

EHMA ANNUAL CONFERENCE 2010



managing radical change in health

quality, efficiency, equity

30 JUNE - 2 JULY 2010, Sibelius Hall, Lahti, Finland



ABSTRACT BOOK

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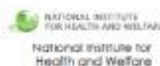


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**Special interest group:
Workshop on health workforce management**

**Wednesday 30 June 2010,
13.30-15.30**

CROSS-NATIONAL COMPARISON OF HUMAN RESOURCES FOR HEALTH IN THE NETHERLANDS AND PORTUGAL

Workshop on health workforce management

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CONTEXT

Manpower is critical for health care systems. It is, however, one of the least strategically planned resources, resulting in mismatches on the health care labour market. There are several approaches available for health manpower planning. Yet little is known about which (if any) is applied by EU countries, and what their success is. Identifying, describing and comparing these approaches provides insights into: (1) how health manpower planning is actually applied; (2) how it can be used by health care systems to improve labour market efficiency; and (3) how new challenges, such as global migration of health workers can be addressed.

METHODS

The objective of this paper is to compare two different European countries, the Netherlands and Portugal. To investigate their health manpower planning, we describe: (1) the health workforce characteristics and trends of both countries, (2) their health manpower planning approaches, and (3) the specific variables that can be explanatory for the differences between the two countries. In our country comparative analysis, we focus on differences in organisation and funding of the health care system in relation to the actual health manpower planning approach. We retrieved data from international registries and national health authorities websites, and interviewed key informants in both countries. Based on these sources, the tradition and approach to health manpower planning is described, as well as the specific manpower planning method. To explain the differences between manpower planning in the Netherlands and Portugal, seven types of determinants were assessed: political, organisational, economic, social, cultural, technical and educational.

RESULTS

The Portuguese Government created a task force in 1998 to prepare a health manpower planning study, among other attributions. That study was published in 2001 and discussed the supply of physicians, nurses and allied health personnel, and made projections for 2021. EU averages were used as a benchmark for future health manpower development. The task force had its mandate extended in 2003, but manpower planning was removed from its responsibilities. In the Netherlands, a 'Capacity Body' was created in 1999 to annually monitor the demand and supply of health care manpower and project the required numbers of doctors and nurses to be trained for the next 10 to 15 years. This model captures parameters for manpower supply and demand, aiming at an equilibrium of the Dutch labour market. While the Netherlands engage in

more detailed health manpower planning than Portugal, both countries equally struggle in achieving optimal human resources planning for health.

ANALYSIS

This study has provided insight into manpower planning approaches in two European countries. The comparison shows that the relationship between manpower planning and labour market stability is a complex one. In a sense, the Netherlands tend to extensively plan their health care workforce, whereas Portugal tends to apply a more reactive approach. For both countries, planning will remain an important tool to cope with changes in size, composition and behaviour of the workforce. Specifically, the challenge is to improve productivity to respond to the increasing health care demand and need for cost-containment. We will expand the study at the EU level. This will allow us to elaborate a chart of health manpower planning approaches adopted by each EU country, and factors that explain cross-national variation. It will provide a knowledge base of international experience that can be used at country level to improve national health manpower planning approach.

FIT TO LEAD: THE EXPERIENCE OF THE ITALIAN ASSOCIATION OF MEDICAL MANAGERS

Workshop on health workforce management

Agnese Lazzari, Anton Giulio de Belvis, Walter Ricciardi
Italian Association of Medical Managers, Rome, Italy

CONTEXT

It is well recognised that clinical leadership and management represent essential requirements for effective health care, enabling organisations to reach their goals within financial constraints. Doctors equipped with management skills have been shown to facilitate changes and improvements, acting as facilitators and leaders. Despite the growing involvement of clinicians in medical management all over developed countries, the Italian National Health Service (INHS) is still lacking an effective medical management culture. A blame culture and defensive medicine, absence of performance evaluation, proper penalties/rewards, limited training and CPD on management and much more, have brought the INHS near collapse.

METHODS

In November 2006, 40 inspired clinicians, representing the different regional needs, set up the Italian Association of Medical Managers (SIMM). The "know-do" gap between legislative initiatives, launched since the early '90s (L.D. 502/92 and updated editions, L.D. 229/99, etc.), the content of educational curricula and the effective development of successful and motivated medical managers, needed to be filled. After a long path of training, doctors come to apical roles late in life (see the profile of Italian apical professionals highlighted in SIMM's research on over 300 doctors), often without appropriate skills and tools to deeply understand the current change and be capable of managing its impact. SIMM mission to promote managerial culture and medical leadership in Italy has been endorsed by the British Association of Medical Management (over 1,200 members) with almost 20 years of experience. Hence, the Italian Association has started to spread the word through a series of formative and development initiatives.

RESULTS

SIMM is supporting the coming changes delivering all over the country residential training programmes, tailored to the needs of clinicians in or moving towards managerial roles. A set of quality standards have been edited and collected in a self-assessment and reflective tool and action learning techniques have been used for the first time in health care, urging the effective integration of management and clinical skills. Daily workshops on specific items have been organised in cooperation with relevant partners (i.e. National Air Force) to better meet regional needs and promote best practice emulation. SIMM visibility in the policy-making process has been significantly increasing by a daily basis, especially thanks to the Annual Conference organised by a Scientific Board of Italian and British relevant professionals. In only a year the event has become a reference point for Italian and foreign professionals and stakeholders wishing to benefit from health care policy transfers.

ANALYSIS

Although Italian doctors are ranked among the best professionals worldwide, effective managerial and leadership cultures are hard to develop even though progress has gradually been made. SIMM strives to ensure leaders develop the right understanding of leadership, promoting a change in management culture through opportunities expanding their knowledge and the skills they possess. Successful results were recorded up to now (counting over 300 members in 2009), considering that curricula requirements for membership have been hardly selective over the last 3 years in order to guarantee the real interest into medical management. From 2010 onwards, core members will be challenged to spread the word to a wider number of professionals, including known critics at the issue. This goal will be facilitated by cooperation with senior scientific associations (see SIGO, SIC, FADOI etc.) that have recognised SIMM's action as cross-sectional to all medical specialties.

VALUE CREATION THROUGH COHESIVE STRATEGIC NETWORKS: A CASE STUDY IN THE FINNISH UNION OF PRACTICAL NURSES

Workshop on health workforce management

Pirjo Lukkari

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CONTEXT

The interplay between institutions and business networks as well as how related strategising in networks emerge has been studied to some extent. However, the impacts of institutional entrepreneurship activities on value creation in strategic networks seem to have received surprisingly little attention by health care scholars. In this explorative study a labour union, the Finnish Union of Practical Nurses, is modelled as a strategic business network. The focus is on how the Union creates value for its members through institutional influence on the labour market.

METHODS

A case study: the focus is on how the union negotiated the employment and collective labour agreement for its members and looked after its members' benefits locally during 2006 and 2009.

RESULTS

The preliminary findings indicate that the union as a cohesive strategic network creates value for its members and acts as an institutional entrepreneur at two levels: the national and the local. The existence of the network is motivated by the pursuit of benefits and strategic goals. The union office acts as a key player that typically takes initiative in institutional influencing and entrepreneurial activities at the national level. Still, the success of influencing and value creation for the members is based on the Union's strategic cohesiveness, which is built up through the local branches. Members have a mutual understanding and acceptance of the game plan for negotiating the collective labour agreement (acceptable level of future benefits and willingness to go on strike for them).

ANALYSIS

In the labour market, the role of an individual actor (the Union office as a hub) and the organisational activity at level of the local branches is highlighted through actor positions, connectivity and strategic cohesiveness of the network.

**Parallel session:
Changing facets of health management**

**Thursday 1 July 2010,
11.00-12.30**

OVERCOMING BARRIERS IN MANAGEMENT TRAINING IN A DEVELOPING COUNTRY: THE ALBANIA HEALTH CARE MODERNISATION PROJECT

Changing facets of health management

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CONTEXT

The Albania Health Care Modernisation Project is a two-year project to enhance the management skills of hospital managers in Albania and funded by the World Bank and Albanian Ministry of Health. The training programme is designed to increase the Albanian health system's capacity in health care financing, operations and management, with a particular focus on improving the coordination between inpatient and ambulatory care. The programme will provide the foundation for more advanced training of managers as they progress in their careers. The programme will train 150 managers drawn from hospitals and ancillary organisations throughout the country.

METHODS

The training programme is predicated on a novel teacher-practitioner model for training health care leaders that has been developed and refined over 30 years at Rush University. The training programme included four principal components: conducting a thorough situation analysis to assess the strengths and opportunities for improving the quality and efficiency of the local system; developing the core curriculum to address the gaps in knowledge in partnership with key local experts; implementing the curriculum using a "train-the-trainer" approach, where experts spent intensive time on-site at Rush University to observe and experience health care management in an academic medical centre dedicated the highest quality patient care within a mature market economy; developing a continuous education framework for Albanian health professionals to ensure a continued investment in management training; and mentoring and technically assisting the local trainers and hospital managers who are implementing improved management approaches across Albania.

RESULTS

An intensive three-week training curriculum was developed to address managing people, managing operations and managing finances in a market economy. The training programme culminates in an applied capstone group project, where trainees apply their knowledge to an operational project within their own health care institution. Experts within the Albanian health care system deliver the curriculum and serve as primary mentors for capstone projects, with monitoring and oversight by the Rush University training team. Several challenges have been encountered and have required immediate attention to ensure the quality and integrity of the training programme. During the training programme, presidential elections occurred, requiring a delay in the training schedule to ensure maximal trainee attendance and engagement in the training curriculum. Recruitment of appropriate trainees required greater interaction with health care organisations than was originally

anticipated. In addition, substantial time has been spent in identifying established local institutions to carry on the programme.

ANALYSIS

Successful implementation of a health care management training curriculum in a developing country such as Albania requires a critical assessment and evaluation of the challenges facing local hospitals and clinicians. The training curriculum must carefully balance theory with practice and the current needs of the health care system with potential changes to the system that may move organisations towards a more market-based system. Our inclusion of an applied capstone project that trainees develop over several months in their own organisation created a mechanism to more comprehensively address trainees' ability to apply concepts to real life.

THE “CLINICIANS INTO MANAGEMENT DILEMMA”: MANAGEMENT OF HEALTH CARE BY PERSONS WITH CLINICAL BACKGROUND - BASIC NECESSITY OR WASTE OF RESOURCES?

Changing facets of health management

Anton Petter, Hetty Saes, Siegfried Walch
Management Center Innsbruck, Innsbruck, Austria

CONTEXT

The management of hospitals and other health care institutions is an increasingly difficult task. Not only administrative, financial and technical skills are needed to do the job, but also different managerial capabilities such as leadership, political networking, negotiating- and representation skills, among others, are inevitable. For many years a subject of much debate was the amount of clinical experience health managers should have. Some countries, such as Romania require compulsory clinical background for candidates of top management positions in health care whereas in the tradition of others, such as Germany and Austria, clinicians in higher management remain an exception.

METHODS

We organised a written online panel discussion on the issue where 20 senior experts with different professional backgrounds in health care from 12 different countries elaborated on the following questions: “Under which conditions can medical doctors be able to assume management positions? What kind of conflict of interests could such a professional situation create?”

In addition a workshop of the Transitional Countries Network was held in Bucharest/ Romania in November 2009, where health care representatives from 6 different Eastern European Countries were discussing different aspects of the “Clinicians into Management-Dilemma”.

RESULTS

Based on these inputs and based on the literature previously published, we developed a framework aggregating all information available to guide decision makers and applicants through the main aspects of the issue. This should decrease misconceptions, wrong expectations and frustrations related to the management job fulfilled by a former clinician. Conflicting opinions during routine work, related to different professional backgrounds can be better anticipated, when well established problems are uncovered in advance.

The framework takes into account the following aspects: (1) The tradition of the health care system and the way how it is organised. (2) Skills needed to perform the management role. (3) Opportunities and risks for both the institution and the individual with clinical background. (4) Possible role conflicts. (5) Established career pathways and other obstacles for accepting the management role by different stakeholders (for example: bad image of managers in health professional’s special interest groups).

ANALYSIS

Opinions concerning the necessity of clinical experience for top management positions in health

care remain controversial. Consensus could be reached among health managers and other experts on the following: Managing health care is different from managing other business (“health care is not a chocolate factory” as one panel member put it) and, certain skills are needed (and need to be trained) for proper management performance. Professional clinical background is probably not that important, but might be an asset. The framework as a tool of decision support will be presented and discussed. It can be used to establish training subjects and to adapt training curricula for health management according to needs in different settings.

APPROACHES ON CHANGING THE CLINICAL TEAM'S CULTURE TOWARDS QUALITY IMPROVEMENT: CONSTRAINTS AND POTENTIALS IN PRACTICE

Changing facets of health management

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CONTEXT

This work is based on the assumption that in order to enhance the quality of services provided the management system must focus on the front line services and deal with clinical work and the clinical staff. Any changing intervention on this field is highly depended on team work, as it is the core part of services and it is characterised by relevant technical expertise. The team culture and its adaptation to quality goals is a key aspect that can strongly support the process' effectiveness and stability. This is a challenging field that this work aims to focus on.

METHODS

The methodology to explore this field has two axes:

The first is a study of different approaches of team level changes, focusing on the culture aspect and its interaction with individuals and transactional factors. The Burke - Litwin causal model is one approach that can illustrate the dynamics of team work as well as the team's environmental factors, which contribute strongly to the team's orientation. Soft Systems Methodology is an approach that can be used to steer the culture, up to a degree, towards the organisation's goals. Lean management and Lean leadership is an approach that can link the team production directly to the culture towards continuous improvement.

The second is a study of clinical teams in three different public Athenian hospitals based on these three approaches, in order to understand the benefits of the methods' use and the real potential of culture change on the practical level.

RESULTS

The main results of the study, including the interpretation of three methodologies - selected based on certain criteria – and three clinical teams of three hospitals, are related to two main dimensions:

- The first result on the comparison between methods is that all methods have certain and important strengths -able to support the change of the culture in a clinical team- but they also face limitations that must be taken into account in order to base a changing intervention on them.
- The second result – on the projection of the methods to the practical side- is that their effectiveness in changing the culture faces constraints, which have the possibility to be overcome by the supplementary use of them.

ANALYSIS

This study can be seen as a challenge to explore the nature of culture change of a clinical team, rather than a comparison between the methods, since the purpose is not to choose one of them,

but to learn more and enhance our managerial capability. The practical study in the hospitals can prove the robustness of the methods on team culture interpretation. A first advantage gain is a deeper understanding of how teams really work. Especially in hospitals the team's technical expertise affects the culture and the quality of service, but other factors, which should also be noted and may be addressed.

One very important lesson is that methodologies can be combined, in both interpretation and intervention phases, in order to lead to better quality and more "holistic" results for the patient. Of course, this supplementary use can take place based on basic rules, in order to reach quality improvements through stable results in culture enhancement.

EVALUATING, ENHANCING AND LEADING THE PROFESSIONAL DEVELOPMENT OF SPECIALIST DOCTORS IN A SPECIALISED ORTHOPAEDIC HOSPITAL.

Changing facets of health management

Teemu Moilanen

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CONTEXT

Specialist doctors are key actors of advanced health care. After formal specialisation most specialists work very independently. Their clinical decision making is influenced by a combination of factors including the evidence based recommendations in the scientific literature, the variety of opinions in their community of colleagues and the administrative instructions set by their hospital managers. These sources set also the frame for their professional development. Formal management of clinical decision making is not widely practised, although it has been estimated that clinical decision making is the single most important factor determining potential variation in health care performance and expenditure.

METHODS

Coxa is a highly focused private hospital performing annually 2600-2900 joint replacement operations. The work is arranged as a process based organisation to maximise quality and productivity. High quality has been set as top priority; in surgical procedures this is usually measured as low rates of complications. The total number of employees in Coxa amounts to 150; 18 of which are medical doctors (orthopaedic surgeons and anaesthesiologists). As doctors form the core competence of surgical work, great emphasis has been placed on organising their clinical capacity into its maximum. The professional skills of doctors translate directly into the quality of the entire hospital. To enable the maximal professional development of doctors various methods have been utilised.

RESULTS

Repertory of types of surgeries performed by each of the surgeons is coordinated by the medical director to ensure that sufficient numbers of repetitions are achieved also in lower volume operations. The 14 orthopaedic surgeons working in Coxa each have a personal profile, according to which the different operations are distributed to them. The profiles and the levels of operative experience are displayed as a matrix of expertise. The development discussion forms another basic instrument of enhancing professional development. During these discussions the operative profiles, and the educational needs of each of the orthopaedic surgeons are evaluated and agreed upon. The annually performed operations and also the encountered complications are recorded and discussed. The well-being at work is measured bi-annually along the surveys performed in the entire organisation. The rates of complications in Coxa have been generally very low, falling below the figures described in the literature.

ANALYSIS

The highly specialised surgeons and anaesthesiologists form the core competence and resource of surgical work in hospitals. Yet, formal management of their professional performance and development has received very little attention. Nevertheless, the advantages of ensuring a sufficient number of surgical procedures to doctors performing rare and complex operations are obvious. The approach of managing doctors clinical work in Coxa constitutes of two main themes: the matrix of expertise coordinates the operative profiles of single surgeons. The profile is agreed upon in general discussions and in personal development discussions, in which the available indicators of personal performance are also reviewed. The approach is well accepted by the doctors.

In conclusion, the formal management of professional skill development of specialist doctors forms one important part of a strategy for maximising the quality of surgical procedures in Coxa.

**Parallel sessions:
New approaches to improve health care quality**

**Thursday 1 July 2010,
11.00-12.30**

EFFECTIVENESS (OUTCOME) EVALUATION PROGRAMME IN LOMBARDY REGION

New approaches to improve health care quality

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CONTEXT

Italian NHS is a public, regionally based, health system. Lombardy Region developed a particular model based on subsidiarity principle and coexistence of public and private providers. In this model, evaluation is a key aspect to regulate and improve health system performance. This outcome evaluation programme allows Regional Health Directorate to evaluate effectiveness of all regional providers (more than 150 hospitals accredited) and to improve regional health policy. The aim of this presentation is to present this outcome evaluation analysis and to discuss results obtained from the data analysis. With 1.200.000 discharges analysed in 2009 this is a very important case study on effectiveness evaluation at international level.

METHODS

This research was developed by CRISP (Interuniversity Research Centre on public services) in collaboration with Lombardy Region General Health Directorate.

The statistical model used to analyse data was a multilevel model with risk adjustment, case mix adjustment and severity adjustment as standardisation methods (coeteris paribus principle). Data source was hospital discharge cards (administrative data source). With this model was possible to obtain seven outcomes for every structure: intrahospital mortality, 30 days mortality, total mortality, voluntary discharges, readmission, discharge patient to another hospital and readmission for the same MDC.

It's possible to analyse hospital effectiveness for single DRG and DRG's effectiveness for single hospitals.

It was possible to compare analysis of different years (last was 2009), so it's possible to evaluate improvements or worsenings during the years.

RESULTS

Multilevel analysis considers 3 groups of variables: patients, hospitals and DRG. The main outcome of the model is total mortality because it's used at international level as important point of reference for effectiveness evaluation.

Through the "residues" of Multilevel model it's possible to get the value of the Odds Ratio (OR) of hospitals, which represent the value of the relative risk of death attributable to any structure: if the $OR > 1$, the effect is negative (increased risk of death), if < 1 the effect is positive (reduction in risk of death). To measure variability, that is the degree of uncertainty in the conclusions concerning the effect, it was calculated the confidence interval at 95% for each Odds Ratio.

The analysis show 2009 results and a comparison of results from different years.

Results show some differences between public and private providers but, in general, demonstrate an improvement of the whole system during the years.

