

IHF News

International Relations & Activities

2012 Geneva Health Forum ' 4th Edition: A Critical Shift To Chronic Conditions: Learning From The Frontliners

The IHF was again invited to collaborate and participate in the scientific programme of 2012 of the Global Health Forum (GHF) - 4th Edition

The focus of the GHF was on chronic conditions which pose major challenges to health systems in high and low-income countries, in stable and emergency situations. In addressing the challenge the GHF solicited accounts from those on the frontlines, working either at the local level in a rural clinic, at the national level in a ministry or developing policy at the international level.

IHF participation included:

Chairing by IHF President, Thomas C. Dolan of the parallel session - **Clinical Pathways for Chronic Conditions**

Hosting of the Roundtable session - **Chronic conditions: Challenges for Hospitals**. The session was chaired by Eric de Roodenbeke, IHF CEO, for which the panelists were IHF Governing Council and full members.

Details of these sessions are reported in this e-newsletter. Further information on the Geneva Health Forum event is available at: <http://www.ghf12.org/>

2012 Geneva Health Forum ' Clinical Pathways for Chronic Conditions (Parallel Session 13 ' PS13)

Thomas C. Dolan, IHF President, was invited to chair this parallel session, in which the speakers presented reviews of the concepts and definitions of care pathways, empirical evidence on the conditions under which pathways successfully improve the quality of care for people with chronic conditions.

The speakers and their presentations were as follows:

- **Clinical Pathways: Definitions and Relevance for Chronic Diseases**

Anne-Claude Griesser, Medical Directorate, Lausanne University Hospital, Lausanne, Switzerland

- **NCDs and Risk Factors Prevention and Control Studies: Policies for Tackling Non-Communicable Diseases and Risk Factors in Turkey**

Nazan Yardim, Ministry of Health of Turkey, Public Health Institution, NCD Department, Ankara, Turkey

- **Implementation of Clinical Pathways In Malaysia: Challenges, Obstacles and Achievements**

Syed Mohamed Aljunid, United Nations University-International Institute of Global Health (UNU-IIGH), Kuala Lumpur, Malaysia

- **Implementing a Heart Failure Ambulatory Care Pathway in the Canton of Geneva, Switzerland**

Séverine Schusselé Fillietaz & Nicolas Perone, Heart Failure Ambulatory Care Pathway, Promotion des Réseaux Intégrés des Soins aux Malades (PRISM-GE), Geneva, Switzerland

2012 Geneva Health Forum ' IHF Roundtable Session Chronic conditions: Challenges for Hospitals

Eric de Roodenbeke, Chief Executive Officer of the International Hospital Federation (IHF), chaired the panel discussion to provide an international overview of the challenges of chronic diseases for hospital leaders in the US, Brazil, Switzerland and Norway. The panelists were called on to respond to various issues on the challenge of chronic conditions for hospitals

Panelists:

Erik Normann, **President**, Norwegian Hospital and Health Service Association (NSH), Norway

Thomas C. Dolan, PhD, FACHE, **Chief Executive Officer**, American College of Healthcare Executives and **President**, International Hospital Federation, USA

Bernard Wegmuller, **Director**, H+, les Hôpitaux de Suisse, Switzerland

Dr. Jose-Carlos Abrahao ' **President**, Confederação Nacional de Saúde, Brazil

Q1: What is the impact of chronic conditions and trends in chronic care treatment on policy?

Switzerland

In Switzerland, the population will vote on a law on June 17th which wants to firstly, regulate the role of family and specialist doctors through introduction of family doctor-centered and insurance-led practices.

Secondly, the law addresses the issue of prevention through coordination of service delivery activities at all levels. The role to be assigned referral and primary health care actors is presenting a challenge.

H+, that represents the Swiss hospitals and clinics, has raised strong objection on the grounds that family doctors are not the only actors involved in the treatment of chronic conditions.

Norway:

In Norway, a reform programme, in light of the increase in elderly population has been initiated. Under this programme - Healthy Population - treatment is being diverted from hospitals to primary health care levels. Over the programme's four year implementation period, it is expected that treatment of 40% of patients within the public healthcare system will be at primary healthcare level as out and in-patients. At the same time community hospitals, for treatment of emergency patients and provision of emergency care, are to be developed.

The challenges will be one of establishing coordination between the various facilities in the delivery of services, as well as increase in competencies of the actors engaged in delivery of care at the primary healthcare level.

Brazil:

Brazil with its unique demographic and population make-up is searching for innovative ways in such areas as professional qualifications, service delivery mechanisms, hospital architecture, in order to manage the causes and effect of chronic diseases in the country's healthcare delivery system.

USA:

The focus of the US delivery system remains on the patient. Chronic conditions are the primary concern of the population. Twenty-five percent of the population has one chronic condition and another 25% have two or more. Seventy-five percent of the 65 and over population have multiple chronic conditions. In addition, the emerging trend in acute diseases, such as cancer, is their transformation into chronic conditions. Chronic conditions account for more than 75% of the \$2.5 trillion spent on healthcare in the United States.

Q2. What is the policy agenda regarding coordination of care delivery services and organization of healthcare facilities as engendered by multi-chronic conditions? Are ethical considerations or resources drivers for decision-making by hospitals?

USA:

Since multiple chronic conditions increase the risk of poor functional status, unnecessary hospitalizations, adverse drug events, duplicative tests, and conflicting medical advice, better coordination of services to individuals with multiple chronic conditions is currently a major emphasis within the US healthcare system.

Switzerland:

The mandatory insurance scheme in Switzerland essentially overrides the ethical issue related to resources. Disease prioritization is applied in cases of multiple conditions.

Norway:

The Norwegian system has yet to fully address the matter. The system of specialization which continues to fragment coordination of service delivery, is currently under review with the objective of creating new 'class' of doctors between GPs and those in hospitals.

Discussion is also currently underway on ethics in prioritization of disease treatment. Norway has recognized that there is need to search for ways to re-organise its healthcare delivery system.

Q3a. What is the way forward for the patient-centered system within continuum of care and the role of electronic medical recording?

