely on family and friends for financing. The fact that most businesses are opened by people with previous ties to the health care industry, either as doctors, nurses, or health care workers suggests the social dimension of this entrepreneurship for some, as well as the fact that their greater familiarity with the health industry probably helps in opening and running a health facility. The degree of paternalism in society is reflected in our statistics: Over 80 percent of businesses were formed by men.

Health care entrepreneurship was also more prevalent among older age groups. Over 90 percent of all start-ups were founded by entrepreneurs over the age of 30. This is in line with research from western countries, which show that older adults in Western countries have created new businesses at significantly higher rates than their younger counterparts (Johnson, Kaufman and Schleifer 1997).

From a public health perspective, our study reiterates the importance of private health care facilities operating along with government facilities to fulfill the health care needs of the local people. Private profit facilities are more likely to operate in districts where there are no or few government facilities, thus greatly complementing the effort to make health care accessible to all.

For governments in sub-Saharan African countries, this study points to a number of important challenges that they face. How can they encourage more entrepreneurship among the young and among women? How can they improve access to formal financing for nascent entrepreneurs? How can they promote more efficient public private partnerships in the underserved areas? Perhaps most importantly, how can all this be done in a patriarchal and collectivist culture in way that takes advantage...
of the local culture’s unique characteristics? |

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References


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The proposed Nelson Mandela Children’s Hospital, Johannesburg: Providing the best care for children in the developing world

ABSTRACT: Construction will soon commence on the Nelson Mandela Children’s Hospital (NMCH) in Johannesburg, South Africa. The Hospital will have 250-300 beds and will provide tertiary and quaternary care to children in specific Centers of Excellence. Admission to this referral facility will be based entirely on medical needs. The disciplines that are catered for include Paediatric surgery, oncology, nephrology, cardiology, intensive care and imaging. The NMCH will be South Africa’s first “Private Hospital – Not for Gain”. Funding for capital expenditure is currently being raised by the Trust. Operational expenditure will come from the Department of Health, private insurers and neighbouring governments.

South Africa has a long history of provision of health care services of a very high standard. In the Apartheid era the White minority enjoyed superior “first world” care while Black Africans were relegated to much lower standards of care. Since democratization, a two-tier system persists; with the medically insured minority population receiving excellent care while the uninsured majority rely on a failing public health system. As noted by Ataguba et al. (2011): “South Africa represents a classic example of the inverse care law; the lowest socio-economic groups bear the largest burden of ill-health but have the lowest level of health service utilization and derive the least benefits from service use.”

The South African government has concentrated its efforts on the provision of primary and secondary care. This is appropriate especially in the face of the rampant HIV and tuberculosis epidemics. After a shaky start, the HIV campaign is beginning to bear fruit with a plateau in new infections and a marked diminution of mother-to-child transmission. Unfortunately, there has been an inevitable, gradual deterioration of some tertiary and quaternary services. The Nelson Mandela Children’s Hospital (NMCH) aims to address some of these deficits in the northern part of South Africa and the sub-continent.

South Africa has, at present, one dedicated, comprehensive children’s hospital, the Red Cross Memorial Children’s Hospital. The hospital enjoys a high reputation for paediatric care. This facility is situated in Cape Town, at the Southern tip of the continent and is not ideally situated to easily provide care outside of the region. Spurred on by the CEO, Sibongile Mkhabela, the Nelson Mandela Children’s Fund decided to build a tertiary children’s hospital in Johannesburg to provide for very specific paediatric needs in a central area of the country and accessible, not only to the local children but to the region. The hospital will be a private-public partnership; the first South African hospital run on a “private but not for gain” mandate.

The vision of the NMCH

The facility will be a state-of-the-art paediatric academic referral hospital providing child-centered, best quality medical care, in specific disciplines, to children of Southern Africa, irrespective of their social and economic status. The project is strongly supported by our patron, Mr Mandela and his wife, Graça Machel who chairs the NMCH Trust.

The hospital

The NMCH will be situated on land donated by the University of the Witwatersrand, adjacent to the Health Sciences Facility and the Charlotte Maxeke Johannesburg Academic Hospital. There will be 250 beds initially with a phased-in planned increase to 300 beds. The design has been facilitated by international and local architects with clinician input at every stage. Building will commence early in 2012.

The NMCH will form an integral part of the service, teaching, training and research platforms of the Department of Paediatrics and Child Health of the Faculty of Health Sciences of the University of the Witwatersrand. There are also close affiliations with other university faculties in the region. Partnerships and “twinning” with international faculties are envisaged.

The “centers of excellence”

To optimise the effectiveness of the NMCH, we have identified...
specific areas of tertiary care that are underprovided for in the existing facilities. Paediatric surgical services are particularly needed as paediatric surgeons are in short supply and surgery needs to be centralized.

**Paediatric surgery:** The NMCH will provide seven modern, large operating theatres. These will be equipped for specific needs including transplant. Surgical training will be provided for nurses as well as surgical and anaesthetic staff. Theatres will be digitized and audiovisual links provided to auditoriums for larger training groups.

**Cardiology and cardiothoracic surgery:** A long queue currently exists for the correction of congenital cardiac defects. There will be a large theatre, a hybrid theatre/interventional cardiology theatre and a cardiac catheterization laboratory. The surgical, anaesthetic and technological skill exists locally to provide this service but many children succumb or develop complications while waiting. The most important rate-limiting step currently is the availability of neonatal and paediatric intensive care beds.

**Intensive care:** There is a chronic shortage of both paediatric and neonatal intensive care and high-care beds in the region. The NMCH will provide 60 such beds which will be available for medical and surgical cases.

**Paediatric oncology:** The oncology unit will re-locate from the current locale and a new facility for bone marrow transplant will be developed. The requisite blood bank and pharmacy is planned to support this service.

**Paediatric nephrology:** There is currently a gross regional shortage of facilities for renal dialysis. Sixteen haemo-dialysis beds will be situated in the NMCH. A renal transplant programme will be developed.

**Imaging:** The Imaging department will provide up-to-date facilities for nuclear imaging, ultrasound, and radiology including CT and MRI. It is envisaged that these services will be widely used, not only by inpatients but also by ambulatory patients from the region.

**Other disciplines:** While concentrating on the above mentioned, other areas catered for will include craniofacial reconstruction, spinal surgery, neurosurgery etc. Special cognisance will be taken on providing for the tertiary and quaternary needs of patients infected by HIV and TB.

**Ancillary services:** Services will be provided by the therapeutic disciplines such as physiotherapy, occupational therapy, speech therapy, social services, psychiatry and psychology. Rehabilitation programs will begin within the hospital and continue in out-patients and follow the patients back to their referral source.

**Transport:** The NMCH will provide a dedicated paediatric...
Management: Paediatric hospitals

Staffing and training
It is envisaged that most categories of paediatric and paediatric sub-specialty medical personnel will be locally available to staff the NMCH. Medical staff will be joint appointees at the University. Specific categories of professional staff, including paediatric surgical staff, will be recruited locally and abroad. The acquisition of paediatric nursing staff remains the largest staffing challenge. South Africa has, over the past decade, seen a deficit in available nurses in all sectors and especially in the public sector, with losses to first-world environments, an aging work force and movement from the public to the private sector. The need to urgently attract and above all train nurses for the NMCH has been recognized as a priority and strategies are underway to address this. The attraction to work in a modern, well-run institution, with competitive earnings, is a strong drawcard.

A large group of paediatric clinicians have constituted the Clinical Steering Committee and they have been consulted widely at all stages of the project. This Committee is chaired by the Academic Head of the Paediatric Department, Professor Peter Cooper. This committee reports to the NMCH Task Team.

Finances
The capital costs for the project will be raised by the Trust and are projected to exceed R1 billion. (US$ 1 = R8). Operating costs will derive from a variety of sources including the National Department of Health (public patients), Health Funders (private patients) and Government-to-Government Funding (patients from neighbouring States). Modelling suggests an 80:20 split of public to private patients. Admission to the NMCH will be based entirely on medical need. No child will be turned away because of an inability to pay.

Discussion
Effective comprehensive health care requires careful attention to all levels of care. The most cost effective care is delivered at a primary level and this includes preventive and promotive health. The South African health services are currently revamping with attention being given to all levels. The implementation of a new National Health Insurance aims to drastically reduce the inequities in health and provide reasonable and affordable health care at all levels. This includes appropriate tertiary levels of care as will be provided by the Nelson Mandela Children’s Hospital. Children in the developing world should also have access to the best!

