

IHF News

Special Japan

The Japan Crisis

On March 11, 2011, an earthquake struck off the coast of Japan, churning up a devastating tsunami that swept over cities and farmland in the northern part of the country. Recorded as 9.0 on the Richter scale, it was the most powerful quake ever to hit the country. As the nation struggled with a rescue effort, it also needs to face the nuclear emergency due to the explosions and leaks of radioactive gas took place in three reactors at the Fukushima Daiichi Nuclear Power Station.

IHF MOBILIZATION:

On Monday 16, 2011, IHF Secretariat received a message from Dr Sakai, President of the Japan Hospital Association and IHF Governing Council Member, giving details of the overall situation of the country with particular emphasis on medical supply. The message outlined that many hospitals, including these outside of the earthquake hit areas, were faced with medical supply shortages. The fact that several companies have their main factories in the affected areas made the situation even more difficult. The list of medical supplies provided by Dr Sakai to the IHF Secretariat was forwarded to all IHF Members. Several IHF Members responded promptly to the appeal and contacted both the IHF Secretariat and the Japan Hospital Association to get details on the required supplies and modalities of shipment.

THE SITUATION TODAY:

As of April 27, the official death toll was 14,508, with 11,450 missing and 5,314 injured. The final toll is expected to reach nearly 20,000. More than 130,155 people remain in temporary shelters; tens of thousands of others evacuated from their homes due to the nuclear crisis. According to the WHO/WPRO Report of April 27 (Japan earthquake and tsunami Situation Report No. 32) after more than one month since the earthquake, health care facilities have started to operate, but some hospitals and clinics are still unable to provide medical care or need to reduce their working hours, particularly in the coastal areas of Miyagi, Iwate and Fukushima. According to the Ministry of Health, Labour and Welfare (MHLW), a survey on the number of hospitals and beds available outside of the affected prefectures was conducted, and is outlined below.

No. of hospitals and beds available outside of affected prefectures

Organisation Collecting Data

No. of hospitals available

No. of beds available

National Hospital Organization

128

1489

National Centre

8

211

Social insurance hospital etc.

53

Approx. 630

Labour health hospital

30

341

Japan Association of medical and care facilities

192

Approx. 1100

Japan hospital Association

469

1649

Japan Report

Dr. Tsuneo Sakai, President of the Japan Hospital Association

2011 Tohoku earthquake and tsunami

One month has passed since the Eastern Japan Great Earthquake hit Japan on March 11. Japan has tried every possible thing to overcome this disaster with kind help from all over the world.

At the JHA, we wish to express its deepest sympathy to all those who have been affected by the earthquake and tsunami. We have received many warm concerns and support from various countries. We are encouraged by the received support and we would like to express our sincere appreciation. Thank you very much.

The 2011 **Tohoku earthquake and tsunami (Higashi Nihon Daishinsai** literally "Eastern Japan Great Earthquake Disaster") was caused by a 9.0-magnitude undersea megathrust earthquake off the coast of Japan that occurred at 14:46 JST (05:46 UTC) on Friday, 11 March 2011. The epicenter was approximately 72 km (45 mi) east of the Oshika Peninsula of Tohoku, with the hypocenter at an underwater depth of approximately 32 km (19.9 mi). On 1 April 2011, the Japanese government named the disaster resulting from the earthquake and tsunami the "Great Eastern Japan Earthquake" (**Higashi Nihon Daishinsai**). The earthquake triggered extremely destructive tsunami waves of up to 37.9 meters (124 ft.) that struck Japan minutes after the quake, in some cases traveling up to 10 km (6 mi) inland with smaller waves reaching many other countries after several hours. Tsunami warnings were issued and evacuations ordered along Japan's Pacific coast and at least 20 other countries, including the entire Pacific coast of the Americas. The Japanese National Police Agency has confirmed 13,013 deaths, 4,711 injured and 14,921 people missing across eighteen prefectures, as well as fires in many areas, and a dam collapse. Around 4.4 million households in northeastern Japan were left without electricity and 1.5 million without water. Many electrical generators were taken down, and at least three nuclear reactors suffered explosions due to hydrogen gas that had built up within their outer containment buildings after cooling system failure. On 18 March, Yukiya Amano, the head of the International Atomic Energy Agency, described the crisis as "extremely serious." Residents within a 20 km (12 mi) radius of the Fukushima I Nuclear Power Plant and a 10 km (6 mi) radius of the Fukushima II Nuclear Power Plant were evacuated. In addition, the U.S. recommended that its citizens evacuate up to 80 km (50 mi) of the plant.

Estimates of the Tohoku earthquake's magnitude make it the most powerful known earthquake to have hit Japan, and one of the five most powerful earthquakes in the world overall since modern record-keeping began in 1900. Japanese Prime Minister Naoto Kan said, "In the 65 years after the end of World War II, this is the toughest and the most difficult crisis for Japan." The earthquake moved Honshu 2.4 m (7.9 ft.) east and shifted the Earth on its axis by almost 10 cm (3.9 in). Early estimates placed insured losses from the earthquake alone at US\$14.5 to \$34.6 billion. The Bank of Japan offered ¥15 trillion (US\$183 billion) to the banking system on 14 March in an effort to normalize market conditions. On 21 March, the World Bank estimated damage between US\$122 billion and \$235 billion. Japan's government said the cost of the earthquake and tsunami that devastated the northeast could reach \$309 billion, making it the world's most expensive natural disaster on record. A second earthquake occurred 66 km (41 mi) off the coast of Sendai on April 7, 2011, just before midnight, with a disputed magnitude. The Japan Meteorological Agency said it was a 7.4, while the U.S. Geological Survey said the magnitude was 7.1. (From Wikipedia, the free encyclopedia)

Collapsed healthcare delivery system and exploration for reconstruction

'Live or dead.' Many people died immediately by destructive tsunami strike. Although many healthcare-related personnel from all part of Japan have been trying to support the affected areas, it seems that we need considerable period of time to

reconstruct the collapsed healthcare delivery system.