ANALYSIS

The most important lesson learned from this analysis is that effectiveness is a very important dimension not only to evaluate health care structures, but also to organise and regulate the regional health care system.

This evaluation in fact was put together with other evaluation's dimensions (as efficiency or customer satisfaction) to determinate which are the best and worst dimension of every organisation.

Outcome evaluation is very important because outcomes are final results of all the health care processes so it give a clear picture of what works or not works to improve health status of citizens. Methods and results of this evaluation programme were discussed with national and international health policy experts and we're working to develop new research projects at national and international level in the next future.

It's very important to share this kind of programmes at international level to improve continuously health systems performance evaluation.

THE USE OF ACTION LEARNING IN A HIGHER EDUCATION SETTING TO IMPROVE THE QUALITY OF HEALTH CARE

New approaches to improve health care quality

Naomi Chambers, Lawrence Benson, Elaine Clark
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CONTEXT

Action learning is advocated as an approach when managers are faced with complex issues where there is no 'right' answer, and where the individuals have the authority to take decisions and enact changes (Revans, 1982). It is based on a theory developed by Revans and others, working in natural sciences as well as social sciences contexts, that learning involves both programmed knowledge and questioning insight, and that learning needs to be greater than the rate of change. The principal vehicle for action learning is the 'set', which is a group of learners who meet regularly to present their issues or problems.

METHODS

The UK National Health Service has used action learning as an approach for generating change and improvement at an individual, organisation and system level for some years. The action learning programmes delivered or evaluated by Manchester Business School have particularly focussed on postgraduate learning, talent management and service improvement. The main method for assessing their impact and effectiveness has been evaluation, making use where appropriate of CASIL and Kirkpatrick frameworks. The CASIL framework developed by the NHS Institute for Innovation and Improvement focuses on completion, adoption, spread, impact and learning, whilst the Kirkpatrick learning evaluation theory examines the four levels of reaction, learning, behaviour and results. In addition to the use of questionnaires, one evaluation took an ethnographic approach, seeking to experience the programme and capture the process using participative enquiry (Clark et al, 2009).

RESULTS

Evaluation of a programme for change agents in the English NHS show that action learning provided an opportunity in a confidential and supportive setting for constructive challenge and critical discussion, and a challenge to perceptions and habitual ways of viewing problems. It provided new solutions with a direct impact at work. The process of action learning allowed the surfacing of questions and the space for knowledge sharing and transfer, and to think and reflect (Clark et al, 2009). Interim evaluation of a programme for graduate health service management trainees identified the value of action learning in utilising a diversity of perspectives, building networks, development of personal confidence and a new skill set whilst acknowledging that the approach doesn't work for everyone (People Opportunities, 2009). Meanwhile, students on a masters level health management programme report the benefit of exchange of tacit academic and work-related knowledge amongst learners (Kislov, 2009).

ANALYSIS

Experience reinforced by evaluation has confirmed that action learning is beneficial for managers at different levels and different stages of their careers in the health care sector. The unifying factor appears to be that action learning set participants should face complex challenges in their work. There are methodological difficulties in pinpointing the benefits of action learning as an approach, but evaluations thus far indicate that positive impact, particularly at the personal level in terms of fresh thinking and strengthened resilience, can be demonstrated. The role of the action learning set facilitator (typically a university lecturer or management consultant) merits further investigation. The approach also needs to be understood within the wider context of organisation development in relation to action learning in change management, and in the wider context of higher education pedagogy in relation to action learning on postgraduate and other senior management training courses.

CHANGING THE MIND SET BY USING NETWORKS TO IMPROVE QUALITY IN PREVENTING NEW LOW ENERGY FRACTURES

New approaches to improve health care quality

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CONTEXT

Strong market and scientific forces have created a mind-set leading to a rising trend of drug treatment of osteoporosis, and thus primary prevention of low energy fractures (LEFs). Primary prevention requires much of resources, and cost-effectiveness of medical treatment is low. Instead, secondary prevention of LEFs with bisphosphonates has better cost-effectiveness, and interventions to minimise risks of falls may be targeted. Therefore, reallocation of the resources to secondary prevention is necessary. The Kymenlaakso Hospital District having two secondary care hospitals and eight autonomous primary health care centres decided to start a programme to improve the secondary prevention of LEFs.

METHODS

The programme aims to create a fluent regional secondary prevention system of LEFs including primary and secondary care. The focus should be shifted from primary to secondary prevention. To change the trend is a managerial and medical challenge: mental orientation and clinical practices must be changed in many organisations without increasing resources.

Multifaceted methods have been applied to combat challenges and to achieve commitment:

- Audit of the treatment of 100 patients with LEFs to document the present clinical practices;
- Feedback based on the audit to catalyse motivation for change;
- Rohto -workshops as interactive methods to seek for consensus of problems and solutions;
- Opinion leaders engaged to act as change facilitators;
- Health care management involved to ensure mandate for change;
- Creating an evidence-based secondary prevention protocol for LEFs based on national clinical guidelines to guarantee scientific background.

RESULTS

A mental change was achieved: insufficient secondary prevention was recognised to be a problem, and the reallocation of the resources was accepted to be one solution. Moreover, the insufficient prevention models were seen not to be in harmony with the clinical recommendations. The professionals set a target, that 100% of the elderly patients with LEFs should receive a standardised mapping and relevant elimination of risk factors.

In one of the workshops a new idea of "a care manager" to insure the good quality was suggested. The specialist nurse network and many of the doctors became accustomed to the idea of secondary

instead of primary prevention. Basic tools to improve care were produced, such as a checklist, documentation and data delivery models, and a regional clinical pathway. The process of making house rules for different health units started.

ANALYSIS

Interactive recruiting of all the relevant professionals was essential for the mental change. This "bottom-up" -working strategy was chosen to achieve critical mass for the change management. This was done to inspire, to induce goal-orientation and commitment of professionals for high quality treatment of the LEF patients.

DESIGNING EXTERNAL HEALTH CARE ASSESSMENT AND IMPROVEMENT SYSTEMS IN SERBIA

New approaches to improve health care quality

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CONTEXT

Significant work was done in preparation of the new Accreditation Agency. New legislation and assistance through international donor sponsored projects over a number of years have laid the corresponding groundwork. Major progress has been made over the last year: The Agency has been established by law, with a Managing Board, an Agency Director has been appointed and staff hired, an office location secured, and a budget allocated. In a relatively short period of time, the Agency has moved forward and is now able to take full advantage of the EU funded project to strengthen its programmes and activities.

METHODS

There is growing worldwide demand for quality in health care, and for mechanisms, such as accreditation, to promote and maintain it. Accreditation (and similar systems of external assessment against standards) has developed as an effective strategy for continuous improvement of health care institutions and systems, with benefits to consumers, regulators, managers, and other stakeholders. But the effectiveness of an accreditation programme, as well as its affordability and whether it will be sustainable depends ultimately on many variable factors in the particular health care environment of the country. It also depends on the kind of programme concerned, and how it is implemented. In Serbia, for the new Accreditation Agency, the major project issues are two-fold: 1) its strengthening processes and long term development plan; and 2) the development, implementation, and institutionalisation of CQI over many years.

RESULTS

The critical issues discussed and planned are as follows:

- The long term financial sustainability of the Agency, including continued donor support until the Agency is financially viable;
- The institutionalisation of a "Culture of Quality" throughout all health professionals, institutions, and services over a number of years;
- The support for accreditation processes and programmes by the HIF, MoH, IPH, Associations/ Chambers of Health Professionals, local governments, and others;
- The process of bringing the "private sector" in health into the accreditation process to ensure all Serbians are included in the benefits of accreditation;
- The preparation of the Agency to meet international standards for accreditation agencies by applying for recognition by the International Society of Quality in Health Care (ISQua);

- The cohesion and integration of various organisational Quality Management programmes and Continuous Quality Improvement activities under the umbrella of the Agency.

ANALYSIS

The development of accreditation occurred as part of broader health reforms in Serbia and in the context of an overall government strategy for quality. The Agency is the principal national centre for the definition, measurement and improvement of standards. The national accreditation programme for hospitals and primary health care centres to meet ISQua principles by enhancing existing accreditation standards, and developing new standards for clinical support services - laboratories, pharmacies and diagnostics imaging involved workgroups of key stakeholders and is scheduled to be completed by April 2010. Field testing in pilot sites will occur April - September 2010, with self-assessment of health care institutions. In parallel, external surveyors will be trained for standards' interpretation, survey process, documentation review, specific or specialised areas (safety, infection control, etc) and report-writing skills.

**Parallel sessions:
Cooperation across boundaries**

**Thursday 1 July 2010,
11.00-12.30**

INTERNATIONAL PUBLIC PRIVATE PARTNERSHIP AND SOCIAL ENTREPRENEURSHIP IN HEALTH CARE, A SUCCESS STORY BETWEEN EGYPT AND GERMANY.

Cooperation across boundaries

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CONTEXT

In transitional countries like Egypt, the health care system is continuously challenged to reach quality and equity. The fact that around 20% of the population lies under the poverty line and another 20% just above it makes funding services to the poor difficult. The centralisation of quality services in the capital city Cairo puts technical and financial burdens on accessibility to services. Compared to hospitals in a European country like Germany, Egyptian hospitals have different levels of quality. Health care managers need to have innovative solutions to create equity of health services between developing and developed countries and within developing countries.

METHODS

The authors developed a model for international public private partnership (PPP) between a public university hospital in Germany and a private hospital in Egypt. The model was based on mutual benefits of both parties and efficient management of available resources. The lines of cooperation included exchange of visits, experience, joint research, seminars and training programmes. Both parties focused on synergies to build on their strengths. The Egyptian private hospital opened branches in a poor area in Cairo and two governorates in Upper Egypt, 1000 km from Cairo, to improve accessibility to the services. In addition to that, an efficient entrepreneurial poverty alleviation system was mutually created between the private hospital, three not-for-profit NGOs and a private bank to support the treatment of poor patients who cannot afford the service. The system also offered subsidised training programmes to nurses and ophthalmologists from public hospitals all over Egypt.

RESULTS

The international PPP model positively affected the quality of services provided in both hospitals. Over the last 18 months, this agreement resulted in one clinician from each country being trained in the other country, three Egyptian-German meetings (two in Egypt and one in Germany), accreditation of the training programmes offered in Egypt, two joint research projects, accreditation of the private hospital in Egypt to reach German standards, e-consultation system between both countries and regular expert-visits. A new centre of excellence is being founded in Cairo, as well as planned other branches to cover remote areas. The mutual poverty alleviation system supported examination of around 35,000 poor patients. It offered subsidised affordable treatment for around 20,000 including 250 advanced eye surgeries. Parallel to that, there were training programmes for doctors and nurses from the private hospital as well as other public hospitals in Egypt and the region.

ANALYSIS

The model presented emphasises the role of private sector in improving the quality and equity of health care. This success story has not put any financial burden on public financial systems. Finance was generated through multi-stakeholder coordination between private sector investments and not-for-profit funding. Synergies between different sectors and cost-containment models linked with efficiency make services affordable to the poor, who get them in the same standards and location as the rich. The integration of social concerns in private business operations represented a practical tool to improve health care services. Linking public sector experience and quality from Germany with private investment and know-how from Egypt maximised the benefits for both parties. Over time, international PPP might equalise the quality of services between different countries. We hope that this model will act as a prototype to induce radical change in dealing with poverty through creation of models more efficient than development aids.

IF PARTNERSHIP IS THE ANSWER, THEN WHAT'S THE QUESTION? ENGLISH HEALTH AND SOCIAL CARE PARTNERSHIP WORKING AND ITS IMPACTS

Cooperation across boundaries

Helen Dickinson

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CONTEXT

Partnership working between health and social care organisations has been extensively promoted by the English central government since the election of the New Labour government in 1997. This trend is not confined to England, and an interest in collaboration between health and social care organisations is of international interest (Glasby and Dickinson, 2009). The rationale for this way of working is most often predicated on the notion that it improves services and consequently outcomes for service users. Yet, despite this there is very little evidence that this way of working improves service user outcomes. This research project investigates this link.

METHODS

This project is based on an extensive review of approaches that have been used to evaluate health and social care partnerships. Some authors have suggested that the lack of evidence relating to health and social care outcomes is related to the difficulties involved in evaluating this way of working. However, this review argues that this is a rather rationalist perspective of policy analysis and the approach adopted in this research is instead based on an interpretive conceptual model. This project employs a theory-led approach rooted in multiple methods of data collection. One of the primary means of data collection was the Partnership Outcomes Evaluation Toolkit, a generic toolkit specifically designed to evaluate health and social care partnership working. The toolkit was employed in an iterative process along with interviews and focus groups in four exploratory case studies.

RESULTS

The process of research took a rather different approach to that originally envisaged at the outset. The partnerships, which provided the exploratory case study sites found it rather difficult to articulate what they were trying to achieve in terms of service user outcomes. Although respondents frequently suggested that their partnership was ultimately aimed at improving service user outcomes, when pressed they found it very difficult to say what they were trying to achieve. When pressed respondents often became incredibly aspirational, with a range of stakeholders having very different perspective of what the partnership was aiming to achieve. Moreover, on further investigation it often appeared that there were very different local organisational and political drivers at play than were being publically acknowledged.

ANALYSIS

What the process of research revealed was that the case studies were not ultimately as orientated around service user outcomes as they initially purported to be. Indeed, there appeared to be other

processes at work than were being explicitly articulated. The case studies illustrate that the use of the notion of partnership not simply as a tool of improvement to bring specific and identified about changes in service user outcomes, but also as an active tool of governance. In this sense the role of partnership is not as a specific mode of governance, but as a technique of framing that might be engaged as a means to mobilise a variety of stakeholders to become involved in a particular course of action or set of activities. This analysis demonstrates the performative value of partnership and one which goes beyond existing concepts of the role of partnership in processes of governance.

MANAGEMENT OF INTERAGENCY COLLABORATION - BETWEEN HEALTH CARE AND OTHER WELFARE SERVICES

Cooperation across boundaries

Susanna Bihari Axelsson, Runo Axelsson

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CONTEXT

With the increasing specialisation of services and personnel it has become important for health and other welfare organisations to collaborate in order to address complex problems of their patients or clients in an efficient and effective way. In Sweden there have been a number of experiments with collaboration between health care, social services, social insurance and employment service in vocational rehabilitation. In 2003 came a new legislation allowing the different agencies to pool their budgets and collaborate in local associations. This presentation will report an evaluation of a collaboration model that was developed in one of these associations.

METHODS

There is growing research on interagency collaboration between health care and other welfare services. A great deal of this comes from the UK, the Netherlands and the Nordic countries, but there is also research from the USA, Canada and Australia. Most of this research is about the care of the elderly and other forms of community care, but there is also research on rehabilitation. There are many different models of collaboration in this field. These models can be described along a continuum from informal meetings to formal partnerships, case management, multi-disciplinary teams, co-location of professionals, and mergers of organisations. Data on the evaluation of this particular collaboration model were collected through 20 individual interviews with professionals involved in the local association. In addition there were two focus group interviews with users of the rehabilitation services provided. These data were also supplemented by documentary data from official sources.

RESULTS

The target groups for this interagency collaboration were young people and immigrants who had complex problems and needed services from at least two different welfare agencies. They were unemployed with physical, mental and/or social problems. The clients had direct contact with job coaches, who followed them through the whole process of rehabilitation and assisted them in finding employment or education. The coaches were supported by groups of professionals from different agencies: the regional health services, the municipal social service, the national social insurance and the national employment service. The groups were responsible for the provision of rehabilitation services. They followed the rehabilitation process and discussed the progress of the clients. The model was quite successful. After rehabilitation, 50-65 % of the clients were in employment or education. The main success factors were the commitment of the job coaches and the collaboration between the representatives of the different agencies.

ANALYSIS

The collaboration model was a combination of case management and multidisciplinary teams. Case management was provided by the job coaches, while the different groups worked like multidisciplinary teams. The collaboration was successful, but there were also some barriers like cultural differences between the agencies and a lack of understanding of different roles and regulations. The professionals in the groups also experienced a lack of interest and support from their own agencies. There are some important management lessons to be learnt from this collaboration. First, a model like this is vulnerable. It is very much dependent on the commitment and professional attitude of the job coaches and the members of the interagency groups.

SYSTEMIC MEETING - DOES IT GIVE ANY RESULTS? - AN INVESTIGATION AMONG CHIEFS WITH EXPERIENCE OF SYSTEMIC MEETINGS IN REGION SKÅNE, SWEDEN

Cooperation across boundaries

Ingrid Ainalem

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CONTEXT

People who come into contact with the health care system and social services expect a good, trustworthy and accessible care. However, inefficient and complicated working systems have made the care inaccessible. There is a gap in communication between different levels of care, and this is a problem for patient and public safety. During recent years, systemic meetings have been tested in Region Skåne, Sweden. The aim of this study was to investigate if systemic meetings in Region Skåne (in the municipality, primary care, psychiatry and hospitals) have given any expiring results of improvements of operations.

METHODS

A systematic meeting contains five phases: observation, reflection, action, leader position and after-reflection (Sarv H.). Every meeting starts with one of the participants giving details of a certain experienced event. This could be related to patient care. In the "reflection phase" the other members in the group would consider the pattern and choice of advice and treatment the narrator has made and suggest alternative of action. Afterwards the person who has introduced the story above would give her/his views on the discussion. Then the leaders give their reflections (leader position) that hopefully end in a document of acting together with the group. Finally, the group engages itself in deeper reflection (after-reflection). The study was made with help of an opinion poll send to 40 chiefs with different positions and five reinstructed interviews, all with experience of systemic meetings. Analysis of interviews was made with quantitative and qualitative content analysis.

RESULTS

Opinion poll

We found results, all from changing in practice, solving problems and increasing understanding for different behaviours.

- Documents of acting;
- New routines;
- Increased understanding;
- Increased co-operation between health and social care;
- New solutions and alternative actions;
- Practical measures;
- Other.

Interview investigation

All respondents had received training and had experience (since 2005) as leaders of systemic meetings. Experiences varied from 30 to 100 meetings per leader.

They were convinced that three conditions were to be fulfilled if systemic meeting was to be adopted in any operation. Professional leadership, leader commitment and favourable group composition.

There was both advantage and disadvantage in systemic meeting. Systemic meeting created mutual understanding among the staff, which in turn meant better teamwork and better results.

The disadvantage was that the method took up much time and demanded more staff.

ANALYSIS

Conclusion: Lessons and message

Systemic meeting is a good method for co-operation between different institutions of health and social care. As a result of systemic meetings, Region Skåne has been able to increase consonance between hospitals, psychiatry, primary and social care, and double working is avoided. The result also points out that systemic meetings have been important for people with psychiatric health problems. In some cases when patients take part in systemic meeting they became positive to the method?

The result also showed that systemic meetings increased consonance between different organisations, but also between different categories of employers.

**Parallel sessions:
Redesigning health care systems**

**Thursday 1 July 2010,
11.00-12.30**

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CONTEXT

A growing body of evidence shows that nursing care and its foundational values strongly contribute to overall organisational performance. Recently, however, many reports have pointed to the failure of current care delivery systems that compromise the optimal use of nursing resources. In the context of nurse shortages, managers are exploring innovative ways to redesign nursing practice in order to improve outcomes for nurses and patients. This paper showcases several models of nursing care that have been implemented in the context of acute care units, compares the distinctive features of those models, and provides evidence on outcomes associated with them.

METHODS

Our research is based on a survey of 22 medical units in 11 acute care facilities in Quebec. Data collection used several methods: a questionnaire administered to 282 staff nurses; interviews with senior managers, head nurses, and staff nurses; focus groups with staff nurses; administrative data on staffing; and screening of 2500 patient charts. Three key variables informed our investigation: nursing care delivery models; nurse outcomes (absenteeism, satisfaction, intent to leave, and burnout); and patient outcomes (adverse events associated with nursing care). We based our construction of the nursing care delivery models on correspondence and cluster analysis. ANOVA and multiples comparisons tests were used to examine their effects.