Keith Bolton is Associate Professor of Paediatrics at the University of the Witwatersrand in Johannesburg. His major clinical and research interests are in neonatology, clinical dysmorphology, ethics and medical law. He serves as the Lead Clinician on the Task Team of the proposed Nelson Mandela Children’s Hospital.

Acknowledgments
This article is based on a paper presented on 8th November, 2011 at the 37th World Hospital Congress in Dubai.

Reference
Assessment of organizational management in the district health centers of Ulaanbaatar

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OCHIR CHIMEDSUREN
DIRECTOR, SCHOOL OF PUBLIC HEALTH, HEALTH SCIENCES, UNIVERSITY OF MONGOLIA

PUREVDORJ TSEDEN
VICE PRESIDENT, ECONOMICS AND MONITORING OF HEALTH SCIENCES, UNIVERSITY OF MONGOLIA

ABSTRACT: This cross sectional study assessed organizational management of district hospitals in terms of operational planning and follow-up, program and guidelines, organizational and work routines, personnel, facilities and medical equipment, process orientation and control. Four district health centers employees (n=208) were involved. We assessed using Likert-type scale ranging from 1 (very poor) to 5 (excellent). The overall mean score given to organizational management was 3.09±0.91. There was statistically significant difference in assessing operational planning and follow-up (p<0.044) and control (p<0.014) by different occupations. In conclusion, the findings confirm our hypothesis that there is a lack of management capacity within the public sector in Ulaanbaatar.

Mongolia’s current health system has been evolving for more than 80 years. During the socialist period, a publicly funded health system was functioning using the Semashko model, and health care provision expanded rapidly. There were several remarkable achievements such as the establishment of western-type hospitals, the training of a national medical workforce and rapid improvements in basic health indicators for the population. However, the health care monopoly was also characterized by overcentralization, bureaucratic planning mechanisms and gross inefficiencies (Bolormaa T., et al., 2007). Since the 1990s the development of Mongolia, has been in transition to a market economy. Due to these transitional changes in Mongolia the health sector has undergone many changes and faces some management problems from hospital managers also being medical doctors.

Moreover aside from an oversupply of hospital services, the provision of hospital services by urban districts in Ulaanbaatar is inequitable due to urban migration, and favors the non-poor areas of the city. Public hospital facilities and services in Ulaanbaatar include 16 clinical and tertiary hospitals and centers and 46 other hospitals in a city of around one million. There are problems of administration, management, overstaffing, and quality. The system of payment provides incentives that encourage the inefficient use of inpatient services, and average hospital stays are unnecessarily long. In Ulaanbaatar City, the capital of Mongolia, specialized care is delivered by district general hospitals, which cover all major clinical specialties and typically have capacities of 200–300 beds for delivering inpatient services (Bredenkamp et al. 2010). The training of specialist medical staff is not up to international good practice and the management of the hospital sector is weak. There are also still too few studies assessed and conducted in hospital organizational management in Mongolia.

Objective
To assess organizational management of district health centers in Ulaanbaatar.

Methods
The study had a cross sectional design. A random sample of 208 employees from Ulaanbaatar City’s four district health centers were selected for the study. A self-administered questionnaire was used for data collection. Participants were informed that participation was voluntary and that the results of the study would be published in a journal. We offered no incentive for completing the questionnaire.

Some 85-question items were generated through literature review and the suggestions of experts and advisors. The questionnaire consists of three main parts such as general information (name of the district, date of survey, health center), demographic details (age, sex, position, years of working) and items on organizational management (operational planning and follow-up, program and guidelines, organizational and work routines, personnel, facilities and medical equipment, process orientation and control). We assessed using Likert-type scale ranging from 1 (very poor) to 5 (excellent).
Data for individual variables were summarized using frequency distribution and focused on the central tendency and dispersion. The ultimate score that each employee assessed for each of the six factors was calculated from the mean of the summed items for that variable. The relationship between variables was analyzed using chi-squared tests for categorical variables. For quantifiable variables, the non-parametric Mann-Whitney test was used for testing for the single item scales, and parametric analysis of variance (ANOVA) for responses that were summed to create a factor. A p-value ≤ 0.05 was considered to indicate statistical significance. All analysis was conducted at a 95 percent level of certainty and allowed for a margin of error of five percent. The primary objective was to assess the hospital performance in terms of organizational management. A secondary objective was to assess the differences between the performance of different departments and between district health centers. Historically, South Gobi's public hospitals did not have a quality management system. However, in recent years, this situation has changed significantly. The private sector is also becoming more important and is facilitating the delivery of health services. The overall mean score for the organizational management section was 3.09±0.91.

There was a statistically significant difference in assessing operational planning and follow-up (p=0.044) and control (p<0.014) by different occupations. The other functions’ assessment was no different depending on occupation (Table 2).

The Cronbach’s alpha and the mean total score for the management function subscales are presented in Table 3. The Cronbach’s alphas for all the scales were at an acceptance level of 0.87. The Cronbach’s alphas were calculated to see the level of reliability, averaging 0.87.

Cronbach’s alphas for all the scales are at an acceptance level of excellent. Cronbach’s alphas for all the scales are at an acceptance level of excellent.

<table>
<thead>
<tr>
<th>Occupation</th>
<th>n (%)</th>
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<tbody>
<tr>
<td>Medical Doctor</td>
<td>87</td>
</tr>
<tr>
<td>Nurse</td>
<td>87</td>
</tr>
<tr>
<td>Administrative worker</td>
<td>23</td>
</tr>
<tr>
<td>Others</td>
<td>23</td>
</tr>
</tbody>
</table>

| Source: Authors calculations |

**Results**

As shown in Table 1, most respondents were female (62.3%), between the ages of 45-54 (40.7%). A third of respondents have worked in their position for 21-30 years (33%). The most common occupations were nurse 87 (41.6%) and medical doctor 91 (39.9%).

Public District Hospital employees contributed to operational planning and follow up, program and guideline, organization and work routine, personnel, facilities and medical equipment, and control: 3.16±0.65, 3.18±0.71, 3.18±0.83, 2.99±0.86, 2.63±0.91 and 3.09±0.91 respectively. The overall mean score given to organizational management was 3.09±0.91.

There was a statistically significant difference in assessing operational planning and follow-up (p=0.044) and control (p<0.014) by different occupations. The other functions’ assessment was no different depending on occupation (Table 2).

The Cronbach’s alpha and the mean total score for the management function subscales are presented in Table 3. The Cronbach’s alphas for all the scales are at an acceptance level of reliability, averaging 0.87. Participants’ scoring of organizational management in any terms were significantly different (p<0.001). The highest score was in Khan-Uul district health center and lowest score was at the Nalaikh district health center.

**Discussion**

There is a significant gap between districts’ competency level of management and this could explain the differences in performance between district health centers. Historically, South

### Table 1: Characteristic of the participant by district

<table>
<thead>
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<td>23</td>
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<td>Others</td>
<td>23</td>
</tr>
</tbody>
</table>

| Source: Authors calculations |

**Table 2: Management function mean score by occupation**

<table>
<thead>
<tr>
<th>Management function</th>
<th>Total n=208</th>
<th>Head of department n=9</th>
<th>Medical doctor n=81</th>
<th>Nurse n=87</th>
<th>Administrative worker n=8</th>
<th>Other n=23</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operational planning and follow up</td>
<td>3.16±0.65</td>
<td>2.70(0.59)</td>
<td>3.13(0.67)</td>
<td>3.25(0.59)</td>
<td>3.53(0.64)</td>
<td>3.04(0.62)</td>
</tr>
<tr>
<td>Program and guidelines</td>
<td>3.10(0.71)</td>
<td>2.88(0.59)</td>
<td>3.13(0.69)</td>
<td>3.3(0.69)</td>
<td>3.41(0.92)</td>
<td>3.09(0.91)</td>
</tr>
<tr>
<td>Organization and work routine</td>
<td>3.10(0.65)</td>
<td>2.77(0.69)</td>
<td>3.18(0.62)</td>
<td>3.27(0.90)</td>
<td>3.34(1.03)</td>
<td>3.09(0.94)</td>
</tr>
<tr>
<td>Personnel</td>
<td>2.99(0.66)</td>
<td>2.62(0.63)</td>
<td>3.04(0.68)</td>
<td>3.06(0.93)</td>
<td>3.09(0.68)</td>
<td>2.76(1.07)</td>
</tr>
<tr>
<td>Facilities and medical equipment</td>
<td>2.63(0.91)</td>
<td>2.36(1.13)</td>
<td>2.67(0.88)</td>
<td>2.67(0.90)</td>
<td>2.6(1.02)</td>
<td>2.48(0.97)</td>
</tr>
<tr>
<td>Control</td>
<td>3.09(0.91)</td>
<td>2.64(0.79)</td>
<td>3.02(0.80)</td>
<td>3.27(0.84)</td>
<td>3.4(1.36)</td>
<td>2.83(1.21)</td>
</tr>
<tr>
<td>Mean</td>
<td>3.04(0.87)</td>
<td>2.62(0.72)</td>
<td>3.02(0.70)</td>
<td>3.13(0.77)</td>
<td>3.23(0.92)</td>
<td>2.85(0.99)</td>
</tr>
</tbody>
</table>

