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Editorial

ERIC DE ROODENBEKE

CHIEF EXECUTIVE OFFICER, INTERNATIONAL HOSPITAL FEDERATION

As we are coming to the end of 2010 it is clear that the economic crisis will not cease very soon as announced earlier by the governments. It may even get worst if there is an increased pressure on all the indebts countries triggered by international speculation on currency.

Anyhow it is clear that reducing the deficits is a priority for most of these governments and this will be translated by budget cuts affecting the health care sector in many countries. But this overall economical situation is also affecting the behavior of the insurance and the corporate sector. Every one is looking on how to save money. This obliges to revise the order of priorities, which is a good thing.

Some may consider that spending on international organization is not a priority because they do not get immediate value for money. This is the usual insular reaction based on the idea that first it is necessary to put home in order before participating to international activities. Unfortunately there is no evidence that such a behavior has been of any help in a crisis situation. On the contrary in a world that is more and more open, it is important to rely on international organizations to best lever the possibilities from international exchanges. Each large organization can do it on its own but uniting forces to give a stronger mandate to the IHF is certainly a wise approach for saving money and having a greater impact.

The IHF Governing Council has given a new impulse to the organization by reinforcing the role of the IHF secretariat as a knowledge hub and a resource for advocacy. The Journal will evolve by playing a better role in this direction and this issue is heading toward this direction with articles under the policy section describing how it is important to work in an international mindset.

Europeans have been making important progresses to deal with cross border healthcare and their example can be a source of inspiration for other countries. More and more countries are organizing themselves into regional bodies to deal with supra national issue. The cross border care is a subject of interest in the Americas, in Africa and in Asia where it is also important to avoid duplication of services and better access to care regardless of national borders, especially when people can easily cross them and insurance companies are more and more interested in getting the best deal for their clients.

On another front when countries are considering the possible evolution of their hospitals it is important for them to learn from others. This is happening in countries which used to be fully under Soviet influence moving now from a "one size fits all approach" to a customized response. The article describing the situation in Ukraine and Moldova gives us a very good description of transformation. Without underestimating the specific situation of a country much can be achieved by taking advantage of best practices from abroad.

When it comes to health workers safety there are no borders for good options. All countries have to face HIV and TB which can put at risk health workers if appropriate measures are not in place. The fact that this article is written by representatives from the International Labor Organization (ILO) is a strong message on its own. This is a matter that can be addressed at a global level for the benefit of all and with the support of governments, employers and trade unions (let's not forget ILO constituency).

I will invite the readers to pay attention to the other articles covering national issues but allowing a perspective from countries which are not always on the spot light in their approaches and solution while they are doing an important work. Iran is unfortunately well known for the seismic risks it must face and you will read how they have prepared themselves to face the next disaster. IHF is committed to support the hospital safety program and recommends to rely on the hospital safety index.(http://safehospitals.info/).

Readers will also be interested to see how the most advanced country is facing the need to reconcile telehealth, electronic health records and health information exchange. This perspective is taking us a step forward as each IT innovation is not anymore considered under its promises but as a piece of a combined approach to address the critical challenges of delivering high quality efficient care.

I am sure that the rest of our selection will capture your attention and would like to remind you that we have an online reader's survey that you are warmly encouraged to fill up. Your feed back is necessary for us to continuously improve topic and content of our articles. Be sure that for the coming year we prepare some other changes that will rise up the profile of our Journal by providing more focused articles along with a mainstreamed editorial line… but you will have to wait for next years first edition to learn more about these evolutions. ❏

Striking a balance between national interests and patients' needs: Cross-border projects meeting European challenges

RENATE BURGER
GUEST TUTOR FOR "INTERNATIONAL HEALTH CONSULTING" AND "HEALTH POLICY AND EUROPEAN INTEGRATION" AT THE UNIVERSITY OF APPLIED SCIENCES IMC AND THE DANUBE UNIVERSITY KREMS

THOMAS KOSTERA
RESEARCH AND TEACHING ASSISTANT AT THE INSTITUTE FOR EUROPEAN STUDIES OF THE UNIVERSITÉ LIBRE DE BRUXELLES IN BRUSSELS, BELGIUM

ABSTRACT: The article deals with the new opportunities for EU member state citizens to go abroad for medical treatment. The European Court of Justice has facilitated the access to medical treatment for EU citizens in other EU states. This development has worried national governments since they feared reduced control in their healthcare systems. The cross-border project "healthacross" between Austria and the Czech Republic however illustrates in which way authorities can respond to patients needs in two different countries. Nevertheless a plethora of administrative and practical problems have to be solved for cross-border co-operation in the provision of healthcare.

The European Union (EU) is often perceived by citizens as some abstract, distant bureaucracy in Brussels. Since the Treaty of Maastricht however, different policy fields have become part of the EU's political agenda that have rendered the EU much more tangible for citizens. Public health and healthcare are among these policy fields, they are both European issues nowadays. Healthcare has stayed an exclusive member state competence until several landmark rulings by the European Court of Justice (ECJ) on cross-border patient mobility. These rulings have shown that EU member states' healthcare systems and the services they provide have to comply with the fundamental principles of the European Single Market. Whereas these rulings have provided European citizens with more opportunities to leave their home country in order to get medical treatment in another EU member state, national governments are worried about an increasing loss of control over their national healthcare systems. Member states will have to strike a balance between individual citizens' rights to medical treatment abroad and the states' general interest in safeguarding the traditional set-up of their healthcare systems. The aim of this article is to illustrate in which way regional initiatives can contribute to strike a balance between the national and patients' interest by fostering a cross-border co-operation of local healthcare providers. A planned co-operation on the border between Austria (Lower Austria) and the Czech Republic (South Bohemia) serves as an example for striking this balance.

European legal requirements increasing patients' choice

Patients might want to seek medical treatment which is usually covered by the domestic health system in other EU member states than their home country for various reasons. One underlying motive is the increased mobility of European citizens due to retirement of northern Europeans living in Southern Europe, but also because of younger generations using low cost airlines that have made traveling more widely available to citizens. Furthermore the price of an operation can play a role in national systems where co-payments are necessary (Rosenmöller, 2006, p.49). A Eurobarometer survey has shown that around half of the European citizens in the EU 27 would be ready to travel for medical treatment, especially if a certain treatment would not be available at home (Baeten & Glinos, 2006, p. 6). A second factor is the costs of medical treatments. In some countries dental treatment or other medical treatments require quite high co-payments by patients. If a patient wants to save money on these co-payments, especially treatments in the recently joint member states such as Poland, Hungary or Slovenia can be an attractive option for an exit from the domestic system (Österle, Delgado, 2006, p. 130). In these countries treatment is usually available. Some of the patients who had used this opportunity have sought reimbursement by their domestic healthcare system for their treatment in another member state. In some cases national legislation did not provide for such a possibility. These patients who had exited their national system used their right to voice their discontent about national legislation in front of the ECJ. As a consequence the Court has

delivered several landmark rulings[i] that have put the "multi-faceted phenomenon" (ibid.) of cross-border patient mobility on the EU's agenda. The ECJ ruled that a member state can only restrict the free movement of patients if these restrictions are objective, non-discriminatory and subjected to possible judicial review. If a national healthcare system therefore allows seeing any physician in the home country this now means that patients must have the permission to see any physician in the EU. Treatment by a physician in another member state is not subject to prior authorization anymore, even if only the amount that would have been reimbursed at home will be granted for treatment abroad. Inpatient care remains however subject to prior authorization by the home member state. This permission has to depend on objective criteria, and a refusal cannot merely be based on the existence of waiting lists in the national healthcare system (Harvey & McHale, 2004, p. 133). These rulings have the potential to create an impetus for a common European space of healthcare. Former national patients can now play the role of European consumers in an EU-wide healthcare market and thus force their sickness funds to act accordingly (Sieveking, 2007, p. 40). European citizenship now grants patients new social rights when trying to exit their domestic healthcare system. From a member state perspective however, the tearing down of national boundaries of the healthcare system by European rules gives rise to severe concerns: member states' obligation to reimburse patients without prior authorization for medical treatment of a physician in another member state jeopardizes the national control over the consumption of medical services (Lamping, 2005, p. 31). This "decoupling" of medical services from the national territory that will occur in some cases also relates to the providers of healthcare services and is linked to the quality of healthcare. Non-national physicians, pharmacists and nurses from other EU member states should not be hindered anymore to provide their services on the national healthcare market. Hence, discrimination against these professions in order to protect national providers is prohibited (ibid.). The ECJ's rulings and member state governments' concerns unsurprisingly have triggered a process of political discussion and bargaining in Brussels that has been lasting now for almost ten years and is still going on. On a more practical level, patients needs can not be longer ignored and have to be met already. Regional and local health authorities have to respond to these needs given the increased willingness of the population in border regions to access medical treatment in a neighboring country. One way of responding actively to these demands can be cross-border co-operation as it can be found between the Austrian region of Lower Austria and the Czech Region of South Bohemia.

In the border region between Lower Austria and South Bohemia, the "divided" city of Gmünd/eské Velenice illustrates the need for co-operation in the healthcare sector in a particularly marked way: on the Czech side, the provision of care – especially emergency care – is problematic, at least in the area close to the border. The next ambulance with physician on duty is stationed at a distance of 17 km in Suchdol nad Lunicí, and the closest hospital is located at a distance of 60 km in eské Budjovice – which may result in considerable delays in the provision of medical care to patients. In contrast, the hospital of Gmünd (LK Gmünd)

i. Reference in the article is generally made to the following rulings: Kohll, case C-158/96, Vanbraekel, case C-368/98, Müller-Fauré, case C-385/99, and Watts, case C-372/04.

On the Czech side, the provision of care – especially emergency care – is problematic, at least in the area close to the border

and the ambulance are situated a few hundred metres from the border. Thus the local population of _eské Velenice became already involved in 1999 in the provision of cross-border health services. In co-operation with the commercial academy Gmünd, the hospital Landesklinikum Waldviertel-Gmünd (LK Gmünd) conducted a survey regarding the image of the hospital. Motivated by this survey a citizens´ initative was started, resulting in the mayor of eské Velenice taking action. He ordered a feasability study for the use of LK Gmünd by Czech patients. The final report was issued in 2003. It showed that the acceptance of cross-border emergency healthcare would be very high. The accession of the Czech Republic to the European Union in 2004 and to the Schengen Agreement in 2008 opened up a large variety of new opportunities, but created also new challenges especially for health care. Cross-border co-operation between old and "new" Member States became a realistic option, and funding-programmes became accessible. Because of the altered situation and the ongoing support of the political authorities in Lower Austria, the decision was made to start a common initiative for cross-border co-operation between health care providers in Lower Austria and South Bohemia. Since also for Austrian patients the possibility to use healthcare services in specific fields on the other side of the border is of great interest due to shorter distances. Jindichv Hradec, for example, has a modern dialysis unit that can be easily reached by patients from the Gmünd region. In addition, there are comprehensive services in the field of rehabilitation in the Czech Republic that could be used by patients from Lower Austria. Therefore, cross-border patient care and exchanges of services would be of great advantage for both partners and the local population In the case of emergency it becomes obvious that for both countries and the regional population a closer co-operation and better co-ordination of services could bring significant benefits, i.e. the fastest access possible to emergency care.

The project-application under the title "healthacross" was submitted by Niederösterreichische Landeskliniken-Holding as lead partner and Jihoeské nemocice, a.s. as project-partner. It aims at taking a first step to co-operate between Austria and the Czech Republic in order to develop an improved access to health care services by all people living in the border region of Lower Austria and South Bohemia. The innovative nature of the project stems from the specific situation in that border region due to enormous wage gaps and cost differentials: inequality and disparity in health status, access to services and the provision of treatment have to be addressed. The main objective of "healthacross" is thus to facilitate co-operation and to ensure better access to health care (especially in case of emergency) in the area Gmünd/eské Velenice. Furthermore, the optimization and co-ordination of health services in the project region are intended. The initiative is trying to implement cross-border co-operation in that region for the first time, preparing sound planning schemes

and binding rules laid down in bilateral co-operation agreements to ensure that cross-border co-operation will be successful and sustainable (Burger, Wieland, 2010). A first pilot project has been started in the field of cross-border emergency care that will be the basis for future co-operation and exchange of services. A very important element is as well the idea to develop and construct a cross-border health centre near the border that is jointly run by both countries. Before setting up such a cross-border health center several practical problems still have to be addressed by the project: obstacles regarding cross-border patient transfers, coordinating communication between emergency services, health providers and hospitals in the regions, the definition of common quality standards and legal coverage of co-operation have to be discussed and tackled by the responsible authorities. Thus "healthacross" put the topic of co-operation on the agenda of regional politicians, of national stakeholders (e.g. insurance funds) and will also be a topic of European interest, given that there are regions with comparable challenges in the EU.