RESULTS

Our research identified four models being used to redesign nursing practice:

- Two professionally-oriented models that emphasise support for professional and innovative practice;
- Two administratively-oriented models that emphasise flexibility in the use of nursing resources and the delivery of essential nursing tasks.

The first two models reflect efforts to incorporate foundational "caring" values in new nursing care arrangements. The second two appear to reflect rationalisation strategies aimed at dealing with economic and labour-market constraints. Our analysis suggests that the four models represent different paths followed by health care organisations to ease recruitment and retention difficulties, and to address patient safety. There are, however, several significant differences among the outcomes of these models, both for nurses and patients.

ANALYSIS

Despite similar performance-oriented claims, emergent models of nursing care delivery do not invariably follow the same path. More complexly, our research shows that the redesign of nursing practice is a multidimensional process that is manifested in diverse ways of mixing nursing resources, using nurses' skills, designing work environments, and supporting unit-level innovation. While economic or labour-market pressures often dictate initiatives to redesign nursing practice, our findings highlight the risks involved in diverting focus away from core nursing values. While some emergent models that deviate from nursing practice ideals provide short-term solutions, they may, in the long run, undermine nursing work and threaten patient safety.

VITAL IN NORTH - A SYSTEMS APPROACH TO IMPROVE QUALITY IN THE CARE OF THE ELDERLY PATIENT

Redesigning health care systems

Camilla Andersson

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CONTEXT

The Swedish governmental campaign to improve care for the elderly is in Norrbotten county council organised as "Vital in North". More than 30 quality improvement-projects have been running since 2007 in rehabilitation, fall prevention, malnutrition and bedsore, dementia-care, pharmaceutical-reconciliations and palliative care. To assure systemic results a quality improvement-office has been set up to coordinate and support all the QI-projects in elderly health care.

METHODS

Improvement areas are decided by a board of directors from the hospitals and primary health care. Improvement advisors are coaching and coordinating in clinical practise and results are measured in patient outcome. Economical analysis, development of IT-systems and communication- and implementation strategies are integrated in the clinical improvement work through the whole process. Improvement advisors are supporting the development of system wide methods in hospitals and primary care practices. Integrated electronic patient records makes information available in the whole system.

RESULTS

- Hip-fractures among elderly reduced;
- Polypharmacy among elderly reduced;
- Prevention methods for fall, malnutrition and bedsores implemented;
- Better routines for safer admissions and discharges to/from hospitals;
- Special forms in the electronical patient records that supports planning and pro-active care for elderly;
- Better measurements and outcome-analysis in the health care for elderly;
- An internal quality register for the system - Norrbotten county council - is under construction.

ANALYSIS

To be successful with improvements in the whole system working at all system-levels are important. National guidelines and quality registers along with internal processes and patient safety work indicates in which areas improvement work needs to be done. Senior leaders that have a will to improve the whole system, not only the business that they represent, are necessary. A delicate task for senior leaders, and improvement advisors, is to eliminate obstacles for co-operation between primary care practices and hospitals in the IT-systems, economical systems and old

agreements. Qualified support from improvement advisors has facilitated the process to be effective and sustainable.

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CONTEXT

Chronic diseases are main causes of mortality and morbidity in the developed world. Health care systems designed to deliver acute care do not meet the needs of the chronically ill population and patient care is often deficient. Growing consensus underpin new approaches to chronic care and shift to disease prevention. Disease registries are databases that contain condition-specific information. However, lack of interoperability has inhibited integrated registers to provide feedback on overall performance in the population. To improve care management strategies and efficiency of municipal health centres, a regional diabetes register (T2DR) was constructed to track progress using process measures.

METHODS

The T2DR is an integrated register based on the Ecomed[®] platform. Patient cases in 2008 were collected from four separate IT- systems - three of these systems were Ecomed[®] systems in the Helsinki University Central Hospital (HUCH), in the municipal health centre of Helsinki, and in the clinical laboratory providing services to HUCH and the region. Furthermore, we retrieved information from an EMR used in the municipal health centre of Espoo. All patient identification was encrypted. To identify the diabetes cohort four different criteria were used: 1) ICD-10 codes E10-E14, 2) ICPC code T90, 3) glycated haemoglobin A1C > 6% and, 4) more than one visit for diabetes care utensil dispensing services in Espoo.

RESULTS

A total of 37 611 diabetic persons from Espoo and Helsinki were identified. T2DR was validated against an administrative register for national monitoring of diabetes. The difference in the number of known diabetics between the two registers was 1 287 (3, 4 % more persons with diabetes in the national register). The match was in general good. Targets for aggregate observations of some cardiovascular risk factors (GHbA1c and LDL-C) were met, but not for all follow-up markers (microalbuminuria, retinal scans). Measurements were done more often in Helsinki, but the quality of diabetes care appeared somewhat better in Espoo. Although the variation was small between the two municipalities, wide fluctuations (up to 40 %) existed between individual health centres within the municipalities. Major parts of the resources were allocated to follow-up of diabetics with good and moderate (57 % and 37 % of visits, respectively) glycaemic balance.

ANALYSIS

Preceding management intervention in Espoo, where feedback information was utilised between

health centres internally, resulted in the redesign of the care delivery system and improvement of diabetes care.

The compliance with diabetes practice guidelines and quality of care may therefore be improved by applying EMR aggregate data in primary care and extending the peer review between populations. When information is retrieved from regional legacy systems into data warehouses and processed with business intelligence, cross-organisational outcome and productivity performance measurement becomes possible. This enables health care management to achieve large-scale, durable improvements in clinical processes resulting in improved efficiency and quality of care. More effective use of existing data allows us to compare actual outcomes with target values, predict risks of future health events and integrate this information into the care of the patient. In addition to redesigning provider processes, patient behaviour changes in prevention are also needed for long-term results.

Taina Mäntyranta, Minna Kaila, Jukka Mattila
Ministry of Social Affairs and Health, Helsinki, Finland

CONTEXT

In Finland municipalities are responsible for organising tax-funded primary health care (PHC). The state has a steering role and participates in funding. Municipalities arrange PHC according to local circumstances independently, with the neighbouring municipalities or by purchasing. PHC is offering preventive, outpatient, home nurse, dental and occupational services as well as some inpatient care. Well educated personnel, developed information technology and strong support from the population characterise PHC. Current challenges include shortage of personnel, especially in the remote areas; problems in access to care; system centred planning (vs. patient centred); overall focus in specialised care and expansion of duties without new resources.

METHODS

The national primary care action programme was launched in 2008 to respond to the challenges. Key professional societies as well as governmental organisations were included in planning. Grass root views were collected in national and local seminars with various methods. The action programme was supported by strong commitment from the political leaders in government. During execution, the programme continued the close co-operation with professional societies. Some minor changes in legal regulations have been conducted. Local and regional development projects have been endorsed with financial support from the national development programme for social and health care (Kaste). Implementation of the actions consists of more traditional methods such as seminars and journal articles, as well as developed implementation methods such as collaborative breakthrough method. Twelve indicators were formulated for evaluation of the programme.

RESULTS

The programme consists of 24 actions, focusing primarily on three areas:

1. Mission clarification: The main message from the field was a blurring mission of PHC. The value of PHC is in health gain that it is able to produce. The actions consist of focusing on the population's health needs, reconsidering certain tasks such as some medical certificates, and on improving chronic disease prevention and management by implementing the Chronic Care Model.
2. Patient to the centre: Patient status has not been strong in Finland. New legislation expanding the freedom of choice is under way. Patients are also a resource in the development of services and in their own care. Support for better self-management and empowerment is implemented.

3. Personnel. Changes in education and division of responsibilities between physicians, nurses and allied health professionals as well as focus in job satisfaction are examples of the actions.

ANALYSIS

The PHC programme has involved the professional societies from the beginning as partners. This has created a strong commitment to the programme amongst the professionals. This has also encouraged discussion with the professional media and active members of societies

The Minister of Health and Social Services` strong commitment to the programme and her active role as supporter has been important for the development. She has set new achievable goals for public PHC and kept discussions open in public. The current economic depression is a challenge, but also an opportunity for the programme. At least it seems to drive personnel from the private sector to municipalities. This strongly supports the momentum of change in developing PHC.

HEALTH PROMeTHEUS SESSION

**Thursday 1 July 2010,
11.00-12.30**

HEALTH PROMETHEUS SESSION: RESPONDING TO MOBILITY OF HEALTH PROFESSIONALS IN EUROPE – POLICY OPTIONS AND MANAGERIAL TOOLS

Health PROMeTHEUS session

CONTEXT

What is the scale of health professional mobility in Europe? To which extent do movements impact on the domestic workforce and health systems? What can policy makers and managers actually do to respond effectively to health professional mobility (HPM)? And, most crucially, are migratory flows big enough to justify action? These are pressing and difficult to answer questions for decision makers since robust data on HPM is scarce, as is information on effective policy responses. The workshop will address this gap by presenting results of the pan-European research project HEALTH PROMeTHEUS (1); co-funded by the European Commission (grant agreement n°223383).

METHODS

To quantify the extent and patterns of health professionals moving in Europe and beyond HEALTH PROMeTHEUS has employed secondary data analyses, critical review and comparison of existing data sources (registries, census data, data of labour force surveys, hospital data) and case studies. This includes all EU countries and selected OECD countries outside Europe. To map the scale, relevance, impact and policy responses to HPM 17, European country cases studies were written, based on literature reviews and expert interviews.

RESULTS

Preliminary results show that HPM does affect all EU countries; however the scale of movements and mobility patterns vary substantially. Hungary, Poland and Romania are countries with relatively high outflows of health professionals. They face the challenges to retain their workforces and to avoid negative spill-over effects on their health systems. The UK has a long history of employing foreign health professionals from outside Europe, but experienced since the EU enlargements an increase of Polish, Bulgarian and Romanian doctors. Other countries with a high proportion of foreign health professionals are for instance Spain, France and Austria. For both, receiving and sending countries, impacts on health services delivery and the availability of resources were observed, albeit evidence is scarce. In times of interconnected labour markets globally and within the EU, national policies on staff retention, self-sufficiency and better working conditions are becoming increasingly important. Policy options will be discussed in light of the wider context of health workforce issues, and recent developments on ethical codes for recruitment, at national and global levels.

ANALYSIS

With the exception of a few countries such as Spain and the UK, health professional mobility in the European region is largely an intra European phenomenon with most health professionals moving within the region. Therefore, effective responses lie within Europe and particularly at national,

¹ Website: <http://www.euro.who.int/en/home/projects/observatory/activities/research-studies-and-projects/prometheus>

regional and organisational levels. Measures to retain staff can be of financial and non-financial nature, including improving working and employment conditions and work-life-balance as well as career development opportunities. At national level, workforce forecasting that includes data on mobility allows for better planning of future workforce needs. There may be scope for EU action on monitoring flows and forecasting mechanisms, in support of activities at national levels.

Satellite session

**Thursday 1 July 2010,
12.45-13.45**

PATIENT ORIENTED PROCESS CREATION, SUSTAINABLE DEVELOPMENT AND LEADERSHIP— ANY DELIVERABLES?

Satellite session

Birgit Byman,

Project Leader, RN, Helsinki University Hospital, Oncology Clinic, Hospital District of Helsinki and Uusimaa, Finland

CONTEXT

The patient-oriented process creation in cancer care is driven by system changes - both in patient care and in leadership - as well as by information needs and other expectations of customers and stakeholders.

METHODS AND TARGETS

Our target has been to develop transparent processes and visible measurements to follow the outcomes of the activities. Our working method has centred on the engagement of different roles and all of the resources of the clinic. Day-to-day work in the project has been driven by discovery and two key questions: what are we doing, and how are we doing it?

RESULTS

We have shared processes that can easily be used by all at the clinic. The organisation has been adjusted to support process-based activities. Moreover, we are continuing with the next 10 development projects created to benefit both customer as well as stakeholder needs.

ANALYSES

The assumptions elaborated together have been clearly tested, and the necessary changes have been implemented in the organisation. The change is sustainable - we have learned a lot, but also know that there is still a long way to go.

Euro DRG

European Hospital Benchmarking Club

**Thursday 1 July 2010,
12.45-13.45**

Chair: Prof Reinhard Busse, *Department Head for Health Care Management, Technical University Berlin, Germany*

Benchmarking as a valuable management tool is widely-used in most industries to compare companies among each other with the help of performance indicators with the aim to learn from the best possible production of goods and services. In health care, this is more problematic and less common due to a variety of problems, e.g.: (1) There are many “products” especially in the hospital sector, which therefore require well-defined and agreed definitions across the broad spectrum of activities, e.g. through defining “products” in the form of diagnosis related groups (DRGs). (2) Cost accounting has to be able to accurately measure and allocate costs of “producing” particular services for particular patients, which is not only problematic due to the high relevance of overheads. (3) Both the definition of the “products” as well as the costs need to adjust for important factors beyond the control of the hospitals regarding patient-mix, technologies used and structural factors beyond the control of hospital managers.

While these issues are addressed within countries – and therefore allow a reasonably valid benchmarking on national levels –, a valid comparison of hospitals on a European level – let alone a true benchmarking – is until now not possible due to the diversity in coding and classification systems as well as cost accounting methodologies and systems across European countries. On the other hand, hospitals interested in assessing their performance often do not find appropriate comparators within their own countries (e.g. because they are the only one specialised for a certain service). Also, increasing patient mobility between European countries means that patients and health care payers are getting interested in transparent comparative figures on costs, quality and efficiency of hospitals beyond their national territory.

As part of the EU-funded EuroDRG project, EHMA will therefore establish a European Hospital Benchmarking Club (EHBC) to increase the exchange about exploring, and possibly implementing a benchmarking system across European hospitals. The aims of the EHBC are:

- To explore meaningful and feasible ways of implementing a benchmarking system between hospitals on a European level;
- To introduce the application of a common benchmarking system that adjusts for differences in costs taking patient variables, technology use and structural variables into account in order to allow fair comparisons of costs, quality and efficiency;
- To create an experience exchange forum for European hospital managers.

Hospital managers interested in participating in this benchmarking club are welcome to the EHBC kick-off meeting during the 2010 EHMA conference. The hospitals will be guided to explore the application of a common benchmarking system taking into account patient, technology and other

structural variables. If participating managers agree that a Benchmarking Club is both worthwhile and feasible, the results of the exploration will then – after the EHMA conference – be interrogated to reveal their usability for benchmarking purposes. This exercise should initially focus on two or three “episodes of care”, which are analysed across countries in the EuroDRG project (e.g. AMI, hip implantation and/or breast cancer/ mastectomy). If the Club comes to the conclusion that this is successful it would open the potential for efficiency comparisons between the hospitals in the club and the implementation of a common benchmarking system between the hospitals in the club. The Benchmarking Club is especially interesting for hospitals, which cannot compare themselves to other hospitals in their own county (e.g. university hospitals in small countries), hospital chains operating hospitals in different European countries, and hospitals interested in attracting patients from other European countries.

Masterclasses

**Thursday 1 July 2010,
16.00-18.00**

EMPOWERING LOCAL COMMUNITIES TO COMMISSION FOR QUALITY, EFFICIENCY AND EQUITY: THE EXPERIENCE OF CONNECTED CARE INITIATIVES IN ENGLAND

Gerald Wistow

University of Durham, United Kingdom

CONTEXT

The concept of connected care was developed by Turning Point, a large charity in England. It aims to deliver holistic responses to the complex needs of people in the most deprived communities. The approach was initially developed in a small area (approximately 5,000 households) of Hartlepool through a partnership between Turning Point, the local community, local services and central government. The 'model' is being implemented in ten authorities and has been commended in government documents for its potential to 'put people in control' and, thereby, enable them 'to shape improvements in provision and contribute to greater fairness in service use'.

METHODS

The connected care pilots aim to secure better quality health and wellbeing outcomes by promoting effective community engagement in governance, commissioning and service provision in areas of multiple deprivations. The model developed by the Hartlepool pilot included the following elements:

1. Partnership board of community and service representatives to develop model and commission service;
2. Connected Care audit conducted by residents of local needs and ambitions;
3. Service specification developed by the partnership to commission services and ways of working based on audit results;
4. Community controlled social enterprise to deliver services;
5. Evaluation by local University.

Residents were trained and employed as community researchers to conduct a multi method audit of the locality including arrangements to engage 'hard to reach' groups. This investment helped build community capacity to understand issues and develop solutions as well as legitimating the audit results among professional partners.

RESULTS

The audit report was critical of the quality of local services and sought improvements in:

- Information;
- Choice;
- Access;
- Continuity and coordination;
- Workforce;
- Service standards.

In addition, local residents reported that services intervened too late and wanted earlier, low level support. They criticised services for working in isolation from each other. Rather than a single intervention to meet their whole needs, they received multiple interventions, leading them on unpredictable and repetitive journeys around different agencies.

In response to the audit, the partnership board designed a service specification based on the following components:

- care navigators, recruited from local residents, to improve access, promote early; interventions and integrate with long term support where necessary;
- complex care team integrating health, social care and other support;
- transformation coordinator to manage the service and promote change;
- a social enterprise to deliver specialist and low level support.

ANALYSIS

Many aspects of the service specification are in place and the pilot has a national social enterprise pathfinder. However, implementation has been slow and partial. Despite formally supporting the model, health and social services have refused to second their staff to the social enterprise and operate from a community sector base. However, three care navigators are employed by a social enterprise providing low level services and currently negotiating responsibility personal budgets for people with complex needs.

The practical implications of this experience for improving quality, efficiency and equity are substantial, but it also highlights the strength of resistance to such change as well as strategies for addressing them. Thus Connected Care appears to offer opportunities for deprived communities to own and drive solutions for themselves, thereby providing better targeted responses and improvements in outcomes associated with community capacity building.

PhD Student session

**Thursday 1 July 2010,
16.00-18.00**

STRATEGIC ENTREPRENEURSHIP IN THE CARE FOR THE ELDERLY: RECOMBINING RESOURCES TO CREATE SOCIAL VALUE

PhD Student session

Maya Fiolet

VU University Amsterdam, Amsterdam, Netherlands

CONTEXT

Non-profit organisations delivering public services are facing increasing turbulence, due to changes in the social, political and institutional environment. These changes have led to a restructuring of health care systems and are offering both opportunities and threats, thus, fostering a rich environment for entrepreneurship. We focus on the (re)organisation of the care for the elderly. Presently, there are severe resource constraints in combination with the entry of commercial providers. Non-profits are challenged to transform their administrative focus by restructuring themselves into innovative organisations that are able to take advantage of opportunities. This is necessary to survive in the increasingly competitive environment.

METHODS

It is well documented that entrepreneurship often fails because companies do not offer favourable organisational conditions for initiatives. Research on strategic entrepreneurship, is burgeoning in the profit-sector. This research offers valuable insights into relevant organisational conditions; yet it does not capture the unique characteristics of non-profit organisations. The most striking feature of non-profit organisations is its mission to create social value for the public good rather than profit for shareholders. Another important distinction lies in different environmental dynamics. The unit of analysis in this study is, "the initiative". An initiative is an entrepreneurial process, by which individuals in the organisation identify and pursue an opportunity to create future goods and services. A multiple-case study in an organisation that provides long-term care for the elderly was conducted. We were not so much interested in a single initiative, but in the general pattern of a multitude of initiatives, allowing comparative analysis.