| Source: Authors calculations |
African hospitals, especially in the public sector, were managed by medical superintendents and this shift is in keeping with a strategy aimed at improvement of sustainable and effective delivery of health services by strengthening management capacity. However it is a concern that the majority of public sector managers are vastly inexperienced in management discipline (Ruben 2008). Currently all Mongolian hospital and district health center managers are medical doctors and according to the study results they need some formal training in health care management (Shirnen and Bulganchimeg 2006). The overall low scoring across all centers could be explained by the lack of knowledge on organizational management by respondents. The organizational management function listed may also not have fully reflected the scope of hospital management. However, despite these limitations, the study has important theoretical and practical relevance for the improvement of hospital management capacity in Ulaanbaatar, Mongolia.

Conclusion

In conclusion, the findings confirm our hypothesis that there is a lack of management capacity within the public sector in Ulaanbaatar. It provides the evidence that there is a great need for the further development of managers, especially those in the public sector. The onus is therefore on administrators and those responsible for management education and training to identify managers in need of development and to make available training that is contextually relevant in terms of program design and delivery.

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References


Management: Mongolia

<table>
<thead>
<tr>
<th>Table 3: Mean Score of Management Function by District</th>
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<tbody>
<tr>
<td>Management function</td>
</tr>
<tr>
<td>----------------------</td>
</tr>
<tr>
<td>Operational planning and follow up</td>
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<tr>
<td>Facilities and medical Equipment</td>
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<td>Control</td>
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<td>Mean</td>
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</table>

Source: Authors calculations.

26 World Hospitals and Health Services Vol. 47 No. 4
Improvement of efficiency and safety in hospitals starts in the beginning of the planning phase and influences patient safety, staff, hygiene as well as logistics, and efficiency within the entire hospital.

ABSTRACT: To increase patient safety and hospital efficiency a new stepwise planning methodology including an early peer review of the future design is shown in the article as well as innovative training concepts for hospital staff.

Today hospitals are operating in a very difficult political and social environment that demands increased efficiency as well as patient safety. In current hospital structures, this leads medical staff to become overloaded with the following alarming effects, all over the world, including countries with a very high health care standard:

- **Not enough time for their patients.** 84 percent of German hospital doctors and 97 percent of hospital nursing staff declare that they do not have enough time for patients due to inefficient workflows and increasing administrative work (DAK-BGW Gesundheitsreport 2005; Merz and Oberlander 2008).
- **Not enough training in medical technology.** 59 percent of German surgeons and 40 percent of OR nursing staff regret the mismatch between complex medical devices and their insufficient training in using these devices (Matern et al. 2006a). In auditing hospitals in various countries, we can observe that complex life-saving devices are sometimes not used because of a lack of understanding of the usage of the technology.
- **Not enough knowledge in infection control.** The World Health Organization (WHO) criticizes the limited knowledge in infection control regarding various issues such as waste disposal, equipment, infrastructure, etc. that lead to health care associated nosocomial infections (WHO 2011).

All of these problems are related to the limited knowledge of the medical staff. It is mandatory that the medical staff to be taught and trained in infection control, safe manipulation of medical devices and efficient administrative and clinical workflow but to reiterate this is time consuming, expensive and hinders the treatment of the patients.

These problems described above might increase within the next decade (Figure 1). The reasons for this are:

- an existing and growing worldwide lack of hospital staff (doctors, nurses, administrators and engineers), which means a reduction in the staff-patient-ratio;
- a reduction in the duration of stay in hospitals, which additionally leads to an increase in the administrative work to...
Two issues to increase patient safety and efficiency

In conclusion it can be foreseen, that the problems concerning inefficiency of hospitals and low level of patient safety will increase in future. To avoid this scenario, one issue is to integrate the specialized knowledge of processes, hygiene, medical and building technology and training at the very beginning of the planning process of a new hospital or the reconstruction of an existing hospital.

The result of such an innovative knowledge based process is:
- workflow adapted architecture;
- workflow adapted medical technology;
- synchronized processes in the various facilities of the hospital;
- decrease of nosocomial infections by implementing the highest level of hygiene standards;
- increase patient safety manipulating complex medical devices and building technology.

Figure 2 shows the magic triangle to increase patient safety and efficiency in health care. Figure 3 shows typical phases of planning and realization of hospital and Figure 4 shows the important sub-phases of the standardized planning process to increase safety and efficiency of the planning process as well as the operation of the future facility or hospital.

To ensure such results it is imperative that all persons involved in the decisions and planning process of a new hospital agree on the procedure and define in a first workshop the goals, e.g. disciplines located in the hospital, number of ambulant patients per day, number of physicians and nursing staff performing procedures, standard of the realization like first class, etc. This has to be fixed in a “Document of specification” and signed by the administration, investors and planning team. This document also includes data and analysis gained from best hospital practice audits of current workflow within the various facilities of the existing hospital, hygiene standards, medical and building technology as well as the degree of training and specialization of the employees.

In the second phase the ideal workflow is discussed and developed with the hospital staff will be described and documented. This will be transformed in a “Layout specification” which describes the rooms including medical technology, building technology and hygiene properties as well as their local relations.

In the third phase the architect uses this “Layout specification” for his first sketches of the floor plan. It will then be discussed with the future users especially the medical staff and will be checked in a kind of second opinion by specialized workflow, logistics, hygiene and waste management professionals, which come out
with a detailed expertise about pros and cons of the concept (Koneczny and Matern 2006a; 2006b). From our experience performing this kind of “peer review,” it is remarkable that most of the concepts fit the needs of nursing staff, administration and doctors, some fit the needs of the patients (regarding protection of privacy) but very few plans fit the needs of ergonomics/safety and efficiency of medical procedures, hygiene. Most of them neglect waste management.

After the first peer review some iterative circles may be necessary to find the most efficient and safest hospital design before the construction can start but it always is much faster than the traditional way of planning and most importantly it drastically reduces the mistakes normally made in during planning.

Additionally, the advantage of this standardized procedure is transparency to all people, experts, investors and administration including the Ministry of Health involved in the project.

Parallel to the construction of a new hospital, designed from scratch, the recruiting of the key personnel has to start. The medical staff should be taught and trained in the processes, as well as the safe usage of medical devices. Minimally the future technical and administrative directors should be integrated in the planning and construction.

Special study and training programs including “train the trainer” concepts ensure the high level of manual, intellectual and team skills that are necessary to operate a new hospital safely and efficiently from the first day of operation. Therefore, fully equipped training facilities like the “Experimental-OR” in Tuebingen are efficiently from the first day of operation. Therefore, fully equipped training facilities like the “Experimental-OR” in Tuebingen are efficiently from the first day of operation. Therefore, fully equipped training facilities like the “Experimental-OR” in Tuebingen are efficiently from the first day of operation. Therefore, fully equipped training facilities like the “Experimental-OR” in Tuebingen are efficiently from the first day of operation. Therefore, fully equipped training facilities like the “Experimental-OR” in Tuebingen are efficiently from the first day of operation. Therefore, fully equipped training facilities like the “Experimental-OR” in Tuebingen are efficiently from the first day of operation. Therefore, fully equipped training facilities like the “Experimental-OR” in Tuebingen are efficiently from the first day of operation. Therefore, fully equipped training facilities like the “Experimental-OR” in Tuebingen are efficiently from the first day of operation. Therefore, fully equipped training facilities like the “Experimental-OR” in Tuebingen are efficiently from the

Lessons learned

To increase safety and efficiency hospital planning has to be organized as a holistic standardized approach. It is necessary to integrate the processes of hospital planning, realization, procurement and start-up as well as recruiting, teaching and training of the future personnel. An initial signed “Document of specification” is mandatory for standardized and transparent realization of new facilities or entire hospitals and clinics.