Conclusion

The European Court of Justice and its rulings on cross-border patient mobility have put healthcare on the European Union's political agenda: a policy field that for a long time has been an exclusive national political domain of EU member states has now to comply with the legal requirements of the European Single Market. European patients have been the driving force behind this development by not accepting their sickness funds' refusal of payment for medical treatment in another EU member state. The European Court of Justice has considerably enlarged patient choice and has changed their role from that of a national patient into the one of a truly European consumer. Furthermore EU member states have difficulties in adapting to European rules and to find an agreement on a common Directive on the issue: the freedom of choice for European patients can become burden for several national healthcare systems in the EU. Regional cross-border co-operation like the one between Austria and the Czech Republic shows however that patients' needs can be satisfied taking into account the national health systems on both sides of the border. Such a co-operation even improves access to healthcare and makes way for a new approach to an effective co-ordination of health policy. Nonetheless there are several administrative and practical obstacles that have to be overcome before a sustainable cross-border provision of healthcare can be set-up. ❏

Renate Burger is currently working for the private company Gesundheitsmanagement Burger-Wieland OG in Vienna (Austria), specialized in project management of cross-border health projects and health promotion measures in Austria and the EU. She is guest tutor for "International Health Consulting" and "Health Policy & European Integration" at the University of Applied Sciences IMC and the Danube University Krems.

Thomas Kostera is currently working as a Research and Teaching assistant at the Institute for European Studies of the Université Libre de Bruxelles in Brussels (Belgium). He is writing his PhD on cross-border patient mobility in the EU and holds a Master's degree in European Political Studies from the College of Europe, Bruges (Belgium) and a degree in Administrative Science from the University of Potsdam (Germany).

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Crisis management, capabilities and preparedness: the case of public hospitals in Iran

DR REZA NAJAFBAGY

DIRECTOR OF THE PHD PUBLIC ADMINISTRATION PROGRAM, FACULTY OF MANAGEMENT AND ECONOMICS,
SCIENCE AND RESEARCH BRANCH, AZAD UNIVERSITY – TEHRAN, IRAN

ABSTRACT: Crises occurred in recent decades show that organizations' preparedness to predict and respond to undesired problems is directly related to the degree of their capabilities and preparedness to manage crises in this context, hospitals compared to other organizations are more viable to suffer damages if a crisis occurs. This study investigates the degree of public hospitals capabilities and preparedness to handled possible crises. Responses from hospital managers and directors show that most of them were not familiar with crisis management, while majority of them mentioned that they had crisis management plan and committee in their hospitals. Moreover, most of the respondents believed that if a crisis occurs in the hospital, patients, personnel and documents will be the first victims of the crisis. The study also indicates that having a crisis plan and crisis committee without being familiar with knowledge of crisis management, do not help managers to cope with crisis. Moreover, correlations show that older managers were more familiar with crisis management experiences abroad, and defined responsibilities contributed to setting up crisis committee, and taking crisis seriously.

Crisis can be simply defined as a situation which is not possible to maintain. Therefore, when a crisis occurs, a change is required until we reach balance and equilibrium. In fact, if there would be no need for a change in the situation, what has happened could be regarded as an accident or an event, like a car crash. In other words, a crisis is a process that an organization may face during an unexpected threat which may lead to organizational damage. Crisis management is the process by which an organization deals with a major unpredictable event that threatens to harm the organization, its stakeholders, or the general public. Crisis management is the systematic attempt to avoid organizational crisis or to manage those crisis events that do occur (Pearson & Clair, 1998). In fact, crisis management is a technique both for avoiding emergencies and planning for the unavoidable ones, as well as a method for dealing with them when they occur (Yheung et al., 2003). Crisis is a major, unpredictable event that threatens to harm an organization and its stakeholders. Although crisis events are unpredictable, they are not unexpected (Coombs, 2004). Three elements are common to most definitions of crisis:

✚ a threat to the organization;
✚ the element of surprise;
✚ a short decision time.

The true test for any hospital executive lies in managing a crisis. A hospital crisis, by definition, is unexpected and unpleasant. No organization seeks it out; no CEO desires to face it. It is the job of a CEO to be prepared for sudden crisis and to manage them.

Types of crisis

We should be familiar with types of crisis, because each crisis requires a different strategy to handle. There are many types of crisis such as:

✚ natural crisis such as earthquake, floods, and storm;
✚ crisis of malevolence, such as hostility or anger toward, or seeking gain from, a company as happened in Johnson and Johnson in 1982 in America. A Tylenol medication, unfortunately, one individual succeeded in lacing the drug with cyanide and seven people died as a result, and a widespread panic ensued about how widespread the contamination might be.
✚ the crises in hospital emergency departments;
✚ events occurring due to negligence such as the Bhopal disaster in 2006 in India;
✚ crisis due to human error, such as mistakes in software or hardware, or calculation mistakes in building wiring installation;
✚ strikes or work stoppage or when workers rebel against employers of organizations;
✚ schools and crisis management; The Beslan school hostage crisis (also referred to as the Beslan school siege or Beslan massacre) was a three day hostage-taking of over 1,100 people which ended in over 300 deaths. The Iran hostage crisis (4 Nov. 1979–20 Jan. 1980) Following the establishment of the Islamic Republic of Iran.
✚ Economic recessions (in 2009, for instance).

In fact, the concept of a crisis portfolio can aid managers

significantly in planning for crisis (Lichtenthal and David, 1999). The essential part of any crisis is to handle it successfully. Therefore, crisis management is a combination of procedures and actions, which in emergencies, are applied in order to handle the crisis in a planned and coordinated manner. Crisis management is an operational plan, and is designed to be executed when the organization faces an unusual situation or, crisis management is a process designed to prevent or lessen the damage a crisis can inflict on an organization and its stakeholders. We can compare crisis management with "risk management." Risk management involves assessing potential threats and finding the best ways to avoid those threats, but crisis management involves dealing with threats after they have occurred, which is an evaluation concerning possible threats to the institution, and an attempt to find the best way to face the threat. Risk assessment is an intrinsic function of the risk-management process and subsequently risk assessment also has become a core part of emergency management (Jones, 2008). In reality, crisis management encounters different types of problems and threat compared to risk management, but it is much broader in that and its dimensions are much wider such as skills and techniques which are used for recognizing, evaluating and eventually facing different situations, particularly from the time that crisis occurs, until it moves towards improvement.

Stages of crisis management

Organizational safety is the top priority of every manager. Moreover, facing any crisis successfully is extremely important, but predicting and being ready to respond any crisis is very essential. Therefore, crisis management can be divided into:
✚ Forecasting or overseeing a crisis (before any crisis happens).
✚ Being ready to face a crisis or respond to a crisis.
✚ Proceeding through, or actions after, a crisis.

Preparedness, is a fundamental step for any organization in order to handle a crisis whenever it occurs. In fact, being prepared to face a crisis means that the organization has reduced the risk of losses and damages when a crisis occurs. In fact, prevention involves seeking to reduce known risks that could lead to a crisis (Augustine, 1995). This is actually a part of crisis-management planning. Therefore, planning involves advanced thinking and designing methods for dealing with a crisis in appropriate steps to not only handle the crisis, but to reduce damages to the organization as much as possible. In the forecasting stage, finding out the weak points or potential threats to the organization is essential. Appointing key individuals for setting communication channels during the crisis is the next step. The essence of the practice of public relations is dealing with the media. Therefore, the responsibilities of key individuals should be assigned. Communication must be open, honest and consistent. Because all actions during the crisis must be documented, forms to make records during the crisis should be prepared. This is followed by the training of key personnel and running simulation programmes to find out whether forecasting plans are feasible and applicable.

Recognizing a crisis is very vital. How an organization, particularly a hospital, handles crises may influence how the public perceives the organization for many years to come. It is therefore essential that such emergencies be managed intelligently and forthrightly with the news media, medical staff, employees, the

government and the public-at-large. First, one must recognize the "warning signs" that almost invariably emerge when a crisis is near (Coombs, 1995).

Barton (2001) says that forecasting plans are successful when (1) organizations yearly set awake a crisis plan, and update it, (2) the plan includes loyal and advocated key personnel, and (3) the plan is practiced yearly. In all three types of (plans) crisis, there should be one person as management spokesperson, because, in the crisis, there is a serious need to prevent crisis news distortion, because consistency in news broadcasting is vital. Being ready to face a crisis, strong coordination and cooperation among groups and individuals are very important to deal with a crisis. Proper and correct training (specialized and general), and appropriate equipment are two main components of facing a crisis. In addition, information given to the public should be accurate, honest and on time. In a study done at the Faculty of Management at Tehran University on crisis management to find out priority of actions during a crisis, the following information was provided by the respondents:
✚ Try to find those who are alive, and treat them as they needed.
✚ Coordination among the teams of the crisis.
✚ Operation of various groups involved in the crisis.
✚ Machines and equipment.
✚ Finding or setting up connecting roads.
✚ Settlement of those who can be settled and hospitalizing those who need it.
✚ Taking care of security in the area affected with the crisis.
✚ Applying what has been learned from international experiences.
✚ Setting up communication.
✚ Air lift or air help.
✚ Receiving goods and other help and distributing them among the people who need these goods and help.
✚ Temporary settlement of those who are alive.
✚ Setting up a telephone communication network.
✚ Burial of dead.
✚ After crisis is a complicated, sensitive and difficult stage to be handled. In a crisis such as an earthquake, individuals try first to save themselves, then take care of others. But right after this stage, they try to search for their belongings, documents and property.

Priorities of actions or proceedings after the crisis are as follows:
✚ Settlement of children and survivors.
✚ Organizing and distributing national and international aid.
✚ Using social workers and providing psychological advice.
✚ Applying international experiences.
✚ Collecting debris and destroyed buildings.
✚ Reconstruction of the region.
✚ Transferring those who lost their houses to the newly built houses (Taslimy et al., 2005).

Boin (2004) indicates that crisis authorities must identify which decisions they must make and which should be left to others. They must make critical decisions without sufficient or adequate information. They must enable cooperation between the various factors involved, and they must organize communication streams within and across the crisis management network as well as with

the outside world.

Theories associated with crisis management

Success in neutralizing or facing a crisis depends on how well we are aware of preventing a crisis such as Tsunami, floods following storms, which brings destruction. Successfully diffusing a crisis requires an understanding of how to handle a crisis before it occurs. Gonzalez-Herrero and Pratt (1995) created a four-phase crisis management model process that includes: issues management, planning-prevention, the crisis, and post-crisis. The art is to define what the crisis specifically is, or could be, and what has caused it or could cause it. Crisis management has three stages: (1) management issues, (2) planning for preventing crisis, and (3) and issues after crisis. The skill involved in implementing this crisis management is that we must know the type of crisis, what has caused it, or what could cause it. Mayer et al. (2008) have identified specific areas that should be addressed in a crises and disaster preparedness plan based on information gathered from organizations that went through a major disaster first-hand.

Crisis-management planning is necessary for any kind of crisis, but organizations cannot sit and wait until a crisis occurs and then deal with it. "Companies are beginning to realize that what happens to a Union Carbide can happen to them, whether they're big or small, publicly traded or privately held" (Rudolph, 1986). Contingency plans in advance, as part of a crisis-management plan, are the first step to ensuring a hospital is appropriately prepared for a crisis. Actually, a crisis management plan is a reference tool, not a blueprint. It provides lists of key contact information, reminders of what typically should be done in a crisis, and forms to be used to document the crisis response (Coombs, 2007). Tasks should be clearly defined and assigned in advance. Any distorted information based on personal opinion, i.e., whether a person may be responsible or irresponsible in a crisis, may result in chaos. In healthcare systems, most healthcare professionals, whether board members, managers, or physicians, generally would say that the environment they face today is much more uncertain than it was even five years ago (Barnum and Kutzin, 1993). The last point which is vital to mention is the readiness of employees of an organization to face a crisis which requires effective crisis management (Seymour and Moore, 2000).