USA:

The electronic health record can be of major assistance in treating multiple chronic conditions because it significantly improves communication, coordination and collaboration between healthcare professionals and healthcare organizations.

Switzerland:

The legal debate currently underway in Switzerland may result in the introduction of compulsory use of electronic medical recording by hospitals for in-patient treatment only. The compulsory use could be expanded to include family doctors, from whom opposition is expected given their traditional reluctance to sharing of patient data.

The debate, nevertheless, is ongoing as to the role of the hospital, its integration into the delivery system in regard to continuum of care and exchange of information.

Current demographic and epidemiological changes together with financial pressures are requiring hospitals to rethink their roles and to address the challenges the need for role change may present.

In Switzerland, drivers of change will be financial and from the professionals responsible for delivery of care at primary health care level and in hospitals.

Norway:

The situation in Norway is one of lack of intra and inter-coordination with regard to electronic patient recording, at hospital, primary health care and community levels. Major challenges are encountered in regard to the level and nature of information to be provided and/or shared.

In order of importance the following have been identified as drivers of change and ethical consideration:

- 1) Professional qualifications
- 2) Level of competencies
- 3) Technology
- 4) Finance
- 5) Data/Information ' its use and confidentiality

Q3b. What consideration can/should be given to Patient Empowerment in chronic disease management and treatment?

Norway:

Discussions in Norway on the issue of home care highlight the need for hospitals to not only be driven internally in provision of services but that patient groups as external drivers, should be welcomed.

Switzerland:

Different financing schemes for in-patient versus out-patient care under the current health financing system in Switzerland

present major challenges to home care practices. The play between the social determinants and medical conditions requiring care at home are often complex to manage and coordinate.

USA

Patient empowerment is very important with respect to chronic disease management and treatment because patient behavior has a far greater impact on chronic conditions than acute conditions. Every effort should be made to enlist the patient in his or her treatment.

Q4. Payment systems have traditionally driven healthcare reforms. Should this be the way forward?

USA:

The current US payment system has not encouraged alignment in the provision of care between physicians and hospitals. The bundling of the physician and hospital payment for an episode of care will significantly increase alignment.

Switzerland:

In principle, striving for higher quality should be the driver of healthcare reforms. In Switzerland, in-patient, out-patient and home care each are financed by different actors and financing schemes. This may lead to wrong incentives that patients are not treated in the most appropriate manner by the most qualified healthcare provider. H+ therefore supports a financing scheme that is the same for all types of care.

Norway:

The reform underway in Norway has as objective decentralization of the joint current DRG co-financing system between central and community facilities. The trend is towards community driven financing.

Brazil:

In Brazil, the public and private sectors are endeavouring to ensure coordination between, hospitals and the demands in chronic disease management. The focus is on the role of doctors and innovative ways in which good coordination is established in the processes of delivery of care.

Q5. What role can hospital and healthcare associations play to be drivers of change?

Switzerland:

In Switzerland, they could serve as vehicles through which flexibility in policy/governance can be introduced.

USA:

Hospital and healthcare associations need to educate and assist their members in transforming healthcare in their countries.

Brazil:

Dr. Abrahao, acknowledged that these actors in Brazil, in view of the impact of change in Brazil's epidemiological, cultural and demographic landscape, should be and have become drivers of change through the search for innovation in such areas as health financing, organization and integration of public and private delivery services.

Norway:

Erik Normann, acknowledged that, for Norway, the way forward is through innovation particularly in management, organization and coordination of health delivery services, for which hospitals and healthcare associations have a role to play as drivers of change.

5th Global Patients Congress

The International Hospital Federation (IHF) was invited to support the 5th Global Patients Congress, held in 17-19 March 2012 in London, UK.

Mr Cédric Lussiez, Director of Communication of the French Hospital Federation and IHF Governing Council member participated in the plenary panel discussion on **Achieving Patient-Centred Healthcare: Moving from Value to Actions**. Mr Lussiez in his presentation addressed the French experience and presented position statements from IHF national member healthcare associations, surveyed on '**Mechanism to Monitor Patient Satisfaction**'. He also reported on the various approaches adopted by the associations in monitoring patient satisfaction in regard to the care provided in facilities in

their respective countries. Click [here](#) to view the presentation.

Full details of the Survey on 'Mechanism to Monitor Patient Satisfaction' prepared by the IHF Secretariat and results are provided in this newsletter.

Mechanism to Monitor Patient Satisfaction

A survey on 'Mechanism to Monitor Patient Satisfaction' was sent to IHF Full and Associate Members.

The total number of respondents was 27 from the following Countries: Australia (7); Canada; China, Hong Kong; Denmark; Finland (2); France (2); Israel; Japan; Kuwait; Lebanon; Morocco; Nigeria; Norway; Philippines; Portugal; Switzerland; United States of America (3). The high number of respondents from Australia (seven) is due to the fact that the AHHA solicited participation from its members.

Within the 17 surveyed countries, 14 have a formal system for monitoring patient satisfaction in facilities. 50% of respondents report existence of national standardized systems and 50% have locally developed systems.

For two thirds of those with formal patient satisfaction monitoring systems, these were mandatory. For 37,5% the systems rely on facility good will.

Lebanon, Nigeria and Portugal reported the absence of formal systems to monitor patient satisfaction in facilities.

IHF Members were asked to describe the kind of system in place to monitor patient satisfaction. Globally, we can say that in one country different mechanisms are in place at the same time. In most cases the system adopted is the satisfaction survey/questionnaire. The latter, in the majority of instances, is internally. Only in two cases the survey is conducted by an external agency.

In two cases the adopted system is the internal assessment. France is the only country which applies a standardized telephone questionnaire of patients one week after discharge.

Five participants did not respond to the question.

The survey shows that half of the countries have a website with public reporting at national level and only 48,1% of the surveyed countries organize annual reports on patient satisfaction which are discussed by healthcare boards or authorities.

From the final comments, we can assume that in the majority of the countries there is still a lack of uniformity in the system of monitoring patient satisfaction, even in cases where these are well developed at local level. However, at national level this remains underdeveloped. In some countries dialogue is open and patient satisfaction is part of the agenda of the national health reform.