1. **90% of death were by drowning**

: different from the Hanshin Awaji Earthquake which struck the western part of Japan in 1955, the tsunami disaster was prominent and enormous this time. According to Prof. Iwase of Chiba University who examined 126 casualties in the district area of Iwate prefecture, 80-90% died of drowning due to tsunami comparing to 80% died due to destruction of buildings in 1995. It was difficult to evacuate from the affected areas and to bring relief supplies to the areas because of widespread destruction, and the affected coastal areas were far from the core cities. More than 400,000 people were evacuated in the safety evacuation areas for a time. Prolonged lifeline breaking such as electricity, water and gas combined with food and fuel shortage affected the people in the evacuation areas. Many of these people suffered from hypothermia and under nutrition. Considerable numbers of elder person were reportedly died during evacuation. Most of the costal hospitals lost their medical supplies due to tsunami however they could not receive enough replacement due to destruction of medical supply factories, and malfunctioned delivery system secondary to destruction of main roads, shortage of manpower and fuel.

2. **'Like a field hospital'**

: many costal core-hospitals lost their function completely due to tsunami. Many inland hospitals also lost their clinical function due to the earthquake destruction. Another problem is whether a nuclear meltdown can be averted and how serious rising level of radioactivity is likely to be. Three major hospitals in the area have been closed. Prolonged wide spread lifeline damage caused many hospitals to restrict their function. In Ishinomaki city, Ishinomaki City Hospital lost their function due to tsunami. To replace their function, nearby Ishinomaki Red-cross Hospital had received about 1,000 outpatients daily. Apparently the hospital was like a field hospital. They were obliged to handle these patients in the outside temporary outpatient clinic.

3. Deployment of the Disaster Medical Assistance Team (DMAT): Japanese Red Cross Society responded immediately following the earthquake and more than 30 teams were deployed on the first day. DMAT's were also sent to the affected areas soon after the disaster to cope with their needs. Most of these Red Cross teams and DMAT's were from JHA member hospitals. More than 600 DMAT's, over 2,400 personnel have been deployed and they have done wide variety of supportive works. However their initial supports were quite difficult due to disrupted transportation and cold weather. Their activity was also limited due to medical supply shortage. Many critically ill patients and dialysis patients could not be treated properly in the affected areas and they had to be transported to the other facilities in the non-affected areas.

4. **Ministry of Health, Labour and Welfare (MHLW) has issued various notice of exception:**

MHLW allowed medical facilities to conduct medical care for those people without Certificate of Insured Person if they could be identified either by their name, date of birth, insurer's name and address. Even though payments for the medical facilities were not full due to insufficient evidence of insurer, MHLW assured to cover the deficit. Strictly regulated rule for number of nursing staffs per hospital beds, for example was also temporarily eased to support hospitals accepting over patients.

5. **Shortage of medical supplies and drugs**

: shortage of medical supplies and drugs struck not only the affected areas but also the remote areas. One example was Levothyroxine for hypothyroidism. Nearly 98% of the drug is produced in Fukushima factory with limited substitutions. Rolling power outage also affected medical facilities widely. Those patients receiving respirator care, for example would face in grave condition. Fortunately no serious accidents were reported. We have to realize preparing for these problems at the time of the crisis.

6. **Gradual settlement of medical system:**

although a part of lifeline is still interrupted and we still have medical supply shortage, many hospitals are returning to their routine works and things are getting better.

7. **What's ahead after massive earthquake, tsunami, nuclear crisis**

: the effects of a major natural disaster can last months or even years. As long as a large number of survivors are displaced and living in crowded temporary camps, infectious disease remains a risk, making vaccinations and sanitation measures a key priority. Other scary long-term risks include the possibility of radiation-related cancers, which may not show up until years after exposure, and birth defects in babies born to women exposed to radioisotopes during pregnancy. Along with restoring primary health services, housing, and clean water, another key long-term priority is providing mental health services, since earthquakes, tsunamis and other disasters can leave even those who are physically unscathed with debilitating post-traumatic stress disorder, marked by nightmares, terrifying flashbacks, panic attacks and other symptoms. Many medical support teams consists of psychiatrists, psychologists,

medical social workers have been working in the affected areas.

8. **JHA's supportive efforts**

: Besides from deployment of the DMAT's in the acute stage, JHA has been working to collect data from the affected areas as well as from the unaffected areas to see the extent of damage, their need and how we could support them. We have sent questionnaires to the member hospitals. We also asked the other hospital organizations to send the same questionnaires so we can merge this information into one database. Many hospitals in the affected areas could not even reply and we had no idea of the extent of the damage. So we used aerophotography data and earthquake scale data to identify the damage. We added hospital database, medical equipment and supply data base to above mentioned tsunami information as well. All these data were used for GIS (geographic information system) analysis. We also made GIS analysis for unaffected areas so as to know how many and what kind of patients could they accept from the affected areas. Anybody can get the information through JHA WEB site. It would remain important to send support teams to the affected areas continuously. However it seems impossible to reconstruct healthcare delivery system in the completely damaged areas in a year or so. Nearby areas might be able to support them for a certain time but they also are in trouble by themselves. JHA is proposing completely different reconstruction scheme. It is to relocate the function of the damaged area as a whole to the unaffected areas. It includes patients, their families, and medical personnel. We are now explaining this idea to the central and regional administrations, hospital organizations, and mass media. We are collecting data needed for this proposal. The affected areas need sufficient time for them to reconstruct the healthcare delivery system. However they would not be able to fulfill their function during these periods. Then we might be able to arrange substitution for them. Therefore it is important to have information of both the affected areas and the unaffected areas for the arrangement.