RESULTS

This multiple-case study in nursing homes and homes for the elderly has gained rich data on the way strategic entrepreneurship in non-profit organisations is manifested. The study showed that a variety in types of innovation exists. They can be classified as new service concepts, new client interfaces and new service delivery systems. Especially cooperation between the historically divided areas, facility management, care and well-being, led to innovations. This study has also identified that the internal (f)actors that stimulate and constrain strategic entrepreneurship in a non-profit organisation are the same as in a profit organisation with the exception of rewards, which due to legislation are very difficult to distribute in non-profit settings, especially in financial terms. This distinction, according to our results, does not seem to constrain initiative. Gaining legitimacy of the diverse stakeholders to change in an innovative organisation is difficult.

ANALYSIS

A prominent finding in this research is that almost all innovations were reached through the creative (re)combining of resources. The concept of bricolage is very helpful in shedding light on the processes, by which these organisations generate heterogeneous value from ostensibly identical resources. The organisation proved able to solve problems and exploit opportunities despite severe resource constraints. Furthermore this study increased our understanding of the creation of social value proving that innovation is not an optional luxury, but rather necessary to develop 'personalised' public services. "One size fits all" services are not suited to an increasingly diverse and heterogeneous population. The motivation of most people working in elderly care is primarily to provide high quality care, with financial rewards being of less importance. The most valued reward is to receive freedom and support for behaving creatively in order to directly increase the quality of life of elderly people.

Gustavo Martins-Coelho², Ronald Batenburg²

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²*Netherlands Institute for Health Services Research - NIVEL, Utrecht, Netherlands*

CONTEXT

Human resources for health are critical for health systems at organisational, demographic and economic levels, but they are in general the least strategically planned element. This results in inadequate numbers, inappropriate training for the tasks assigned, and poor functional and geographic distribution of health workers. There are several approaches available for health manpower planning, yet little is known about which (if any) is chosen by each EU country. Identifying, describing and comparing such approaches can inform how health manpower planning is used by health care systems to improve efficiency, and address the issue of global migration of health workers.

METHODS

The global objective of this study is to identify and characterise health manpower planning approaches applied by European Union (EU) countries and to explain cross-national variations found.

We will perform an international comparative analysis. Data will be retrieved from international registries and national health authorities websites. Key informants will be contacted and interviewed. Population characteristics and health status, as well as trends in health manpower supply and distribution, will be described for each country. Dependent variables will be general characteristics of health manpower planning, and specific characteristics of the last health manpower planning study in selected countries. Seven types of explanatory variables will be assessed: political, organisational, economic, social, cultural, technical and educational.

RESULTS

Our study will take a stepwise sequence. We are now concluding Phase 1, which consisted of comparing health care systems and manpower planning models in the Netherlands and Portugal. We will then identify which EU countries have performed health manpower planning and broadly characterise these studies, through a search of relevant political, technical and scientific literature and an expert survey. Drawing from these findings, we will select a number of countries for deeper study of their health manpower planning models; we will take into consideration parameter selection, collection and estimation. We will then assess how political, organisational, economic, social, cultural, technical and educational characteristics of a country influence the design of its health manpower planning. Finally, we will discuss the quality of health manpower projections

based on current experience and future challenges and directions of health manpower planning in the EU.

ANALYSIS

By the end of the project, we expect to elaborate a chart of health manpower planning methods and factors that have some impact on the models adopted by each EU country, and provide a knowledge base that can be used by each country to improve its own planning strategies through introducing international beneficial experience.

Marco Giovanni Rizzo

Catholic University of Sacred Heart of Rome, Italy

CONTEXT

Recently, we can observe within the Italian health care system, a tendency from health care delivery organisations to focus on specific specialties and services. This phenomenon developed in Italy within a broader context of health care reforms inspired by the New Public Management principles such as regionalisation, quasi-markets and managerialism. This research aims to investigate both the change in specialisation index and its determinants. Previous studies have identified two different categories as possible explicatory variables of health care specialisation: organisational variables (e.g. hospital dimension, length of stay, geographic location, ownership status) and institutional variables (e.g. market concentration, regional commitment towards the DRG reimbursement system).

METHODS

The study sample consists of 739 Italian acute care hospitals both public and private. The period of analysis goes from 2001 to 2005. The source of data is the Italian Ministry of Health. The study aims to test which variables have an impact on the specialisation index of Italian health-care organisations. The data collected were modelled to define the measures and variables used in the descriptive statistics and in a multivariate regression model. The variables considered are: hospital dimension, ownership status, location, market concentration and regional commitment in the DRG payment system. Both organisational and institutional variables are used as explanatory variables. The dependent variable, hospital specialisation, is measured using the internal Herfindahl-Hirschman Index (HHI). In order to calculate this index, defined as the sum of squares of the proportion of discharges from each lines of production, the 523 DRGs were grouped in 38 lines of production.

RESULTS

Preliminary results show that specialisation increased during the examined period. Many hypotheses are confirmed by the multiple regression analysis. Four organisational (hospital dimensions, length of stay, location and ownership) and two institutional variables (concentration and type of regional commitment towards the DRG reimbursement system) are significantly related to specialisation index. The multiple regression analysis confirmed that hospitals located in Southern regions of the country and large hospitals are less specialised. Regional commitment towards the DRG reimbursement system positively affects the specialisation index whereas a decrease in competition has a negative impact on specialisation. Finally, the specialisation index is positively correlated to the private ownership status of the health care organisations. The other variables have no statistical relevance.

ANALYSIS

The findings of this study provide evidence for the identification of the variables that influence hospital specialisation. So far the scientific literature did not pay attention to the variables that influence hospital specialisation within the Italian context. This issue is worth being analysed in depth in order to better understand the determinants of this phenomenon. The results have interesting implications also for health care policy makers. Private providers are more specialised than the public ones because they enjoy more autonomy to define the range of services to be delivered and they seem more prone to adjust their case-mix in order to obtain economic advantages from the DRG system. Public providers have to balance their managerial autonomy with financial and clinical goals as well and equity and accessibility defined by the policy makers. The results show that enhanced regional commitment towards the DRG reimbursement system provides positive enhanced on specialisation index.

PROMOTING BETTER VALUE IN HEALTH CARE: DEFINING AND IMPLEMENTING A PROGRAMME BUDGETING MARGINAL ANALYSIS (PBMA) IN ITALY

PhD Student session

Agnese Lazzari, Paola Galli, Mariarosaria Gualano, Antonella Venditti, Valeria Fabbrini, Walter Ricciardi

Institute of Hygiene and Public Health, Catholic University of Sacred Heart, Rome, Italy

CONTEXT

The Italian National Health Service (INHS) has been experiencing, like many Western countries, a deep cultural revolution.

The challenges of the new millennium have shifted the focus from medical dominance, technical and allocative efficiency to citizens-centred care oriented to create value. The changing context has put much pressure on Italian decision-making processes, pressing for the set-up of top priorities to be met using clearer, evidence-based methods of resource allocation. Nowadays, planning and priority setting at macro level are determined by the requirements of Essential Benefits Packages (LEA), and policies are still focusing on the bureaucratic dimension of services delivery, hindering better value for health care.

METHODS

The purpose of the present project is to apply PBMA to the Italian health care context, to support decision making choices and guarantee resources to be optimised and public health needs to be satisfied.

Programmes of care with epidemiological and financial priorities (female cancers, cardiovascular disorders) will be selected, and pilot projects will be launched in order to identify a PBMA model that suits the INHS. Economic expenditures connected to each programme budget category will be identified. Then, they will be related to outcome data collected for each programme to create a map aimed to 1) strengthen the link between economic and outcome performance, and 2) better understand where and how public resources are placed. This will promote benchmarking between health care organisations, institutions and decision-makers. Additionally, it will allow the elaboration of an Annual Population Value Review to better inform the population on health care benefits/returns deriving from public investments.

RESULTS

An accurate feasibility plan considering data availability, legislative obstacles and cultural factors must be elaborate to set up PBMA models that are easily achievable and repeatable in any context. A panel of consultants will be trained to follow day-by-day PBMA implementation and developments in order to identify pros and cons of the approach and adopt guidelines to guarantee its successful implementation. Communication and data flow among health care actors will increase because relevant and multidisciplinary stakeholders (DoH, Department of Economics and/or regional branches, analysts of health services dynamics such as the National Observatory on Regional Health Systems, hospital administrations, etc.) will be supporting the research project.

Evidence-based literature and guidelines will be produced to give an additional contribution to benefits deriving from health care policy transfer.

ANALYSIS

Many undefeatable issues are pressuring health care, including raising demand and needs within resource constraints and safety management, poor quality, strong inequalities and lack of prevention. PMBA can produce better value in health care focusing on diseases and not on services any longer. The current allocation of resources and the planning criteria in Italy are often difficult to be identified, without any awareness on the effects of the investments done. Due to a PBMA approach, shifting resources from one health programme to another will be more feasible and transparent. This method, in fact, allows identification of marginal effects to re-allocating resources in different services, which probably need to be improved to add value. Cost-effectiveness analysis needs to be done on both programmes before deciding to move resources, but a clearer scenario on health care benefits and effective tools will be provided to policy makers and payers to inform value choices.

BETWEEN QUALITY AND EFFICIENCY: HOSPITAL WARD MANAGERS IN VALUE SQUEEZES.

PhD Student session

Arne Orvik¹, Sølvi Røsvik Vågen¹

¹Aalesund University College, Ålesund, Norway, ²Akershus University Hospital, Lørenskog, Norway,

³Nordic School of Public Health, Gothenburg, Sweden

CONTEXT

Quality and continual improvement have for years been emphasised by Norwegian health authorities through specific strategies and intensified control. At the same time, researchers have found an under-reporting of quality deviations, and that communication issues in health care organisations are of great importance for whether deviations are being reported or not. Managers' actions when deviations are reported have implications for communication and climate. Against this background, there is a need for more knowledge about what contributes to dialogue and an open culture of reporting. Additionally, quality deviations should be studied, as ward managers are cross-pressured by organisational dilemmas.

METHODS

The methodological approach included qualitative interviews of 10 managers (nurses) from inpatients and outpatients wards, lasting for approximately one hour. Qualitative research interviews were selected to achieve deep reflections, reactions and emotions on sensitive research questions. Approval was given by the Privacy Ombudsman for Research in April 2007. Ward managers were selected because of their key positions and closeness to diverse health professionals and patients in the wards, which are optimal settings for measuring quality. Ward managers' positions are important to improve quality in case of deviations. To achieve geographical and cultural diversity, and to achieve data saturation, participants were recruited from various types of wards in six Norwegian hospitals. Some participants were selected randomly, others conveniently. The respondents make up a heterogenic group, reflecting their diversity of experiences and competencies.

Content analysis was used, and transcribed data were divided into meaning units, codes and categories.

RESULTS

Transparency, trust and an open culture characterised by active handling of deviations were management strategies to improve unacceptable practice and promote collective learning. However, our data show differences in the ways ward managers followed up specific routines for reporting, and to what extent they actively handled deviations. Dealing with severe cases, for example professionals who treated patients unethically, was especially conflicting. Such cases were rarely reported, apart from situations where the ward managers focused particularly on unacceptable practice. Some pointed out a considerable discrepancy between responsibilities and resources, which implied a kind of managerial powerlessness. Handling of deviations affected them ethically, professionally, personally and emotionally. Emotional distress seemed to move managers'

focus from professional growth and improvement of skills to an issue of blame. In general, the managers experienced that requests for quality of patient care have less impact in hospital organisations than financial requirements.

ANALYSIS

The ward managers were squeezed between quality and efficiency, responsibility and shortage of resources, improvement and blame, openness and secretiveness. Such tensions affected their organisational relations and integrity; working in accordance with personal values, doing what one wants to do and being integrated into the (organisational) environments (Schabracq 2003). As nurses, the managers had been socialised into norms like individualised care. However, to some degree such values are squeezed by budget constraints and also by top managers who ignored value tensions. To integrate quality and financial requirements and to promote organisational learning (Argyris 1990; Senge 2006), ward managers should act communicatively as well as strategically (Habermas 1984; Nordby 2009). Integrity threats may be induced by conflicting organisational logics and should be analysed on a cultural level. Pressure on integrity may cause health problems for managers and thus challenge the sustainability of hospital organisations.

MEDICAL LEADERSHIP: EXPERIENCES, COMPETENCIES AND DEVELOPMENT NEEDS OF DOCTOR MANAGERS IN THE UNITED KINGDOM.

PhD Student session

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¹University of Manchester, Manchester, United Kingdom, ²Kenyatta National Hospital, Nairobi, Kenya, ³University of Nairobi, Nairobi, Kenya

CONTEXT

The aims of the study were first to explore the experiences, leadership and management competencies and development needs of doctor managers in the United Kingdom, and secondly to test the applicability of a leadership competency framework specifically developed for doctors. There is widespread support in the literature for the establishment of clinician management structures. In the UK, there is considerable interest in doctors becoming more involved in management of the National Health Service. A recent surge in international projects studying various aspects of leadership and developing leadership frameworks in health care indicates an interest in better understanding and defining leadership.

METHODS

Data for this study was collected using a multi-method approach; qualitative interviews and a survey. In the first stage of the study, face-to-face interviews were conducted with 13 doctors in management in two strategic health authorities in the National Health Service (NHS) in the UK. An interview schedule was used to focus data collection. In the second stage of the study, a self administered questionnaire based on the Medical Leadership Competency Framework (MLCF) 2008 was sent to 518 doctor managers in the NHS, with a response rate of 38%. The survey design also allowed for testing of some hypothesis that had been constructed before the data was collected. The two sets of data were analysed together to test the applicability of the MLCF (2008). A template method was used for qualitative data analysis while appropriate univariate, bivariate and multivariate statistical tests in SPSS were used for quantitative data analysis.

RESULTS

Data from the survey validated the findings of the interviews in addition to providing additional information on applicability of the MLCF (2008). Some doctors are interested in medical management although generally doctors resent the word management and prefer the term leader. Doctor managers in the UK find the job difficult and stressful. Various reasons for and ways of addressing some of the difficulties were proposed. The participants reported a large number of leadership and management competencies and equated management processes to patient care. Clinical credibility was reported as the most important and mandatory 'skill'. The doctors identified training and development needs and the majority recommended this training at the specialist registrar level. Results of data analysis suggest that the MLCF (2008) may not be applicable for use by doctor managers and that some of the assumptions made when appointing medical and clinical directors may not be valid.

ANALYSIS

From this study, it may be concluded that the experiences, competencies and development needs of doctor managers in the UK to a large extent are similar to previous findings. However, the findings from this study have provided some additional data in areas such as what is transferable from medicine to management, views on leadership development, validity of some hypotheses and the applicability of competency frameworks in health care. The study raises some issues that may require further investigation like the proposition that certain medical specialties are more suitable for management than others. Literature suggests that medical specialties may be predictors of competency, and the survey data validates part of this finding. There is need to further explore practical ways of encouraging doctors to take on leadership roles and the use of leadership competency frameworks in health care. A key limitation of the study was the degree of objectivity in self evaluation.

**Parallel sessions:
Introducing changes at system-level: what can we
learn?**

**Friday 2 July 2010,
11.00-12.30**

Suzanne Robinson, Helen Dickinson, Tim Freeman, Iestyn Williams
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CONTEXT

The recent economic downturn places increasing pressure on the financing of health care services. For many health care providers, this means difficult decisions need to be made over what will and will not be funded. The need to distribute scarce resources in an efficient and effective manner has led to a range of cost-containment strategies, with a number of tools and approaches being used to aid priority-setting processes in the UK and beyond. The aim of this study is to empirically explore how different strategies and approaches are enacted, in terms of their deployment within decision-making processes in English Primary Care Trusts

METHODS

Based on a case study design, our analysis draws on existing documents, observation of priority setting processes and semi-structured interviews with participants. The case study site introduced a new priority setting process that follows the Accountability for Reasonableness framework (Daniels and Sabin, 1998), which requires the involvement of deliberation and debate as well as information and evidence to support decision making. The approach is at odds with previous policy and clearly places responsibility for service innovation on clinicians, seeking to incorporate them in their own self management. This paper adopts an interpretive approach to explore priority setting at the local level, focusing on the effects of process design (format and tools) and on the manner in which decisions are reached within these processes. Our analysis allows for exploration of the ways in which respondents make sense of complexity, developing a rich and nuanced account of the tensions attendant with priority setting.

RESULTS

Results suggested an apparent (rhetorical), rather than real, devolution of decision-making responsibility. For some respondents there was a dissonance with the rational process of priority setting, which tended to relate to a lack of availability of relevant clinical and cost-effectiveness data. The deliberative element, central to the approaches rationale, was typically honoured in the absence rather than the observance, with discussions tending to focus on technical aspects rather than more fundamental deliberation. While the process did allow for priority setting to be performed, which gave some semblance of delegated autonomy, managerial control was largely maintained, and we argue that the approach may be best viewed as an exemplar of the 'cultural performance' of decision-making (McKenzie, 2004).

ANALYSIS

Findings from this study highlight the tensions between the rational approach to decision making and the performance of decision making. The attempt to import approaches from one context to

another served to provoke dissonance between the stated intent of the process and its ability to deliver in practice. Our study enabled us to explore the types of meaning, which a variety of stakeholders attribute to various aspects of the priority setting process and therefore the sense which they make of approaches to rationing decisions. What this exemplifies are a number of different groups, who value types of evidence and therefore give precedence to different aspects of the priority setting process. Rather than considering priority setting tools and processes as clear and bounded, this approach provided an in-depth exploration into how these processes were enacted in practice within a specific locale.

PLANNING THE DUTCH GP WORKFORCE

Introducing changes at system-level: What can we learn?

Ronald Batenburg, Lud Van der Velden, Malou Van Greuningen

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CONTEXT

For a long time, shortages of health care personnel have been a major worldwide concern of health policy makers, professional bodies and patient organisations (cf. OECD, 2008). It is commonly acknowledged that manpower planning can be an important instrument to control shortages (and oversupply) within the health care labour market, in particular by increasing or decreasing the numbers to be trained (cf. Maynard & Walker, 1997). The Netherlands is one of the countries that has a long tradition of manpower planning in health care, more specifically of general practitioners (GPs), and is therefore an interesting case to study.

METHODS

For this paper, we describe and evaluate the Dutch manpower planning system with regard to the largest medical profession in the Netherlands, the GPs. Based on NIVEL registration of (nearly all) GPs in the Netherlands since 1975, data is re-analysed that has been used for the manpower planning before and after 1999. In that year, the capacity body was established to centrally plan the entrance to the medical bachelor and master (specialist) studies, including the training for GP. We perform a historical policy analysis describing the critical decisions and stakeholders between 1975 and 2008. This is combined with a statistical description of the planned and realised GP student entry numbers, as well as trends in the size and composition of the GP workforce. An interpretative and backward evaluation perspective is applied to address the question if the Netherlands was successfully in overcoming the pork cycle in GP manpower planning.

RESULTS

Registry survey data shows that GPs in the Netherlands are probably the most complex and dynamic medical occupation to monitor and, hence, to plan. Over time, the popularity of becoming a GP strongly varied among medical students, and so has the entrance of graduated GPs on the labour market. During the last decade, preferences of GPs have changed with regard to the type of practice, career length and attitude towards generalisation, specialisation and multidisciplinary collaboration. Contrary to the autonomous trend towards medical specialisation, GPs are increasingly put forward by the Dutch government as the corner stone of a strong and integrated primary care. These conditions have heavily challenged the Dutch manpower planning system and the potential the pork cycle in GP manpower supply. Still, the system appears to be successful in controlling and capturing most fluctuations, although the cycle time of planning is decreasing rapidly.