This topic seems to be of high interest for IHF members and IHF has been asked to provide information (documents, studies, experiences, etc.) that could help them to improve their system.

Copenhagen Roadmap for Diabetes

Eric de Roodenbeke, IHF Chief Executive Officer, participated in the European Diabetes Forum

<http://www.diabetesleadershipforum.eu/>, organized - 25-26 April 2012 - by the Organisation for Economic Co-operation and Development (OECD) and the Danish Diabetes Association under the auspice of the Danish Ministry of Health.

Possible solutions to the diabetes question are known and are well described in the Copenhagen road map -

http://www.senato.it/documenti/repository/commissioni/comm12/documenti_acquisiti/copenhagen%20roadmap.pdf . The urgency now lies in the need to better mobilize all stakeholders and move them from advocacy to result-oriented actions

This meeting dominated by health professional, was an illustration of a situation where speakers are preaching to the converted but are not reaching out to those who should change their policies to influence risk factors.

This illustrates also the current challenges with chronic conditions for which most preventive measures have to be taken outside the 'jurisdiction' of ministries of health. Ministries of health and all other health-related stakeholders become advocates for actions to be taken by finance ministers, agriculture ministers, trade and commerce ministers, etc. It seems that as long as global public health threats are not place high on society's agenda, chances to achieve results are limited. For this to happen it will be necessary to engage the civil society to push the issue of global public health threats as a major political agenda item. In

the current economic and social climates, it is very difficult to envision such a mobilization although the absence of proper answer to the chronic condition threats will dramatically aggravate the economic and social situation in the coming years. It is the responsibility of all health stakeholders to participate in such awareness campaigns in addition to all their other respective work programmes. We are all confronted with the crisis, however, it should not hide the longer term threats which have to be addressed now, before they become a major source of crisis on their own.

This meeting was also an opportunity to consider the need for changes in health services to address the multidimensional nature of diabetes. Continuum of care and patient-centered care, need to be implemented, in order to provide effective responses to those already suffering from diabetes. The way forward is obvious in principle but implementation is limited by the multiplicity of funders and payment systems in each country. The rationale behind the financing of healthcare is not supportive of a change in the delivery model. For this reason the IHF representative in the meeting asked for the roadmap to be completed by an outcome framework indicating:

- how countries have made efforts in changing health service payment systems to align incentives for patient-centered care
- what results are actually achieved by way of transparent monitoring and evaluation of progress on key targets

In addition it is also important to include in policy development a mechanism to benchmark practices and results and to recognize and celebrate best performers. It is not because diabetes is a major source of concern for the sustainability of health systems that all communications should be alarming. It is also important to give more light to accomplishment which gives also hope for the future.

IHF Secretariat News

'Geneva Study Tour': Students Nuffield Centre for International Health and Development (University of Leeds) UK

The International Hospital Federation (IHF) Secretariat again had the pleasure of hosting students from the Nuffield Centre for International Health and Development (University of Leeds) UK.

The 20 students, all undertaking the Masters programme in Hospital Management, Planning & Policy / International Public Health, were from Ghana, Oman, Nigeria, India, Germany, Pakistan, Jordan and Afghanistan.

The students in addition to the presentations on the IHF and its activities, were provided a tour by Dr Hubert Vuagnat, Head Physician of the Geneva Hospital of Loex, location of the IHF Secretariat.

The IHF and the World Health Organization are among the Geneva-based international organizations visited by the students on the week-long 'Geneva Study Tour' which is part of the Masters programme.

IHF Secretariat welcome a new staff member

James Moreno Salazar has joined the IHF staff Office and Program Officer on 1 May 2012. His portfolio includes administration and projects. With his computer literacy background, he will also be in charge of IT and databases.

James has much experience working in the private and public sector. Before joining the IHF, from June 2009 to December 2011, he was at the NGO's Service of the state of Geneva where he was in charge of analyzing submitted information from NGO's and the development and maintenance of databases. Other experience includes working as a cost controller for an international airline catering at Geneva airport.

Mr. Moreno Salazar is a graduate of the University of Geneva where he completed a B.A. in Economic and social sciences and a Masters degree in Public Management in 2004.

James is Colombian by birth and Swiss by nationality. He is married and he enjoys sports such as cycling and holds a black belt in taekwondo. He speaks Spanish and French as mother tongue and also English and Italian.

IHF Events

3rd IHF Hospital and Healthcare Association Leadership Summit

The **3rd IHF Hospital and Healthcare Association Leadership Summit**, which will be held **5-6 June 2012 in Sun City, South Africa**, will be the first major official IHF event to be held in sub-Saharan Africa. The Summit is an IHF Members only event, the goal of which is to pave the way for an effective advocacy strategy for hospitals and hospital associations. It is an instrument by which IHF is able to fulfil its mandate in serving as a platform for knowledge sharing and discussion. By restricting participation, the Summit creates an arena for the frank exchange of concerns, opinions and ideas.

The local host is the Department of Health, who will hold a pre-Summit programme on 4 June, which will address the Summit topics of **Performance based financing of hospitals, Error reduction to enhance patient safety, Current trends on public private mix in health service delivery**, within the African context. A joint IHF/host country Forum, open to IHF and non-IHF Members as well as local participants, on 5 June, will address the same topics but within the international context.

The IHF members only Forum to be held on 6 June will include plenary sessions and discussions on one of the above-mentioned Summit themes, as well as roundtable debates on the topics of **Medical Tourism & Leadership Competencies**. Position statements will be developed by participating members for adoption by the IHF Governing Council.

Click to view the Summit preliminary scientific programme.

IHF 38TH WORLD HOSPITAL CONGRESS

The 38th World Hospital Congress will be held 18-20 June 2013 in Oslo, Norway.

For more information, please visit: <http://www.oslo2013.no> or see the flyer.