JHA is determined to try our best for reconstruction of healthcare delivery system in Japan to bring a bright future.

International Relations & Activities

The American College of Healthcare Executives (ACHE) Congress on Healthcare Leadership

We are pleased to announce that IHF participated at the American College of Healthcare Executives (ACHE) Congress on Healthcare Leadership which was held in Chicago between March 21 and 24. This gave IHF the opportunity to have a booth and present its activities, events and publications to a wide North American audience. Dr. Eric de Roodenbeke, IHF CEO also made two presentations on the situation of the hospital sector in developing countries, and international hospital partnerships, themes that appealed to a wide audience.

We would like to thank, Dr. Tom Dolan, President and CEO of the American College of Healthcare Executives and IHF President-Designate for giving us the opportunity to participate in this event.

IHF's main objective during the ACHE Congress was to provide more visibility to the organization and its activities, and expand its associate membership. The latter represents one of the main goals of the organization for this year, and falls within the Federation's aims to expand membership to individual hospitals and healthcare institutions. The associate membership mainly targets University Hospitals, as a University Hospital Chapter will be inaugurated during the 37

CNS President attends international seminar about healthcare and sustainability

The National Health Confederation (CNS) and International Hospital Federation (IHF) President, Dr. José Carlos Abrahão M.D., attended the seminar 'Healthcare and sustainability', held in March 17

The healthcare sector is an important sector of the world economy and has a significant impact on environmental issues, which are two of the 'Triple Bottom Line', or Sustainability Tripod, components composed by economic development, social issues and environmental concerns ' said Dr. Abrahão.

The panel moderated by Dr. Abrahão, with the theme 'Business, Health and Sustainable Development' featured speakers who are experts on the issues that compose the Sustainability Tripod, such as Gregory Stackle, RTKL Diretor ' a company that cares about the environment and specializes in healthcare facilities to the public and private sectors ', as well as Diego Belmonte from Esound Energy, renewable energy expert. Other important contributors to the debate were Dr. Luis Donosco, Director of Barcelona's Clinical and Provincial Hospital ' world reference for liver transplants ', and Dr. Santiago de Torres, President of E-Diagnostic. Gesaworld, an institution specialized in advising improvements in healthcare services was represented by its

Director General, Dr. Roser Vincent, and José Maria Pérez Gallego, the company's Director in the United States.

The event provided elements that started the a debate on issues that may lead the healthcare sector to engage the Sustainability Tripod patterns; issues that have to be balanced and integrated to work efficiently. To achieve a sustainable activity in the sector, issues such as reducing carbon emissions, sustainable architecture, efficient transportation, environmental education programs target to the healthcare sector, health centers adapted to environmental sustainability and sustainable development politics were discussed.

The creation of a forum of discussions about different strategies of sustainable development in healthcare and social sector scope was among the seminar goals. Other important objectives included the exchange of pioneer experiences in sustainability, healthcare and social sector in North America, South America and Europe.

Student Visit - Nuffield Centre for International Health and Development

In April, the IHF Secretariat had the pleasure of a study visit from the Nuffield Centre for International Health and Development: a one week stay allowed international post graduate students in Hospital and International Health Management to visit some of the International Organizations located in Geneva, such as the World Health Organization, the International Committee of the Red Cross and the International Hospital Federation.

This 'Geneva Study Tour', organized by the Nuffield Centre has been an annual event since 2008 and has allowed students from Sudan, Oman, India, Dominica, Saudi Arabia, Nigeria, Philippines, Thailand, and Cameroon to benefit from the program.

IHF Events

IHF 37th World Hospital Congress

Eric de Roodenbeke and Sheila Anazonwu, IHF CEO and Partnerships & Project Manager, respectively, undertook a site visit to Dubai, UAE, host country for the IHF 37

We invite you to visit www.ihfdubai.ae to view the updated scientific programme as well as take advantage of early bird rates or discounted group registration.

We look forward to seeing you in the attractive city of Dubai.



WHO Round Up

User's Guide to the WHO Global Code of Practice on the International Recruitment of Health Personnel

The Code aims to establish and promote voluntary principles and practices for the ethical international recruitment of health personnel and to facilitate the strengthening of health systems. It was designed by Member States to serve as a continuous and dynamic framework for global dialogue and cooperation.

This User's Guide aims to provide a concise overview of the Code and to help readers understand its content. It explains the

context in which it has been developed and teases out its main messages. It targets all stakeholders concerned with or interested in the international recruitment of health personnel. The Guide provides a simple and user-friendly introduction; readers are encouraged to refer to the Code itself for a fuller understanding of its recommendations.

This document, published in January 2011, is available in
http://whqlibdoc.who.int/hq/2010/WHO_HSS_HRH_HMR_2010.2_eng.pdf

Sixty-fourth World Health Assembly

The Sixty-fourth World Health Assembly opened on Monday, **16 May 2011 at 09:30** in Geneva. The working hours of the Health Assembly are from 09:00 to 12:00 and from 14:30 to 17:30 and the Health Assembly will close no later than Tuesday 24 May 2011, as decided by the Executive Board at its 127th session.