ANALYSIS

Although manpower models have successfully supported policy makers to steer the (numerical)

entrance in the medical bachelor and GP specialist training, it can be questioned if these remain feasible for the developments to come. Specifically, two trends need to be incorporated in the manpower planning for GPs that are yet underspecified. First, substitution within the primary care occupational structure will increasingly change the GP position - as tasks are re-allocated to new health occupations (such as Physician Assistants). Second, the need for local and regional health care planning will increase - in line with the policy trend to match health demand and supply as close to clients as possible. We reflect on the opportunities and barriers to extend the Dutch system of manpower system for GPs on these elements, both in terms of manpower modelling and its policy consequences for government and stakeholders.

DECENTRALISATION IN HEALTH CARE: AN CROSS SECTORIAL COMPARATIVE ANALYSIS

Introducing changes at system-level: What can we learn?

Guilhermina Rego, Joana Monteiro, Rui Nunes

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CONTEXT

The successive reforms in the health care systems of the developed countries have the fact in common that maximising efficiency is considered a factor as important as the guarantee of adequate performance levels in health care. Besides these important drivers of the reform of health care institutions, the health care system should cater for the citizens' perceived needs. Nevertheless, responsiveness, or rather the capacity to meet the citizens' wishes, is normally linked to problems of centralisation of health care decisions. Due to the specificity of the economic good, at issue decentralisation policies are an important step towards the modernisation of public health care systems.

METHODS

In this context we intend to analyse the possibility of a gradual change in the health care governance model through the political, financial, and operational decentralisation of the system. Methodologically the authors propose a comparative analysis between health care and the education sector, a social sector where empirical evidence does exist in many European states. In Portugal, as an example, each county is responsible for the first cycle of education, and finances it out of county income and property taxes along with block grants from the state. This analysis tries to identify if this type of administrative change tends to be globally better, and if it has more capacity to positively influence values such as efficiency, equity, quality, governance, empowerment and accountability than the previously existing administrative model. A strategic analysis was performed applying decentralisation practices in education, and afterwards a projection of its impact was evaluated in the health care reform.

RESULTS

The health care systems of the industrialised countries are confronted with important challenges due to the rise in health care costs and the subsequent lack of financial sustainability. The convergence of various factors, specially, the demographic transition, will create the need for considerable creativity to overcome the inevitable economic pressures that the social protection systems will encounter. The introduction of a quasi market approach in health care is the reflection of this evolution, but this reformist course is not by itself able to drive the necessary administrative changes. Following the experience in other social sectors such as education, administrative decentralisation seems to be an appealing driver in order to protect important social values. It may even originate closer community links and therefore reinforce political accountability as well as public accountability.

ANALYSIS

Modern managerial models are also easier to implement in a decentralised system, more distanced from the Government. However, these changes in the system must be also characterised by expenditure control, reasonable positive development in productivity, and a high degree of patient and citizen satisfaction. That is, management models are to be found that will not only incorporate the market rules, but also allow the implementation of principles and values protected in the modern societies, such as accountability and responsiveness in accordance with the communities' interests.

CANCER NETWORKS: AN EXPLORATORY ANALYSIS OF THE ITALIAN CASE.

Introducing changes at system-level: What can we learn?

Marco Sartirana, Valeria Tozzi
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CONTEXT

Managed Clinical Networks are emerging internationally as an innovative organisational model of care for complex and chronic diseases, since they allow to improve quality of care while increasing the equity of access and making better use of scarce resources, primarily expertise. Cancer Networks represent an important and early example of MCNs, since the lengthy and articulated process of cancer care hides a relevant potential for interorganisational integration. Cancer Networks, that were firstly developed in the UK National Health System, have recently been introduced by some Italian Regions and are in the political agenda of most of the others.

METHODS

On the basis of prior research on coordination mechanisms adopted in Cancer Networks of the United Kingdom, an exploratory analysis of the Italian case is developed. The experience of the 15 regional network coordinators (or project managers, for the Regions in which MCNs have not been formalised yet) is gathered thanks to telephone semi-structured interviews, designed to analyse the following dimensions:

- Organisational: analysis of the organisational structure and mechanisms which favour intra- and inter-organisational interactions;
- Operational: analysis of the operating systems for the network management;
- Professional: analysis of the network under the perspective of the generation and diffusion of clinical knowledge and the integration with Primary Care.

RESULTS

The article assesses the following issues:

Which, among the coordination tools that demonstrated effective in the British experiences, have been introduced in Italian Cancer Networks. The rate of adoption of case management, multidisciplinary teams, clinical pathways and finances for implementation are presented.

Which lessons can be learned from these experiences with regard to success factors and implementation problems. Two pre-existing environmental factors appeared to facilitate the network development: the inadequate qualitative level of cancer care and the presence of a recognised clinical leadership. The main problems arose with respect to the collaboration with General Practitioners; the clinical vs organisational dimension of guidelines; and the financial support granted to network projects.

ANALYSIS

It is shown how most Regions are adopting models that resemble the Cancer Network of Piedmont Region, which in turn is designed according to the Cancer Networks of the NHS of United Kingdom. One Region only has opted for a different type of network, although it cannot be properly defined a Managed Clinical Network. These differences seem motivated on the basis of the pre-existing features of cancer care services in different territories, and the correlated need for a higher level of either quality, equity or efficacy. As a consequence, the common referral to a single model appears inadequate for different regional contexts presenting heterogeneous initial conditions. We finally identify that a number of recurring problems emerged during the implementation phase that hampered the potential impact of the network on the quality of the care process. With reference to this point some suggestions are provided to regional policymakers and network managers.

**Parallel sessions:
Patient empowerment**

**Friday 2 July 2010,
11.00-12.30**

INTRODUCTION AND DEVELOPMENT OF PROTECTION OF PATIENTS' RIGHTS IN SERBIA: GOALS, DILEMMAS AND RESULTS

Patient empowerment

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CONTEXT

From 2002 Serbia undergoes substantial health sector reforms. Patient oriented system and quality assurance are milestones of the reform. One of the very first activities started in 2002 was to assure patient centred environment was establishment of Patients' Rights Ombudsman in each health care institution across Serbia, and on higher instance, at the Ministry of Health. This process relies on European Charter on Patients Rights and Declaration of Human Rights and latter institutionalised at Health Care Law adopted in December 2005. National Ombudsman for Citizen Rights' protection demonstrates orientation of Serbian Government. Protection of patients' right presents pioneering job.

METHODS

This research presents a descriptive analysis of developments in the area of patient rights in Serbia from 2002. Moderate volumes of data have been collected to demonstrate trends described within Results and Discussion. According to the Law, each health care institution must provide a patient rights' protector. The protector of patient rights deals with patients complaints, renders legal advices, acts as a mediator between patients and health care professionals, and tries to solve patients' problems at the health care institution level. Patient can address the Ministry of Health at the second instance. Public campaigns at national and local level were conducted in several waves, each followed with public opinion research to asses outcomes achieved. Patients were questioned about their basic knowledge and understanding of their rights and response of the institutions to protect them. Collected data was analysed at the Ministry of Health, Patient Rights Ombudsman office.

RESULTS

Based on a five year analysis of received complaints, it has been concluded that the most frequent reason of complaint submission is "misbehaviour" of health care professionals. Lacking information to be addressed by health care professionals is also frequent. It was favourable that the number of complaints increasing during the time period showing increased awareness of patients. Patients are better informed about their rights, and health care professionals have become aware that it is their legal obligation to respect rights. There is evidence that the protection of patients' rights is needed in Serbia. Also, it is clear that this area should be further developed from the current level. Increasing trends of patients seeking protection of their rights encourage further development. The

nature of cases also evolves to more demanding issues as patient acquire a better understanding of their rights.

ANALYSIS

Work on patients' rights protection has been envisaged as a continuous process and team work, which is one of indicators of quality of health care service. This research demonstrates that awareness of patient rights increased, among both patients and providers, during the seven years period. The nature of complaints has been changed slightly, mostly in figures, providing also certain levels of protection to health care professionals. Major benefits from preventive activities focus on resolution of misunderstandings, avoiding of conflicts, adjudication and mediation in solving of problems and avoiding of expensive trial procedure. Most of complaints can be resolved through such mechanisms. Recommendations are that further development should be toward wider public debate and introduction of different societies (NGOs, and associations dealing with vulnerable groups, human rights, Chambers of different health professionals etc) to promote positive values.

PATIENT EDUCATION IN GENERAL EMPOWERMENT SKILLS - FIRST EXPERIENCES WITH A NEW EDUCATION OPPORTUNITY

Patient empowerment

Thomas Nebling (Presented by Susan Klein)

Techniker Krankenkasse, Hamburg, Germany

CONTEXT

Quality of health care not only depends on what physicians and health professionals do. It is also influenced by patient's behaviour and knowledge. At the same time, patients require an active role in medical decision-making, but face difficulties like managing the flood of health information, choosing the right provider, service or product. This situation not only results in frustrated patients, but also leads to an ineffective and inefficient use of the health care system. To increase quality of health care, patients need skills of empowerment, which enable them to make sound decisions on what is best in the individual situation.

METHODS

TK (one of Germany's biggest sickness funds) has developed a special education opportunity for patients: the tutorial series "generic patient skills". Here, patients can acquire skills that are helpfully independent from a certain situation (e.g. a certain disease) or a certain task (e.g. changes in life style). The tutorial series consists of three courses:

- Course 1: "How to find, assess, and use health information";
- Course 2: "Successful communication with physicians";
- Course 3: "How to find and assess health providers".

The duration of a course is on three evenings with two and a half hours each. The methods used are on exchange of experiences, moderated discussions and especially many exercises. Besides brief introductory presentations held by the tutors, participants have active parts at about 50 per cent of the time available. Small numbers of participants (10-15 per course) allow intensive dialogues among participants and with the tutors.

RESULTS

For the first time the tutorial series took place from September to November 2009. The courses attracted mainly women with a high level of education. Average age was at 42 years. The self-reported health status showed a heterogeneous picture: "very poor" and "rather poor" were almost as often mentioned as "very good" and "rather good". Almost every participant reported that he or she has learned something new, which was of relevance for him or her, and that the methods used felt adequate. Some participants booked two or all three courses. Being in action with exercises has made participants feel like they really have learned something. Flyers were displayed in our customer offices and at the medical centre where the courses took place. It was

not as easy as we thought to get the courses fully booked. But those that we reached in the first round were all very enthusiastic about the courses.

ANALYSIS

Without doubt, there is a need for patient empowerment skills. What we will have to do in future is to improve public announcement and to evaluate the sustainability of our courses. The aim of our education opportunity is to enable patients making informed and confident decisions concerning their health, no matter if they look for prevention, early detection (e.g. cancer screening), diagnosis, or therapy. This describes truly a radical change in health management where traditionally physicians are seen as the main decision-maker in patients' medical treatment. But this is crucial to improve quality of health care, as patients are the main 'producers' of their own health. This is not to make physicians unnecessary, but to allow equal shared decision-making between physician and patient.

Risto Kuronen¹, Pilvikki Absetz², Kristiina Patja³, Mikko Nenonen⁵, Tom Wiklund⁴, Erja Oksman¹, Martti Talja¹

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CONTEXT

Primary health care in Finland is based on public services and guided by national guidelines, which are customised regionally and locally. Latest scientific information and modern therapies are available. Still only 24 % of males and 30 % females with e.g. hypertension reach their target blood pressure. Available tools seem to be ineffective in creating health value to patients.

METHODS

TERVA, a structured telephone-based, technology-supported health coaching programme, was developed in 2007 to promote patients' motivation, knowledge and skills in disease self-management and to improve their adherence to clinical care. Patients with undertreated type 2 diabetes (T2DM), recent myocardial infarct (MI) or cardiac insufficiency (CI) were identified from regional databases. 1515 persons were randomised in intervention (n=1017) and control (n=498) groups. The intervention included two calls for engagement and assessment, and a median number of 12 outbound, structured coaching calls in a one-year period. The programme was supported by a web-based database for the coaches, which provided structured questions and key recommendations based on national guidelines on each disease. Coaches also had access to patient records in both primary and secondary care, and an opportunity to consult the patients' physician/nurse. All health coaches worked in one call-centre.

RESULTS

Preliminary results show that while improvements were reported in several health behaviours during the research period (12 months), improvements in primary endpoints (laboratory tests, blood pressure, waist circumference) were relatively modest in comparison to the control group. Creating collaboration with local primary care turned out to be a major challenge. Coaching of the patients revealed many gaps in the care such as lack of treatment plans and failures in disease co-management. In fact, it seemed that many health professionals regarded the health coaches as competitors and a threat to their profession rather than as team members in improving patient care.

ANALYSIS

The goal of health coaching is to empower patients in healthy lifestyle and disease self-management. In this study, coaching led to changes in health behaviour. However, for the changes to translate into improved health outcomes, clinical practice needs to be supportive of the patient's

efforts. As long as practices in the Finnish primary care do not support treatment planning and disease management in collaboration between the patient and different health professionals such as physicians, nurses and health coaches, the goal cannot be reached. Better outcomes may be achieved with a comprehensive chronic care model (CCM) covering multiple elements: health system, delivery system design, decision support, clinical information systems, self-management support and the community. In a such model, tele-based health coaching has potential, as a feasible means for self-management support. In the future, CCM could provide a framework for development and organisation of effective, patient-centred health care in Päijät-Häme.

**Parallel sessions:
Raising the performance of hospitals**

**Friday 2 July 2010,
11.00-12.30**

A FRAMEWORK FOR THE ANALYSIS OF HOSPITAL PATIENT FLOWS: THE RESULTS OF AN ITALIAN BENCHMARKING STUDY.

Raising the performance of hospitals

Stefano Villa, Giuliana Bensa, Isabella Giusepi, Anna Prenestini

Bocconi University, Milan, Italy

CONTEXT

There is growing evidence that many of the problems that characterise modern hospitals (such as bottlenecks, queues, delays, workload variability, waste of resources, errors) are due to badly designed patient flow logistics systems. Patient flow logistics have to do with the complicated set of decisions related to the physical movement of patients throughout the hospital chain from the first point of access until discharge and follow-up. Just few studies have suggested a system-wide and solid methodology to help hospitals in the diagnosis of their own patient flow problems, a key starting point to carry out effective patient flow improvement strategies.

METHODS

With the present contribution we intend to provide a four-steps methodology to assess hospital patient flow problems. The findings presented are the results of a cross-sectional study that has involved six different hospitals that have shared, with the research team, all their data in order to understand the causes of their problems and perform a benchmarking analysis.

RESULTS

The assessment model is developed around four different levels:

- **Hospital-wide system**

The study compares the six hospitals along a series of standard indicators (beds occupancy rate, percentage of emergency cases, average length of stay, etc.);

- **Hospital pipelines**

We have distinguished five different physical pathways (that we called pipelines):

1. Emergency patients;
2. Surgical patients;
3. Medical patients;
4. Day-surgery;
5. Outpatient.

For each of these, we computed the temporal distribution of cases and we mapped (with the tool of a flow-chart) the flow of phases and activities.

- **Production lines**

We narrowed down the analysis and identified the clinical macro processes that characterise each pipeline;

- **Production Units**

Finally, each production line is characterised by the utilisation of a series of specific production units. The final step of the analysis is dedicated to analyse the capacity utilisation patterns of these

units paying particular attention to the different horizontal interdependencies that exist between one another.

ANALYSIS

Besides proposing a sound and thorough methodological approach to assess hospital patient flow problems the study sheds light on two important issues:

1. Hospitals are characterised by a quite large component of artificial variability in the way patient flows are planned and managed, variability that can be eliminated and is often cause of several typical hospital problems;
2. The source of variability is often far from the area where problems are actually recorded. For example, the study shows that in a specific setting ED problems were actually associated with variability in the discharging process.

Minna Kaila, Tuija S. Ikonen, Sirpa-Liisa Hovi, Aino-Liisa Oukka, Marjukka Mäkelä
Finohta /NIHW THL, Helsinki, Finland

CONTEXT

Health care systems focus on effectiveness and safety to deliver high quality care. New technologies such as drugs and diagnostic methods are developed to increase either effectiveness or safety, or both. At the same time, significant costs are incurred, as up to 50% of new health care costs are considered to be related to such new technologies. Specialised care directors and specialists of health technology assessment agreed that there was a need to intervene in the uncontrolled and variable uptake process. As a result, the MUMM programme was launched in December 2005.

METHODS

The aim has been to build a structure for critical appraisal and joint decision making for take-up of new methods. Hospital chief physicians, clinicians and HTA experts convene biannually to deliberate and develop the process. The programme leader visited the hospitals, met with more clinicians and the clinic head physicians. Articles were published in the Finnish Medical Journal (FMJ) and others. The 1st five methods were selected from 56 suggestions for review in 2006. Methods for evaluation were adapted and a structure for the reviews has been developed. The review group consists of HTA and clinical experts. The FMJ agreed to publish the reviews on the internet as well as in print. A second countrywide round of visits took place in 2008, with first reviews available. An advisory committee considers effectiveness, safety and costs outlined in the systematic reviews. Concise recommendations are finalised biannually by the MUMM committee.

RESULTS

There are 20 hospital districts in Finland, and all have been more or less engaged in MUMM. The network is now organised in a three tier structure: the secretariat (mainly HTA experts, responsible for the running of the programme in practice), the advisory committee (preliminary work both for selecting topics and making recommendations), and the MUMM committee (consisting of representatives from the decision-making bodies of hospitals). Considering effectiveness, safety and costs, 'traffic lights' are assigned: red for do not use, green for should be used and yellow, when there are e.g. concerns over safety. There are now 19 reviews and 18 recommendations (1 red, 10 yellow and 7 green).

ANALYSIS

Even though the MUMM programme now is past its early childhood, a number of challenges remain. These include topic selection complicated by difficulties of defining what is new and as defined by whom. Methodological purity of the systematic reviews and producing reviews quickly enough are in constant conflict. Clinicians' input is essential, and their busy schedules sometimes an

impediment. These are universal challenges that HTA organisations as well as health care systems face throughout the world, discussed repeatedly in the EuroScan International Network. The MUMM programme will need to be critically evaluated in a few years time, once stabilised: is it useful? Is it effective and safe? Does it hinder the uptake of great innovations, and does it ensure equity and equal uptake?

Kaila M. "Managed Uptake of Medical Methods". Health Policy Monitor, April 2008. Available at <http://www.hpm.org/survey/fi/a11/2>

<http://finohta.stakes.fi/FI/halo/index.htm>

ACCURACY OF PRICING BASED ON DIAGNOSIS RELATED GROUPS (DRGS) IN A RESPIRATORY WARD

Raising the performance of hospitals

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CONTEXT

Diagnosis Related Groups (DRGs) are among the most well-known inpatient classification systems for pricing and billing. DRGs organise inpatient stays into approximately 500 groups. Grouping is based on diagnoses and procedures performed. These, in turn, are based on International Classification of Diseases (ICD) and procedure classification codes, respectively. If the ICD-codes or procedure codes presented in the final statement at discharge are not correct, it may lead to inadequate DRG classification and pricing. The aim of the present study was to evaluate whether the DRG-grouping and subsequent pricing is adequate at the respiratory ward at Seinäjoki Central Hospital.

METHODS

286 inpatient stays at the respiratory ward at Seinäjoki Central Hospital (Seinäjoki, Finland) during 2007 were analysed. The DRG-grouping and pricing for these hospital stays were from the hospital billing files obtained by using NordDRG version 2005 with 2004 weights. These individual inpatient stays were then retrieved from electronic patient records. The final statement of each hospital stay was then evaluated (H. Kankaanranta) to estimate 1) whether the main diagnosis coding was correct; 2) whether the coding of additional diagnoses was correct; and 3) whether the procedure codes were correctly included. Finally, to obtain the adequate DRG grouping (DRG) and pricing (2004 weights, 2007 point price), the correct (as judged by H. Kankaanranta) diagnosis and procedure codes were then recorded in the VisualDRG version 2005. A permission for the study was obtained as a part of hospital development procedures.