WHO Round Up

E-health in low- and middle-income countries: findings from the Center for Health Market Innovations

This article, written by Trevor Lewis et al., has been published in WHO Bulletin, Volume 90, Number 5, May 2012

Objective: To describe how information communication technology (ICT) is being used by programmes that seek to improve private sector health financing and delivery in low- and middle-income countries, including the main uses of the technology and the types of technologies being used.

Methods: In-country partners in 16 countries directly searched systematically for innovative health programmes and compiled profiles in the Center for Health Market Innovations' database. These data were supplemented through literature reviews and with self-reported data supplied by the programmes themselves.

Findings: In many low- and middle-income countries, ICT is being increasingly employed for different purposes in various health-related areas. Of ICT-enabled health programmes, 42% use it to extend geographic access to health care, 38% to improve data management and 31% to facilitate communication between patients and physicians outside the physician's office. Other purposes include improving diagnosis and treatment (17%), mitigating fraud and abuse (8%) and streamlining financial transactions (4%). The most common devices used in technology-enabled programmes are phones and computers; 71% and 39% of programmes use them, respectively, and the most common applications are voice (34%), software (32%) and text messages (31%). Donors are the primary funders of 47% of ICT-based health programmes.

Conclusion: Various types of ICT are being employed by private organizations to address key health system challenges. For successful implementation, however, more sustainable sources of funding, greater support for the adoption of new technologies and better ways of evaluating impact are required.

The full article is available in <http://www.who.int/bulletin/volumes/90/5/11-099820.pdf>

Ethical tensions in dealing with noncommunicable diseases globally

This article, written by Sridhar Venkatapuram, Martin McKee and David Stuckler, has been published in WHO Bulletin, Volume 90, Number 3, March 2012

Noncommunicable diseases pose an increasingly high burden of disease that threatens economic and social development, yet cost-effective health interventions exist. World leaders recognized the compelling case for action with the declaration at the United Nations high-level meeting on noncommunicable diseases in September 2011. Since that meeting, the World Health Organization (WHO) has been developing a Global Monitoring Framework and the United Nations Secretary-General is preparing to report to the 67th session of the General Assembly in September 2012 on ways to tackle noncommunicable diseases across different sectors.

This paper aims to inform these debates by reviewing the declarations that resulted from WHO regional meetings held in preparation for last September's high-level meeting. We identified four 'ethical tensions' that must be resolved. These tensions are not exhaustive or mutually exclusive but provide a framework for debate.

The full paper is available at <http://www.who.int/bulletin/volumes/90/3/11-094789.pdf>

Modern health care delivery systems, care coordination and the role of hospitals

The existing models of health care provision, often subject to fragmentation and insufficient coherence, appear to be one of the main causes limiting efficiency of interventions and quality of health outcomes.

Ageing populations with multiple co-morbidities, increasing expectations of health service quality and safety and the ability to access these services through cross border care require due attention given to coordination mechanisms. Work in this field in the European context is closely linked to the global initiative started by the World Health Organization (WHO) headquarters on the global hospital agenda within the wider context of coordinated care. The present events aimed to move a step further on the road to better integration and coordination of health promotion and care, by creating a shared understanding of the current state of health care delivery systems and strengthen their capacity to address change, determine priority areas for research and seeking expert guidance in how best WHO can support Member States in these areas.

The full report is available in

http://www.euro.who.int/__data/assets/pdf_file/0008/158885/BRU-report-Modern-health-care-delivery-systems.pdf

Provider-payment assessment tool in development

WHO, along with the World Bank and the Joint Learning Network for Universal Coverage (JLN), is developing a diagnostic and assessment guide to support countries making reforms to mechanisms for paying health-service providers.

This initiative is part the global effort to achieve universal coverage, which was the theme of the 2010 world health report. Health-systems financing is one of the key factors determining access to health services, the costs to patients and the quality and efficiency of service delivery. Many countries in the WHO European Region and globally seek ways to make health services available to all, as a key component of health-system reform.

Assessing and reforming provider-payment mechanisms can improve efficiency and quality in service delivery, which means increased value for money. In turn, efficiency gains can be used to extend population coverage or add new services to the benefit package. Improving efficiency helps health ministers make a stronger case for investing more in health.

Assessment tool

The new tool will enable the assessment of provider-payment mechanisms in the wider context of health-system performance, and focus on avoiding unintended consequences from making reforms. Its development will take a year, and include field tests in selected countries.

The project to develop the tool is a JLN initiative, guided by a group of experts. Partners in the project include the Rockefeller Foundation, the Bill & Melinda Gates Foundation, the governments of Germany and the United Kingdom, the World Bank and the Results for Development Institute. The work of the expert group on provider payment is led by co-chairs from the World Bank, JLN and WHO.

For further information visit

World Health Statistics 2012

World Health Statistics 2012 contains WHO's annual compilation of health-related data for its 194 Member States, and includes a summary of the progress made towards achieving the health-related Millennium Development Goals (MDGs) and associated targets.

This year, it also includes highlight summaries on the topics of noncommunicable diseases, universal health coverage and civil registration coverage.

The full document is available in http://www.who.int/gho/publications/world_health_statistics/EN_WHS2012_Full.pdf

Sixty-fifth World Health Assembly and the WHO Reform

The Sixty-fifth session of the World Health Assembly is taking place in Geneva during 21-26 May 2012. At this session, the Health Assembly will discuss a number of public health issues such as universal health coverage, Millennium Development Goals, noncommunicable diseases, mental disorders, nutrition and adolescent pregnancy.

Until Saturday, May 26, the World Health Assembly will discuss the program budget, administration and management matters of WHO.

On May 23, the World Health Assembly appointed Dr Margaret Chan for a second five-year term as Director-General of the World Health Organization (WHO). In her acceptance speech to health ministers and representatives of WHO's Member States, Dr Chan pledged her continued commitment to improve the health of the most vulnerable.

For further information on the World Health Assembly visit <http://www.who.int/mediacentre/events/2012/wha65/en/index.html>.