The Health Assembly will discuss a specific health agenda prepared by the Executive Board as well as the programme budget, administration and management matters of WHO.

The agenda and complete documentation on the World Health Assembly are available in
http://apps.who.int/gb/e/e_wha64.html

The World Malaria Report 2010

The **World Malaria Report 2010** summarizes information received from 106 malaria-endemic countries and other sources and updates the analyses presented in the 2009 Report. It highlights continued progress made towards meeting the World Health Assembly (WHA) targets for malaria to be achieved by the end of 2010 and by 2015.

Over the last decade, 11 countries in the WHO African Region and 32 countries in other Regions have reported reductions of 50% or more in either confirmed malaria cases or malaria admissions and deaths. Malaria control is making an important contribution to attaining the health-related Millennium Development Goals.

The report outlines the evolving situation of financing for malaria control, how these growing resources have resulted in increased coverage of WHO-recommended malaria control interventions, and the association between this rapid scale-up and substantial reductions in malaria burden.

The full report is available in http://www.who.int/malaria/world_malaria_report_2010/worldmalariareport2010.pdf

The effects of medical tourism: Thailand's experience

This research article, written by Anchana NaRanong and Viroj NaRanong, is published in the Bulletin of the World Health Organization, Volume 89, Number 5, May 2011.

Objective

To explore the positive and negative effects of medical tourism on the economy, health staff and medical costs in Thailand.

Methods

The financial repercussions of medical tourism were estimated from commerce ministry data, with modifications and extrapolations. Survey data on 4755 foreign and Thai outpatients in two private hospitals were used to explore how medical tourism affects human resources. Trends in the relative prices of caesarean section, appendectomy, hernia repair, cholecystectomy and knee replacement in five private hospitals were examined. Focus groups and in-depth interviews with hospital managers and key informants from the public and private sectors were conducted to better understand stakeholders' motivations and practices in connection with these procedures and learn more about medical tourism.

Findings

Medical tourism generates the equivalent of 0.4% of Thailand's gross domestic product but has exacerbated the shortage of medical staff by luring more workers away from the private and public sectors towards hospitals catering to foreigners. This has raised costs in private hospitals substantially and is likely to raise them in public hospitals and in the universal health-care

insurance covering most Thais as well. The 'brain drain' may also undermine medical training in future.

Conclusion

Medical tourism in Thailand, despite some benefits, has negative effects that could be mitigated by lifting the restrictions on the importation of qualified foreign physicians and by taxing tourists who visit the country solely for the purpose of seeking medical treatment. The revenue thus generated could then be used to train physicians and retain medical school professors.

The full report is available in <http://www.who.int/bulletin/volumes/89/5/09-072249/en/index.html>

From International Organizations Chances for Change: more value for money

The Dutch Alliance for Human Resources for Health is concerned about the global maldistribution of human resources for health (HRH), which particularly affects the health of people in developing countries. This publication presents measures, composed by the Alliance, to be taken by Dutch actors to improve the distribution of health staff across countries.

The Dutch Alliance brings together a wide range of actors of the health and development cooperation sectors in the Netherlands: non-governmental organizations (NGOs), health professional organizations, labour unions, research institutions, HRH consultants, and other actors involved in the global shortage and international recruitment of health personnel. The Alliance joins forces and expertise, and aims to explore and promote policies and actions that are required for sufficient health staff and for strengthening health systems worldwide.

This publication is to inspire Dutch stakeholders involved in training, recruitment, retention, and employment of health personnel to collaborate and undertake tailor-made actions, which jointly constitute a substantial Dutch contribution to global health.

This publication is available in http://www.who.int/workforcealliance/knowledge/resources/wemos_Chances_for_Change.pdf

Health at a Glance: Asia/Pacific 2010

This first edition of Health at a Glance: Asia/Pacific presents a set of key indicators of health status, the determinants of health, health care resources and utilization, and health care expenditure and financing across 27 Asia/Pacific countries and economies in the Asia/Pacific region.

Drawing on a wide range of data sources, it builds on the format used in previous editions of Health at a Glance: OECD Indicators, and gives readers a better understanding of the factors that affect the health of populations and the performance of health systems.

Each of the 32 indicators in the book is presented in a user-friendly format, consisting of charts illustrating variations across countries and over time, brief descriptive analyses highlighting the major findings conveyed by the data, and a methodological box on the definition of the indicator and any limitations in data comparability. An annex provides additional information on the demographic contexts in which health systems operate.

This publication is available in

<http://www.oecd-ilibrary.org/docserver/download/fulltext/8110241e.pdf?expires=1303832669&id=id&accname=guest&checksum=906F4B4F10844EE4BB27D5DBACB5D6BF>

Health care systems: Getting more value for money

The OECD has assembled new comparative data on health policies and health care system efficiency for its member countries. The aim is to better identify strengths and weaknesses of each country's health care system and assess whether there is scope for improving value for money and the policy reforms that will boost efficiency. Key findings are as follows:

- There is room in all countries surveyed to improve the effectiveness of their health care spending.
- On average across the OECD, life expectancy at birth could be raised by more than two years, while holding health care spending steady, if all countries were to become as efficient as the best performers. By way of comparison, assuming no reform,

a 10% increase in health care spending would increase life expectancy by only three to four months.