RESULTS

For 286 inpatient stays the original (uncorrected) pricing was 649.910 €. From these, in 62 cases (21,7 %) the DRG-group was incorrect. After correction of the grouping, the adequate pricing for these 286 hospital stays was found to be 746.737 €, indicating under-pricing of 96.827 € (13 %). The main reason for incorrect grouping and subsequent pricing were inadequate additional diagnoses (29 cases) in the final statement. Other reasons included inadequate main diagnosis (24 cases), incorrect procedure codes (8 cases) and coding errors (1 case). In addition, there were minor coding errors in 130 (45 %) final statements, but these did not affect DRG-grouping or the subsequent pricing.

ANALYSIS

The results suggest that inadequate ICD and procedure coding in the final statements in a respiratory ward is relatively common. This leads to incorrect DRG grouping and significant under-

pricing of hospital stays. As these coding errors do not significantly affect the adequate clinical treatment of these patients, the adequate coding may not be considered as very important by clinicians. The results imply that clinicians need to be trained to increase their awareness of the importance of correct coding and DRG-grouping and its impact on pricing.

REALLOCATION OF EXPENDITURES CAUSED BY THE IMPLEMENTATION OF DRGS AND THE IMPACT ON THE OUTCOME LEVEL OF MEDICAL CARE (REDIA-STUDY).

Raising the performance of hospitals

Wilfried von Eiff, Stefan Schüring, Christopher Niehues

Center for Hospital Management, University of Münster, Münster, Germany

CONTEXT

The Institute for Hospital Management (IKM), Westfälische Wilhelms-Universität Münster, evaluated in a prospective, randomised, multicenter study from 2003 to 2009 the impact of the DRG system on the quality and costs in the rehabilitative care in Germany.

Experiences from other countries reveal that the introduction of DRGs does not only have a significant impact on hospitals, but also on rehabilitative care institutions. The study's approach ensures a comprehensive analysis because clinical, therapeutic, psychological and economic aspects were considered.

METHODS

The REDIA-Study is the only nationwide empirical study where all stages of the implementation process are included: before the implementation of the DRG, during the convergence phase and after the implementation. To reveal potential changes of the patient-status and -flow in the years 2003/2004, 2005/2006 and 2008/2009 datasets of 2291 orthopaedic and cardiologic patients were collected and analysed. The patients were segmented by medical indications: hip prosthesis (n = 525), knee prosthesis (n = 442), spinal disk operation (n = 368), bypass operation (n = 419) and myocardial infarct (n = 537). The necessary data regarding the acute and the rehabilitative stay were collected by indication specific data entry forms, which contained several questions about the medical condition and the expended effort of nursing medical and therapeutic care.

RESULTS

Due to the implementation of the DRGs, the average length of the stay (ALOS) of the evaluated prosthesis procedures declined by five days. Despite an increase of the time between the acute stay and the beginning of the rehabilitative care, the length of the whole treatment process declined from 46 to 41 days. In contrary to these changes, the stationary treated cardiologic patient revealed only a slight decline from 46.7 to 46.6 days. Within the treatment process the reduction of the ALOS was totally overcompensated by a decreased transition time.

Furthermore significant changes of the evaluated scores could be ascertained. The findings of the orthopaedic patient indicated a significant worsening of their medical status; the documented blood values validated these findings. In contrary to the findings about the orthopaedic indications, no significant changes regarding the medical status of the cardiologic patient were revealed.

ANALYSIS

Overall, the implementation of the DRGs led to significant changes. The reduction of the ALOS led to a worsening of the medical status of the orthopedic patients. One can come to the conclusion that the implementation of DRGs in the acute sector led to an increase of expenditures caused by wound care and an increase of the number of treated patients per employee.

**Parallel session:
Achieving radical change in health: actors or
structures?**

**Friday 2 July 2010,
11.00-12.30**

RADICAL STRUCTURAL CHANGE: AN OPPORTUNITY FOR INTER AND INTRA PROFESSIONAL ENGAGEMENT.

Achieving radical change in health: actors or structures?

James O'Brien, Nancy Savage

Horizon Health Network, Saint John, New Brunswick, Canada

CONTEXT

Canada, has a universal health care system for its citizens. The mandate for ownership and delivery of care falls under provincial government jurisdiction. Rapidly escalating costs have posed a serious challenge to provincial treasuries and effort has been put into planning for more efficient and economically sustainable health care systems. In 2008 the government of New Brunswick implemented sweeping structural changes reducing the administrative framework for 8 Health Authorities to 2, split primarily along linguistic as well as geographic lines. The subsequent upheaval and consolidation has been challenging for health care leaders.

METHODS

Horizon serves approximately $\frac{3}{4}$ the population of New Brunswick for all primary and secondary care. Primary, secondary and tertiary care. The blending of medical/administrative staffs from hospitals in four cities and a large number of towns has provided an opportunity to address issues of physician/staff engagement in the larger organisation by focusing primarily on structural organisation issues in the largest surgical programme in the health authority. It will be demonstrated that lessons learned can be applied across specialties and across the region. Similarly the need to address clinical programme delivery, quality and equity posed an even larger challenge. Rather than attempting to diminish existing hospital cultures, regional clinical care networks were constructed. These were designed to be interprofessional and multi-institutional. The goal is to develop common principals and goals, and to standardise clinical and administrative best practices. The alignments will become more integrated as trust develops while preserving local identities.

RESULTS

Since the restructuring, steady measurable progress has been identified in the surgical programme being targeted. Administrative leadership, both medical and management, has been established, funded and given clear lines and authority and responsibility. The surgeons have responded by actively engaging in programme committees and sub committees. When asked to comment in focus sessions all participants felt that the new system was both respectful and responsive. The larger policy and standards of care issues under consideration by the regional clinical care networks has also been marked by high attendance, keen participation and the development of operational plans that serve as road maps to standardise to region policies, procedures, adoption of standardise financial, utilisation, and quality and safety indicators as well as clinical best practices. Duplication of effort has been greatly minimised across all zones. Despite advances in tele and video communication ability, distances and travel time continue to pose logistical challenges.

ANALYSIS

The trend towards greater and more integrated regionalisation in Canadian health care continues, with New Brunswick being just one of many provinces embarking on the journey. The evidence from a series of focus groups with medical staff department heads and programme committee members indicates that medical staff will engage in leadership activities when they perceive a professional benefit for their patient care or an improvement in day to day efficiency. The programme networks approach continues to evolve. This innovative concept has allowed individual facilities to keep their unique community identity while belonging to a larger entity that defines and applies standards. It is this approach that has contributed to the high attendance and participation from larger regional hospitals as well as smaller community facilities. It remains to be seen if the efficiencies created will also be the answer to the ongoing financial pressures within the system.

MANAGING RADICAL STRATEGIC CHANGE: THE CASE OF TELECARE

Achieving radical change in health: actors or structures?

Jane Hendy, Theopisti Chrysanthaki, James Barlow
Imperial College, London, United Kingdom

CONTEXT

A key agenda for governments worldwide is how to constrain the costs of providing care whilst maintaining quality. One solution is the development of ehealth solutions, such as the remote delivery of health care. Commonly called telecare or telehealthcare, the potential of remote care to improve the efficiency and quality of health care delivery has been recognised in the UK. The government has supplied large amounts of funding (c. £177m) and began one of the largest randomised controlled trials of remote care services. Our purpose is to understand how this major change in health care delivery is best managed.

METHODS

Our sample is 9 remote care sites in the UK. All 9 sites are actively implementing remote care with varying levels of support. Three sites are wholly supported by the Government, and form part of a trial, called the Whole System Demonstrator programme. Three sites are part of a network that receives some supported learning from the Government. Three sites are developing without direct Government intervention. Between 2006 and 2009 we completed over 200 interviews with senior managers and staff responsible for the strategic management of remote care implementation across the sites. This work is supplemented with over 90 hours of observations and large scale document review, concerning national and local remote care policy and decision-making. Data collection is ongoing.

RESULTS

Early results indicate that the successful strategic management of remote care implementation requires more than increases in funding or additional organisational support. As remote care shifts, from small pilot projects towards a mainstream part of everyday care delivery, a significant shift in orientation, at both organisational and individual levels, is required.

A strongly committed, narrow and tightly focused workforce lead by champions serves to bind people together at the start of the initiative. As implementation gains momentum, the workforce and organisation may struggle to evolve, with paradoxically the same force that initially bound members together serving to blind people to new possibilities and way of operating. During times of uncertainty new behaviours and understanding do not easily spread, but become trapped within work sub-groups, with new dysfunctional core rigidities resulting. The provision of strategic managerial support has attempted to prevent these rigidities, with mixed results.

ANALYSIS

For remote care to be a mainstream part of care delivery, both individuals and the wider

organisation need to accept that the present framework no longer works. Tinkering at the edges of the framework will not change the whole system. Leaders and managers need to reorientate organisational strategy to one of wider systemic change and find social and symbolic management strategies to help people solidify and cope with this new understanding.

A RADICAL APPROACH TO HEALTH CARE COMMISSIONING

Achieving radical change in health: actors or structures?

Rod Sheaff¹, Susan Pickard², Susan Child³, Jill Schofield⁴, Russell Mannion⁵ (Presented by Nigel Charles)

¹University of Plymouth, Plymouth, Devon, United Kingdom, ²University of Manchester, Manchester, United Kingdom, ³University of Exeter, Exeter, Devon, United Kingdom, ⁴University of Edinburgh, Edinburgh, Scotland, United Kingdom, ⁵University of Birmingham, Birmingham, United Kingdom

CONTEXT

Responsiveness of models of care and of service delivery to patient preferences are arguably among the defining elements of health care quality. To achieve them, managers at health care organisation (commissioner and provider) level often apply consumer research and marketing methods. At health system level, patient choice exercised through quasi-market structures has a similar purpose. A radical alternative is for patients themselves to establish and control health care commissioners; and through them, health care provision. This paper describes and classifies one of the largest of such organisations, analysing what organisational conditions are required to sustain patients' governance, then drawing managerial and policy implications.

METHODS

Framework-based systematic comparison of consumer cooperatives engaged in commissioning health care with alternative forms of commissioning organisation, especially English PCTs, in terms of:

1. Organisational structures and managerial practices observed or reported in them.
2. What conditions cause a commissioning co-operative's 'degeneration' in terms of maintaining control by the member-patients, especially during periods of economic instability and health system reform;
3. Methods for maintaining the quality of clinical care, including clinician involvement in them;
4. How the organisations define, identify and attempt to remedy inequitable access to health care.

Data for the comparisons are drawn from:

1. A case study of a large US health care consumer cooperative during 2008-9, using data obtained by site visits for interviews, observation and document collection;
2. Systematic review of published studies of cooperatives inside and outside the health sector.

RESULTS

1. The case study and similar organisations have two-layer organisational structures: an elected controlling body; and a hierarchy of managers and staff subordinate to it;
2. The case study organisation responded to radically changing contexts (HMO and commercial insurer competition) by raising managers' expertise, discretion, status and pay. Managers began to manage the elections to the controlling body, shifting power from the consumer-electorate to the managers. Similar patterns were reported in some, but not all other cooperatives;

3. Initially clinicians in the case study organisation were involved in maintaining clinical quality through a medical hierarchy nested within the main organisational hierarchy. Subsequently an 'arms-length' medical cooperative was replaced that nested medical hierarchy. The former arrangement is more typical of consumer-controlled organisations;

4. Despite their democratic structure patient-controlled commissioners did not display obviously greater interest in equity (promoting the health care interests of socially marginalised groups) than public health care (e.g. NHS) commissioners do;

ANALYSIS

Consumer-controlled health care commissioning organisations give proof-of-concept of the feasibility of two radically heterodox organisational structures in health care:

1. Direct democratic patient control of health care commissioning (as opposed to indirect control via an elected government);
2. Democratic self-organisation of professional staff for purposes of managing clinical quality (which also occurs in other kinds of health care organisation).

Unequal participation in governance by different consumers appears inevitable, but other studies show that the same applies to public sector health organisations. To prevent 'degeneration' and sustain the democratic character of consumer control of health care commissioning, it appears necessary that a division of labour and of competence between the consumers (on one hand) and the managers and clinicians (on the other) should be appropriately defined and strictly maintained in managerial practice. Promotion of equity appears to require (at least) that patient-controlled commissioners have a wide, representative electorate as their membership.

Poster sessions

**Thursday 1 July 2010
15.30-16.00**

**Friday 2 July 2010,
13.30-14.00**

EQUALITY FOR RAPE VICTIMS. UNIFORM INSTRUCTIONS FOR TREATMENT OF RAPE VICTIMS IN THE HOSPITAL DISTRICT OF SOUTHWEST FINLAND

Poster sessions

Pirjo Immonen-Räihä, Rauni Klami, Lea Kauhava, Turkka Tunturi

Turku University Hospital, Turku, Finland

CONTEXT

Annually about one hundred rape victims visit the emergency units at the Hospital District of Southwest Finland for sample taking and treatment. Each health care unit has their own instructions for rape victims. It is known that the number of victims is multifold in comparison with the number of persons seeking examinations. Instructions for sexually assaulted children have already earlier been drafted as a part of the hospital district's regional care chain.

METHODS

The hospital district constitutes of 29 municipalities; these produce the services of the primary health care. Four regional hospitals and Turku university hospital offer specialised health care services. A multiprofessional team consisting of representatives of primary and specialised health care, the police, the Department of Forensic Medicine of the University of Turku, the Victim Support and the Evangelical Lutheran Church drafted the care chain for rape victims as cooperation. The care chain has been published on the care chain pages of the hospital district, and it is available for all actors in the area through the web environment maintained by the hospital district.

RESULTS

The care chain has specific examination referral instructions of both female and male victims. In life threatening cases the victims are referred to specialised health care. Treatments of other acute cases have been divided between primary and specialised health care. Non-acute cases are treated within primary health care.

The care chain has instructions for meeting the patient, examination, sample taking and for treatment. Rape victims are encouraged to file a report of an offence and to arrive for examinations without delay, in order to take necessary DNA samples and so that prophylactic medication for contagious diseases, such as HIV, hepatitis, chlamydia and syphilis, can be administered in time. Each victim is offered the opportunity for psychiatric aftercare. The church and various organisations also provide spiritual support.

ANALYSIS

The aim of the regional care chain is to guarantee the same treatment for both female and male rape victims; a treatment based on the most recent knowledge, and which is of high quality concerning mental survival and holistic health. The instructions are intended for professionals, but it has also been found that patients benefit from the additional information. A considerable amount of shame and self-blame are connected with rape victims. These feelings may stand in the way of

seeking examinations and care. The new instructions will hopefully correct the situation and also improve the judicial status of the victim. Special attention has been placed on mental support in the care chain, since up to half of rape victims acquire posttraumatic stress reactions, which in some cases may become permanent. Utilisation of the care chain demands continuous follow-up and development; thus the internet pages are monitored and regularly updated.

WHY DO PATIENTS FOLLOW A MEDICATION REGIMEN? A MATTER OF FREEDOM OR CONTROL?

Poster sessions

Sonja Geisel-Marbaise, Harald Stummer

UMIT Health & Life Sciences University, Vienna, Austria

CONTEXT

The aim of modern medicine is to develop innovations in health care like better therapy methods and more effective medication. But what about the dark horse, the patients? From all prescriptions made by physicians, patients do not convert 20% - so called primary nonadherence. Two thirds of the remaining 80% medication regimens are not adhered to correctly. That means in total only 26% of all prescriptions are executed like advised by the physician. The negligence of 74% of physicians' instructions can have severe consequences especially for patients with chronic diseases like diabetes.

METHODS

The present work analyses the refill adherence of diabetic patients of two German pharmacies. The aim of the study is to find out if based on diabetes adherence criteria researched in a World Health Organisation paper, a kind of identification matrix can be developed. Thus, 4,474 patient datasets in pharmacy 1 respectively 2,650 patient datasets in pharmacy 2 are analysed regarding the refill behaviour of diabetic patients. Relevant patients and their medication have been selected based on ATC-levels and their variations in the conversion of prescriptions for drugs with ATC-codes are calculated and aggregated to the overall refill adherence rate for a research period of two years, 2006 and 2007. To possibly detect a pattern of behaviour, the following factors are gathered: adherence to prescriptions for drugs for the cardiovascular system, gender, age, health insurance, sum of expenses, number of medication dates, several possibly adherence issues affecting drugs.

RESULTS

Unsurprisingly, the adherence rate to oral antidiabetics is low with an average at 30.0% at P1 and 26.9% at P2. In contrast, the average overall refill adherence of the same patients with their drugs for the cardiovascular system is high at an average of 73.8% at P1 and 64.1% at P2. Chi-square and Creamer's V excluded an effect of one adherence behaviour on the other.

Salient is the average oversupply with drugs for the cardiovascular system with 222.3% at P1 and 176.6% at P2, where 100% coverage would be perfect. Against, the supply with oral antidiabetics was at 48.9% at P1 and 37.9% at P2.

From the above mentioned selected factors only at P2 antacids and psycholeptics show an effect on the adherence to oral antidiabetics. The adherence to drugs for the cardiovascular system is only influenced at P1 by antiemetics, psycholeptics, psychoanaleptics and ophthalmological preparations.

ANALYSIS

The result of the present research does not support the existing hypothesis that several factors influence the adherence behaviour of patients. It has not been possible to extract a kind of matrix that could help to identify possibly nonadherent patients. That means that an often neglected problem, which causes Euro 10 billion costs per year only in Germany, may not easily be contained with the existing structures. Besides, the existing judgement of patients and their health behaviour may have to be adjusted as it seems that they individually decide when to adhere and when not. New approaches involving more health providers than only physicians are needed to get to know patients better and to probably support communication with and involvement of patients. For innovations in health care will be ineffective if patients do not comprehend the need of more adherence.

DECISION AID: TAKING PART IN A CANCER SCREENING OR NOT?

Poster sessions

Susanne Klein, Monica Burkhardt
Techniker Krankenkasse, Hamburg, Germany

CONTEXT

Over the last two years the TK has published several information sheets to assist people deciding whether to take part in a screening programme for cancer (breast, bowel and cervical cancer). They contain detailed information about the particular diagnostic test.

METHODS

These brochures aim to help the reader to be a fully adequate partner in the decision making process for the screening. Information tools used in the brochures to highlight advantages and disadvantages of particular investigations include: patients' experience, scientific studies, absolute instead of relative numbers and patient centred information such as morbidity, mortality or quality of life. The objective of these brochures is to guide patients to an informed decision whether or not to participate in the screening programme. At present there is no data on the effect of these brochures on people's decisions for or against their participation. A survey is currently underway to answer this question. Over a three months period 1,500 insured persons will be questioned about the most recently published brochure "Screening for bowel cancer". Anyone who orders this brochure will be sent a questionnaire, which may be sent back on a voluntary basis.

RESULTS

The survey emphasises the brochure's effect on the patient's personal decision. It is not aimed of assessing whether the patient made use of the screening. In addition, the patients are asked to evaluate the brochure. At EHMA 2010, TK will present the results of this survey.

ANALYSIS

The results will help to determine whether this kind of information sheet will influence patients' decisions. Effectiveness and applicability of the tools used in these particular brochures in a wider range of patient information leaflets remain to be audited.

TRIALING PATHS TO ORGANISATIONAL INTEGRATION BETWEEN UK HEALTH AND SOCIAL CARE SERVICES. DELIVERING REMOTE CARE IN THE CONTEXT OF WHOLE SYSTEM WORKING.