The World Health Organization (WHO) has initiated a reform process to help it adapt to the changing complexity of public health and to fulfil more effectively its role as the world's leading public health agency. The reform process began to consider financing challenges being faced by WHO but soon encompassed organization-wide reforms in the areas of governance, financing and human resources. Since May 2011, reform proposals have been discussed, debated and deliberated upon internally before being presented as concept papers for further consultation and discussion. The papers, revised on the basis of consultations, were presented to a special session of the Executive Board on reform. The special session of the Executive Board on the reform proposals approved reform proposals in many areas along with request for further amplification in other areas. Thus, the reform process of WHO is still a work in progress.

At the special session of the Executive Board during which the reform proposals were considered, the Board also decided to proceed with an independent evaluation to provide input into the reform process through a two-stage approach, the first stage consisting of a review of existing information with a focus on financing challenges for the organization, staffing issues, and internal governance of WHO by Member States, following up where possible to produce more information in response to questions arising from the Executive Board at its special session. It proposed that the firststage evaluation be completed in time for the Sixty-fifth World Health Assembly. The first stage of evaluation was also to suggest the scope of the second phase of evaluation.

The responsibility of conducting the first-stage evaluation has been entrusted to the Comptroller and Auditor General of India, the current external auditors of WHO. The first-stage evaluation of the reform proposals, based on existing information, took place from 27th February to 30th March, 2011 and sought to come to an understanding about the completeness, comprehensiveness and adequacy of the reform proposals formulated by WHO Secretariat in the areas of finance, human resources and governance, as contained in the relevant documents. The evaluation also analysed areas where more information may be required to be produced in response to questions arising from the Executive Board at its special session and proposed a roadmap for the stage-two evaluation.

Some of the significant recommendations made after evaluating the reform proposal are:

? Linkages among governing bodies at headquarters and regional offices have to be carefully created, as these would have far reaching impact on organizational coherence and would provide the Organization with a strategic focus.

? Accountability and responsibility structures for three layers of governance would need to be redesigned, keeping in view the new programmatic approach, a resource allocation mechanism and a country focus on programme planning and delivery. A robust results-based management system and an effective performance management and development system could provide the requisite links.

? Country focus strategies need a detailed action plan interlinking various aspects of proposed changes along with structural and procedural support.

? Wide ranging changes require acceptance at various levels. An advocacy plan, to explain the implications of the change strategy, identification of change agents and a detailed change management plan would be required to implement the plan of action, after the approvals are received from the appropriate authorities. ? The reform proposal is still a work in progress. However, it is of paramount importance that desired outputs, outcomes and impact are identified, indicators to measure these are designed, and a monitoring and feedback mechanism is put in place.

? The Organization is proposing a comprehensive reform programme, which involves action on a large number of fronts. It is recommended that a prioritization plan may be prepared to allow smooth and gradual shift.

? The success of the reform proposal, in parts, would be dependent on carrying out of changes in HR policies. Given the fact that HR policies do have inbuilt rigidities, WHO may have to resort to innovative solutions. It is recommended that best practices in similarly placed organizations may be considered.

? The success of any change strategy is directly correlated to understanding of its gains by the stakeholders. It is suggested that regular communication should be maintained with all concerned on the progress of the reform proposal, which would help in creating the right environment for implementation.

? The proposed reform proposal has highly interdependent components, the success of the process would require that this interdependence is recognized and woven into the implementation strategy.

The evaluation also proposed the scope, approach and key questions for the second stage of evaluation. According to the decision taken by the Executive Board at its 130th session, certain proposals are to be brought before the Executive Board at its 131st session and before the Sixty-fifth World Health Assembly. The second-stage evaluation should be undertaken only after these proposals have been considered by these governing bodies. This might help in deciding the exact scope of evaluation to be undertaken.

The full report is available in http://apps.who.int/gb/ebwha/pdf_files/WHA65/A65_5Add2-en.pdf

From International Organizations

External Evaluation of the Global Health Workforce Alliance

The Board of the Global Health Workforce Alliance (the Alliance), commissioned in 2011 an external evaluation of the work of the Alliance, with a view to take stock of its experience to date, and help define a strategic framework for the following years.

The external evaluation, which was conducted by the firm Oxford Policy Management, recognized several important areas of contribution and value added of the Alliance, together with some areas that require improvements.

Although there are no Human Resources for Health related agenda items tabled for discussion at the 65th World Health Assembly, which takes place from 21-26 May, the Global Health Workforce Alliance (the Alliance) will host a preview session of the new strategic agenda for the second phase of the Alliance.

The International Hospital Federation is a partner of the Alliance:

http://www.who.int/workforcealliance/members_partners/partners/en/index.html

Details of the evaluation report and the Board response are available at:

http://www.who.int/workforcealliance/media/news/2012/boardresponse_EE_final_En.pdf

Hospital and Health Services Worldwide News

Patient safety, satisfaction, and quality of hospital care: cross sectional surveys of nurses and patients in 12 countries in Europe and the United...

The article "Patient safety, satisfaction, and quality of hospital care: cross sectional surveys of nurses and patients in 12 countries in Europe and the United States", written by Linda H Aiken, Walter Sermeus, et al., is published by the British Medical Journal in March 2012 (BMJ **2012;344:e1717**).

Objective To determine whether hospitals with a good organisation of care (such as improved nurse staffing and work environments) can affect patient care and nurse workforce stability in European countries.

Design Cross sectional surveys of patients and nurses.

Setting Nurses were surveyed in general acute care hospitals (488 in 12 European countries; 617 in the United States); patients were surveyed in 210 European hospitals and 430 US hospitals.

Participants 33 659 nurses and 11 318 patients in Europe; 27 509 nurses and more than 120 000 patients in the US.

Main outcome measures Nurse outcomes (hospital staffing, work environments, burnout, dissatisfaction, intention to leave job in the next year, patient safety, quality of care), patient outcomes (satisfaction overall and with nursing care, willingness to recommend hospitals).