Case study: hospital crisis management, capabilities and preparedness in Iran – purpose and objectives

The goal of this article is to present the findings from an exploratory empirical study of hospitals' capabilities and eventually their preparedness to face crisis, if it occurs in their hospitals. Below we have presented short general country information as the background data which may contribute to better understanding of this article.

Method

In Iran, there are 856 hospitals (governmental and private) of which I have concentrated only on 121 hospitals (65 governmental and 55 private) located in Tehran (the capital). A sample of 41 hospitals (out of 121) were selected, and I interviewed all of either hospital directors 31 (76%) or hospital managers 10 (24%). Most hospitals have a senior doctor as the head of the hospital (director), and some have hospital managers. For statistical analysis of data, frequency, percentages,

TABLE 1: FAMILIARITY OF RESPONDENTS WITH CRISIS MANAGEMENT

Degree of familiarity	f	%	C%
Little	2	5.00	4.90
Not very familiar	22	54.00	58.90
Familiar	13	32.00	90.00
Very familiar	4	10.00	100.00
	41	101.00	

TABLE 2: CRISIS MANAGEMENT PLAN IN THE HOSPITALS

Responses	f	%	C%
Yes	39	95.00	95.10
No	2	5.00	4.90
	41	100.00	100.00

TABLE 3: NUMBER OF HOSPITALS WITH CRISIS MANAGEMENT COMMITTEE

Responses	f	%	C%
Yes	37	90.00	90.00
No	4	10.00	100.00
	41	100.00	

TABLE 4: POSSIBLE CRISIS IN HOSPITALS AND EFFECTIVE FACTORS TO FACE IT

Responses	f	%	C%
Qualified personnel	1	2.50	2.50
Trained personnel	4	5.00	12.30
Coordination between authorities	1	2.50	14.80
Having a committee comprised of members of all sections	10	24.00	39.00
Applying instructions already formulated by the Ministry of Health	2	5.00	43.90
Following crisis management standards	9	22.00	65.90
Applying successful past experiences	4	5.00	76.00
No reply	10	24.00	100.00
	41	100.00	

TABLE 5: IN CASE OF CRISIS, AND DAMAGES IN THE HOSPITAL

Sources	f	%
Patients	13	32.00
Personnel	35	85.00
Documents	30	73.00
Equipments	11	27.00
Cash	2	5.00

cumulative and correlations have been used.

Research question and samples

The main reason to concentrate on governmental (or public) hospitals in relation to private ones, is that in most public hospitals, some are not as equipped and modern as private hospitals, and they are more vulnerable to crisis. The main research question is: Are governmental hospitals capable and

TABLE 6: FAMILIARITY WITH HANDLING CRISIS MANAGEMENT IN IRAN AND EXPERIENCES ABROAD

Scales / Age groups	very familiar	familiar	fairly familiar	not very familiar
25 – 30	0	2 (5%)	0	0
30 – 35	2 (5%)	3 (7.%)	1 (2.5%)	0
40 – 45	0	18 (44%)	3 (7.%)	2 (5%)
45 – 50	0	0	4 (10%)	0
50 – 55	0	1 (2.5%)	2 (5%)	0
55 and over	2 (5%)	1 (2.5%)	0	0

TABLE 7: THE RELATION BETWEEN AGE GROUPS AND FAMILIARITY WITH CRISIS MANAGEMENT

Responses	F	%	C%
Very familiar	4	10.00	10.00
Familiar	21	51.00	61.00
Not so much familiar	12	29.00	90.00
Very little familiar	4	10.00	100.00
	41	100.00	

prepared to predict and face crisis? This quantitative exploratory study utilized a closed-ended questionnaire and all respondents were interviewed. In this case, out of 41 respondents, 30 were surgeons, and 11 were professional managers (with MA or PhD degree). The questionnaire was divided into two parts: (1) personal data, and (2) management data. At the end of the questionnaire we added one open question to obtain extra information.

Findings
The first part of the questionnaire included "personal data" of the respondents which shows gender, education, age groups and length of service, discussed below.

Out of 41 hospital directors and managers, 8 were women (19.5%), and 33 were men (80.5%). This indicates that almost one fifth of them were women which might be due to the nature of the job and type of hospitals which are governmental. More than 50% of the respondents hold MA and PhD degree, around 60% were between 35 and 45 years of age, which is an indication that hospital mangers in the coming years seem to be available, and 57% had less than 10 years of service.

Tables 1 through 9 include questions related to respondents' capabilities and hospitals preparedness to crisis.

1. To what extent hospital managers in Iran are familiar with crisis management?

As the above table shows, around 40% of the respondents seem to be familiar or very familiar with crisis management.

2. Is there a crisis management plan in your hospital?

Table 2 shows that almost 95% of respondents mentioned that their hospitals have a crisis plan. However, this statement contradicts with responses on familiarity with crisis management of which around 58% of the respondents believed that they are either "not familiar" with the subject of "crisis management" or "very little" are familiar.

3. Is there a crisis committee in your hospital with clear function of its members?

4. For facing crisis in a hospital, what factors could be very helpful and effective?

The above table shows inconsistency among the responses. Moreover, out of 41 respondents, 10 have not responded to this question.

5. Is there a possibility of a crisis in your hospital?

Out of 41 respondents, 36 of them replied: yes (85.4%) and 6 said: no (14.6%) This shows that there is a high risk of crisis in hospitals.

6. In case a crisis occurs in your hospital, what sources might be harmed or face damages?

Table 9 shows that in case of crisis in hospitals, personnel and documents seem to be more vulnerable compared to even patients.

7. To what extent are you familiar with hospital crisis management in Iran and in other countries?

It seems that majority of the respondents are familiar with the subject of crisis management in Iran and abroad. We also tried to see whether there was a relationship between age and familiarity with crisis management. Managers under 35 and those above 45 years of age were not very familiar with crisis management, while those between 35 and 40 years of age seem to be very familiar or fairly familiar with crisis management.

As we mentioned earlier, at the end of the questionnaire, we added an open question in order to find out extra information which the respondents might like to express. Table 8 illustrates their reactions.

The above table indicates that among factors which seem to have effects on hospitals' crisis management, budget limitation is the most common factor. Further statistical analysis was carried out, and correlations between factors showed that managers who were older, had higher level of education. On the contrary, women mangers who were older, had lower level of education. Length of service showed strong correlations with age. It seems that age has played a key role in this study, because the older the managers, the more they considered crisis serious. There was also strong correlation between those who had received training on crisis management and responsibilities during crisis defined. Age played important role on being familiar with crisis in other countries. Length of service seems to have impact on familiarity with crisis in

TABLE 8: HOSPITAL MANAGERS' EXTRA COMMENTS ON CRISIS MANAGEMENT ISSUES

Responses	F	%	C%
Possibility of more crisis in hospitals due to limitation of facilities	3.00	7.00	7.00
Limited budget devoted to hospital crisis, and lack of top management support	25.00	61.00	68.00
Low motivation among hospital personnel, and lack of proper training	5.00	12.00	80.00
Strong need to design crisis management plan as a compulsory task of hospital managers	2.00	5.00	85.00
Lack of utilizing other experiences, and lack of communication between hospitals	2.00	5.00	90.00
Lack of skilled personnel in handling crisis	4.00	10.00	100.00
Total	41.00	100.00	

Table 9: Cross tabulation correlations

	Spearman's correlation	(Q 1)	(Q 2)	(Q 3)	(Q 4)	(Q 5)	(Q 6)	(Q 7)	(Q 8)	(Q 9)	(Q 10)
						Correlations (N:41)					
Age (Q 1)	Correlation Coefficient Sig. (2-tailed) N	1.000 –. 41									
Gender (Q 2)	Correlation Coefficient Sig. (2-tailed) N	-.379* .015 41	1.000 . 41								
Education (Q 3)	Correlation Coefficient Sig. (2-tailed) N	.423** .006 41	-.436** .004 41	1.000 . 41							
Length of Service (Q4)	Correlation Coefficient Sig. (2-tailed) N	.878** .000 40	-.269 .093 40	.374* .018 40	1.000 . 40						
Taking crisis seriously (Q 5)	Correlation Coefficient Sig. (2-tailed) N	.431** .005 40	-.258 .108 40	.166 .306 40	.272 .094 39	1.000 . 40					
Whether crisis plan exists (Q 6)	Correlation Coefficient Sig. (2-tailed) N	.173 .280 41	-.174 .276 41	-.028 .863 41	.115 .481 40	.345* .029 40	1.000 . 41				
Training on crisis given or not (Q 7)	Correlation Coefficient Sig. (2-tailed) N	.016 .922 41	-.381* .014 41	.179 .261 41	-.049 .763 40	.270 .092 40	.608** .000 41	1.000 . 41			
Responsibilities defined (Q 8)	Correlation Coefficient Sig. (2-tailed) N	.056 .729 41	-.460** .002 41	.125 .435 41	-.047 .773 40	.282 .078 40	.689** .000 41	.882** .000 41	1.000 . 41		
Familiarity with crisis in other countries (Q 9)	Correlation Coefficient Sig. (2-tailed) N	.511** .001 41	-.337* .031 41	.134 .402 41	.303 .058 40	.736** .000 40	.280 .077 41	.296 .060 41	.225 .158 41	1.000 . 41	
Existence of crisis committee (Q 10)	Correlation Coefficient Sig. (2-tailed) N	.029 .866 36	-.360* .031 36	.034 .842 36	-.046 .794 35	.302 .073 36	.804** .000 36	.853** .000 36	1.000** . 36	.228 .181 36	1.000 . 36

*. Correlation is significant at the 0.05 level (2-tailed).
**. Correlation is significant at the 0.01 level (2-tailed).

other countries. Having crisis committee in the hospital was also strongly related with being trained in crisis management.

Conclusion

In this study, we have tried to study managers' capabilities and preparedness to face crisis in state hospitals if it occurs. We have also studied factors which could contribute to reveal certain information related to crisis management and perception of mangers of hospitals under the study, their knowledge and experiences on crisis management. The data shows that majority of hospital managers were not familiar with crisis management, but on the contrary, 95% of them mentioned that there was a crisis-management plan in their hospitals, and have set-up crisis-management committees. Most managers believed that if a crisis occurs in their hospitals, the existence of a crisis-management committee and certain standards are the most effective factors which could help them to face the crisis. In reply to the possibility of a crisis in hospitals, the majority of respondents reacted positively. In case of a crisis, patients would be the first target to be harmed, and next would be the hospital personnel. Most hospital managers seemed to be familiar with handling a crisis, and familiar with experiences on this issue in Iran and abroad. The study shows that there was a relationship between age and familiarity with crisis management. In fact, managers under 35 and those above 45

years of age were not very familiar with crisis management, while those between 35 and 45 years of age seems to be very familiar or fairly familiar with crisis management. Correlations show strong relationship between length of service and taking crisis seriously, defined responsibility and training. ❏

Reza Najafbag received his PhD from Utrecht State University-the Netherlands, in Comparative Management. and has more than 30 years of continuous teaching and research experience. He has organized and planned academic programs and activities on leadership are performed executive and management training programs. He is a personnel management advisor to Coopers & Lybrand-Iran. (Management and accounting multinational firm).

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Patient-centred care: more than the sum of its parts – Planetree's patient-centred hospital designation programme

SUSAN B FRAMPTON PhD
PRESIDENT, PLANETREE IN DERBY, CT

SARA GUASTELLO
MANAGER OF DESIGNATION AND RESOURCE DEVELOPMENT, PLANETREE IN DERBY, CT

ABSTRACT: When a nurse at the Celilo Cancer Center at the Mid-Columbia Medical Center in The Dalles, Oregon, found out that his patient was scheduled to receive chemotherapy on her wedding anniversary, he asked the woman and her husband what song they'd first danced to on their wedding day. It was "Save the Last Dance For Me," and the next day, when the couple rose from their chairs after the patient's six-hour infusion, the song began playing. Right there in the infusion area, with their arms around each other, they danced.