- There is no health care system that performs systematically better in delivering cost-effective health care. It may thus be less the type of system that matters but rather how it is managed. Both market-based and more centralised command-and-control systems show strengths and weaknesses.
- Health outcomes are highly disparate across individuals and such inequalities can be reduced without sacrificing efficiency. Inequalities tend to be relatively low in countries with a well-regulated private insurance-based system. Centrally-managed systems can also deliver good equity outcomes at the same time as keeping spending low.
- There is no 'one-size-fits-all' approach to reforming health care systems. Policymakers should aim for coherence in policy settings by adopting best practices from the many different health care systems that exist in the OECD and tailor them to suit actual circumstances.
- By improving the efficiency of the health care system, public spending savings would be large, approaching 2% of GDP on average in the OECD.

This paper is available in <http://www.oecd.org/dataoecd/21/36/46508904.pdf>

The International Health Facility Assessment Network

The International Health Facility Assessment Network (IHFAN) is a multi-agency network committed to strengthening health facility-based data collection and use worldwide. IHFAN develops resources to help users better understand existing health facility assessment (HFA) tools; the development of a core set of indicators for cross-country comparison of health systems performance; and technical assistance for developing training courses to improve country capacity in health system data analysis and use.

A number of tools, white papers, and resources can be consulted at http://ihfan.org/home/index.php?editable=yes&page_type=home.html

Hospital and Health Services Worldwide News

Benchmarking: a method for continuous quality improvement in health care

This article, written by Ettorchi-Tardy A, Levif M, Michel Ph, is published in *Pratiques et Organisation des Soins* Volume 42 Number 1, January-March 2011.

The benchmarking, a managerial process of best practices implementation at the best cost, is a recent concept in the health system.

The objectives of this paper were to define the concept and its evolution in the healthcare sector, to suggest an operational definition and to describe French and international ways of implementing benchmarking in healthcare.

A non-exhaustive literature review was carried out in the industrial and service sectors to answer the first two objectives and in the healthcare sector the latter one. Benchmarking is most often used for the comparison of indicators. It is yet not perceived as a tool based on a voluntary and active cooperation among several organizations to build emulation and implement best practices. The main characteristic of a real benchmarking approach is indeed to participate in a global and participative continuous improvement. Among the key factors of success, are an appropriate and thorough preparation of the project, a monitoring based on relevant indicators, frontline staff involvement and inter-healthcare organisation visits.

Compared to methods previously implemented in France (Breakthrough series and Collaboratives), benchmarking includes specificities which enable this approach to be considered as innovative in healthcare. Specifically, its implementation by healthcare or social organisations will be perceived as new because the principle of visits inter-institutions do not belong to the local culture. An evaluation of its feasibility and acceptability is therefore necessary before generalisation.

This full article is available in French in

http://www.ameli.fr/fileadmin/user_upload/documents/POS1101_Benchmarking___amelioration_de_la_qualite_en_sante.pdf

Innovations in Hospital Management success with limited resources

This book, written by Dr. Rufino L. Macagba (2010) and reviewed by Dr Elvira Beracochea (MIDEGO President, Wash. DC, Feb. 2011), is Available on-line from Amazon.com (soft cover or Kindle book).

This is the only book available on Hospital Management written from a developing country perspective for today's challenges. The principles and methods presented have been field-tested successfully in more than 40 years. Students and professors of international programs in health administration (as well as hospital leaders and department heads in developing countries) will find them helpful in setting the stage for continuous improvement in the face of increasing costs, competition, and limited resources.

'This book is packed with practical advice to hospital managers and health staff in developing countries -- a must in health administration programs and schools of public health'.

Quality in health care and globalization of health services: accreditation and regulatory oversight of medical tourism companies

This research article, written by Leigh G. Turner, is published in the International Journal for Quality in Health Care, Volume 23, Number 1, February 2011.

Patients are crossing national borders in search of affordable and timely health care. Many medical tourism companies are now involved in organizing cross-border health services. Despite the rapid expansion of the medical tourism industry, few standards exist to ensure that these businesses organize high-quality, competent international health care. Addressing the regulatory vacuum, 10 standards are proposed as a framework for regulating the medical tourism industry. Medical tourism companies should have to undergo accreditation review. Care should be arranged only at accredited international health-care facilities. Standards should be established to ensure that clients of medical tourism companies make informed choices. Continuity of care needs to become an integral feature of cross-border care. Restrictions should be placed on the use of waiver of liability forms by medical tourism companies. Medical tourism companies must ensure that they conform to relevant legislation governing privacy and confidentiality of patient information. Restrictions must be placed on the types of health services marketed by medical tourism companies. Representatives of medical tourism agencies should have to undergo training and certification. Medical travel insurance and medical complications insurance should be included in the health-care plans of patients traveling for care. To protect clients from financial losses, medical tourism companies should be mandated to contribute to compensation funds. Establishing high standards for the operation of medical tourism companies should reduce risks facing patients when they travel abroad for health care.

Africa

Positive Practice Environments in Morocco

This paper, developed by Dr. Dr Hassan Semlali, is published by The Global Health Workforce Alliance in October 2010.

The report was initiated by the Moroccan Association of Nursing Sciences and Health Techniques on behalf of the Positive Practice Environments (PPE) Campaign core partners. The PPE Campaign core partners include the International Council of Nurses, International Hospital Federation, International Pharmaceutical Federation, World Confederation for Physical Therapy, FDI World Dental Federation and the World Medical Association in addition to the supporting partner the Global Health Workforce Alliance. This report was written within the context of the PPE Campaign and aimed at examining the main problems faced by health care professionals in Morocco. In particular the report focuses on working environments, recruitment and staff retention. Positive practice environments are settings that ensure the health, safety and personal well-being of staff. They support the provision of quality patient care and improve the motivation, productivity and performance of individuals and organizations. This report is an essential tool and resource to guide the participants of the positive practice environments workshop to respond to the needs and concerns of health care professionals and develop sustainable projects for the future. This report makes recommendations to inform and drive improvements within working environments in the future.