Results The percentage of nurses reporting poor or fair quality of patient care varied substantially by country (from 11% (Ireland) to 47% (Greece)), as did rates for nurses who gave their hospital a poor or failing safety grade (4% (Switzerland) to 18% (Poland)). We found high rates of nurse burnout (10% (Netherlands) to 78% (Greece)), job dissatisfaction (11% (Netherlands) to 56% (Greece)), and intention to leave (14% (US) to 49% (Finland, Greece)). Patients' high ratings of their hospitals also varied considerably (35% (Spain) to 61% (Finland, Ireland)), as did rates of patients willing to recommend their hospital (53% (Greece) to 78% (Switzerland)). Improved work environments and reduced ratios of patients to nurses were associated with increased care quality and patient satisfaction. In European hospitals, after adjusting for hospital and nurse characteristics, nurses with better work environments were half as likely to report poor or fair care quality (adjusted odds ratio 0.56, 95% confidence interval 0.51 to 0.61) and give their hospitals poor or failing grades on patient safety (0.50, 0.44 to 0.56). Each additional patient per nurse increased the odds of nurses reporting poor or fair quality care (1.11, 1.07 to 1.15) and poor or failing safety grades (1.10, 1.05 to 1.16). Patients in hospitals with better work environments were more likely to rate their hospital highly (1.16, 1.03 to 1.32) and recommend their hospitals (1.20, 1.05 to 1.37), whereas those with higher ratios of patients to nurses were less likely to rate them highly (0.94, 0.91 to 0.97) or recommend them (0.95, 0.91 to 0.98). Results were similar in the US. Nurses and patients agreed on which hospitals provided good care and could be recommended.

Conclusions Deficits in hospital care quality were common in all countries. Improvement of hospital work environments might be a relatively low cost strategy to improve safety and quality in hospital care and to increase patient satisfaction.

The full article is available at http://www.bmj.com/highwire/filestream/574655/field_highwire_article_pdf/0.pdf

Africa

AfDB launches eHealth Award to seek African ICT health solutions

The International Society for Telemedicine & eHealth (ISfTeH) is pleased to announce that the African Development Bank (AfDB) launched a competition for innovative and sustainable information and communication technology (ICT) solutions for the health sector in Africa.

Initiated by the AfDB's Human Development Department, the eHealth Award aims to discover current work being done in the fields of eHealth and mHealth in Africa, to encourage the production and sharing of knowledge on eHealth solutions, and provide added value through the sharing of lessons learnt in eHealth and mHealth.

The award targets a range of participants, including individuals, NGOs, development organizations, companies, academic institutions and research facilities. The criteria and focus of the award are centered on

- a) using ICT to increase access to health services, particularly for the poor and marginalized,
- b) using ICT to increase the utilization of essential health services and/or

c) the evaluation of eHealth solutions to improve efficiency in the delivery of health services.

The **deadline for submissions** from participants is **30 May 2012**. Submissions should be an abstract of 500 words from their projects, after which the shortlisted candidates will need to produce an evaluation report.

The online submission form is available at www.afdb.org/en/forms/ehealth-award-application-form.

The winning projects will be presented in an AfDB publication and winners will be given a prize.

For more information, see: www.isfteh.org/files/media/African_Bank_Brochure_16April2012_hiquality-2-2.pdf.

Americas

Improving patient access to specialized health care: the Telehealth Network of Minas Gerais, Brazil

This article, written by Maria Beatriz Alkmim et al., has been published in the WHO Bulletin, Volume 90, Number 5, May 2012

Problem: The Brazilian population lacks equitable access to specialized health care and diagnostic tests, especially in remote municipalities, where health professionals often feel isolated and staff turnover is high. Telehealth has the potential to improve patients' access to specialized health care, but little is known about it in terms of cost-effectiveness, access to services or user satisfaction.

Approach: In 2005, the State Government of Minas Gerais, Brazil, funded the establishment of the Telehealth Network, intended to connect university hospitals with the state's remote municipal health departments; support professionals in providing tele-assistance; and perform tele-electrocardiography and teleconsultations. The network uses low-cost equipment and has employed various strategies to overcome the barriers to telehealth use.

Local setting: The Telehealth Network connects specialists in state university hospitals with primary health-care professionals in 608 municipalities of the large state of Minas Gerais, many of them in remote areas.

Relevant changes: From June 2006 to October 2011, 782 773 electrocardiograms and 30 883 teleconsultations were performed through the network, and 6000 health professionals were trained in its use. Most of these professionals (97%) were satisfied with the system, which was cost-effective, economically viable and averted 81% of potential case referrals to distant centres.

Lessons learnt: To succeed, a telehealth service must be part of a collaborative network, meet the real needs of local health professionals, use simple technology and have at least some face-to-face components. If applied to health problems for which care is in high demand, this type of service can be economically viable and can help to improve patient access to specialized health care.

The full article is available at <http://www.who.int/bulletin/volumes/90/5/11-099408.pdf>

Integrated Health Service Delivery Networks: Concepts, Policy Options and a Road Map for Implementation in the Americas

This paper has been published by Pan American Health Organization (PAHO) in 2011.

This position paper analyzes the challenge of health services fragmentation, proposes a conceptual and operational framework for understanding IHSDNs, presents public policy instruments and institutional mechanisms to develop integrated networks, and proposes a 'road map' for implementing IHSDNs in the Americas. The document focuses on the integration of the health services delivery function, and as a result it does not address mechanisms to integrate the health systems functions of financing and/or insurance. Furthermore, it does not address in detail the mechanisms to integrate programs targeting specific diseases, risks and populations (vertical programs) into health systems.

The full report is available at http://new.paho.org/hq/dmdocuments/2011/PHC_IHSD-2011Serie4.pdf

Health financing strategy for the Asia Pacific Region (2010-2015)

Despite impressive economic development in the Asia-Pacific region, many people suffer financial catastrophe and impoverishment each year because they have to pay for health care. Many others forgo health services because of the costs of health care.

This reflects insufficient health spending by many countries in the region, limited prepayment mechanisms and safety nets, and an overreliance on out-of-pocket expenditures to finance the costs of health care. The World Health Organization developed a new health financing strategy for Asia Pacific region to address these concerns, with the ultimate aim of achieving universal coverage, where all people have access to appropriate promotive, preventive, curative and rehabilitative services at an affordable cost.