This story illustrates the kind of care that has become the norm at the 10 hospitals in North America recognized since 2007 as patient-centred hospitals by Planetree's Patient-Centred Hospital Designation Program. At these hospitals "patient-centred care" is more than a buzzword. Rather, it's reflected in their mission statements, strategic plans, models of nursing care, and day-to-day operations.

While many organizations, including the Institute of Medicine,[1] the Institute for Healthcare Improvement,[2] and Planetree,[3] have endeavored to define patient-centred care, no definition conveys its essence as well as the patients at these hospitals can. "This place has a special character," one patient said in a focus group. Others have said, "You can tell the nurses here care about you as a person," "They are a special breed of people here," and "I don't think it's just a job for them; they're here for a reason." Over the past year, this series, *Putting Patients First*, has explored several aspects of the patient-centered approach – encouraging patients to review their medical records, lifting restrictions on family involvement in care, and lowering noise levels in hospitals, among others. We believe they show that, ultimately, patient-centered care is more than the sum of its parts.

Planetree's goal with the designation program is to make patient-centred care less of an ambiguous notion and more of an attainable goal (for more information, go to http://planetree.org/consultation.html). Many facilities have aspired to become more patient centred as the concept has garnered attention in recent years. The Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey, for example, compiles patients' assessments of hospital care and makes them available online (see www.hospitalcompare.hhs.gov). Also, the major health care reform legislation passed this year includes financial incentives to hospitals that meet certain standards of patient-centeredness, "such as the use of patient and caregiver assessments or the use of individualized care plans."[4]

Still, there's a gap between aspiration and reality at many organizations when it comes to patient-centredness. The designation program provides a framework for evaluating the a hospital's systems and processes, one that's based on Planetree's

three decades of work with hospitals in the United States and abroad, especially data gathered from focus groups conducted with thousands of patients, family members, and healthcare professionals. Using these perspectives, Planetree shaped 50 criteria for designation in 11 categories (see Table 1).

Criteria include whether hospitals balance patients' needs with their safety, whether transparency remains a priority even when something unexpected occurs, whether the work environment is supportive of staff, and whether patient-centred approaches are applied to billing and community outreach. Community outreach at Griffin Hospital in Derby, Connecticut, for example, includes its Mini Med School, a free 10-week class in which volunteer physicians present lectures on illness and prevention, while encouraging "students" to participate in their care.

The designation is granted to hospitals that meet all 50 criteria. The process begins with a self-assessment that requires hospital leaders to appraise the organization's culture – an appraisal that can be valuable, regardless of whether it's part of the designation

process. After all, Planetree designation recognizes a job well done, not a job all done. (Designation lasts for three years.)

After the self-assessment, a hospital provides to Planetree documentation of its patient-centered practices. Next, a team including representatives of facilities that have achieved designation make an on-site visit; the written documentation is verified through a facility tour and feedback from patients, family members, and staff. This team's assessment is then reviewed by an independent committee of healthcare leaders, with representatives from the American Hospital Association, the Institute for Healthcare Improvement, and patient advocacy groups, among others. This feedback informs a decision to designate a hospital as patient-centred.

Involving patients, family members, and staff in the assessment supports a facility's efforts to foster a patient-centered culture. At the on-site visit at Northern Westchester Hospital in Mount Kisco, New York, for example, it was revealed that although the hospital had in place a number of means for meeting patients' nutritional needs, patients were largely unaware of their options. Consequently, the Just Ask Campaign was born. Now, signs assure patients: "If you're thinking it, ask it." Examples of questions include, "May I request a different meal selection?"

Patient-centred care requires flexibility and discourages a one-size-fits-all approach. For instance, despite a policy in support of open medical records at Waverly Health Center in Waverly, Iowa, only a few Waverly patients reviewed their charts. The hospital sought out an alternative and created the Personal Health Information notebook, given to every medical–surgical patient. Over the course of a hospitalization, the notebook accumulates laboratory results, medication lists, consultation reports, and DVDs of scans. The hospital gets the notebook into the hands of a far greater number of patients than it did the medical record.

The role of nurses

Everyone working in a healthcare facility can contribute to a patient-centred approach – by keeping it safe and clean if they work in environmental services, for example, or by preparing healthful foods if they work in dietary services. Yet partnerships between nurses and patients are a cornerstone of patient-centered care. This is reflected in the questions on the HCAHPS survey, which includes patients' perceptions of nurses' communication and responsiveness.[5] A number of the designation criteria also focus on the involvement and leadership of nurses, for example, in their support of family members as "care partners" who participate in care.

As nursing theorist Jean Watson, PhD, RN, has written: "Clinical care and healthcare practices are grounded in human communication, human interactions and relationships. At the same time, approaches to system solutions are often

> Everyone working in a health care facility can contribute to a patient-centered approach – by keeping it safe and clean if they work in environmental services

> The Planetree program's emphasis on relationships can help to remind nurses of what drew them into the profession, especially when the entire organization is committed to supporting nurses' adoption of patient-centered practices.

disconnected from relationships and caring."[6] The Planetree program's emphasis on relationships can help to remind nurses of what drew them into the profession, especially when the entire organization is committed to supporting nurses' adoption of patient-centered practices. "For me," one nurse said in a focus group, "it's returning back to what nursing was when I started. It's being able to have the time to spend with patients and families, to do the little back rubs we used to do, to give that little bit more of yourself. We're saying to nurses that you do have time for that."

Nurses have long championed patient-centered care and continue to study its value. Susan Stone, former chief nursing officer and chief operating officer at Sharp Coronado Hospital in Coronado, California, engaged the nursing staff there in meeting the designation criteria and conducted research on the impact of patient-centered care in the facility. The study retrospectively examined data from two comparable medical-surgical units over five years—one that had implemented the Planetree model and one that had not.[7] In each of the five one-year cohorts studied, the Planetree unit consistently demonstrated:

✚ shorter average lengths of stay;

✚ statistically significant lower costs per case (an increase in RN hours per patient day was augmented by a simultaneous increased use of "lower-cost personnel" such as aides; shorter hospitalizations also led to decreased costs);

✚ higher average overall patient-satisfaction scores;

✚ higher scores in seven of the nine dimensions of patient satisfaction measured.

When bedside staff appear to be burdened, patients notice, and they might, as a result, hesitate to ask for help or make their needs known.[8] As one patient in a focus group said of a nurse, "I asked her about getting a pain medication. She responded in a rude manner—'You didn't have that pain med.' I gave them the benefit of the doubt that they were having a bad day, that they were overworked." Nurses and consumers alike have identified overworked, fatigued staff as contributing to the potential for medical errors.[9, 10]

Given the alarming rates of turnover,[11] vacancy,[12] and burnout[13-15] among nurses, the experience of staff is a critical consideration in the Planetree designation. Giving bedside staff rewards and recognition, retreats, access to minutes of leadership meetings and other information on organizational priorities, a say in how care is delivered, and services supporting work–life balance are among the ways that hospitals uplift staff while putting patients first. Griffin Hospital, for instance, makes an on-site fitness center available to staff, sponsors a farmer's market at the facility during the summer, and offers prepackaged "meals to go" in its cafeteria.

Table 1: The patient-Centred hospital designation program: categories and selected criteria

Categories	Examples of Criteria
Structures and functions necessary for implementation, development, and maintenance of patient-centred concepts	Processes are in place to obtain and use feedback from patients and families on a variety of hospital practices and initiatives.
Human interactions	A model that embraces continuity, consistency and accountability in care and permits staff to personalize care for each patient.
Patient education and access to information	Educational materials available for patients and families and accessible to staff.
Family involvement	Flexible, 24-hour, patient-directed visitation.
Nutrition programme	24-hour access to a variety of foods and beverages.
Healing environment: architecture and interior design	Removal of barriers at nurses' stations such as high counters and counter-to-ceiling glass partitions, as well as those at family lounges, unit-based kitchens.
Arts programme	A therapeutic-distractions programme involving music, visual arts, crafts, animal visitation, bedside reading.
Spirituality and diversity	Documenting and addressing the needs of diverse cultural groups.
Integrative therapies	Assessment of staff and patient interest in and need for alternative, complementary, and integrative therapies.
Healthy communities	A plan to improve community health.
Measurement	Satisfaction of inpatients and outpatients assessed using a validated instrument, with performance exceeding national averages.

Connecting patient-centredness and quality

Care safety and quality go hand in hand in any patient-centred approach. Accordingly, Planetree evaluates outcomes as a part of the designation process by comparing a hospital's scores with national benchmarks. We've found that collectively the 10 designated hospitals exceed the Centers for Medicare and Medicaid Services (CMS) national averages on several "core measures" such as pneumonia care (see Figure 1). This conforms to the Institute of Medicine's conclusion that patient-centred care is a part of the foundation of high-quality care.[1] Also, as a group the nine US designated hospitals perform above the CMS national average in nine of the 10 publicly reported HCAHPS categories and at the national average for the "quiet at night" category (see Figure 2). The most significant differences appear in the overall rating and in willingness to recommend the facility, suggesting a link between patient-centered care and patient satisfaction.

The benefits of designation

Accolades received by the designated hospitals include the 2007 Malcolm Baldrige National Quality Award, a presidential award for excellence given to the Sharp Healthcare System, which Sharp Coronado Hospital is a part of, and Magnet accreditation from the American Nurses Credentialing Center in recognition of nursing excellence at Delnor Hospital in Geneva, Illinois. Also, Griffin Hospital appeared on Fortune magazine's 100 Best Companies to Work For in the United States from 2000 to 2009, and in 2009 Centre de réadaptation Estrie, a rehabilitation hospital in Quebec, was recognized in Canada's *Les Affaires* magazine's Best Employers Challenge.

On its Quality Check Web site (www.qualitycheck.org), the Joint Commission recognizes hospitals that have received the Planetree designation. Planetree-designated hospitals have been featured in the Washington Post[16] and the New York Times.[17] But the greatest benefits have little to do with publicity. Marcia Hall, CEO of Sharp Coronado Hospital in Coronado, California, said: "We are extremely proud of becoming one of the first five nationally noted Planetree Designated Patient-Centered Hospitals. But it's not about awards. They confirm that we're on the right track, but it's mostly about progress toward a vision to make a difference for the people we work with and the people that we serve."

Next steps

When Planetree launched it in 2007, the designation program was specific to acute care hospitals. Since then, advisory councils in behavioural health and continuing care have worked to revise the designation criteria so that they're applicable to a greater range of settings. The new criteria establish a consistent set of standards for what consumers can expect from any patient- or resident-centred provider.

Also, an International Designation Advisory Council is shaping a set of international criteria that are globally applicable. Designation programs are under way in Canada and the Netherlands and in development in Brazil and Japan.

The designated hospitals

As of June, Planetree had designated the following 14 healthcare organizations as patient-centered:
+ Centre de Réadaptation Estrie, Sherbrooke, QC, Canada;
+ Delnor Hospital, Geneva, IL;
+ Fauquier Hospital, Warrenton, VA;
+ Griffin Hospital, Derby, CT;
+ Mid-Columbia Medical Center, The Dalles, OR;
+ Northern Westchester Hospital, Mount Kisco, NY;
+ Sharp Coronado Hospital, Coronado, CA;
+ Valley View Hospital, Glenwood Springs, CO;
+ Waverly Health Center, Waverly, IA;
+ Windber Medical Center, Windber, PA;
+ Longmont United Hospital, Longmont, CO;
+ Judith Leysterhof (Rivas Zorggroep), Hardinxveld-Giessendam, The Netherlands;
+ De Merlinge (Rivas Zorggroep), Arkel, The Netherlands;
+ De Toonladder (Zorggroep Almere), Almere, The Netherlands. ❏

Susan B Frampton, PhD is President of Planetree, a non-profit organization, Frampton works with a growing network of hospitals and health centres around the world that are implementing Planetree's unique patient-centered model of care. Prior to her work with Planetree, she spent over 20 years at several hospitals in the New England area. She has written numerous publications, is a sought-after keynote presenter and serves on expert advisory

panels for the Institute of Medicine, Joint Commission and National Quality Forum.