This full article is available in http://www.who.int/workforcealliance/knowledge/PPE_Morocco_CaseStudy.pdf

Positive Practice Environments in Uganda: Enhancing health worker and health system performance

This paper, developed by Dr. Charles W. Matsiko, is published by The Global Health Workforce Alliance in October 2010.

This paper aims to explore the current key issues facing Uganda's health human resource climate with particular attention to practice environments including recruitment, retention and productivity of its health workforce, to identify the HR solutions that are being or have been employed to address these main challenges.

The paper will also help in identifying knowledge gaps for future in-depth research and recommendations for future strategies.

This full article is available in

<http://www.ppecampaign.org/sites/ppecampaign.org/files/images/Publications-Uganda-PPE-CS.pdf>

Positive Practice Environments in Zambia: Quality Workplaces for Quality Care

This paper, developed by Dr. Thabale Jack Ngulube, was published by The Global Health Workforce Alliance in October 2010.

This desk review has put together a situation analysis of the health professional practice environment in Zambia today, bringing out a picture of unhealthy, unproductive work environments.

The paper reviews available evidence on practice environment, motivation and job satisfaction, recruitment, retention and productivity of health workers and offers a set of recommendations related to HR policy, research areas and interventions/strategies to consider in the future.

This country case study aims: to explore the current key issues facing Zambia's health human resource climate with particular attention to practice environments and recruitment/retention of its health workforce; to identify the human resources (HR) solutions that are being or have been employed to address these main challenges; to identify knowledge gaps for future in-depth research and recommendations for future strategies. The study will also contribute to the knowledge base being amassed by WHO related to 'Increasing access to the health workforce in remote and rural areas through improved retention'.

This full article is available in

<http://www.ppecampaign.org/sites/ppecampaign.org/files/images/Publications-Zambia-PPE-CS.pdf>

Americas

Challenges of postgraduate human health programs in Brazil

This article, written by **Reinaldo Guimarães**, is published in the Revista de Saúde Pública, Volume 45, Number 1, February 2011.

Recognition for the growing role of extra-academic demands and players in the dynamics of human resource training for the market and, in particular, for research is discussed. Their synergies with the movement towards maturation of the sectoral system of healthcare innovation and with the priorities of the Sistema Único de Saúde (Brazilian National Health System) are discussed. The methodological adequacy of the process for evaluating these trends used by the Coordenação de Aperfeiçoamento de Pessoal de Nível Superior (Coordination Office for Advancement of University-level Personnel) is analyzed. In a general manner, these trends mean adding new indicators for technological and social productivity to the predominantly academic criteria that already exist. The continuation and deepening of ongoing initiatives aimed at bringing in new formats for postgraduate programs and courses and new courses customized for the demands of the extra-academic market, among other markets, either of a social or technological-business nature, are discussed. In addition, the deepening of initiatives for stimulating postdoctoral training work, which is scarce in Brazil, is discussed.

The full article is available in Portuguese in <http://www.scielo.br/pdf/rsp/v45n1/2549.pdf>

Health Technology Assessment at the University of California- San Francisco

This article, written by **Christina Gutowski, John Maa, Kent Soo Hoo, and Kevin Bozic**, is published in the Journal of Healthcare Management, Volume 56, Number 1, January/February 2011.

Over the past thirty years, various efforts have been made to align the incentives of hospitals and physicians to control healthcare costs while assuring the provision of high-quality patient care. One innovative strategy used by some hospitals involves the creation of technology assessment programs to develop a more thorough and objective review process for new clinical technology. The University of California's San Francisco Medical Center has been a pioneer in this area. Its physician-led healthcare technology assessment program has been successful in changing the culture of how innovative technology is evaluated and adopted by the hospital and fostering an increased awareness among physicians of the clinical, financial, and programmatic implications of their technology decisions. We explore the operational characteristics and various effects of this program and highlight the key components to its success and opportunities for improvement in the context of its reproduction at other medical centers.

Hospital Payment Policy in Canada: Options for the future

This document, written by Dr Jason M. Sutherland, is a publication of the Canadian Health Services Research Foundation. Canada's publicly funded healthcare system is facing increasing cost control pressures. Hospitals alone represent a substantial burden on provincial health budgets, accounting for 28% of total costs. Presently, in the Canadian system, the primary source of funding for hospitals is through a global budget. Under this model, a fixed (global) amount of funding is distributed to each hospital to pay for all hospital-based services for a fixed period of time (commonly one year).

Global budgets:

- Are based on historical spending, inflation, negotiations and politics in many provinces, rather than on the type and volume of services provided.
- Constrain hospital spending growth and create budgetary predictability; however, its consequences may be decreased services and increases in waiting times.
- Do not provide incentives to improve access, quality or efficiency of hospital care.

Funding hospitals on the basis of the type and volume of services they provide has become the international norm. Known as activity-based funding (ABF), these systems have been systematically supplementing global budgets in public and private insurance-based health systems around the world. ABF:

- Provides powerful financial incentives to stimulate productivity and efficiency: efficient hospitals retain the difference between the payment amount and the hospital's actual cost of production.
- Is associated with higher volumes of hospital care, shorter lengths of stay, and yet has not been linked to poorer quality of care.
- Is linked to higher overall spending, due to higher volumes of patients being treated, and evidence of lower cost per admission is mixed.