The health financing strategy for the Asia Pacific Region (2010-2015) will help governments analyse their health financing situations and identify specific actions to achieve universal coverage. It was developed as a result of regional health financing reviews and consultations and is based on a growing body of global research and evidence. It adds three new areas intended to improve aid effectiveness, more efficiently use resources and improve provider payment methods. All contribute to attaining universal coverage of quality health services

The full report is available at

http://www.searo.who.int/catalogue/2005-2011/pdf/healthcarefinancing/health_financing_strategy_asia_pacific_region2010-2015.pdf

Eastern Mediterranean Region

Patient Safety Friendly Hospital Initiative from evidence to action in seven developing country hospitals

This article, written by S. Siddiqi et al, is published in the International Journal for Quality and Health Care 2012, Volume 24, Number 2.

Quality problem Recent evidence in the level of patient safety from hospitals in six developing countries in the Eastern Mediterranean Region has demonstrated the high prevalence of adverse events, the excessive rate of death and permanent disability and their high preventability. The Patient Safety Friendly Hospital Initiative (PSFHI) has been launched to respond to these challenges.

Initial assessment The principal approach of the PSFHI has been to develop an assessment manual that has 140 patient safety standards across five domains: leadership and management, patients and public involvement, safe evidence-based clinical practices, safe environment and lifelong learning.

Choice of solution and implementation Ministries of health of seven countries: Egypt, Jordan, Morocco, Pakistan, Sudan, Tunisia and Yemen were asked to nominate one hospital for assessment and then follow-up with an improvement plan.

Evaluation The standards are divided into critical (20), core (90) and developmental (30). The range of critical standards, the compulsory standards with which a hospital has to comply, achieved by participating hospitals was 87.8%. Overall, in the domain of leadership and management the highest compliance was 47%, for patients and public involvement 25%, for safe evidence-based clinical practice 53%, for safe environment 64% and for lifelong learning 27%.

Lessons learned This is the first systematic multi-country initiative in the Eastern Mediterranean Region, which provides compelling evidence that assessment of patient safety standards is feasible and applicable in resource-poor settings and there are significant opportunities for improving the level of patient safety in these hospitals.

Health Care Reform in the Former Soviet Union: Beyond the Transition

This article, written by Dina Balabanova et al., is published in Health Service Research (HSR)

Objective: To assess accessibility and affordability of health care in eight countries of the former Soviet Union.

Data Sources/Study Setting: Primary data collection conducted in 2010 in Armenia, Azerbaijan, Belarus, Georgia, Kazakhstan, Moldova, Russia, and Ukraine.

Study Design: Cross-sectional household survey using multistage stratified random sampling.

Data Collection/Extraction Methods: Data were collected using standardized questionnaires with subjects aged 18+ on demographic, socioeconomic, and health care access characteristics. Descriptive and multivariate regression analyses were used.

Principal Findings: Almost half of respondents who had a health problem in the previous month which they viewed as needing care had not sought care. Respondents significantly less likely to seek care included those living in Armenia, Georgia, or Ukraine, in rural areas, aged 35-49, with a poor household economic situation, and high alcohol consumption. Cost was most often cited as the reason for not seeking health care. Most respondents who did obtain care made out-of-pocket payments, with median amounts varying from \$13 in Belarus to \$100 in Azerbaijan.

Conclusions: Access to health care and within-country inequalities appear to have improved over the past decade. However, considerable problems remain, including out-of-pocket payments and unaffordability despite efforts to improve financial protection.

Leadership and Governance in Seven Developed Health Systems

This article, written by P. C. Smith, A. Anell, R. Busse et al., has been published online by the Health Policy Journal in January 2012.

The Issue According to the World Health Organization, a government's responsibility for its health care system has three components: setting population health goals, assessing progress toward those goals, and ensuring accountability. In a Commonwealth Fund-supported study, researchers use this model to compare the leadership and governance arrangements in seven nations with advanced health systems: Australia, England, Germany, the Netherlands, Norway, Sweden, and Switzerland.

What the Study Found Approaches to health system governance and leadership vary substantially. While there is some consensus around broad goals such as ensuring the quality and safety of health services, the seven nations take varying approaches in setting priorities to reach them. They are in general agreement about the need to measure health system performance. On the other hand, the nations take widely different approaches to holding health system actors accountable. For example, the Netherlands relies on health care markets, in which patients or insurers exert pressure on providers to uphold standards of care, and England appears to be moving in this direction. By contrast, Norway has more direct control through four regional health authorities that set health plans' terms and contracts.

Conclusions The researchers suggest that a blended approach to accountability including market mechanisms, electoral processes, direct financial incentives, and professional oversight and control is likely to be most effective. They conclude that further challenges for the governance and leadership of these health systems are 'setting realistic priorities based on sustainable financing, performance monitoring that encourages rather than stifles innovation, and designing accountability mechanisms that strengthen rather than undermine professional responsibility.'

International Events

Hopital Expo

May 22-25, 2012

Porte de Versailles, Paris

France

For more information: <http://www.hopitalexpo.com/>

National Health Leadership Conference

June 4-5, 2012

Halifax, Nova Scotia

Canada

For more information: <http://www.nhlc-cnls.ca/default1.asp>

HOSPAGE Aging health workforce ' aging patients: multiple challenges for hospitals in Europe

12-13 June 2012

DKG ' HOPE

Berlin, Germany

HOSPAGE is a two days conference, which is dealing with the major challenge for the healthcare systems of EU Member States: the aging of patients and of health workforce.

For more information please visit <http://www.hospage.eu/> or see the brochure.

NHS Confederation Annual Conference and Exhibition

June 20-22, 2012

Manchester, United Kingdom

For more information: www.nhsconfed.org/2012

Healthcare Financial Management Association's Healthcare Finance Conference

June 24-27, 2012

Mandalay Bay Resort and Convention Center,
Las Vegas, NV
USA

The Healthcare Financial Management Association (HFMA) is a membership organization for healthcare financial management executives and leaders. HFMA's more than 37,000 members range from CFOs to controllers to accountants and can be found in all areas of the healthcare system, including hospitals, managed care organizations, physician practices, accounting firms, and insurance companies. HFMA helps healthcare finance professionals meet the challenges of the modern healthcare environment by providing education, analysis, and guidance.