Sara Guastello oversees the Planetree Designation Program which formally recognizes hospitals and healthcare centers that are effectively identifying and responding to the full range of patient, family and staff needs. Sara collaborates and consults with Planetree members and other partners to expand understanding of patient- and resident-centered approaches to care through development of a variety of resources.

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At the crossroads: NRTRC white paper examines trends driving the convergence of Telehealth, EHRs and HIE

CHRISTINA BEACH THIELST, FACE

EXECUTIVE DIRECTOR, NORTHWEST REGIONAL TELEHEALTH CENTER (NRTRC)

ABSTRACT: From the American Recovery and Reinvestment Act (ARRA) and the newly passed healthcare reform legislation to emerging reimbursement models and shifting consumer health trends, a confluence of events are driving radical change in the nation's healthcare system and bringing about the convergence of telehealth, electronic health records (EHRs) and health information exchange (HIE).

That is the focus of "The Crossroads of Telehealth, Electronic Health Records & Health Information Exchange: Planning for Rural Communities," a new white paper from the Northwest Regional Telehealth Resource Center (NRTRC).

"Accelerating adoption and utilization of telehealth technologies, telemedicine in particular, will be critical to a successful stakeholder response to the disruptive changes that are underway in healthcare," said NRTRC Executive Director Christina B. Thielst, FACHE. "By leveraging telehealth networks and their existing infrastructures, Regional Extension Centers, HIEs and other data-sharing initiatives will be better-positioned to fulfill their commitments to the healthcare delivery system of the future – a system in which even the most rural and remote populations have timely access to care and their health records."

The white paper explores emerging trends and recent disruptors impacting the healthcare delivery system and examines the opportunities they present for the advancement of telecommunications-based health solutions and the broadband infrastructure available through telehealth networks. It also takes an in-depth look at the various uses of telehealth and the most common delivery models of telemedicine, as well as the role of the telehealth network and Telehealth Resource Centers (TRCs) in expanding the reach of these vital initiatives.

Finally, the white paper highlights the evolution of the REACH Montana Telehealth Network from facilitating tele-radiology at three remote sites into a consortium of healthcare providers at 18 sites linked by high-bandwidth telecommunications in the north central region of Montana. REACH, which considers HIE to be a primary function, is currently working to leverage its existing T1 infrastructure to create the "railroad tracks" that will carry medical data and information within the region and beyond.

"This white paper is an excellent analysis of the intersection of telehealth and health information technology, and the opportunities and challenges this electronic technology will bring to rural America," said Terry J. Hill, Executive Director of the Rural Health Resource Center, the Duluth, Minn.-based national knowledge center for rural hospitals providing technical assistance, information, education and other resources to rural health care providers and their communities.

Adds Thielst: "Crossroads is a valuable planning tool for any healthcare stakeholder, but it is especially important for rural communities wanting to address health information exchange. It is just one of many resources available through the NRTRC to help advance the involvement of teleheatlh networks in HIE initiatives and to help transform the telehealth infrastructure into the 'superhighway' across which remote and rural areas will finally be able to participate in the widespread exchange of electronic health information."

One of five TRCs in the nation, the NRTRC leverages the collective expertise of 33 telehealth networks across Alaska, Hawaii, Idaho, Montana, Oregon, Utah, Washington, Wyoming, and United States-affiliated Pacific Islands to share information and resources which assist in the development of new telehealth programs. The NRTRC is focused on further growth and new provider adoption of telehealth technologies to enhance delivery systems and reduce organizational and patient costs.

Recent federal actions and several emerging trends are indicative of future change for healthcare and, more specifically, telehealth. The convergence of the American Recovery and Reinvestment Act (ARRA) of 2009, Federal Communications Commission (FCC) Broadband Plan and recently passed health reform legislation – the Patient Protection and Affordable Care Act and the Reconciliation Act of 2010 – has the potential to radically disrupt the U.S. healthcare system.

Other potential disruptors include widespread attention to the cost-benefit analysis of care processes and treatment (outcomes-based medicine), reimbursement models favouring preventive care and bundled payments, as well as provider shortages, significant payor technology investments and the emergence of the next generation of mobile devices. Also at play are an aging population, the growing popularity of medical tourism and shifting consumer expectations of healthcare.

Telehealth, the delivery of health-related services and information via telecommunications technologies, offers solutions that can facilitate the outcomes needed to respond to these changes. Currently, telehealth is most often utilized for education and administrative or operational purposes and less often to enable clinical encounters (telemedicine).

The reasons for slow adoption rates and underutilization of telemedicine are varied. Among the most significant is that the benefits of its use most often accrue to others, rather than to the provider or network of providers who assume the upfront and ongoing costs. Also frequently cited are high equipment costs, outdated regulations and reimbursement limitations. However, when it comes to the financial impact of provider-to-provider telehealth technologies, research shows that, overall, the benefits of these systems far outweigh the costs to implement[1].

Emerging telehealth opportunities

There are opportunities on the horizon that will likely improve telemedicine utilization rates. For example, ARRA allocates $19 billion for adoption of health information technology (IT) systems and promotion of electronic health information exchange (HIE). The Health Information Technology for Economic Clinical Health (HITECH) Act also creates funding opportunities to support the advancement of health IT.

Existing telehealth networks will also benefit from ARRA and HITECH. Participating in related incentive programs, capitalizing on funding opportunities and achieving meaningful use of health IT requires hospitals and physicians to have broadband Internet access. However, commercial T1 lines are prohibitively expensive in rural areas. In fact, it is estimated that 93 million residents and 3,600 small physician offices in these regions don't have broadband access[2].

Because they can deliver more affordable equivalent access, this presents a very real opportunity for telehealth networks to expand their value to members and the community by connecting rural and remote providers to the Internet across existing infrastructures. It also presents new partnership opportunities that will enable telehealth networks to expand those infrastructures and increase connection speeds.

Further, while telehealth and health IT initiatives have historically operated on relatively separate tracks with limited crossover, their goals and activities are complimentary and truly synergistic. This is especially true of the broader systems-based approach to delivery

of care.

For example, telehealth networks provide the infrastructure that enables Internet access and drives HIE in areas where commercial broadband is lacking or cost-prohibitive. Correspondingly, health IT offers enabling components for remote care and provides complimentary tools and systems, such as electronic health records (EHRs) and digital data/information sharing.

We are approaching the intersection of telehealth, EHRs and HIE. At this crossroad, we can expect to see this interdependence become more pronounced as more common ground is realized, shared visions are established and opportunities for mutual support and collaboration are identified. This will lead to converged paths, more efficient use of resources and the integration of health information and telehealth technologies.

Drivers of change

The Office of the National Coordinator (ONC), FCC and federal reform legislation will be key drivers of radical change that ultimately leads to an alignment of telehealth and health IT. The healthcare system and stakeholder (providers, payors, employers, suppliers, consumers, etc.) response to those changes will likely result in an expansion of the role of telemedicine, remote monitoring and other telehealth applications. For example, many stakeholders will be seeking technology tools that increase efficiencies, expand access to care and reduce costs – which are some of the primary benefits of telemedicine.

In the case of ONC, which is charged with overseeing health IT funding, the agency has been focused on facilitating EHR adoption and clarifying the definition of meaningful use. However, as evidenced by ONC's recent testimony at the Senate Special Committee on Aging[3], the agency's attention will soon shift to the important role the telehealth infrastructure can play as an enabler of interoperability and HIE, especially in rural and remote communities.

At its core, meaningful use[4] is about improving health, transforming healthcare and:
+ Improving quality, safety and efficiency.
+ Reducing health disparities.
+ Engaging patients and families in their healthcare.
+ Improving care coordination.
+ Improving population and public health.
+ Ensuring adequate privacy and security protections for personal health information.

In order to reach Stage 1 and beyond, demonstrate meaningful

Figure 2: Medicare and Medicaid timeline

MEDICAID

HHS develop interoperability standards end of 2009

Setting of standards complete

Medicaid Incentives begin

Medicaid: non-hospital based physicians 1st yr cost no later than 2016

Medicaid: hospitals that adopt after 2017 not eligible for incentives

Medicaid: non-hospital based physicians no payments after 2021 or more than 5 yrs.

2009 2010 2011 2012 2013 2014 2015 2016 2017….. 2021

Medicare (FY2011) Incentives begin Oct. 2010 for hospitals

Medicare phase down incentive payments for physicians

Medicare penalties begin for non -meaningful users FY15 for hospitals calendar 2015 for physicians

Medicare Incentives begin Jan 2011 for non -hospital based physicians

Medicare: Physicians who 1st payment Is after 2014 receive no incentives

Medicare Incentives End 2016

MEDICARE

Sources: HIMSS http://www.himss.org/ASP/index.asp and AHIMA http://www.ahima.org/

+ electronically generate and transmit permissible prescriptions;
+ send reminders to patients about preventive/follow-up care in the patients' preferred format; and
+ provide patients with timely electronic access to their health information within 96 hours of information being available to eligible providers.

Leveraging and expanding existing telehealth network infrastructures will deliver to providers, particularly those in remote and rural areas, the affordable broadband connections they need to achieve meaningful use and avoid financial penalties.

For its part, the FCC, through its National Broadband Plan, established healthcare as a national priority and laid out its plan for driving broader adoption of and innovation in e-care technologies. The plan addresses outdated regulations and establishes funding to help providers purchase services and build out broadband networks in areas where connections are lacking or are insufficient to support video consultations and EHRs.

use and ultimately avoid penalties which will be levied beginning in October 2015, hospitals, physicians and other eligible providers will need both an EHR and broadband Internet access to:
+ report ambulatory quality measures to Centers for Medicare and Medicaid Services (CMS) or the States;
+ check insurance eligibility electronically from public and private payors;
+ submit claims electronically to public and private payors;
+ provide patients with an electronic copy of their health information upon request;
+ be capable of electronically exchanging key clinical information with other providers and patient-authorized entities;
+ submit electronic data to immunization registries;
+ electronically provide syndromic surveillance data and reportable lab results to public health agencies;

The FCC has adopted a new, broader view that looks beyond the single network connectivity perspective and addresses government decisions that influence the system in which private individuals operate. The commission is looking at the whole ecosystem of networks, applications, devices and individual actions that drive value – not just the networks themselves.

In doing so, the FCC has recognized that broadband-enabled IT solutions can only be successful if critical issues are addressed – inadequate reimbursement, outdated regulations, insufficient data capture and utilization, deficient connectivity, etc. – and existing barriers removed.