An early “peer review” of the ground floor plans as well as the desired equipment is the challenge to eliminate expensive failures and increase the safety and efficiency of the new facility or hospital.

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References


ABSTRACT: Noncommunicable diseases (NCDs) are on the rise and multi-morbidity becomes more and more the rule, no longer the exception. Therefore, a paradigm-shift from “problem-oriented” toward “goal-oriented” care is needed, reorienting the care toward the goals formulated by the patient. By doing so, we will avoid care that may lead to “inequity by disease.”

Today we face an important demographic and epidemiological transition, confronting us with the challenge of noncommunicable diseases (NCDs), which occur more and more in the context of multi-morbidity. In the next decade, multi-morbidity will become the rule, no longer the exception. Especially in developed countries, with increasing life expectancy, NCDs are more and more a phenomenon, accompanied by a rise in multi-morbidity: 50 percent of the 65+ have at least three chronic conditions, whereas 20 percent of the 65+ have at least five chronic conditions (Anderson and Horvath 2002). In the case of Chronic Obstructive Pulmonary Disease (COPD) e.g. more than half of the patients have at least one comorbid disease (Mannino and al. 2008). Describing the rising prevalence of NCDs as a “crisis” (Beaglehole et al. 2011) makes for good drama, but misleads us into thinking that this problem is amenable to a quick fix. NCDs represent a set of chronic conditions that will require a sustained effort for many decades.

In this article we describe how patients with multi-morbidity are approached today. We will argue for the need for a paradigm-shift from problem-oriented to goal-oriented care, which requires new types of evidence and research, and we try to integrate this development into the perspective of quality and equity in health.

The care for patients with multi-morbidity today
In recent years, not only Western countries, but also developing countries started with “chronic disease management—programs” in order to improve care. Wagner has described the different components of the Chronic Care Model (CCM) as developed in the context of primary health care (Wagner 1998). The CCM has inspired policymakers and providers all over the world and is widely accepted in North America, Europe and Australia. The design of disease management programs includes most frequently: strategies for case-finding, protocols describing what should be done and by whom, the importance of information and empowerment of the patient and the definition of process- and outcome-indicators that may contribute to the monitoring of care. Finally, incentives have been defined in order to stimulate both patients and providers to adhere to guidelines. This development has led to spectacular results e.g. in process- and outcome-indicators in the United Kingdom under the Quality and Outcomes Framework (Gillam and Siriwardena 2011). Moreover, the “chronic disease management” approach has led to an acceleration of the implementation of the subsidiarity-principle in primary health care with important task-shifting from physicians, to nurses, dieticians, health educators, etc. In spite of some critical reflections with respect to equity (Norbury et al. 2011; Boeckxstaens et al. 2011), to the sustainability of the quality improvement, and comprehensiveness versus reductionism (Heath 2009), in general, these programs have received positive feedback from providers, patients and politicians.

Taking into account the epidemiological transition, we are faced with the question: “How will this approach work in a situation of multi-morbidity?”

Let us illustrate this with a patient from our general practice, we call her “Margaret”. In Box 1 we describe her case.

According to the actual guidelines, Margaret is faced with a lot of tasks (Boyd et al. 2005): joint protection, aerobic exercise, muscle strengthening, a range of motion exercising, self-monitoring of blood glucose, avoiding environmental exposure that might exacerbate COPD, wearing appropriate foot wear, limiting intake of alcohol, maintaining body weight. She has to receive patient education regarding diabetes self-management, foot care, osteoarthritis and COPD medication delivery system training. Her medication schedule includes 11 different drugs, with
Box 1: Margaret

Margaret is 75 years old. Fifteen years ago she lost her husband. She has been a patient at the practice for 15 years now. During these last 15 years she has been through a difficult medical history: hip replacement surgery for osteoarthritis, hypertension, diabetes type 2, and COPD. She lives independently at home, with some help from her youngest daughter, Elisabeth. I visit her regularly and each time she starts by saying: “Doctor, you must help me”. Then follows a succession of complaints and feelings. Sometimes it has to do with her heart, another time with her lungs, then the hip, etc. Each time I suggest – according to the guidelines – all sorts of examinations that do not improve her condition. Her requests becomes more and more explicit, my feelings of powerlessness, inadequacy and irritation, increase. Moreover, I have to cope with guidelines that are contradictory: for COPD she sometimes needs corticosteroids, which always worsens her diabetes control. The adaptation of the medication for the blood pressure (once too high, once too low) does not meet with her approval, and nor does my interest in her HbA1C and lung function test-results.

After so many contacts, Margaret says: “Doctor, I want to tell you what really matters to me. On Tuesday and Thursday, I want to visit my friends in the neighbourhood and play cards with them. On Saturday, I want to go the supermarket with my daughter. Foremost, I just want some peace. I do not want to have to cope with guidelines that are contradictory: for COPD she sometimes needs corticosteroids, which always worsens her diabetes control. The adaptation of the medication for the blood pressure (once too high, once too low) does not meet with her approval, and nor does my interest in her HbA1C and lung function test-results.

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Source: Author

a total of 20 administrations a day. The clinical tasks for the general practitioner include vaccination, blood pressure control at all clinical visits, evaluation of self-monitoring of blood glucose, foot examination, laboratory tests, etc. Moreover, referrals are needed to physiotherapy, for ophtalmologic examination and pulmonary rehabilitation. So, Margaret’s reaction is not unexpected.

Margaret’s case clearly illustrates the need for a paradigm-shift from Problem-Oriented to Goal-Oriented Care. In 1991, Mold and Blake (Mold et al. 1991) recognized that the problem-oriented model, focusing on the eradication of disease and the prevention of death, is not well suited to the management of a number of chronic illnesses. Therefore they proposed a goal-oriented approach that encourages each individual to achieve the highest possible level of health as defined by that individual. This represents a more positive approach to health care, characterized by greater emphasis on individual strengths and resources. Goal-Oriented Care assists individuals in achieving their maximum individual health potential in line with their individually defined goals. The evaluator of success is the patient, not the physician.

And, what really matters for patients is their ability to function (functional status), and social participation. So, certainly in the context of multi-morbidity, there is a need for a shift from “Chronic Disease Management” toward “Participatory Patient Management”, with the patient at the center of the process.

Exploring the goals of patients will require new conceptual frameworks, new types of research and new research-designs and methods. Nowadays, understanding self-determination and self-agency in relation to the disease, is highly valued by patients. For many people, giving meaning to the chronic illness-process they are going through, is of the most importance. Safety and avoiding side-effects (not having to suffer more from the treatment than from the disease) is very important. Patients expect comprehensiveness in their care instead of fragmentation.

A recent survey of “Chronic disease management” in ten European countries illustrated that most of the countries chronic disease management programs are organized by the label of one chronic condition, sometimes focusing on subgroups, within a specific chronic disease (Rijken and Bekkema 2011). The five conditions most frequently addressed are cancer, cardiovascular disease, COPD, depression and diabetes. Most of the programs use a vertical disease-oriented approach. Although much has been learned from vertical disease-oriented programs, evidence suggests that better outcomes occur by addressing diseases through an integrated approach in a strong primary care system. An example is Brazil, where therapeutic coverage for HIV/AIDS reaches almost 100 percent which is much better than HIV/AIDS programs in other countries with less robust primary care (Ramte et al. 2011). Vertical disease oriented programs for HIV/AIDS, malaria, tuberculosis and other infectious diseases foster duplication and the inefficient use of resources, produce gaps in the care of patients with multi-morbidity, and reduce, especially in developing countries, government capacity by pulling the best health care workers out of the public health sector to focus on single diseases (De Maeseneer et al. 2008). Moreover, vertical programmes cause inequity for patients who do not have the “right” disease (De Maeseneer 2011). Horizontal primary care provides the opportunity for integration and addresses the problem of inequity, providing access to the care of all health problems, thereby avoiding “inequity by disease” (Starfield 2011).