Poster sessions

Theopisti Chrysanthaki, Jane Hendy, James Barlow
Imperial College Business School, London, United Kingdom

CONTEXT

The 'whole system' working concept has become an international health policy imperative. This proclaims the benefits of 'joining' up individual parts of system(s) in organisations that traditionally have worked in separatist or even competitive ways. In UK care organisations, the idea that service delivery should be redesigned under a whole system approach is supported by the fact that patient needs rarely fit within one set of professional groups and organisational boundaries. Using findings from the Whole System Demonstrator programme, the paper discusses the challenges in deploying remote care technologies as a vehicle for stimulating whole system change.

METHODS

Semi-structured interviews (N= 90) were carried out with stakeholders in health and social services across the 3 sites participating in the WSD programme. Interviews aimed to assess participants' views on whole system working and the implications of rolling out remote care technologies on the organisations of care. The interviews were conducted at three time points over the duration of the study.

RESULTS

The results corroborate that implementing remote care services in a whole system context is a complex endeavour. Successful implementation requires collaborative thinking, inter-organisational communication, the re-evaluation of organisational approaches in the delivery of care, and personal and organisational flexibility to address new opportunities. There was also diversity in meanings and practices of integration across and within the organisations involved whilst barriers to integration were mainly attributed to the absence of policy pressure and to the deployment of short sighted management strategies. The aims of the WSD programme and its visions were framed within a patient-centred discourse, which in most instances was perceived by the multiple stakeholders as a mean of dealing with or silencing conflict. Issues of asymmetrical power amongst the organisations and the professional groups were also apparent.

ANALYSIS

WSD represents a unique research opportunity, because it identifies in real time what processes should be in place when rolling out an innovation such as remote care as a stimulus to whole system working. The success of introducing a whole system ethos and delivering integrated care lies in the acknowledgement and management of the complexities involved due to the current structure and culture of work practice of health and social care organisations. Moreover, it requires the active involvement of user and professional groups in the strategic decision making processes.

The study increases our understanding of how the whole system working concept is perceived and enacted and how complex organisational innovations across health and social care can be successfully implemented and managed.

IMPLEMENTING CORPORATE GOVERNANCE BEST PRACTICE TO IMPROVE EFFICIENCY OF HOSPITALS IN EGYPT

Poster sessions

Mostafa Hunter

Egyptian Institute of Directors, Ministry of Investment, Cairo, Egypt

CONTEXT

Egypt has been undergoing intensive improvement of corporate governance (CG) practices over the last years. Backed by the Organisation for Economic Cooperation and Development (OECD) and the International Finance Cooperation (IFC), the Egyptian Institute of Directors (EIoD) was founded in 2004 under the Ministry of Investment. Ever since, the EIoD has taken the lead in developing CG in the MENA region. Led by the author, a special programme for the health care sector has been developed in the EIoD since 2008. The programme addresses complex issues related to improving CG practices of health care organisations in Egypt and the MENA region.

METHODS

The EIoD has five strategic directions in its methodology: 1) Awareness through seminars about CG and presentations at health care conferences. 2) Continuous professional development through developing and conducting the 'CG for health care organisations' course, which is the first in the region. It was accredited from the National Association of Corporate Directors (USA) and the Egyptian Financial Supervisory Authority. 3) Consultancy by offering CG assessment with recommendations for improvement to hospitals. 4) Posting of independent directors and promoting the presence of independent directors on the boards of hospitals. 5) Policy advocacy to bring CG on the national political agenda as a part of the health reform in Egypt. As we are coming from the perspective of the Ministry of Investment, our priority was the private sector with private hospitals being first. Later on we will start to focus on not-for-profit and public hospitals as well as health insurance funds.

RESULTS

Despite a difficult start, some changes have been happening. Professionally trained board members are now serving on boards of nine hospitals. The knowledge of CG and its importance among clinicians, health care managers and policy makers increased. Three hospitals started improving their CG practices. We will focus in this presentation on one hospital to highlight the positive impact of improving CG on efficiency. As a family business with a board including the mother and six children, of whom five are doctors, the board of this hospital almost never met. Now the board has four independent directors (with expertise in CG, strategy, quality and finance) with an audit and quality committee. The Chairman and CEO are separate positions. Because of a professional independent board that meets regularly and continuously challenges and guides the management, the performance improved with higher quality of services at lower costs due to more efficient utilisation of resources.

ANALYSIS

There is great emphasis on improving the efficiency of health care systems at the level of managerial and clinical operations. Addressing this at the level of the board of directors and governing structures is commonly neglected. Irrespective of their ownership, hospitals might have unprofessional boards without the skill mix and independent directors. Lines of authorities and responsibilities between boards and executive management are not clear, and board committees are not effective. Corporate and ownership structures are ill-defined and disclosure is not enough. Placement of independent directors with diversified experiences, board education, and redesigning board structure and CG can make a huge change in the performance of a hospital. Reproducing this would achieve radical change in the performance and efficiency of hospitals in Egypt and similar transitional countries. It would also help in attracting capital investments to the health care sector. This would improve quality, accessibility and affordability of health care services.

Ingrid Ainalem

Centre of development, innovation and improvement, Region Skåne, Sweden

CONTEXT

The aim was to evaluate a new revised version of health care guidance for district nurses in one health care centre in Skåne with the help of systemic meeting. Before the new version was put into practice, a survey was carried out where participants were asked to express their needs and expectations of health care guidance. A survey was also carried out at the end of the course to explore feelings and reactions of the participants.

METHODS

The leader of the care centre got in touch with an instructor, and both agreed to draw up a one year course plan of care guidance. It was also decided at this meeting that all the district nurses of this care centre were to receive a two hours lecture on patient care based on their special needs. Systemic meeting was used as the method of care guidance on all these occasion.

Every meeting consisted of two hours' instruction. Altogether nine meetings were held from spring 2008 to summer 2009. In eight of nine meetings an alternative plan of action could be put forward after a thorough discussion with the whole group. The same procedure was applied to all meetings, and they were all documented. The documents together with the results of the two surveys were analysed and rearranged into a summery.

RESULTS

Care guidance for district nurses based upon systemic meeting gave good results. We could see improvements both in the field of organisation and practical nursing such as triage, schedule, telephone reception, interpretation of rules, competence and communication. Other improvements were related to stress, insecurity, frustration etc.

The last survey clearly showed that the care guidance course significantly improved competence and cooperation.

ANALYSIS

There are different ways of pursuing care guidance; systemic meeting is one of them. Our study above gave good result for district nurses, and now we plan to use the method for other professions.

FINANCING OF TERTIARY CARE SERVICES IN SERBIA: MORE THAT JUST A ONE-OFF CAPITAL INVESTMENT IN THE 4 CLINICAL CENTRES.

Poster sessions

Ivan M. Jekic, Annette Katrava, George Boulton, Miroslav Obrovacki, Aleksandar Milojkovic
Tertiary Care Project Serbia - SOFRECO

CONTEXT

The presentation will look at the current development proposals (200M EUR EIB Loan) for the 4 clinical centres, where discussion continues to focus mainly on the 'bed' numbers. Two main planning scenarios are considered, the difference between future bed requirement estimates arising from a business planning process and separately through a master planning process. The difference amounts to 1,235 beds. The key issue here is not the affordability of the capital investment, but the capacity of the system to adequately finance the recurrent costs of these tertiary level centres over the next decades, without detriment to other policy priorities.

METHODS

The lower business planning figure from the business planning process takes account of developments in day, ambulatory and other care delivery modalities and links future capacity and work volumes to level of recurrent resources necessary to run services at a proper level and standard. This amounts to something approaching a zero-based budgeting approach. The higher level of bed provision arising from the master planning process is principally dominated by investment planning considerations only. The current assessment, based on a crude cost per bed calculation for each model is that the recurrent consequences of providing an additional 1235 beds (the equivalent of a fifth clinical centre) can be estimated to be between €31.43 million and €50.94 million above existing (2008) recurrent funding levels.

RESULTS

The major current weakness is the systematic evaluation rigour applied to investment planning and the need to coordinate investment planning with the planning of recurrent resources. Most investment should affect activity levels and will certainly have revenue implications, which need to be measured. Even the replacement of an old technology with a new technology is likely to have revenue consequences (either positive or negative). All major investment proposals considered by the MoH or donors should be supported by a detailed business case. The imminent investment programme planned for the four clinical centres enabled through a loan arrangement between the Serbian Government and EIB will produce a substantial new set of infrastructure and major technological investment. The former will need continuing maintenance to sustain the new accommodation standards, and the latter a replacement budget on new technologies, which will depreciate and become obsolete over periods ranging from 5 to 9 years.

ANALYSIS

Clinical centres alone consume approximately 26 B dinar representing 30% of the total secondary

and tertiary health care allocation. If one adds all the other designated tertiary level institutions, the importance of the tertiary level services in terms of their resource impact cannot be overstated. However, most of the designated tertiary level centres undertake a mixed secondary care and tertiary care case load, so it is not possible at this stage to produce an estimate of actual tertiary level expenditure.

It is understood that the MoH and HiF intend to introduce a DRG based system of financing secondary care services in the near future. This will positively support the various proposals for improved and specialty - based approaches to the planning, performance management and financing of tertiary level services and will assist, at the macro resource allocation level, in improving overall allocative planning and financing of the health care system.

EFFICIENCY IN RESOURCES ALLOCATION: HEALTH TECHNOLOGY ASSESSMENT OF A TWELVE YEAR SCHISTOSOMIASIS CONTROL PROGRAMME IN CAMBODIA

Poster sessions

Emanuela Foglia, Umberto Restelli, Emanuele Porazzi, Anna Vanzago, Luca Casartelli, Davide Croce
CREMS - University Carlo Cattaneo - LIUC, Castellanza (VA), Italy

CONTEXT

HTA is a systematic review of existing patients' evidence that provides an evaluation of the effectiveness, cost-effectiveness and impact both on patients' health and on health care systems (Fox-Rushby and Cairns, 2005). Its applications are wide, and it can be useful to assess the impact of the introduction of a new technology on a macro, meso and micro level (Batista, 2005) in order to support decision makers with an analytical methodology. The evaluation to be performed may concern vaccines, devices, medical and surgical procedures, disease prevention and screening activities, health promotion activities and health care delivery initiatives (Canadian Agency Guidelines, 2006).

METHODS

HTA is a multidisciplinary process that summarises information about medical, social, economic and ethical issues related to the use of technologies in a systematic, transparent, unbiased, robust manner. It informs the formulation of safe, effective health policies that are patient focused and seek to achieve best value (www.eunethta.net). Using this definition and the Canadian Agency Guidelines (2006) as a starting point, the study was performed considering HTA's five main areas of analysis (complete economic evaluation, budget impact, organisational impact, equity and generalisability). The methodology provides additional information on health care programmes, within a national context, to support public payers both in terms of ex post evaluation and ability to forecast future impacts. Its usefulness was evaluated through the analysis of a study based on the assessment of a twelve-year schistosomiasis control programme, through a Mass Drug Administration, in Cambodia, commissioned by the WHO (in 2008) and carried out by CREMS.

RESULTS

The comparator, an alternative of the programme, was the "do nothing" situation. The economic evaluation (cost-effectiveness analysis) is in favour of the programme implementation (the ICER resulted to be 7.02 USD per capita). The organisational impact of the control programme, assuming the Ministry of Health's (MoH) viewpoint, is low and in favour of programme implementation. The equity analysis demonstrates the utility for the users of the control programme to be carried out rather than to maintain the "do nothing" situation. The generalisability of the results is limited due to the unique characteristics of the Cambodian territory, in which the study took place, while the approach used is highly replicable. HTA methodology provided useful information to assess the real impact of the programme on the budget of the MoH: it would not have been implemented without the help of external donors, and their support is also needed to maintain it.

ANALYSIS

The study presented is the first analysis of a multi-year programmes, which considers all cost categories: direct costs, indirect costs and general costs (Croce et al., 2009). The study was performed within a developing country, but the analysis can also be applied to different health technology typologies in developed countries. The introduction and use of HTA supports decision makers in performing complete, balanced and transparent evaluations in order to assess the efficiency in resource allocation. HTA's multidimensional approach provides a wide range of information, which allows detailed analysis of the advantages and disadvantages of the introduction of the new technology. A complete analysis of the results may help to perform reliable forecasts and to provide information on the sustainable actions to be undertaken in the future. This is essential both within developing and developed countries, but mainly within the latter where health care expenditures shall be strongly contained.

EVALUATION OF MOTORCYCLE HELMET INTERVENTIONS IN HIGH AND MIDDLE-INCOME COUNTRIES: AN ECONOMIC REVIEW.

Poster sessions

Marta Marino¹, Ferruccio Pelone², Giuseppe Avallone¹, Danila Basso¹, Maria Avolio³, Walter Ricciardi¹, Antonio Giulio de Belvis¹

¹Department of Public Health and Preventive Medicine, Catholic University of Sacred Heart, Rome, Italy, ²Department of Public Health and Preventive Medicine, Catholic University of Sacred Heart, Rome, Italy, ³Institute for Social Affairs, Rome, Italy

CONTEXT

Road traffic injuries are a major public health issue, both in epidemiological and economic terms. Motorcycle accidents are one of the major causes of traumatic injuries and deaths. In European countries, head injuries contribute to around 75% of deaths among motorised two-wheeler users and the social costs of head injuries for survivors, families and communities exceed €180 billion. We performed an economic review on both total costs and economic benefits as well as the costs per additional unit of effectiveness as result of from public health interventions targeting to motorcycle helmets to prevent non-fatal and fatal injuries in high and middle-income countries.

METHODS

Motorcycle helmet interventions were classified as follows: compulsory/non compulsory helmet laws; programmes promoting compliance with the law; economic incentives on helmet purchase/use; health promotion/education campaigns targeted at bikers, parents, educators and GPs; enforcement of road traffic controls; and combinations of these interventions. Economic analysis studies have been searched by scanning electronic data sources according to the Task Force on Preventive Services methods.

We included studies if they 1) reported on an economic analysis (cost analysis, cost-benefit analysis, cost-utility analysis and cost-effectiveness analysis); 2) evaluated any helmet programme to improve the rate of motorcycle helmet use, to increase helmet use awareness; 3) focused on motorcycle riders in all countries except for low-income nations.

RESULTS

58 papers were selected from 207 references found. 14 studies met all the inclusion criteria. Our preliminary results found that all the selected studies referred to “compulsory/non compulsory helmet laws”, as non focused on public health policies/interventions to promote its purchase/use or to verify the law enforcement. Most of the studies assessing the economic impact of helmet laws were cost-benefit analyses, as only one could be classified as cost-effectiveness study.

ANALYSIS

Road traffic injuries are estimated to be the fifth cause of death by 2030 and users of two-wheelers particularly motorcyclists make up more than 50% of those injured or killed on the roads. Preliminary results of our review are likely to outline that despite the fact that several interventions

to reduce the disease burden due to road traffic injuries are routinely used in high-income countries, the evidence for their cost-effectiveness is not easily or widely available. In addition, no evidence on the cost effectiveness of other interventions (i.e. investments in health promotion/education campaigns, programmes promoting compliance with the law, economic incentives on helmet purchase/use and others interventions generating additional benefits) is available.

IMPROVING REHABILITATION IN PATIENTS WITH CEREBRAL PALSY THROUGH CARE PATHWAYS' TOOL: A CASE STUDY

Poster sessions

Danila Basso¹, Ferruccio Pelone², Laura Murianni¹, Marta Marino¹, Maria Avolio³, Antonio Cosentino⁴, Barbara Montagnana⁴, Guido Francesco Fumagalli⁵, Walter Ricciardi¹, Antonio Giulio de Belvis¹

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CONTEXT

Infantile Cerebral Palsy (ICP) represents a relevant public health concern both in epidemiologic (in Western Countries the prevalence of ICP varies from two to three cases for 1,000 live births) and in economic terms (approximately \$1,406 in health care costs for a child with ICP).

The aim of our research is to assess the organisational appropriateness of care processes delivered in a disability rehabilitation centre in Italy and to develop an evidence-based integrated care pathway for the management of Cerebral Palsy by introducing a innovative rehabilitative treatment (Gait Trainer Therapy).

METHODS

Since June 2008, and expected to finish by April 2010, a "before and after" study design has been developed to assess the organisational and economic impact of an innovative rehabilitation technology (Gait Trainer, GT). Therefore we set up a pathway development process through four stages: 1) by applying a literature search on the best available evidence and practice, the identification of the optimal sequencing and timing of interventions; 2) development of a set of indicators to evaluate quality of care pre- and post- the GTT introduction; 3) the drawing of maps of care processes and outcomes, to track the process of care delivery before and after the intervention, by analysing medical records of each access and by interviewing health professionals; 4) the final assessment on the effectiveness and organisational sustainability of the whole intervention.

RESULTS

We identified no randomised controlled trial nor any other experimental trial, and only one clinical practice guideline. Therefore, we have set out the mapping of optimal processes for children cerebral palsy in the rehabilitative centre. We have identified a set of measures, framed in structure (5), process (7) and outcome (4) indicators. By considering a sample group of fourteen children, from 6 to 18 years old, we focused on five of them (2 with Spastic Tetraparesis and 3 with Spastic Diplegia, with comparable clinical histories) chosen according to the following criteria: socio-demographic features, diagnostic functional profile, burden of disability and burden of care interventions.

ANALYSIS

As ICP represents a public concern, for its epidemiological, social, and economic impact, our study is still one of the first, which assesses the organisational and economic features of the ICP rehabilitation process. By building up care pathways maps and applying quality indicators, we adopted an useful tool to assess the impact of the GT technology. Moreover, despite a considerable degree of uncertainty about the most appropriate approaches to children with Cerebral Palsy, such an organised, goal-defined and time-specified management plan complemented the assessment of rehabilitative pathways. Our research needs further development to evaluate other impact measures than previously considered (i.e. social and quality of life impact). The definition, introduction and implementation of programmes of continuous quality improvement, even considering the long-life need for rehabilitation in ICP should also be considered.

NETWORK MANAGEMENT IN PRACTICE: AN EMPIRICALLY GROUNDED PROCESS MODEL FOR NETWORKED INNOVATION IN ELDERLY HEALTH CARE

Poster sessions

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CONTEXT

Network management is a topic of increasing interest and scope, also in the field of health care. Trust and commitment have been identified as basic ingredients of a functioning network, and we know that there are certain factors (shared values, communication, etc.) that cultivate or discourage their existence. However, what we lack is an understanding of the managerial practice of network management. We ask a simple question: what should a manager do to improve the functioning of a network? Our aim is to formulate a model of the activities that managers can or should perform to improve network collaboration.

METHODS

Since we are interested in understanding the patterns of actions required to manage a network, we chose action research as our research method. In spring 2008, we started a two and half year project on improving the functioning of elderly care networks in two cities in Finland, Espoo and Vantaa. In collaboration with the cities, we have organised in total more than 40 workshops in five different networks; the number of workshop participants ranging from about ten to a hundred from various organisations and health care sectors. The aim of the workshops has been to develop both service quality and network functioning in the field of elderly care in these cities. In relation to these workshops, we have collected and analysed various forms of data, including field notes, researchers' diaries, and transcribed focus group interviews.

RESULTS

Our main result is an empirically grounded process model of network management that outlines required roles and actions for network managers. The five-stage model helps managers to improve trust and commitment in a focal network. The first phase focuses on the starting situation where a manager has identified a need for networking, but does not really know if a network already exists or not. The second phase focuses on the first discussions to frame the aim, scope, structure, and means of the network. The third and fourth phases build on the initial framing through a systematic process of planning, doing, measuring, and reframing. The fifth phase is about explicating the gained knowledge of network management, assessing its potential applicability in other contexts, and then spreading this knowledge out to other potential users. This process model improves our understanding of the processual nature of network management at the managerial activity level.