The FCC has also recognized the important role of mobile devices, remote monitoring and interoperability. It estimates that remote monitoring of vital signs and EHRs alone can generate savings of US$700 billion over the next 15-25 years. This includes US$200 billion from remote monitoring of congestive heart failure, diabetes, chronic obstructive pulmonary disease and chronic wound or skin ulcers[5] and US$500 billion from implementation of EHRs.
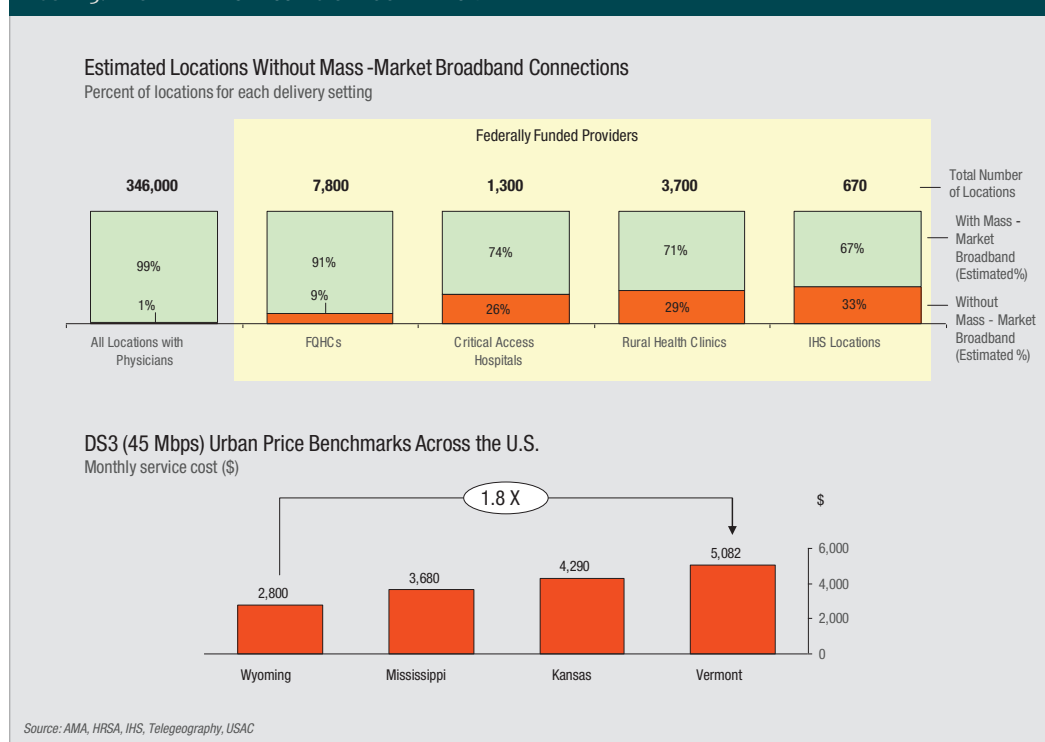
Further, the FCC has stated its intention to remove barriers and transform the US healthcare system by:
+ Ensuring all providers have affordable access to sufficient broadband connections
+ Creating incentives for

Figure 3: Broadband is missing or too expensive

Estimated Locations Without Mass -Market Broadband Connections
Percent of locations for each delivery setting

Federally Funded Providers

346,000	7,800	1,300	3,700	670	Total Number of Locations
99%	91%	74%	71%	67%	With Mass -Market Broadband (Estimated%)
1%	9%	26%	29%	33%	Without Mass - Market Broadband (Estimated %)
All Locations with Physicians	FQHCs	Critical Access Hospitals	Rural Health Clinics	IHS Locations	

DS3 (45 Mbps) Urban Price Benchmarks Across the U.S.
Monthly service cost ($)

1.8 X

Wyoming	Mississippi	Kansas	Vermont	$
2,800	3,680	4,290	5,082	6,000

Source: AMA, HRSA, IHS, Telegeography, USAC

adoption of EHRs and remote monitoring technologies, including the expansion of reimbursements where outcomes are proven

✚ Transforming the Rural Healthcare Program by subsidizing both ongoing costs and network deployment, as well as by expanding the definition of eligible providers.

✚ Creating next-generation interoperability across clinical, research and administrative data

✚ Ensuring patients have access to and control over their health data

✚ Modernizing credentialing, privileging and regulatory requirements to increase access to care and enable broader health IT adoption

Funding will be closely tied to meaningful use and other outcome measures to ensure that the FCC's support goes to providers who are following the guidance of the Office of the National Coordinator for Health Information Technology. It will require participating organizations and providers to meet outcomes-based performance measures and will track and publish progress.

Finally, health reform legislation extends insurance coverage to an estimated 32 million people at a cost of $940 billion over the next 10 years. Supporters expect it will lead to measureable improvements in the delivery of and access to care, as well as to patient outcomes and overall population health. But it will also drive the need for more efficient care processes to accommodate increased demands, particularly given current limitations in healthcare workforce resources and the push for lower costs.
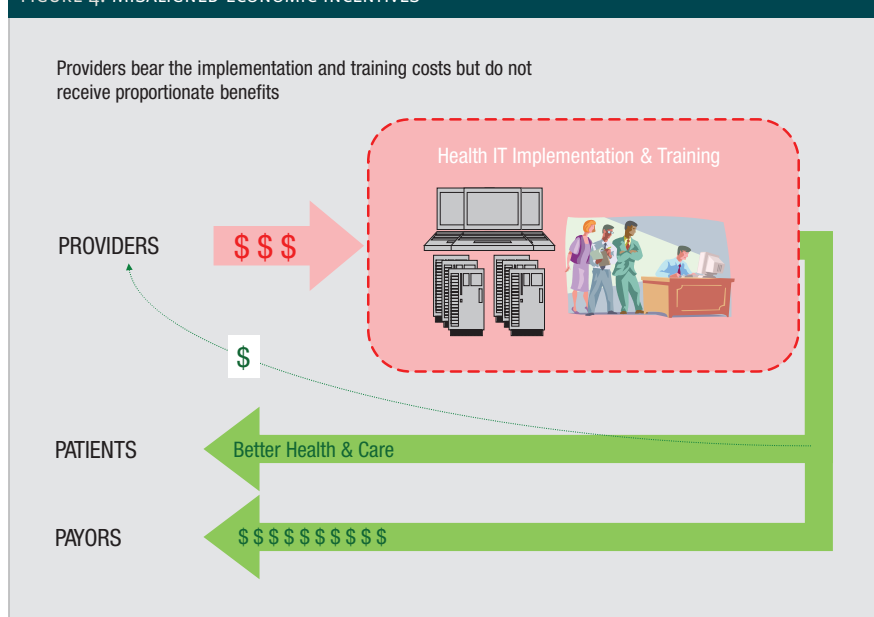
Telemedicine, remote monitoring and other telehealth technologies may become attractive solutions for many providers, payers, researchers and consumers as we begin responding to these drivers of change and addressing such mandates as:

✚ improving care coordination;

✚ promoting solutions to address healthcare workforce needs;

✚ researching comparative effectiveness of medical treatments;

✚ increasing the burden of payors for managing the chronically ill;

✚ levying penalties against hospitals for re-admissions; and

✚ increasing payments to physicians who can provide high-quality care compared with costs

Numerous studies demonstrate that telehealth can improve efficiency and lower costs. A remote monitoring study of elders in a senior living facility revealed a 36 percent reduction in billable medical procedures, a 78 percent reduction in hospital days and a 68 percent reduction in the cost of care. Additionally, researchers found that the efficiency of caregivers increased by more than 50 percent[6]. Further, a Veterans Hospital System Care Coordination/Home Health program realized a 20 percent reduction in hospital admissions and a 25 percent reduction in bed days with telehealth technologies[7]. Finally, of the 2.2 million patients transported between emergency departments each year, real-time video consults could avoid 646,000 of these transports, resulting in total savings of $408 million[8].

It is important not to overlook the role healthcare consumers

FIGURE 4: MISALIGNED ECONOMIC INCENTIVES

Providers bear the implementation and training costs but do not receive proportionate benefits

Health IT Implementation & Training

PROVIDERS $ $ $

$

PATIENTS Better Health & Care

PAYORS $ $ $ $ $ $ $ $ $ $

play in driving radical change that is expected to accelerate telehealth adoption. Approximately 61 percent of US adults look online for health information[9], 78 percent of Baby Boomers use the web to gather health information and nearly 80 percent of healthcare consumers are interested in accessing their medical records online[10].

Clearly, consumers are turning to the Internet with rapidly increasing frequency too seek out information on symptoms, diseases and conditions, and then discussing their findings with their physician and/or other healthcare providers. As such, they are demanding broadband Internet access to help them do so more efficiently. This will lead to better health choices and enable them to better manage their healthcare dollars and find the best care at the lowest price – even if it means traveling to other communities, states or countries.

Consumers are also demanding more affordable healthcare, as well as access to their personal health information on their home computers and/or mobile devices. A growing number also welcomes the opportunity for remote monitoring of their medical conditions and is seeking ways to participate in online self-diagnostic questionnaires. In fact, one study found that when rural home care patients had video visits exchanged for some of their in person visits, 98 percent reported satisfaction with the video supplemented care and all found the equipment easy to use.[11]

As a result of these shifts, we can expect to see more of a patient-physician partnership as healthcare consumers take a more active role in their healthcare decisions. They may ultimately translate into an increased demand for telehealth applications, including telemedicine, remote education and peer-support, and access to home monitoring technologies.

The role of telehealth

Telehealth has demonstrated its effectiveness in educating clinical staff and patients and facilitating administrative and operational functions, as well as for clinical care purposes. These activities are typically undertaken using one of three primary modes: 1) store-and-forward; 2) real-time monitoring; and 3) remote monitoring. Each mode offers the potential for significant, measurable

benefits. For example, one network has documented improvements in access to and quality of care, as well as enhanced efficiency in the delivery of healthcare, decreased costs and reduced health disparities from using store-and-forward technology alone[12].

At the higher end of the spectrum, the longitudinal EHR and telemedicine network facilitated by the Louisiana Rural Health Information Exchange (LARHIX) and featuring remote consultations has shortened rural patients' wait times for access to specialists. It also drove a 93% decrease in duplicative testing at participating hospitals[13].

The primary benefits of telehealth are its ability to enable more cost-effective use of patient and provider resources and to increase access to both routine and specialist care. Some of the most common/popular uses[14] of telehealth include:

✚ A specialist participating in a remote consult with a family physician to assist with a diagnosis.
✚ A family physician facilitating a consultation with a specialist by transmitting radiology images and/or video along with patient data to a specialist for viewing.
✚ Patients and health professionals sharing audio, video and remotely captured medical data to design or monitor treatment plans, verify prescription refills or provide advice.
✚ Using devices to remotely collect and send data to a monitoring station for interpretation, such as telemetry devices that capture a specific vital sign (blood pressure, glucose, ECG or weight), and to supplement the use of visiting nurses.
✚ Medical education and mentoring, such as the provision of continuing medical education credits, special medical education seminars for targeted groups, and/or interactive expert advice during a medical procedure.
✚ Utilization of the Internet by consumers to obtain specialized health information or to access online discussion groups and peer-to-peer support.

Of the three primary modes of telehealth, the most underutilized application is telemedicine, which allows providers to remotely perform monitoring, diagnosis, triage, consultation and procedural care processes. It is highly effective, and technical advances are creating new opportunities for providers to expand remote services, such as the provision of ongoing chronic care management.

The four most common delivery models[15] for telemedicine are:

1. Networked programs linking tertiary care hospitals/clinics with outlying clinics and community health centers in rural or suburban areas through either hub-and-spoke or integrated networked systems.
2. Point-to-point connections using private networks that allow hospitals/clinics to deliver services directly or outsource specialty services to independent medical service providers. Or point-to-point connection between the health provider and patient home (including residential care, nursing homes and/or assisted living facilities) over single line phone-video systems for interactive clinical consultations.
3. Direct patient-to-monitoring-center links, which allow patients to maintain more independent lifestyles and are most often used for pacemaker, cardiac, pulmonary or fetal monitoring and related services
4. Web-based e-health patient services, which provide direct

consumer outreach and services over the Internet.

Key to the success of these models is the ability for providers to access the patient's medical record at the time of the remote encounter – just as it is with in-person care. This is made possible by the establishment of telehealth networks, which offer a link between provider EHRs and the secure movement of health-related information between doctors, hospitals and other providers when needed for care and treatment.

When telehealth networks provide the broadband to healthcare facilities, they not only offer Internet access, but more importantly create a secure network connecting providers so they can exchange information without going through the public Internet. By taking this role, telehealth networks become responsible for network management and information security.

There are currently approximately 200 telehealth networks linking more than 2,500 institutions in the US[16], all at varying degrees of maturity. That is an impressive number considering that the telehealth pioneers of the 1990s had to build their networks from scratch. To support these pioneers and the advancement of telemedicine, the Office for the Advancement of Telehealth in the Office of Health Information Technology, Health Resources and Services Administration[17] began providing funding to support Telehealth Resource Centers (TRCs) through the Telehealth Resource Center Grant Program.

Today, five TRCs[18] are available to leverage existing knowledge, share information and resources, and assist with the development of new telehealth programs. These invaluable resources also support emerging telehealth networks with readiness, technology and equipment assessments, business model development and program guidance. Other services typically include resources and assistance with clinical protocols, training, reimbursement, legal/regulatory and strategic planning.