Need for new types of evidence: Medical, contextual and policy evidence

Clinical decisions must be based on adequate knowledge of diseases (medical evidence) but at the same time, they must take into account patient-specific aspects of medical care (contextual evidence) and efficiency and equity (policy evidence) (De Maeseneer et al. 2003). As far as medical evidence is concerned, within primary health care, we are confronted with the tension between the results of clinical research on the one hand and the needs of daily clinical practice on the other hand. The available research generally does not include a representative sample of patients with respect to age and ethnic origin or comorbidity, and does not take into account the typical non-specific presentation of symptoms at an early disease stage. As the case of Margaret (Box 1) illustrates, within primary care, questions arise on which evidence to follow in the case of multi-morbidity. Treatment according to the guidelines for one condition (corticosteroids for COPD) may interfere with the guidelines for another disease.
glycemic control in diabetes type 2). There is a lot of evidence available on the treatment of COPD or the management of type 2 diabetes for patients younger than 75 years but there is little, if any, evidence about how to treat a 75-year old woman who has both or even additional disorders. This problem implies a need for research on the effectiveness of diagnostic and therapeutic interventions that take into account these aspects of patients in primary care. The challenge of multi-morbidity illustrates the lack of appropriate evidence. A basic assumption in the development of guidelines is that clinical research follows clinical relevance. In reality, a lot of research is driven by commercial interests (Bodenheinemer 2000). A consequence is that the focus has shifted from “treat-the-patient” toward “treat-to-target”. And in achieving the “target” much more evidence is available for pharmaceutical treatments than on the effects of interventions aimed at changing health behaviors. So, the threat in evidence-based medicine is pursuing what is possible and available, rather than what is relevant. If we want to take the goals of the patient into account, we need a new type of evidence: contextual evidence, to assist doctors in addressing the challenge of how to treat a particular patient in a specific situation. Contextual evidence deals with the principles of good doctor-patient communication in order to create trust in the interpersonal relationships, the exchange of pertinent information, exploration of the goals of the patient, and negotiation of treatment-related decisions.

We will have to look for research-tools and approaches that focus on subjective determinants of well-being, and not only at biomedical parameters. In the new research-designs, patients with multi-morbidity will be the rule (instead of an exclusion criterion) and complexity will be embraced instead of avoided (Heath 2009).The International Classification of Function (ICF) (WHO 2001) might become as important as the International Classification of Diseases (ICD), as it provides a conceptual framework in which different domains of human functioning are defined. These domains are classified from an eco-bio-psycho-social viewpoint by means of a list of body functions and structures, and a list of domains of activity and participation. As an individual’s functioning and disability involves a context, the ICF includes a list of environmental factors and the concept of personal factors in its framework.

Finally, there is a need to enrich daily practice in primary care with more “policy evidence”, which entails efficiency and equity. The achievement of individual treatment benefits is in itself not the final argument for promotion of that treatment for all patients. In one of her last editorials “The hidden inequity in health care”, Barbara Starfield re-instates that organ systems based medicine is becoming dysfunctional, because most illness nowadays is multi-morbidity – cutting across diseases and types of diseases and organ systems. The information on health problems is collected as disease by disease. Doing so masks the greater needs of people in different population subgroups, because they are more vulnerable to and suffer more different types of illness and combinations of illness. Disease-oriented medicine, whether directed towards guidelines or through a focus on particular chronic diseases and their management, is thus highly inequitable as it cannot address the adequacy of interventions when people have many problems. Diseases are not unique entities; there are greater differences in resource needs within disease categories than across them. We need guidelines that are appropriate to person-focused care, not disease-focused care (De Maeseneer 2003).

Therefore, health systems should be assessed in relation to their capacity to deal with multi-morbidity in an equitable way (Swanson et al. 2009).

Conclusion
Approaching a patient with multi-morbidity challenges both practitioners and researchers. It challenges institutions for health professionals’ education to train providers that are not only “experts”, or excellent “professionals”, but that are also “change agents” (Frenk 2010) that continuously improve the health system and question the reality of knowledge and care. It requires fundamental reflection on the individual provider-patient interaction, on the need for a paradigm-shift from problem-oriented to goal-oriented care, on the organisation of the health care services and the features of the health system. Most fundamentally, it will also require dialogue and communication methodologies between the health sector and persons in need of health care and with other stakeholders within society involved in health care at the practice, research and policy level, in order to guarantee the essential characteristics of an effective health system: relevance, equity, quality, cost-effectiveness, sustainability, people-centeredness and innovation.

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References continued

What are you prepared to see?

ABSTRACT: A hospital system is made up of interconnecting circles of complex activity; however, we are conditioned to see and think in straight lines. What we see depends on what we are prepared to see. This article asks the question: What do you see in terms of patient safety and quality of care?

I posed myself a somewhat rhetorical question: in order to realize safe care and quality improvement, what will be more difficult: the challenge of scientific discovery or the challenge of changing human behavior and mindsets? That may seem like an odd question. Obviously, scientific progress is essential, but so is change. I believe that we, as health professionals, health system managers and administrators, need to take patient safety and quality improvement change as seriously as we do scientific discovery.

We need to “see quality as not just method, technique, discipline or skill, but as a human and organizational accomplishment, a social process” (Bate et al. 2008, p.13).

To achieve the promise of the future in the quality of health care, change will be required at several levels; changes in our personal behavior, changes in our hospital institutional cultures and changes at the level of our health care system and leadership to create the conditions for positive change.

At the personal level, I believe great leadership starts with deep personal self-reflection. Moments of self-reflection restore personal balance and make it possible for us to take the next risk. We have to create the conditions for change in ourselves before we can foster them to our colleagues. How we have evolved as leaders is important to understand, given “what a person becomes is influenced by the culture and milieu that person grew up in” (Kofman and Senge 1995, p. 29). I have had my fair share of teachable moments over the past 30 years of my health care work life. If I had to pick one, it would be letting go and trusting others to deliver. I, too, have experienced the political and organizational “urgencies” of leadership and the conflict between planning and the daily demands of the position. I, like many executives, managers, professionals and front-line staff developed careers in a silo-centered, bureaucratic model of health care delivery, driven by the provider’s control of health services, not the consumer’s perception of need. In command-control hierarchies behavior is honed to enable survival of the most political.

So, join me for a moment in a thought experiment. Imagine that you could step out of your day-to-day hospital role for a moment. Leave the lab, or the bed side, or the desk or the board table and come with me up a steep flight of stairs. At the top of the stairs, you will see that we have emerged onto a wide balcony. Below us is spread the entire health care system. From here we can see all its components. We can see the degree to which it is a system and the degree to which it is not. We can see the strengths and we can see the problems. We can see the interface with your hospital. We can see the providers, working in their manifold tasks and we can see the patients and their families. “System seeing and thinking is the corner stone of how learning systems move forward”. (Senge 1990, p.57)

On this balcony, we are joined by our muse, a challenging voice who lives on the periphery of our consciousness and in the comments of our colleagues. Sometime we cannot wait to hear from our muse. Sometimes we try to ignore our muse. Generally, to hear the muse, it is best to free ourselves of the day-to-day pressures, if only for a moment. Every conversation with a muse is different. Here is one sample:

Muse: You look terrible.
Self: Gee, thanks. I’m feeling overwhelmed and seem to be out of ideas. I thought coming up here and looking things over would help.
Muse: That’s good news. That you are out of ideas, I mean. That’s good soil for a new vision to take root.
Self: What are you talking about? We already have a vision for our hospital. We wrote it all down. I’ve got it here somewhere. Let me read it to you.
Muse: That’s good news. That you are out of ideas, I mean. That’s good soil for a new vision to take root.
Self: What are you talking about? We already have a vision for our hospital. We wrote it all down. I’ve got it here somewhere. Let me read it to you.
Muse: Oh, please, not again! That thing sounds like a badly written obituary, or so much of the same old, same old...it doesn’t capture the essence of what drives you.
Do we need a very public wake-up call on how erratic our behavior is? Can I really do this now? Can I develop the skills needed? Do we congratulate ourselves based on short term results? Do we fear the risk of losing control and have the need to be more functional when they are congruent with principles. I ask myself experiences. Our personal maps and values will be more functional when they are congruent with principles. I ask myself over and over again “What do I see?” “How much am I fooling myself?”