Combining properties of ABF and global budgets may optimize the strengths of both global budgets and ABF. Many countries that have ABF to fund their hospital systems utilize a blend of global budgets to control spending, while instituting an ABF mechanism to create incentives for hospitals to provide timely and equitable access, appropriate volume of care, and efficient care.

In the Canadian context, recommendations are:

- Adopt population-based funding at the regional level to reduce historical funding inequities by recognizing differences in need across populations, regions and over time.
- Blend ABF and global budgets to create incentives for hospitals to improve hospital efficiency and access.

This document is available in

http://www.chsrf.ca/Libraries/Commissioned_Research_Reports/CHSRF_Hospital_Funding_Sutherland_ENG-final.sflb.ashx

How Do Quality Information and Cost Affect Patient Choice of Provider in a Tiered Network Setting? Results from a Survey

This research article, written by Anna D. Sinaiko Ph.D, is published in Health Services Research (HSR) Journal, Volume 46, Number 2, April 2011.

Objective. To assess how quality information from multiple sources and financial incentives affect consumer choice of physicians in tiered physician networks.

Data Source. Survey of a stratified random sample of Massachusetts state employees.

Study Design. Respondents were assigned a hypothetical structure with differential copayments for 'Tier 1' (preferred) and 'Tier 2' (nonpreferred) physicians. Half of respondents were told they needed to select a cardiologist, and half were told they needed to select a dermatologist. Patients were asked whether they would choose a Tier 1 doctor, a Tier 2 doctor, or had no preference in a case where they had no further quality information, a case where a family member or friend recommended a Tier 2 doctor, and a case where their personal physician recommended a Tier 2 doctor. The effects of copayments, recommendations, physician specialty, and patient characteristics on the reported probability of selecting a Tier 1 doctor are analyzed using multinomial logit and logistic regression.

Principal Findings. Relative to a case where there is no copayment differential between tiers, copayment differences of U.S.\$10-U.S.\$35 increase the number of respondents indicating they would select a Tier 1 physician by 3.5-11.7 percent. Simulations suggest copayments must exceed U.S.\$300 to counteract the recommendation for a lower tiered physician from friends, family, or a referring physician. Sensitivity to the copayments varied with physician specialty.

Conclusions. Tiered provider networks with these copayment levels appear to have limited influence on physician choice when contradicted by other trusted sources. Consumers' response likely varies with physician specialty.

Regionalization and political dynamics of Brazilian health federalism

This article, written by **Daniel de Araujo Dourado and Paulo Eduardo Mangeon Elias**, is published in the Revista de Saúde Pública, Volume 45, Number 1, February 2011.

The implications from the Brazilian federal structure on the regionalization of health actions and services in the National Unified Health System (SUS) were analyzed, considering that the regional health planning in Brazil takes place within the context of intergovernmental relations as an expression of cooperative federalism in health. The analysis was based on a historical approach to Brazilian health federalism, recognizing two development periods, decentralization and regionalization. Regional health planning of SUS was explored in light of the theoretical framework of federalism. It is concluded that relative centralization of the process is needed in intergovernmental committees to actualize federal coordination and that it is essential to consider formalizing opportunities for dissent, both in regional management boards and in the intergovernmental committees, so that the consensus decision-making can be accomplished in healthcare regionalization.

This full article is available in Portuguese in <http://www.scielo.br/pdf/rsp/v45n1/1944.pdf>

Asia

Analysis of Health Leadership and Management Capacity in Six Asia and Pacific Island Countries

This report, written by A. Asante and J. Hall, is published by Human Resources for Health Knowledge Hub.

This report reviews the current status of health leadership and management capacity in six countries in the Asia Pacific region: Cambodia, Lao PDR, Timor-Leste, Papua New Guinea, Fiji and Solomon Islands. It collates and synthesizes the available information on leadership and management capacity in the health systems of these countries and then critically analyses the key issues that affect their development.

Worldwide, weak leadership and management, especially at sub-national levels of health systems, are perceived as an impediment to scaling up health services and to achieving the health-related Millennium Development Goals (MDGs) in some countries. In the Asia Pacific region, there is a perception that health leadership and management capacity is weak, despite considerable investments in this area over the past decades. This situational analysis provides the basis for developing viable and innovative policy options for strengthening leadership and management capacity in the selected countries. The framework

for the analysis is based on the WHO MAKER Framework and has five component parts: numbers and distribution of managers, competency, working environment, functional support systems and socio-cultural context. Data were collated mainly from secondary sources: annual reports, strategic plans, policy documents, research reports, administrative manuals, online presentations, job descriptions, among others. Key informant interviews were conducted where possible. District management and leadership is the unit of analysis, although where appropriate, central and provincial levels management are also analyzed.

The report has five sections: section one provides a general background and rationale for the situational analysis, section two describes the framework and methodology and section three provides an overview of each country's health system and management structure. The fourth section presents the issues that affect health leadership and management capacity in each country using the five component parts of the framework as sub-headings. The final section of the report discusses the key findings and analyses the implications of these findings for HRH policy and health systems strengthening. Policy options for strengthening health leadership and management capacity in the selected countries have been discussed in a separate paper (Asante and Hall 2010).