One TRC, the Northwest Regional Telehealth Resource Center (NRTRC), leverages the collective expertise of 33 telehealth networks in Alaska, Hawaii, Idaho, Montana, Oregon, Utah, Washington, Wyoming and US-Affiliated Pacific Islands. It collaborates with other TRCs and supporting organizations to identify and design sustainable enterprise-wide solutions that contribute to improved health and a more efficient healthcare system.

The NRTRC supports physicians, hospitals, clinics and other providers as they strengthen the role and contributions of telehealth, including its ability to address interoperability with EHRs and HIEs. It is poised to also assist Regional Extension Centers (RECs), which are now being funded to support providers in the adoption of EHRs. The NRTRC facilitates collaboration and connections in an effort to eliminate gaps in service and will:

✚ Explore best practices of member networks that relate to patient care and improved outcomes as they work to simultaneously adopt EHRs and telehealth.
✚ Provide technical support services to new and existing members as they begin to:
  – Engage in EHRs (if they haven't done so already);
  – Engage in telehealth and incorporate it into their EHR; and/or
  – Participate in HIE opportunities to attain meaningful use and access incentives.
✚ Educate stakeholders on the role of health IT and telehealth.
✚ Address barriers, including network security, ISP contractual

issues and interoperability of telehealth and health IT.

✚ Assist participating providers as they plan for and manage the adoption of remote monitoring technologies, including the re-design of clinical workflows; revision of protocols for processing data and information; changing job roles and responsibilities; and integrating interoperable medical devices.

✚ Create a template for rolling together EHR, HIE and telehealth so that the physician can see diagnostic images and the EHR during the telemedicine encounter.

Case study: REACH Montana Telehealth Network

REACH (Realizing Education And Community Health) Montana Telehealth Network has evolved from facilitating tele-radiology at three remote sites into a consortium of healthcare providers at 18 sites linked by high-bandwidth telecommunications in the north central region of Montana. From its hub site at Benefis Health System in Great Falls, this telehealth network serves rural and frontier counties that are geographically large, remote and sparsely populated, providing both distance learning and medical services.

Since REACH's beginning in 1995, the federal government has helped fund the build-out of its T1 infrastructure and the current move toward fiber to create the "railroad tracks" that will carry medical data and information within the region and beyond. Because of its overlaid relationship with the Northcentral Montana Healthcare Alliance, REACH has been part of the EHR and HIE conversation since the Alliance began developing its health IT projects. It is using its hub-and-spoke network and leveraging its collaborative provider relationships to offer its existing infrastructure as a solution to integrate health IT and prepare the region for HIE to bring the patient record to providers at the time of the telemedicine encounter.

REACH views HIE as a primary function of the network. Its leaders have long believed in the need to be collaborative, if not integrated, with the health IT conversation. As the conversation has moved toward implementing EHRs and establishing a health information exchange, REACH has relied on its synergistic relationships to position the infrastructure (the railroad tracks) to carry health information and its organizational structure to facilitate the business and governance processes. The first HIE project involves implementing an EHR at one of the small rural hospitals and connecting it to Benefis Health System.

REACH manages the relationships, network of T1 lines and deployment of hardware and software between participating sites and relies upon the Benefis IT Department to support the network technically (servers, bridges, technology, etc). As health IT matures, it envisions an expansion of the network to other rural hospitals and providers, as well as to support medical homes with remote monitoring.

In addition to demonstrating the potential of a telehealth network, REACH is an example of the role TRCs play in expanding these vital entities. REACH has benefited from the resources offered by the NRTRC, including utilizing the evaluation tool for new site selection and the reimbursement pocket guide. It has also relied upon the NRTRC to help establish connections beyond its immediate service area to foster a growing network of support.

As REACH proceeds down the path of HIE, it will rely on the NRTRC to scan the horizon, distill information, share innovative resources and make the new connections that will help the network prosper in the new healthcare delivery system.

Conclusion

We can expect telemedicine and remote monitoring to play a significant role in the healthcare delivery system of the future. Existing telehealth networks will prove to be an important resource for providers who want to enhance service offerings, improve efficiency with remote care applications and/or participate in HIE. Their involvement in HIE initiatives will lead to the next generation of interoperability and a blended vision for both health IT and telehealth. It will also lead to a transformation of the telehealth infrastructure into the highway for electronic health records and information exchange for many rural and remote areas.

TRCs like the NRTRC will leverage the depth of their resources and work in conjunction with RECs, HIEs and other supporting organizations to enhance the value telehealth programmes deliver to their individual initiatives. We recommend that telehealth networks prepare now and get involved in the conversation to ensure that the initiatives covering their community or region are aware of the network's existence and capabilities.

Telehealth leaders have unique insight and are ideally positioned to influence the development of HIEs, minimize the risk of duplicative efforts and resources and increase the likelihood of success as we improve the delivery of healthcare and access to the patient's health record.

As we move away from a fee-for-service model and put more value (and reimbursement) into health promotion and prevention we can expect to see new business cases supporting telehealth applications. We also expect to see more and more small hospitals and providers applying the telehealth technologies to help them care for their patients and compete for those willing to travel for the best care at the best price. ❏

Christina Beach Thielst, FACHE is a former hospital administrator who has experienced the evolution of the healthcare delivery system for the past 30 years. She also has expertise establishing governance and administrative structures for health information exchanges and most recently lead activities of the Northwest Regional Telehealth Resource Center to promote the adoption of telehealth and related technologies to enhance delivery systems and reduce organizational and patient costs.

Her innovative work has been published in leading healthcare magazines and journals, and she served as editor for the HIMSS Guide to Establishing a Regional Health Information Organization. Her latest book, Social Media: Connect, Communicate, Collaborate, was published in May.

Christina received a Masters Degree in Health Administration from Tulane University, School of Public Health and Tropical Medicine and is a member of the American College of Healthcare Executives, Health Information and Management Systems Society and the American Telemedicine Association.

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Institutional transfer from the European design practices to Ukraine and Moldova: the case of hospital design

RODICA PLUGARU, PhD

INSTITUTE OF POLITICAL STUDIES, GROUPE-6 ARCHITECTURE FIRM, GRENOBLE, FRANCE

ABSTRACT: This article explores the development of post-soviet hospital design through the analysis of recent modernisations in Moldova and Ukraine. It consists of two parts. First, an introduction of the definition of hospital design as well as its main characteristics during the Soviet period.

Secondly, a presentation of two hospital modernisations in Ukraine and Moldova. In a comparative perspective, the paper presents the actors involved, the difficulties in modernising the hospital regarding the inherited rules as well as the solutions advanced in order to implement a change.

An introduction to the hospital design in Moldova and Ukraine will allow an in-depth study of the involvement of international actors in the post-communist transformations.

My research concerns the institutional transfer from European Union actors to Ukraine and Moldova. Part of the studies on post-soviet states development, the thesis is focused on the transformation of institutions and the participation of foreign actors into the observed process[i]. In this article, I present a brief introduction to the post-soviet hospital design through the analysis of two hospital modernisations. The countries of my analysis are Moldova and Ukraine, due to their geopolitical strategic position: at the crossroads of Europe and Asia, at the centre of European and Russian influences (Serebrian, 2004). Rather different in terms of territory, demography and economic indicators, both states experienced over fifty years of similar background. In line with historical approach of the new institutionalism in political science, I argue that Ukraine and Moldova present similar characteristics of hospital design following Soviet Union's collapse.

A complementary hypothesis stresses the involvement of international companies in the design of new hospitals in these states. This paper is structured in two parts. First, I expose the hospital design characteristics of Ukraine and Moldova during the Soviet Union. Second, I present two hospital modernisations following the independence. The comparative presentation of the two projects will allow verifying the announced hypotheses, while enlarging the existing literature on post-soviet transformations[ii].

Part I: hospital design characteristics

In this first part of the paper, I present the definition of the hospital design, while introducing several of its characteristics during the Soviet Union.

1. The hospital design as a process

Giving its role of diagnostic and treatment, but also of teaching and research, the hospital is a major element of the health care system (Rechel et al., 2009b). Over the last decades, the hospital acquired an economical and societal role, by employing significant personnel and using the most advanced medical technologies[1]. These elements stress the fact that the design of a hospital is not only a technical concern – of using the most innovative design and construction methods, but also a political one – of providing the adapted care to the health needs of the population (Rechel et al., 2009a). Despite this, as some commentators deplore, the political science has paid little attention to the hospital as institution (McKee and Healy, 2000).

Defining the hospital design is not a simple task. Several explanations can be found in the literature of architecture and construction which describe the process of design for the specialists of the field. It can be noticed that the hospital design involves a large amount of information from different areas: medicine, architecture, engineering, urbanism etc. The 665 pages of the "Planning the hospital space" of Maurice le Mandat, called more usually "The Bible" by the French architects, give an idea of the knowledge to at least broadly understand while designing a hospital (Le Mandat, 1989).

In this paper, I define the hospital design as a process according to which a large amount of actors interacts upon a significant corpus of regulations in order to deliver appropriate design solutions. More precisely, I will focus on the design of tertiary care

hospitals, which deliver high-complex services of diagnostic and treatment[2].

2. Characteristics of a design process

Put bluntly, the realisation of a building involves three main stages:

✚ **The programming:** determines the general and detailed characteristics of organization, functioning, areas, equipments, personnel staff and cost of the building.

✚ **The design:** implies the making of the plans for the future building. A design team composed of architects, engineers, programmists and economist are working together in order to prepare the drawings for the construction.

✚ **The construction:** according to the previous phases and the received plans, construction firms work for the realisation "in flesh" of the project.

The process of design during the soviet period was characterized by "typical projects" (called in Russian language *typovyie proekti*). Specialized design institutes issued "typical projects" for different buildings: hospital, schools, laboratories etc. The "typical project" was supposed to contain the best practices for a specific object. This sort of soviet "benchmarking" aimed to control the public expenditure on design and construction. Also, it partly explains why the buildings similarity all over the USSR territories.

Following the independence, the stages of building construction did not really change in Moldova and Ukraine. Nevertheless, the "typical projects" disappeared, as the centralized soviet model collapsed.

3. The hospital design regulations

The hospital design is a process largely framed by State authorities. As Maurice Le Mandat puts it "the Department of Health in the United States produces about 600 regulations per year (…) while in France, there are about 450 texts to know for designing a hospital building". In other words, the hospital design regulations allow States to control and supervise the construction of health care institutions, which represent after all, master pieces of their national health care policies.

During the soviet times, both Ukraine and Moldova had a unique corpus of regulations that applied to the design of any building. Called SNIP ("building norms and regulations"), they applied to every construction on its territory. Additionally, there were GOST ("national standard of USSR") which indicated the required conditions for construction materials. State control authorities checked each design project upon the soviet SNIP and GOST before allowing the construction of a building.

In 1991, Ukraine and Moldova inherited of the soviet significant framework of rules for the hospital design. The majority of documents are kept in their soviet form until today. In Moldova, the norms are still essentially in Russian, while the official language after independence is Romanian[3]. Ukraine inherited of all the soviet norms as Moldova, but rewritten them in Ukrainian and called them DBN[4].

Part II: hospital modernisations in Ukraine and Moldova

In the next section, I present several elements on two case studies: the Children Hospital of the Future (CHF) in Ukraine and the Republican Clinical Hospital (RCH) in Moldova[5]. A comparative description between the two examples will be used in order to reveal the similarities and the differences of the hospital design. The scheme I suggest contains the involved Actors, the Obstacles in implementing new design preferences as well as the Solutions adopted in order to move away from the inherited paths.

The actors

The idea of the Children Hospital of the Future in Kiev, Ukraine was launched by the Foundation Ukraine 3000 when Kateryna Youchschenko, the first lady and Chairman of the organization, noted the absence of medical institution for cancer diseases in the country[6]. The idea gained political support and was launched as a project in 2006. The Administrative Department of the Presidency (ADP) of Ukraine prepared the legal framework of the initiative[7].