For more information: <http://www.hfmaconference.org/>

10th International Symposium on Pharmaceutical Sciences

June 26-29, 2012

Ankara, Turkey

American Hospital Association's Leadership Summit

July 19-21, 2012

San Francisco Marriott
San Francisco, CA
USA

The American Hospital Association (AHA) leads, represents and serves hospitals, health systems and other related organizations that are accountable to the community and committed to health improvement with 5,000 institutional members and 40,000 individual members.

The Leadership Summit is an educational meeting which focuses on the organizational characteristics, structures, and processes that lead to a high-performing system of care.

For more information: http://www.healthforum.com/healthforum/html/conferences/12Summit/Summit_home.html

Hospital Management Asia 2012

September 13-14, 2012

Hanoi, Vietnam

For more information: <http://hospitalmanagementasia.com/>

American Nurses Credentialing Center: ANCC National Magnet Conference

October 10-12, 2012

Los Angeles Convention Center, California
USA

For more information: <http://www.anccmagnetconference.org/>

Medical Group Management Association Annual Conference

October 21-24, 2012

Convention Center, Grand Hyatt

San Antonio, TX

In 2011, the Medical Group Management Association (MGMA) and its standard-setting body, the American College of Medical Practice Executives (ACMPE), voted to merge to form a new association, MGMA-ACMPE. MGMA-ACMPE is the premier association for professional administrators and leaders of medical group practices with 22,500 members who lead 13,600 organizations nationwide. Its diverse membership comprises administrators, CEOs, physicians in management, board members, office managers and many other management professionals. They work in medical practices and ambulatory care organizations of all sizes and types.

For more information: <http://www.mgma.com/mgma12/>

Healthcare Supply Chain Association: 2012 International Expo

October 22-24, 2012

JW Marriott Grande Lakes

Orlando, Florida

For more information: http://www.supplychainassociation.org/events/event_details.asp?id=167432

4th International Hospital Congress

November 7-9, 2012

Lisbon, Portugal

For more information: <http://www.apdh.pt/node/389>

Healthcare Information and Management Systems Society's Annual Conference and Exhibition

March 3-7, 2013

Convention Center

New Orleans, LA

USA

The Healthcare Information and Management Systems Society (HIMSS) is a membership organization exclusively focused on providing global leadership for the optimal use of information technology (IT) and management systems for the betterment of healthcare. HIMSS represents more than 44,000 individual members, of which more than two thirds work in healthcare provider, governmental and not-for-profit organizations. HIMSS frames and leads healthcare public policy and industry practices through its educational, professional development, and advocacy initiatives designed to promote information and management systems' contributions to ensuring quality patient care.

For more information: <http://www.himssconference.org/>

American College of Healthcare Executives: Congress on Healthcare Leadership

March 11-14, 2013

Hilton Chicago & Palmer House Hilton

Chicago, Illinois

USA

The American College of Healthcare Executives (ACHE) is an international professional society of more than 35,000 healthcare executives who lead hospitals, healthcare systems and other healthcare organizations. ACHE is known for its prestigious FACHE® credential, signifying board certification in healthcare management, and its educational programs including the annual Congress on Healthcare Leadership, which draws more than 4,500 participants each year.

For more information: <http://ache.org/Congress>

American Organization of Nurse Executives' Annual Meeting and Exposition

March 19-22, 2013

Convention Center

Denver, Colorado

USA

The American Organization of Nurse Executives (AONE), a subsidiary of the American Hospital Association, is a national membership organization of over 8,000 nurse leaders who design, facilitate and manage care. AONE provides leadership, professional development, advocacy and research in order to advance nursing practice and patient care, promote nursing leadership excellence and shape healthcare public policy.

American Hospital Association's Annual Meeting

April 28 - May 1, 2013

Hilton Washington
Washington, DC
USA

The American Hospital Association (AHA) leads, represents and serves hospitals, health systems and other related organizations that are accountable to the community and committed to health improvement with 5,000 institutional members and 40,000 individual members. The AHA Annual Meeting is an educational meeting with a primary focus on national legislative and regulatory issues.

For more information: www.aha.org

Healthcare Financial Management Association's Healthcare Finance Conference

June 16-19, 2013

Orange County Convention Center
Orlando, FL
USA

The Healthcare Financial Management Association (HFMA) is a membership organization for healthcare financial management executives and leaders. HFMA's more than 37,000 members range from CFOs to controllers to accountants and can be found in all areas of the healthcare system, including hospitals, managed care organizations, physician practices, accounting firms, and insurance companies. HFMA helps healthcare finance professionals meet the challenges of the modern healthcare environment by providing education, analysis, and guidance.

American Hospital Association's Leadership Summit

July 27-29, 2013

San Diego Hyatt
San Diego, CA
USA

The American Hospital Association (AHA) leads, represents and serves hospitals, health systems and other related organizations that are accountable to the community and committed to health improvement with 5,000 institutional members and 40,000 individual members.

The Leadership Summit is an educational meeting which focuses on the organizational characteristics, structures, and processes that lead to a high-performing system of care.

American Nurses Credentialing Center: ANCC National Magnet Conference

October 2-4, 2013

Orlando, Florida
USA

For more information: <http://www.anccmagnetconference.org/>

Medical Group Management Association Annual Conference

October 6-9, 2013

Convention Center, Marriott

San Diego, CA

USA

In 2011, the Medical Group Management Association (MGMA) and its standard-setting body, the American College of Medical Practice Executives (ACMPE), voted to merge to form a new association, MGMA-ACMPE. MGMA-ACMPE is the premier association for professional administrators and leaders of medical group practices with 22,500 members who lead 13,600 organizations nationwide. Its diverse membership comprises administrators, CEOs, physicians in management, board members, office managers and many other management professionals. They work in medical practices and ambulatory care organizations of all sizes and types.

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