The full report is available in

[http://www.med.unsw.edu.au/HRHweb.nsf/resources/LM_Capacity_AsiaPacific.pdf/\\$file/LM_Capacity_AsiaPacific.pdf](http://www.med.unsw.edu.au/HRHweb.nsf/resources/LM_Capacity_AsiaPacific.pdf/$file/LM_Capacity_AsiaPacific.pdf)

Fixing the Public Hospital System in China

The World Bank has recently released five **China Health Policy Notes**. This series, produced by the World Bank in collaboration with the Government of China, focuses on lessons and experiences from China's ongoing healthcare reforms. The papers track and analyze the reform process and evaluate early results. Each paper focuses on a key challenge that is central to the success of the healthcare reforms. The papers also offer ideas on how the reforms can be refined and improved as the process unfolds over the coming 5 to 10 years.

Fixing the Public Hospital System in China presents approaches to hospital reform adopted by various countries, some successful and others less successful. Given China's scale and complexity, there is no standard set of recommendations that are appropriate at all levels of the hospital system or in all parts of the country. However, there is a need for more rational, evidence-based provision of services in China's current circumstances, building up of a cadre of well-trained hospital managers, and development of an information system for policy planning, performance monitoring and accountability, and evaluation.

In recent years, Chinese health care has improved rapidly, especially in the areas of equity and accessibility of services, as well as the movement toward universal coverage. A new round of health care reform, which was announced in April 2009, began implementation in 2010, with reform pilots in 16 urban areas. This paper analyzes a key pillar of this ongoing reform process, public hospital management. First, the paper reviews the history of public hospital reform, discusses hospital functions and responsibilities, and describes the structure and supply of health services. Second, it describes the main policy issues facing public hospitals, including financing sources and the hospital market environment. Third, it examines organizational arrangements in public hospitals, focusing on decision rights and governance. Fourth, the paper offers an international perspective and framework for assessing hospital reform. Finally, it summarizes the main policy issues and suggests next steps for policy reform. The paper draws on recent publications, grey literature, media reports, and interviews with key stakeholders

The full report is available in

http://www-wds.worldbank.org/external/default/WDSCContentServer/WDSP/IB/2010/12/15/000333037_20101215002448/Rendered/PDF/584110NWP0V20P10No21Hospital0Reform.pdf

Europe

Effective cooperation influencing performance: a study in Dutch hospitals

This research article, written by A.H.J. Kloppe-Kes, N. Meerdink, C.P.M. Wilderom and W.H. Van Harten, is published in the International Journal for Quality in Health Care, Volume 23, Number 1, February 2011.

Objective This study focuses on cooperation between physicians and managers and aspects of that cooperation that can provide leads for interventions aimed at enhancing hospital performance.

Design We performed a qualitative study on cooperation between physicians and managers and the influence of that cooperation on hospital performance, and structured the resulting data according to the conditions of Allport's theory on intergroup conflicts.

Setting General hospitals in the Netherlands.

Participants Thirty physicians (surgical and internal) and managers (strategic, tactic and operational) working in five different hospitals.

Interventions In-depth interviews exploring the influence of cooperation between physicians and managers on hospital performance.

Main Outcome Measures Respondents confirmed the complexity of the relationship between physicians and managers and the link between their cooperation and hospital performance. Mentioned aspects such as power and status differences, clarity in decision-making and personal click, are important in determining the effectiveness of the cooperation between physicians and managers.

Results Our study suggests that the effectiveness of cooperation between physicians and managers is related to the uptake of quality initiatives and hospital performance.

Conclusions The complex relationship between physicians and managers can be referred to as an intergroup conflict situation. We combined Allport's Contact theory conditions with aspects found in our study leading to the following facilitating conditions: address common goals; create interdependent tasks; arrange the support of authorities and respect the medical domain. They will enhance intra-hospital cooperation and therewith hospital performance.

H+ Published the Annual Report 2010

H+ is the national organization of hospitals, clinics and institutions of public and private care in Switzerland. For 80 years, H+ is actively involved in developing the health system. As a national association, H + represents the interests of its members as service providers and employers.

H+ published the Annual Report 2010 in which is presented the 2015 vision of the organization: five strategic objectives have been fixed and ten new projects defined.

This full report is available in French in

http://www.hplus.ch/fileadmin/user_upload/Publikationen/Jahresberichte/archiv_fr/Hplus_JB_10_fr.pdf

Implementing health financing reform: Lessons from countries in transition

This book, edited by J. Kutzin, C. Cashin and M. Jakab, is published by the European Observatory on Health Systems and Policies and the World Health Organization Europe.

Since 1990, the social and economic policies of the transition countries of central and eastern Europe, the Caucasus and central Asia have diverged, including the way they have reformed the financing of their health systems.

This book analyses this rich experience in a systematic way. It reviews the background to health financing systems and reform in these countries, starting with the legacy of the systems in the USSR and central and eastern Europe before 1990 and the consequences (particularly fiscal) of the transition for their organization and performance. Using in-depth country case experiences, chapters focus on how policies were implemented to change the mechanisms for revenue collection, pooling of funds, purchasing of services and the policy on benefit entitlements. Later chapters highlight particular reform topics:

- the financing of capital costs;
- the links between health financing reform and the wider public finance system;
- the financing of public health services and programs;
- the role of voluntary health insurance;
- informal payments; and
- accountability in health financing institutions.

From practical experience of implementing, advising or evaluating health financing policies in the region, the authors offer important lessons, as well as pitfalls to avoid in the reform process. This book is essential reading for health finance policy-makers, advisers and analysts in this region and beyond.

This article is available in http://www.euro.who.int/__data/assets/pdf_file/0014/120164/E94240.pdf