- Do we play it safe with easily attainable goals?
- Do we avoid action that may or may not succeed?
- Do we bury or spin bad news, avoiding internal and external transparency that could provide a compelling case for change?
- Do we fear the risk of losing control and have the need to be the recognized leader?
- Do we put on blinders about the preventable harm to patients, staff and families?
- Do we truly listen to the patients and are they engaged in our new directions?
- Do we congratulate ourselves based on short term results made at the expense of long term sustainability?
- Do we over focus on getting a bigger and bigger job and the need for ever increasing status?
- Do we ask ourselves these key questions? Can I really do this and should I have been better prepared for it? Is this my big test, moving past the talk, to delivering? Do I have the will to prove to myself and to others that I can measure up? What behavior have I tolerated in myself or others that can no longer be tolerated given my full commitment to patient safety and quality of care?
- Do we need a very public wake-up call on how erratic behavior by boards, senior managers and government policy makers cause poor performance at the operational level? Do dysfunctional hierarchies harm and kill people? (adapted from The Beautiful Lie by Gilbert and Balk 2010)

Like so many of you, I, too, have been engaged in confrontation, clashes of priorities, struggles for status quo and battles of beliefs. You know what I mean; those experiences that cause a combination of excitement and anxiety in our bellies.

My grandfather gave me a leadership gift when he said: “Remember to look through and around the obvious, you have two ears and one mouth, listen and time your talking. Never tell them what you can do, show them what you can do, and remember to be true to yourself”. The key lesson for me was – free up time to see opportunity for transformation and search for “leverage” points to create the fire of change.

My favorite leadership story and the one I read to my grandchildren is: The Little Engine That Could. It is about a journey, community involvement, overcoming roadblocks, crisis conquering, competition, ego and self indulgence, work jurisdiction and turf, old versus new technology, courage and the power within, and getting on with it. And what did I learn from this simple story about courage, attitude and risking self? Leadership is the result of saying at a deep level, “I think I can, I think I can” in an organization that sets the tracks up the hill and just at the right angle of challenge. Someone must take the first step so it is recommended that leaders need to go first and thus demonstrate a willingness to trust others (Kouzes and Posner 1995, p. 167).

Imagine the health care system to be a multi-story building. We have stairs, halls, ladders and balconies called networks, institutes, agencies, foundations, etc... In addition, we have independent stairs and ladders called the delivery system (hospitals, long-term care facilities etc...). Often, leaders have been far more concerned with the dramas taking place in the upper rooms of the building than the relationship flaws on the stairs and ladders. (Macleod 2011, pp. 61-66).

Instead of thinking and acting as isolated silos under siege, governance and managerial leaders can choose to see themselves through another lens; a lens in which you can see yourself and your Hospital in relationship to a local health service delivery system – your community partners in the delivery of care.

“Change requires more than the identification of the problem and call to action. It requires looking beyond the problem and finding the source of trouble. The real problem is frequently located where we would least expect to find it – inside ourselves.” (Quinn 1996, p. 55)

Based on moments of personal reflection, as leaders, we can undertake our key responsibility, which is to create the systemic conditions within the health care system that provide solutions to today’s challenges. Another important learning for me has been how to frame the question, the timing of its asking, in an appreciative inquiry (Cooperrider et al. 2008) manner that creates a commitment to a cause, to a challenge and to the other person.

Examples include:
- What do you want to create and contribute to the health care system as an individual, a team and a hospital?
- What will it look like, its vision for achievement?
- What will it take from you to do it?
- How is what you are doing right now helping you get there?
What is hampering you in achieving this now?
What are you afraid of losing?
What might you gain by doing something differently?

What I know for a certainty is that health care people are capable of brilliance. I know that the answers to the questions we need to ask are within the hearts and minds of the people in the health care system. The answers to the dilemmas that you face are within your own organization – from your front-line health care providers, from your managers and from your boards. Accurate and transparent information must be the air that we breathe. The more open the flow, the more easily we learn to translate the information to meaningful awareness and knowledge. To return to our analogy of a multi-storey building, we need to ensure that all levels are properly aligned, with sturdy staircases and ladders placed exactly where they are needed.

My professional experience provides me with three points of observation:
- Context is everything – organizational history, sense of urgency, readiness for change, culture and degree of leadership commitment.
- Denial is our greatest treat – silence, unawareness, indifference and complacency are the greatest enemies of improvement.
- It is all about relationships – what goes on between people defines a health care system.

In closing, our reality is made up of interconnecting circles of complex activity; however, we are conditioned to see and think in straight lines. What we see depends on what we are prepared to see.

Acknowledgments
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1. Evolution du système hospitalier chinois
Résumé: Le système de santé chinois s’est rapidement amélioré, notamment dans les secteurs des assurances-maladie et d’une évolution vers une couverture universelle. Toutefois, les réformes des hôpitaux publics sont beaucoup plus lentes, et se heurtent à des obstacles majeurs. L’objectif de cet article est de décrire les défis actuellement rencontrés en matière de réforme des hôpitaux publics en Chine par le biais de l’évolution du système hospitalier. Les auteurs tentent également des leçons générales qui sont applicables à d’autres pays.

2. Qu’avons-nous appris de catastrophes majeures comme le séisme, le tsunami et l’accident nucléaire ?
Résumé: Dix mois se sont écoulés depuis que le terrible tremblement de terre du Japon oriental a frappé le pays le 11 mars 2011. Bien que depuis dix mois, nous faisons tout notre possible pour venir en aide aux régions touchées, les personnes et les hôpitaux de ces régions souffrent encore de diverses calamités dûes au séisme, tsunami, accident nucléaire, secousses dangereuses et désastres imputables à l’homme. Cet article décrit les divers travaux de soutien menés par l’Association hospitalière japonaise (JHA) à court, moyen et long terme. D’après notre expérience, nous proposons un nouveau système de soutien médical et plan de reconstruction pour assurer les soins de santé dans les zones affectées.

3. Politique publique et tourisme médical : Implications éthiques du système de santé égyptien
Résumé: L’industrie égyptienne du tourisme médical connaît un essor remarquable. Toutefois, l’Égypte continue à manquer des investissements nécessaires en matière de santé publique pour pouvoir soigner efficacement sa population. La politique actuelle et l’émergence du tourisme médical ont entraîné l’irréabilité d’accès aux soins de santé qui a abouti à une forte incidence de maladies infectieuses et à un manque de ressources pour les populations les plus vulnérables. Avec l’avènement d’un nouveau gouvernement égyptien, il importe que les décideurs comprennent les questions vitales et les préoccupations éthiques de la politique publique actuelle et proposent une politique nouvelle avec un partage des ressources plus équitable pour une prise en charge efficace de sa population.

4. Entrepreneurs de systèmes de santé privés dans la République démocratique du Congo: Profils et Sources des fonds de démarrage
Résumé: Une enquête a été menée en juillet 2010 pour étudier la création d’entreprises de santé privées à Mbuji Mayi, la capitale de la province orientale de Kasai (EKP) en République Démocratique du Congo (RDC). Cette enquête a obtenu 68 réponses. Les résultats montraient que les entrepreneurs étaient surtout des Congolais qui avaient une formation en matière de services de santé, qui avaient essentiellement réuni les fonds de démarrage sur leurs économies privées ou celles de parents ou amis. Leurs entreprises, qui pour la plupart n’appartenaient qu’à un seul propriétaire, étaient le plus souvent situées dans des régions mal desservies par les services médicaux publics.

5. Futur hôpital pédiatrique Nelson Mandela de Johannesburg: Amélioration de la médecine pédiatrique dans les pays en développement

6. Évaluation de la gestion organisationnelle dans les dispensaires de district de Ulaanbaatar
Résumé: Cette étude croisée a évalué la gestion organisationnelle des hôpitaux de district du point de vue planification et suivi opérationnel, programme et directives, organisation et travaux quotidiens, personnel, installations et équipement médical, orientation et contrôle des processus. Quatre employés de dispensaires de district ont participé (n208). L’évaluation a été effectuée sur échelle de type Likert allant de 1 (très mauvais) à 5 (excellent). Le score total moyen attribué à la gestion organisationnelle était de 3.09±0.91. Il existait une différence statistiquement significative dans l’évaluation de la planification opérationnelle et le suivi (p<0.044) et le contrôle (p<0.014) selon différentes professions. En conclusion, les résultats confirment notre hypothèse selon laquelle on manque de capacité de gestion dans le secteur à Ulaanbaatar.