ANALYSIS

Our theoretically grounded starting premise was that the functioning of a network requires trust and commitment among its various participants. Existing research in network management has

indeed outlined a model of network success as a function of trust and commitment, with specific antecedent factors such as communication and empowerment. However, our empirical work shows that this theoretical abstraction of network management does not translate into practice in any simple terms. Managers do understand the requirements of network management, but do not know what they should do in practice. What we therefore lack is an empirically grounded, yet theoretically consistent, plan of action for the people that are actually coping with their everyday networks in the field of health care. Our process model depicts the required activities in a five-stage process model.

EXECUTIVE TRAINING FOR RESEARCH APPLICATION (EXTRA): SMARTER DECISIONS... STRONGER HEALTH SYSTEM

Poster sessions

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CONTEXT

Senior health care managers work in increasingly complex systems where they are required to deal with conflicting demands and information. Evidence-based decision-making, while fairly commonplace in clinical settings, is an approach that has so far been limited in managerial practices (Lomas, 1997). Part of the reason for this is that the highly diverse group of health care managers often has no formal training in research use. "We need to make managers more aware of research, more interested in undertaking or participating in research, and better equipped to understand and act on the results of research" (Walshe and Rundall, 2001)."

METHODS

The EXTRA programme is a learning intervention designed to support decision makers and their organisations to more effectively use research to inform decisions about health priorities and services. Launched in 2004 with a grant from Health Canada for a 10-year intake period, the EXTRA programme is a two-year fellowship programme for health care leaders - physicians, nurses and other health care executives - that uses blended learning methodologies (residency sessions, electronic learning platform, intervention projects, mentoring, and networking) designed to:

- Develop individual skills and competencies to find, assess, interpret and apply research findings;
- Build organisational capacity to use research to bring about health system innovation and change; and
- Foster interprofessional collaboration.

RESULTS

According to the 2010 programme evaluation data:

- 81% of fellows felt that their organisation engaged in evidence-informed change management strategies based on the fellow's intervention project;
- 97% of fellows felt that colleagues involved in their intervention project increased their capacity to critically examine their actions related to problem-solving and decision-making;
- 69% of fellows felt that their intervention project (and change management experiences derived from the project) were transferred beyond their organisation;
- Over the duration of the fellowship the proportion of fellows who felt their:
 - Knowledge of research evidence was 'excellent' to 'good' increased from 64% to 95%;

- Skill-set for assessing quality of evidence was 'excellent' to 'good' increased from 64% to 95%;
- Organisation used research evidence 'frequently', 'most' or 'all of the time' increased from 31% to 51%.

ANALYSIS

As demonstrated by the data, EXTRA's evaluation results indicate that research skills and strategies are being transferred to fellows and their organisations. Also, the data indicate that changes are being effected within leadership and interprofessional ranks. The EXTRA experience is transferable to other contexts and jurisdictions. In 2008 the programme was expanded to include interdisciplinary teams and policy makers from government ministries. In 2007 and 2008, the Centre for Health Systems Research at the National Institute of Public Health in Mexico adapted the EXTRA curriculum for use in its Research Use and Application course designed for senior health care managers from Central America and Mexico. We are currently looking at a regional capacity building model of the EXTRA programme for 5 regions in Canada.

ONLINE-PATIENT-SURVEYS IN HOSPITALS - OPPORTUNITIES, LIMITS AND COSTS OF A SURVEY METHOD

Poster sessions

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CONTEXT

The competitive health care environment forces hospitals to gather information about their strengths and weaknesses. Therefore it is necessary to comprehend, which experiences had been gained from the perspective of a patient. The internet offers hospitals new ways in achieving these goals. The aim of this study was to show the opportunities of online surveys and to observe its limits within a health care facility environment.

METHODS

The study was realised in cooperation with two hospitals within the framework of a cost-benefit equation. The analysis is based upon an empirical survey where the patients have been asked in different ways to fill out the survey. In order to compare the different methods, three samples were allocated. In the first round, they received a letter on their last day in the hospital. In the second round, they received a personalised invitation to fill out the survey via e-mail two weeks after their stay. The last was realised via small cards with an alternating access code. Only the results due to an invitation via e-mail produced data for further probing. To compare the results of the online-survey with conventional methods, the findings were compared to a postal survey.

RESULTS

The data quality is mainly affected by the coverage error caused by those people without internet access. Assuming that the possibility for participation of highly educated young males is much higher than that of other clusters, the analysis showed that only people over the age of 72 are strongly underrepresented ($\chi^2=-5,3$). The average age of the sample was 44, and the age of the basic population 53 years. The proportion of female patients was as high as in the basic population (46 %, $p=0,526$). To compare the impartiality of the answers, the results of three questions were compared with the results of the postal surveys. The Mann-Whitney-U-Test indicates that patients in both methods showed identical patterns of response behaviour.

ANALYSIS

The findings indicate that the data quality of online-results is as high as with postal surveys, but reaches its limits when sociodemographic patterns should be depicted. The costs are mainly affected by the sample size. The equated cost functions of both methods showed that the critical sample size is reached with 314 patients. The cost advantage for a hypothetical short term survey with 1000 patients amounts to 1.835 €. The cost function of an online-survey is primarily distinguished by the overhead costs. Thus a continuous inclusion of all treated patients would be

possible. To avoid gaps in coverage, the online-survey should be combined with a postal survey to include older patients or those without internet access.

FUNCTIONAL AND ERGONOMIC ASPECTS OF TECHNOLOGY DEVICES AS A KEY FACTOR IN SUPPORTING CHANGE MANAGEMENT PROCESSES: THE CASE OF INTERCONNECTED GLUCOSE-METERS IN HOSPITALS

Poster sessions

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CONTEXT

Change management activities are often accompanied by the introduction of new technology devices that should positively impact the existing service processes and support the management activities for change. In order to become accepted by the individual user, who can be seen as the key actor involved in the change management process, the ergonomic design of medical devices plays a crucial role. Nevertheless, ergonomic aspects are often neglected within the purchase process of medical devices. Based on the example of interconnected hospital glucose-meter, functional and ergonomic aspects as a key factor in supporting the change management process will be examined.

METHODS

The intersubjective orientated study design was based on focus groups and semi-structured interviews. The focus groups were conducted within hospital wards for internal medicine, diabetology, surgery and laboratory. The assessment of priority criteria was based on a paired comparison. Setting: The assessment took place within three hospitals of different care levels in Germany and Austria.

RESULTS

It could be observed that functional and ergonomic aspects are affecting the adaption of new technologies, influencing the learning curve and are crucial to advantages related to the economic process. Using the example of interconnected point of care meters, it could be shown that depending on the professional background of the focus group participants different functional and ergonomic aspects are seen as being important for a successful integration within change management processes. Furthermore, a correlation between satisfaction and usage intensity of the device could be observed: Low users show a tendency to be less satisfied if the device is not intuitively applicable and see the usage within an emergency setting as being more critical. Frequent users are often criticising ergonomic aspects that influence their daily work and the successful application of the devices within the process concerned.

ANALYSIS

Functional and ergonomic aspects of medical devices are playing an important role, if used as a key factor in supporting change management processes. It is therefore urgent to integrated these components within the purchase decision-making process and to involve the user. Furthermore,

possible barriers that might negatively influence the acceptance and usage of the device within the wards should be examined before the purchase decision is made.

ACHIEVING CHANGE THROUGH PREVENTION CAMPAIGNS: THEORETICAL METHODS AND THEIR IMPLICATION FOR ANALYSING A PREVENTION CAMPAIGN'S IMPACT

Poster sessions

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CONTEXT

The increase in non-communicable diseases, demographic developments and medical innovations are challenging health systems throughout the world and are seen as being the leading factors for rising health care costs. Health promotion is increasingly seen as one option to change the emphasis within health systems from a pathogenetic to a salutogenetic approach. Prevention campaigns can thereby be seen as one instrument to influence the behaviour of the population concerned. This analysis identifies these approaches and method, and assesses their appropriateness for impact evaluation.

METHODS

The databases PubMed, Scopus, EBMR and Web of Science were used as basis for a structured search to identify published literature that reported on methods and approaches to evaluate the impact of prevention campaigns from a theoretical (methodological studies) and practical point of view (case studies of public health and prevention campaigns). Parallel searches were executed in the Cochrane library and the Health Economic Database. The search within the databases and libraries contained the same search terms or phrases (e.g. prevention campaigns, public health campaigns, campaign impact evaluation). Unpublished literature was identified through searching on web pages of health promotion and prevention related agencies like the NHS or the Centers for Disease Control and Prevention. Internet search engines were used to identify additional information and materials on the Internet.

RESULTS

Based on the result of the literature review, different approaches and methods could be identified for assessing the impact evaluation of prevention campaigns. A criteria catalogue was developed in order to assess the appropriateness of methods to assess the impact of prevention campaigns. Based on a structured analysis of prevention campaign case studies, it could be shown that the impact capacity of a health prevention campaign depends on different key drivers. Knowledge of these key drivers can increase the success and impact of a prevention campaign.

ANALYSIS

Prevention campaigns can be seen as a preferred communication instrument within health promotion interventions. Knowledge of how to evaluate their impact on the behaviour of the target group is important in order to increase the likelihood of a successful intervention.

SOCIAL CHANGES AND SYSTEMS' CHANGING TRENDS: THE CASE OF THE GERMAN AND THE GREECE ELDERLY CARE SYSTEM

Poster sessions

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CONTEXT

One of the main challenges for health systems in developed countries is the demographic development of their population. The number of inhabitants being over 80 years is continuously rising; at the same time the size of the working population decreases. This leads to a critical bottleneck: The working population is the main funder of elderly care and the main provider - either as employees within the care sectors or members of a family. To address this challenge, the implementation of innovative solutions is necessary.

METHODS

The databases PubMed, Scopus, EBMR and Web of Science are used as basis for a structured search to identify published literature that reported on a) assessment methodologies for health system and health sectors analysis and b) on social change and systems' changing trends within the elderly care system in Germany and Greece. The search within the databases and libraries contained the same search terms or phrases. Unpublished literature was identified through searching on web pages of the ministries of health and other public and private agencies. Internet search engines were used to identify additional information including current policy reports.

RESULTS

Based on the result of the literature review, different assessment methodologies for health sector analysis could be identified. A criteria catalogue was developed and applied to the German and Greek elderly care system showing the main differences and conceptual elements. The solutions to meet future challenge in this sector differ. Nevertheless substantial overlaps could also be identified.

ANALYSIS

The cross-country comparison of the elderly care system in Germany and Greece showed that both countries are facing similar challenges. In both countries, innovative approaches to meet these could be identified.

HEALTH CARE PROVIDERS ABROAD CATERING TO THE INTERNATIONAL PATIENT

Poster sessions

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CONTEXT

Cross-border travel for medical care has received recent attention as a means to improve quality, increase access, and decrease cost for health care treatments. Despite growing attention on international medical travel, very little is known about hospitals that treat large numbers of patients from other countries. The specific aim of this project was to better understand international medical travel from the provider's perspective, specifically related to physician training and experience abroad, the organisational infrastructure in place to facilitate international patients travelling to the hospital, and the challenges of caring for patients from different cultures.

METHODS

We conducted a series of semi-structured interviews with clinicians and administrators, who either led or were involved with international patients at hospitals actively engaged in treating international medical travellers across the world. Interviews were audio-recorded and transcribed. The transcriptions were coded and classified into key themes.

RESULTS

We conducted interviews with 22 clinicians and administrators at four hospitals in three different countries across the world. The transcribed interviews resulted in 168 pages of transcription. Of the 26 themes identified through the transcriptions, four global themes emerged:

(1) The international patient care service or programme plays an important role in facilitating the patient's care at hospital before and during the visit. (2) The clinician plays a unique role in providing care to international patients. Clinicians treating international patients often have either been trained or have experience abroad. (3) The hospitals proactively cater to the distinct cultural needs of international patients. International patients often stay longer than local patients, and providing "comfort" to these patients is an important element. (4) Caring for international medical travellers is a separate line of business, and is a way to diversify the organisation's patient care base.

ANALYSIS

Health care providers catering to international patients must carefully consider the value proposition for these patients. Careful consideration is given to the quality of the patient experience, starting with the patient's initial contact with the provider. Providers viewed their care as high value, by catering to the international patient's health and cultural needs. Intermediaries interested in working with patients seeking international health care providers need to provide value in addition to simply connecting patients with providers. One of the biggest challenges is in

ensuring follow-up care for patients in the United States and Canada, where providers are reluctant to care for patients seen abroad. Improvements in communication among the home and international providers would further enhance the quality and value of care provided abroad.

HEALTH CARE COSTS ATTRIBUTABLE TO CHILDHOOD OBESITY: IS THERE A RELATIONSHIP WITH HEALTH CARE SYSTEMS? A SYSTEMATIC REVIEW

Poster sessions

Mancuso Agostino², Pelone Ferruccio¹, Capizzi Silvio², Marta Marino², Basso Danila², Bucci Sabina², Specchia Maria Lucia², de Belvis Antonio Giulio², Ricciardi Walter²

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CONTEXT

Obesity is a serious public health issue for children and adolescents. According to the WHO, childhood obesity accounts for 2-6% of total health care costs in several developed countries. In this context, improvement of evidence-based multifaceted public health interventions is needed. Our systematic review is firstly aimed at analysing direct and indirect costs of Childhood Obesity (CO) on the Health Care System (HCS), and secondly, at investigating the relationship between different models of HCS ("Private health insurance", "Beveridge" and "Bismarck" system) and childhood obesity health care costs.

METHODS

A systematic review was undertaken according to 'the US Task Force on Community Preventive Services'. We have included studies if they: 1) focused on young people aged 18 or less; 2) reported a Cost-Effectiveness Analysis, Cost-Benefit Analysis, Cost-Utility Analysis, Cost Analysis conducted alone or alongside with epidemiological studies; 3) estimated both direct and indirect costs attributable to health care management of CO; 4) referred to HCS of developed countries.

We systematically searched databases (Medline, Cochrane Library, EconLit, Health Technology Assessments, NHS Economic Evaluation Database, Health Business and CINAHL) for studies published between January 1990 and December 2009. A keyword search has been performed by using a specific search strategy for each electronic database. Measures of interest were: 1) Resource use (i.e. Length of hospital stay, Outpatient visits, Pharmaceuticals ect.); 2) Costs (i.e. Cost of hospital stay, Cost of operation, Patient out-of-pocket expenses etc.); 3) Cost-effectiveness measures.

RESULTS

The search resulted in 4318 publications, of which 432 were included by reviewing titles. Among them, 52 articles were included in the review. Some retrieved papers were just economical studies focusing on cost analysis and cost-effectiveness analysis (19), while the largest number were economical studies conducted alongside with an epidemiological study (33).

Three of the selected articles (5% of total amount) referred to "Bismarck" HCS, 7 analyses (13%) referred to "Beveridge" HCS, and the majority of the included studies (75% of total) took into account "private insurance" HCS. Three studies analysed worldwide health care costs of CO, each

HCS experiencing different burdens of CO health care costs. To date, two teams of reviewers are editing in parallel data abstraction and quality appraisal of the included papers according to the framework developed by 'the York Centre for Reviews and Disseminations'.

ANALYSIS

The prevalent scientific literature warns that without intervention the costs of childhood obesity may well become "catastrophic" as obesity and its consequences are raising their impact on health care costs. Firstly, costs attributable to childhood obesity include both direct and indirect costs on welfare systems. Obesity is likely to produce high indirect costs in terms of loss of production. We focused on the relationship between models of CO health care costs and HCS. Our preliminary results show that each health care system framework would be associated with its own CO prevention and management system and different kind of expenditures (public and private). This could explain why there are substantial disparities in epidemiological patterns and health care costs associated with each health insurance coverage and services delivery system.

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CONTEXT

Patient safety should be defined as a major objective in social and health care. Patient safety constitutes the basis for the quality of health care and medical care. Safe care and treatment is provided in the right way and at the right time. It makes use of the available resources in an optimal way. In safe care, efficient methods are used so that the treatment does not cause unnecessary harm to the patient.

METHODS

The Ministry of Social Affairs and Health (MSAH) set up a steering group for the promotion of patient safety in 2006 consisting of a number of representatives from major stakeholders. The work of these dedicated individuals was divided into three wide areas. Three subgroups convened jointly and separately, looking at the evidence and experiences from other countries, and drawing also on the extensive knowledge of the group members and on previous quality work that had been done. There were two important outcomes: the first national patient safety convention in 2009 and the publication of the first national patient safety strategy. The strategy covers the years 2009-2013 and deals with patient safety from four perspectives: safety culture, responsibility, management and legislation.

RESULTS

The MSAH is in charge of drafting the legislation on patient safety. Agencies and institutions under the Ministry develop and coordinate patient safety at the national level. The performance agreements made with them specify their duties and the role of the coordinating body. The five main objectives of the strategy are: (1) The patient is actively involved in improving patient safety, (2) Patient safety is managed proactively and through learning, (3) Patient safety incidents are reported, and we learn from them, (4) Patient safety is promoted systematically and by means of adequate resources, and (5) Patient safety is taken into account in health care research and teaching. Of the national institutions, the Institute for Health and Welfare is responsible for supporting the practical implementation of the strategy, promoting research on patient safety, and monitoring the development of patient safety by means of national indicators.

ANALYSIS

The strategy paves the way towards a safer service system. Patient safety as a term originates in the health care system, and the next step is to adapt this type of ideology and culture to the social service system as well. The strategy will when effectively implemented guide Finnish social and health care to adopt a uniform (patient) safety culture. The strategy supports the Government in deciding and issuing legislation on patient safety. It serves social and health care organisations,

patients, customers and their family members in the provision of safe and effective care and treatment. The strategy is implemented in both public and private, social and health care.

Vision in 2013: to ensure safe and effective care and treatment.

Mission statement: We are promoting patient safety together.

Ann Mahon

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CONTEXT

Most advanced industrial societies are faced with the challenges of how to control increasing health care costs alongside demographic and sociological transitions that have seen increasing demands for health care. As a consequence many policy makers and senior managers in health care organisations around the world are seeking to find practical initiatives that will help them to secure "more for less". One response to this is to look at how managers and policy makers in different countries and in different health systems have responded to these challenges in ways that have - or have the potential - to enhance productivity and effectiveness.

METHODS

KPMG and Manchester Business School worked on a joint project with the aim to identify a series of good practice case studies reflecting a range of countries, organisations and interventions with broad appeal and potential for learning and transferability. A pragmatic, multi-method approach was used. This involved four distinct phases. First, a comprehensive literature across extensive journal holdings and indexes of journal citation and abstracts was undertaken in order to gather information. Second, the team contacted professional networks and personal contacts to identify potential case studies. Third case studies were shortlisted by assessing the quality of the information available alongside the potential to gather further information within a limited timescale and finally more in-depth investigation at each selected case study organisation was carried out. The emphasis in compiling the case studies was to facilitate learning from rather than about - a useful distinction made by Klein [Klein 1997].

RESULTS

The results presented will focus on two aspects of this work. First a critical reflection on the methods and the timescale adopted in compiling the case studies will be offered. Second the paper will present two typologies, one typology of the potential case studies identified from the literature searches and personal and professional networks and a second typology of the final case studies selected for more detailed research and publication. The second typology will include more detail of the country, the organisational context and the nature and impact of the interventions. More detailed descriptions of two or three of the case studies, drawing out the innovative nature of the case study, the learnings and the potential for raising productivity and effectiveness in health care will be given.

ANALYSIS

Arguments can be made for the value of looking at good health care practices in other countries to facilitate learning. International comparison through case studies may promote humility and

curiosity about the ways things are done, it may offer an additional tool to the manager's repertoire and it can help managers to understand the particular contexts that initiatives are grown from and transplanted into. However, as Marmor and colleagues point out there are also some serious "perils" associated with comparative learning [Marmor, 2005]. The discussion will focus on the learnings we gained from this project about the value and the challenges associated with identifying good practice in an international context.