7. L’amélioration de l’efficacité et de la sécurité des hôpitaux commence dès la phase de planification et se répercute sur la sécurité des patients, le personnel, et l’hygiène, ainsi que sur la logistique et l’efficacité de tout l’hôpital
Résumé: Cet article explique comment améliorer la sécurité des patients et l’efficacité de l’hôpital par une nouvelle méthodologie de planification progressive prévoyant un examen précoce par des pairs de la future conception ainsi que des concepts novateurs de formation pour le personnel hospitalier.
8. Soins concernant les maladies non transmissibles (MNT): Il est temps de revoir le paradigme
Résumé : Les maladies non transmissibles (MNT) sont en hausse et la multimorbidité est de plus en plus souvent la règle et non l’exception. Pour ces patients, les programmes de prise en charge de la maladie parviennent mal à réaliser un ensemble de soins complets. Il faudrait donc passer du concept « cibler le problème » au concept « cibler l’objectif », et orienter les soins dans le sens des objectifs formulés par le patient. Ainsi, nous évitons que la qualité des soins entraîne “l’inégalité devant la maladie.”

9. Que voulez-vous voir ?
Résumé : Un système hospitalier se compose de cercles interconnectés d’une activité complexe ; cependant, nous sommes conditionnés pour voir et penser en lignes droites. Ce que nous voyons dépend de ce que nous voulons voir. Cet article pose la question…. Que voulez-vous voir en termes de sécurité des patients et qualité des soins ?
3. Política pública y Turismo médico: las consecuencias éticas para el Sistema de Salud de Egipto

Resumen: en Egipto, la industria del turismo médico ha experimentado un aumento muy notable y sin embargo, el gobierno sigue sin asignar a su sistema de salud pública los fondos necesarios para poder prestar una asistencia adecuada a su población. La política actual y la aparición del turismo médico han dado lugar a una desigualdad del acceso a los cuidados de salud, lo que se ha traducido en una prevalencia muy elevada de enfermedades contagiosas, además de una falta de recursos para sus habitantes en situación más precaria. Con la llegada de un nuevo gobierno, es de suma importancia que los responsables de formular la política reconozcan los problemas más cruciales y los asuntos éticos de la política pública actual y propongan nuevas políticas encaminadas a asignar fondos de manera más equitativa para atender a sus habitantes de una manera adecuada.

4. Creadores de empresas privadas de seguros de enfermedad en la República Popular del Congo: Perfil y fuente de ingresos para los costes para la puesta en marcha

Resumen: en julio de 2010 se llevó a cabo un estudio encaminado a examinar la creación de empresas privadas de seguros de enfermedad en Mbuji Mayi, la capital de la provincia del este de Kasai, República Popular del Congo. El estudio produjo 68 respuestas. Según los resultados, los empresarios son en su mayor parte congoleños con antecedentes en la esfera del servicio de salud, que obtuvieron el crédito inicial principalmente gracias a los ahorros personales o a préstamos procedentes de familiares o amigos. Las empresas que en su mayoría son propiedad única, suelen estar ubicadas en zonas desatendidas por instalaciones de salud pública.

5. El proyecto del Hospital Infantil Nelson Mandela, Johannesburgo: la mejor atención sanitaria para los niños de los países en desarrollo

Resumen: En breve comenzará la construcción en Johannesburgo, Sudáfrica, del Hospital Infantil Nelson Mandela. El hospital constará de 250-300 camas y dispensará cuidados infantiles terciarios y cuaternarios en centros de excelencia específicos. La admisión a este sistema por remisión estará completamente basada en las necesidades médicas y entre las esferas que abarcará caben citar, la cirugía pediátrica, la oncología, la nefrología, la cardiología, los cuidados intensivos y el procedimiento por imágenes. El Hospital Infantil Nelson Mandela será el primer “Hospital privado sin fines lucrativos” de Sudáfrica. Un fideicomiso está movilizando fondos para la financiación de los gastos de capital, mientras que los gastos de funcionamiento serán financiados por el Ministerio de Salud, las aseguradoras del sector privado y los gobiernos de los países vecinos.

6. Evaluación de la gestión orgánica de los centros de salud locales de Ulaanbaatar

Resumen: este estudio transversal realizó una evaluación de la gestión orgánica de los hospitales locales en función de la planificación operativa y el seguimiento, los programas y las pautas, los procedimientos de organización y trabajo, el personal, las instalaciones y el equipamiento médico, la orientación y el control de procesos. En el estudio participaron los empleados (n=209) de cuatro centros de salud locales. Para la evaluación se utilizó la escala tipo Likert, que oscila entre el 1 (deficiente) y el 5 (excelente). La puntuación media obtenida para la gestión orgánica fue de 3.09+0.91. Desde el punto de vista estadístico, se observó una diferencia muy notable en la evaluación de la planificación operativa y el seguimiento (p<0.044) y el control (p<0.014) entre los distintos cargos laborales. Para concluir, los
7. La mejora de la eficacia y seguridad en los hospitales empieza en los comienzos de la fase de planificación y se refleja en la seguridad de los pacientes, el personal, la higiene, la logística y en la eficiencia general de todo el hospital.

Resumen: este artículo describe un método de planificación escalonado, con inclusión de una evaluación por parte de un grupo de compañeros, con el fin de mejorar la seguridad del paciente y la eficiencia de los hospitales. El artículo comprende además una serie de métodos de capacitación sumamente innovadores para el personal hospitalario.

8. El cuidado de las enfermedades no contagiosas (en inglés NCDs): ya es hora de un cambio de paradigma

Resumen: las enfermedades no contagiosas van en aumento y la multimorbosidad es cada día más la norma y menos la excepción. Para estos pacientes, los programas de control de la enfermedad tienen la dificultad de que la atención integral no se hace realidad. De ahí que sea necesario llevar a cabo un cambio de paradigma y pasar del concepto “orientado hacia el problema” a la idea “orientado hacia un objetivo”, dirigiendo la atención hacia los objetivos formulados por el paciente. De esta manera evitaremos que la atención se convierta en una “injusticia por la enfermedad”.

9. ¿Qué estamos dispuestos a ver?

Resumen: el sistema hospitalario consiste en una serie de círculos entrelazados de actividades muy complejas y sin embargo, estamos condicionados para mirar y pensar en línea recta. Lo que vemos depende en gran manera de lo que estamos dispuestos a ver. Este artículo formula la pregunta siguiente: ¿qué es lo que vemos con respecto a la seguridad del paciente y la calidad de los cuidados?
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owns the Capital’s six leading private hospitals all based in central London and each with an international reputation for the highest standards of care. They are: The Wellington – the largest private hospital in Europe, The London Bridge Hospital, The Harley Street Clinic, The Portland Hospital for Women and Children, The Lister Hospital and The Princess Grace Hospital. HCA also has four outpatient and diagnostic centres – soon to be six – a blood and bone cancer treatment joint venture with the NHS at University College Hospital, The London Gamma Knife Centre, another joint venture with the NHS at St Bartholomew’s Hospital and Harley Street at Queen’s, a private patient cancer centre at the NHS Queen’s Hospital in Romford.

The six HCA hospitals treat around 300,000 patients per year. They also specialise in the most complex medical procedures including cardiac care, liver transplantation, inter cranial surgery and complex cancer care. The HCA CancerCare network, for example, is the largest provider of cancer care in the UK outside the NHS. Uniquely, HCA has its own clinical trials unit based in Harley Street in central London. Medical teams in HCA are involved in research programmes aimed at finding new treatments in areas such as heart disease and cancer. In recent years HCA has invested around £250 million in capital expenditure including new diagnostic and treatment technology. As an example, HCA has recently installed at The Harley Street Clinic, the revolutionary CyberKnife robotic radiotherapy machine, which is able to target previously untreatable tumours. It is the first machine of its kind in the UK.

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uses its 125 years of experience to help healthcare organizations create comfortable, safe and sustainable healing environments while providing measurable results. By utilizing our expertise in energy and sustainability, facilities, building and technology infrastructure, healthcare organizations can improve their financial results, the environment of care and their standing in the community. Johnson Controls provides design assist and construction management, funding solutions, network integration solutions for clinical and non-clinical systems, energy management and central utility plants, operations support and best practices, systems maintenance and facility management services. Johnson Controls helps healthcare organizations create comfortable, safe and sustainable healing environments while providing measurable results.

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a business of Ingersoll Rand – the world leader in creating and sustaining safe, comfortable and energy efficient environments – creates ideal environments of care for healthcare organizations all over the globe. Our products, services and solutions optimize the link between the physical environment to patient outcomes, staff satisfaction/productivity and the bottom line.

Trane/Ingersoll Rand solutions optimize healing environments with a broad portfolio of energy efficient heating, ventilating and air conditioning systems, building and contracting services, parts support and advanced controls for healthcare buildings. Our market-leading products also include electronic and biometric access control systems, time and attendance and personnel scheduling systems, mechanical locks and portable security, door closers and exit devices, steel doors and frames, architectural hardware and technologies and services for global healthcare markets.

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MEDTRONIC is the global leader in medical technology alleviating pain, restoring health, and extending life for people with chronic conditions around the world. Medtronic develops and manufactures a wide range of products and therapies with emphasis on providing a complete continuum of care to diagnose, prevent and monitor chronic conditions. Each year, Medtronic therapies help more than seven million people.

Founded: April 29, 1949 in Minneapolis, Minnesota, USA, by Earl E. Bakken and Palmer J. Hermundslie.

Financial: Revenue for the year ended April 24, 2009: $14.6 billion. New York Stock Exchange ticker: MDT.

For further information please visit www.medtronic.com
ROYAL PHILIPS ELECTRONICS OF THE NETHERLANDS (NYSE: PHG, AEX: PHI) is a diversified health and well-being company, focused on improving people’s lives through timely innovations. As a world leader in healthcare, lifestyle and lighting, Philips integrates technologies and design into people-centric solutions, based on fundamental customer insights and the brand promise of “sense and simplicity.” Headquartered in The Netherlands, Philips employs 119,000 employees in more than 60 countries worldwide. With sales of EUR 25.4 billion in 2010, the company is a market leader in cardiac care, acute care and home healthcare, energy efficient lighting solutions and new lighting applications, as well as lifestyle products for personal well-being and pleasure with strong leadership positions in flat TV, male shaving and grooming, portable entertainment and oral healthcare. News from Philips is located at www.philips.com/newscenter.

GE Healthcare’s Performance Solutions business partners with hospitals and health systems across the globe to help improve their overall performance. The business provides knowledge solutions to reduce unnecessary waste - which comes in three forms (1) underutilization of resources (2) unintended clinical variation (3) and fragmented care delivery - and create safer more efficient patient care. Performance Solutions leverages GE’s operational improvement tools and advisory capabilities with GE Healthcare’s clinical and technological capabilities, providing a unique combination of advisory, technology and healthcare expertise. The business splits its global headquarters between Barrington, United States and Buc, France. Visit www.gehealthcare.com to learn more.

Signium International truly is a global executive search firm. With more than 40 offices spread across nearly 30 countries, Signium International’s network of search consultants offers local healthcare market knowledge with a global reach. Our consultants cover the globe like no other firm. When you choose Signium International to search for your next CEO, CFO, or any other senior management member, you’ll find we are able to recruit from all over the world, while being mindful of the specific needs of your organization, community and patients. Our consultants actively engage and advise throughout the entire search process – we’re there from the initial site visit all the way through the first months of the winning candidate accepting the position. Signium International is effective in finding the right executive quickly and efficiently because we collaborate easily with our colleagues around the world. Having local knowledge of the healthcare market, culture and business practices of your country can’t be substituted with having solely a large team of consultants in the United States. With offices throughout the Americas, Europe, Middle East, Africa, and Asia Pacific, we are confident we can best serve your needs. With more than six decades of experience, Signium International’s consultants have an in-depth understanding of the various facets of the healthcare industry: integrated healthcare systems and hospital systems; hospitals (independent, community, academic, government, nonprofit, for-profit, start-up, etc.); physician practice groups; medical schools; medical associations; boards; and more. For more information, please contact: Email: ltyler@signium.com
VEOLIA ENERGY NORTH AMERICA is a leading U.S. developer and operator of sustainable energy systems. Veolia Energy provides sustainable energy services, and facility operations and management to nearly 5,550 healthcare institutions in 42 countries around the world, representing almost 500,000 beds.

Veolia Energy delivers solutions that enhance the economic, technical and environmental performance of complex systems and equipment within a hospital: energy supply, including on-site power generation for critical areas such as operating rooms, neonatology, and research and testing laboratories; steam for use in heating, sterilization, and service water heating; mechanical refrigeration facilities for food service and morgues; and more basic services such as HVAC, heating and cooling systems. Partnering with Veolia Energy permits hospitals to transfer their operating risks to a firm that specializes in preventive and predictive maintenance, energy optimization, and carbon footprint reduction.

Veolia Energy North America is part of the Veolia Environnement companies in North America, employing more than 28,000 North American personnel. Veolia Environnement (NYSE: VE and Paris Euronext: VIE), is the global standard for environmental services. With approximately 313,000 employees in 74 countries who deliver sustainable environmental solutions in water management, waste services, energy management, and passenger transportation, Veolia Environnement recorded annual revenues of nearly $50 billion in 2009. Veolia Environnement is in the Dow Jones Sustainability World Index (DJSI World) and Dow Jones STOXX Sustainability Index (DJSI STOXX). Visit the company’s Web sites at www.veoliaenergyna.com and www.veolianorthamerica.com.
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## IHF Events calendar

### 2012

#### IHF

- **IHF Hospital and Healthcare Association Leadership Summit**  
  June 5-6, 2012 – Sun City, South Africa  
  (By invitation only)  
  For more information, contact sheila.anazonwu@ihf-fih.org/ModisK@health.gov.za

#### MEMBERS

- **Canada**
  - **National Health Leadership Conference**  
    June 4-5, 2012 – Halifax, Nova Scotia  
    For more information: [http://www.nhlc-cnls.ca/default1.asp](http://www.nhlc-cnls.ca/default1.asp)

- **France**
  - **Hôpital Expo**  
    May 22-25, 2012 – Porte de Versailles, Paris  
    For more information: [http://www.hopitalexpo.com](http://www.hopitalexpo.com)

- **USA**
  - **Healthcare Supply Chain Association: 2012 National Pharmacy Forum**  
    February 8-10, 2012 – Hyatt Regency Tampa, Tampa, Florida  

  - **American College of Healthcare Executives: Congress on Healthcare Leadership**  
    For more information: [http://ache.org/Congress](http://ache.org/Congress)

  - **American Nurses Credentialing Center: ANCC Pathway to Excellence Conference**  
    May 2-4, 2012 – Washington, DC, USA  

  - **American Nurses Credentialing Center: ANCC National Magnet Conference**  
    October 10-12, 2012 – Los Angeles Convention Center, California, USA  
    For more information: [http://www.anccmagnetconference.org/](http://www.anccmagnetconference.org/)

  - **Healthcare Supply Chain Association: 2012 International Expo**  
    October 22-24, 2012 – JW Marriott Grande Lakes, Orlando, Florida  
    For more information: [http://www.supplychainassociation.org/events/event_details.asp?id=167432](http://www.supplychainassociation.org/events/event_details.asp?id=167432)

  - **American Hospital Association’s Annual Meeting**  
    May 6-9, 2012 – Hilton Washington, Washington, DC  
    For more information: [http://www.aha.org/advocacy-issues/annual-meeting/12-schedule.shtml](http://www.aha.org/advocacy-issues/annual-meeting/12-schedule.shtml)

#### Germany

- **European Hospital and Healthcare Federation (HOPE)**  
  Aging health workforce – aging patients: Multiple challenges for hospitals in Europe  
  June 12-23, 2012 – Berlin, Germany  
  For more information: [http://www.hospage.eu](http://www.hospage.eu)
COLLABORATIVE

Geneva Health Forum – 2012 Edition
18-20 April 2012 – Geneva, Switzerland
A critical shift to chronic conditions: Learning from the front liners

Hospital Management Asia 2012
September 13-14, 2012 – Hanoi, Vietnam (to be confirmed)
For more information:  http://hospitalmanagementasia.com

2013

IHF

38th World Hospital Congress*
June 18-20, 2013 – Oslo, Norway
Theme: Future health care: The Opportunities of new technology
Email: Sheila@ihf-fih.org / kine.martinez@nsh.no
Website: http://oslo2013.no

MEMBERS

USA

American College of Healthcare Executives: Congress on Healthcare Leadership
For more information:  http://ache.org/Congress

American Hospital Association’s Annual Meeting
April 28 - May 1, 2013 – Hilton Washington, Washington, DC
For more information: www.aha.org

Events marked * will be in English/host country language only. IHF members will automatically receive brochures and registration forms on all the above events and will be entitled to a discount on IHF Congresses, and Leadership Summits.
For further details contact the: IHF Partnerships and Project, International Hospital Federation,c/o Hôpital de Loëx, 151 Route de Loëx, 1233 Bernex, Switzerland; E-Mail: sheila.anazonwu@ihf-fih.org Or visit the IHF website: http://www.ihf-fih.org

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