In Republic of Moldova, the idea of restructuring the Republican Clinical Hospital was presented within the reform of the hospital sector[8]. During the implementation of a main reform project, the Ministry of Health edited a report presenting the deplorable situation of hospitals. Following this state of the art, the Ministry launched in 2007 the idea of creating 4 Centres of Performance – 4 Republican hospitals in the country. The Republican Clinical institution of Chisinau, being the most important health facility, was placed on the top of the list.

Both Moldova and Ukraine called for international experience in the field of hospital design following independence. International competitions selected foreign design firms. The French-British consortium bdpgroupe6 was chosen for the CHF in Kiev, while the German practice Top-Konsult was named for the feasibility study of the RCH in Chisinau. These international companies made partnerships with local architecture firms: Budova Centre-1 in Ukraine and Dolmen firm in Moldova. Their role was to help implementing the foreign design solutions into the national specific contexts.

The obstacles

The main difficulty of international actors involved in hospital modernisations in Ukraine and Moldova was to implement their ideas of developing the medical institution. During the Soviet Union, architects and engineers strictly applied the "rule book" and thus had little space left for their creative ideas. In Western countries, the techniques of designing a hospital were related to a mutual exchange of practices and ideas all over the world[9]. These differences in designing the hospital as medical institution were at the core of the debates between international and national actors.

Very soon after winning the international design competition for the CHF in Kiev, the consortium bdpgroupe6 understood that they will not be able to put in practice their model of hospital if they had to comply with Ukrainian regulations. In the case of Moldova, it can not be said that Top-Konsult need to go against the national regulations while preparing the feasibility study[10]. In the same time, this does not imply that they had no obstacles in introducing their ideas in the Moldavian healthcare system[11].

The solutions

Facing difficulties in adopting the design solutions for the Kiev CHF, the Foundation Ukraine 3000 obtained the Experimental status for the hospital project. This option represented an "opened window" for the international design companies. As their

If in Ukraine it can be observed that a mechanism was found in order to integrate the foreign ideas into the hospital design, in Moldova it is not exactly the case

modifying the old hospital design rules. The fact that the inherited prescriptions are more and more challenged, despite their official character, defends the assumption of a gradual transformation following the independence of both states. ❏

Rodica Plugaru has a Master Degree in European Governance from the Institute of Political Studies of Grenoble, and a PhD in political science.

Since July 2008, she works at the PACTE laboratory and the French architecture firm Groupe-6, in Grenoble, France.

representatives explained, it was considered an official opportunity to integrate the foreign solutions into designing a hospital in Ukraine. In the same time, local representatives stressed the importance of national features during the project implementation. The Experimental status need thus to be considered as an opportunity for the international actors to express more easily their ideas, rather than an immediate approval of the latter.

If in Ukraine it can be observed that a mechanism was found in order to integrate the foreign ideas into the hospital design, in Moldova it is not exactly the case. After analysing the experience of RCH as well as more generally the design of a private hospital in Chisinau, I did not identify any institutional procedure for breaking with the existing design regulations. The only possibility left for international design companies is to convince the State organs that their ideas are more advanced than the old rule book prescriptions[12].

Conclusion

This paper presented hospital design characteristics in Ukraine and Moldova through the observation of two case studies. I adopted a definition of hospital design in line with the institutional approaches in political science. According to it, the hospital design can be analysed as a complex process of establishing the outline of a hospital upon a specific corpus of regulations. The content of this definition – the actors, the rules and the scheme of the process can differ from one country to another as well as from one period of time to another. Given the fact that Moldova and Ukraine had common hospital design trends during the Soviet Union, this paper aimed to observe if they adopted similar or different solutions following their independence.

I assume that there is a similar feature of hospital design in Ukraine and in Moldova as international design companies are present in both states during the post-soviet period. As the two case studies suggest, the post-soviet hospital design is the outcome of complex debates between foreign and national representatives. Confirmed by numerous interviews during my stay in Ukraine and Moldova, none of these elements were present during the Soviet Union regime.

At the same time, Ukraine and Moldova adopted different solutions for the introduction of foreign design elements. In Ukraine, the Experimental status, a procedure available since 2007, allows some projects to adopt international experience. In Moldova, the absence of such a procedure entailed the respect of national regulations. The foreign designers had yet the possibility to directly convince the national administrations to approve their solutions. Consequently, the mechanisms adopted in order to transform the medical institutions in Moldova and Ukraine, either different, intended to respond to the common problem of

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End Notes

1. On the roles of the hospital as a medical institution, see McKee, M. and Healy, J. (2000) The role of the hospital in a changing environment. Bulletin of the World Health Organisation. 78 ed., pp. 803-10.
2. There are several types of hospitals. They can be classified by the level of care provided: primary, secondary and tertiary. The primary care concerns "the services of sanitary education, prevention and first emergency" oriented to the population of immediate proximity. The secondary care concern "more specialised fields where patients are oriented from the primary care services". Tertiary care are the most specialised type of medical services (Le Mandat, M. (1989) Prévoir l'espace hospitalier. in Berger-Levrault (ed) Paris.).
3. In the Constitution of Republic of Moldova, the name of the official language is Moldavian. The latter is identical to Romanian and there is no scientific demonstrated difference between the two. Nevertheless, the language definition is used for political questions, as for avoiding per example a closer identification of Republic of Moldova with the neighbour state Romania.
4. Interview with Volodimir Pidgirniak, Director, Budova Centre-1, May 2010, Kiev, Ukraine.
5. The information is issued from my participation and observation within the design practice Groupe-6 in France. The hospital design project in Ukraine, which the firm realises, started in August 2007 and finalised in May 2010.
6. In Ukraine, there is no possibility nowadays to realise complex surgical operations due to the lack of necessary medical technologies and equipments (i.e. bone-marrow transplant from other donors than relatives).
7. The presidential decree N° 1694/2005 on 6th December 2005 specified the creation of the All Ukrainian Mother and Children Health Centre. The Cabinet of Ministers approved the adoption of the presidential decree by the resolution N°72 on 25th of May 2006.
8. Several legislative acts put the basis of the hospital sector development: the National Strategy of development for the years 2008-2011, adopted by the Law N°295-XVI of 21.12.2007, the Action Plan for implementing the National Strategy of development, approved by Government decree N°191 of 25.02.08 and the Development Strategy of the health care system for the period 2008-2017, approved by Government decree N°1471 of 24.12.2007.
9. Interview with Conor Ellis, Health Director, EC Harris, Montpellier, France, 21st of July 2010.
10. The main reason is that there is no check out upon the design norms, as the solutions presented are at their very initial stage.
11. For example, the reorganisation of operating theatres was intensively debated by the Board of the Hospital and Top-Konsult. The designers suggested reducing the number of theatres, from 27 nowadays to 7. In the opinion of foreign specialists, the operating theatres had to work 24 hours a day in order to optimize their cost. This solution was found inconvenient by the Moldavian part.
12. In this context, each time Top-Konsult suggested a new concept of organising the future hospital of Chisinau, it need to convince the Ministry of Health representatives, the Board of the Hospital as well as other concerned national authorities. There was no regularity on the acceptance or the refusal of authorities concerning the suggested schemes.

Quality and culture of health

SARA ALICIA PONCE DE LEÓN MUÑOZ
NURSE AND MIDWIFE, FOUNDING DIRECTOR OF THE SCHOOL OF NURSING
AND OBSTETRICS OF THE NATIONAL POLYTECHNIC INSTITUTE

ABSTRACT: Healthcare has as its framework, a culture of disease which primarily comes from biology, and is meant to: diagnose, cure, prevent and rehabilitate. Health problems show that the efforts and great advances in medicine are not enough. To improve actions within this same culture does not seem effective. Changes are needed to create a culture of health. The characteristics of nurses' work and its potential, open opportunities to improve the quality of care, having LIFE at the centre.

A general reflection on living conditions and health shows the lack of equity among populations. Any work on quality must address this problem. It is evident there are great advances and efforts to improve treatment, prevention and rehabilitation, but results in people's quality of life and the serious health problems which are present, manifest that these are not enough, nor do they achieve the level of efficiency that is consistent with the needs.

The great majority of people live in conditions of poverty which determine serious deficiencies in fundamental aspects such as nutrition, education and the lack of healthy lifestyles. In this situation, the unavoidable consequence, if the causes are not addressed, is the creation of a state of vulnerability where multiple factors are involved with need to be solved.

Providing care mainly for people who are already sick and treating the damage without considering the primary causes, the involved factors and the context in which they are produced, leads us to question the quality of care.

The predominant orientation in healthcare has disease as its axis. Those who provide care have also been trained with this focus that emphasizes the cure. One of the consequences of this is the medicalization of problems.

Health services and their personnel, governments, users and the general society are conditioned by the culture of disease. Even nurses' work, in spite of their training in public health, leads them to perform their professional duties according to policies and actions centered on this culture.

Health is much more than a biological phenomenon; quality care requires changes based on a perspective that will consider human beings in all their breadth and the training of health personnel with a life-affirming vision, carrying out their work in multidisciplinary teams.

Generally, improvements in care are oriented towards doing better what is already being done, within the guidelines of a culture of disease. Nurses, with the potential of their training and having acquired new skills in their work with individuals, families and communities, can provide healthcare that modifies this culture, strengthens healthy lifestyles and contributes to improving society's quality of life.

With this conviction, we have started in Mexico a project in continuous education that we believe can give nurses' work the power to improve the population's living conditions.

Quality and culture of disease

The great scientific and technological advances are amazing; these have had a great impact on healing and on the prevention of disease, as well as on the rehabilitation of patients, and have greatly increased life expectancy.

However, any reflection on the serious physical and psychological health problems that exist, and the shortcomings which make it impossible to have a harmonious family life, at the national and international levels, as well as with the environment, show the great discrepancy existing between society's health needs and the system's response to satisfy them.

Actions are partial, although there is insistence on providing integral care. The predominant actions are in curing and the prevention of physical diseases, but in spite of all resources and efforts invested, the old physical problems still exist, to which are added those which appeared more recently, the psychological and social ones. All pose a threat to the quality of life and to life itself.

To give some examples, we can mention problems such as:

✚ The ancestral diarrhea, which is the cause of 50% of deaths.

✚ One out of twelve children dies before age 5, due to foreseeable causes.

✚ Malnutrition leads to an infinite number of problems; specifically, to infections and a difficulty in the healing of wounds, which in turn extend hospital stays.

✚ Iron deficiency causes 100 thousand deaths annually, of mothers during childbirth.

✚ Depression, not wholly quantified, has an impact on all spheres. It is very significant that of every three persons with depression, two are women.

✚ Family violence has increased, according to UNICEF reports.

Poverty is manifested as well as educational poverty, which limits people's ability to be and to do, their work opportunities and

access to basic and general services for their health.

The analysis of health problems and healthcare may help us understand and value the level of quality of care. Is the system responding in a reactive way to the symptoms of problems? To what extent are the fundamental causes not being addressed? It is clear that the health system cannot solve all the socioeconomic system, but this does not mean that it cannot work in multidisciplinary teams and establish interaction with the other sectors in the system.

Malnutrition, for example, from which multiple problems arise – physical and educational problems, as well as those related to productivity and, in general, to all actions and relationships of those who have this condition – clearly shows the lack of quality in care when only the physical aspects are cared for.

The same can be said for violence, which goes beyond generations and affects family life, in all social spheres of each country and between countries. It is the common denominator affecting health at all levels, from the family to the socioeconomic system. An example of violence is the concentration of wealth.

For women it is evident there is a lack of equity, above all in the inequality of opportunities; it reflects on nutrition, on the acknowledgment of capabilities and values, on education, employment and on citizen and political participation. It is not possible to think of healthy lifestyles if in daily life violence is manifested in diverse forms, including with physical aggression. Faced with this situation, the system provides care for the physical damage, the wounds, but does not address the causes that lead to this harm.

The health system provides care to individuals without relating their disease to the deficiencies that are implicit in the disease. The perspective of healthcare does not consider the social context nor the socioeconomic factors which have an effect on health. This model of care requires an expensive advanced technology, which not only affects the economy but also productivity, human relations and leads to suffering.

Policies and decision-making come from a perspective of disease, above all of physical disease, in order to cure it. The system acts mainly when people are already sick and conditions the population to seek for care in order to get cured, thus promoting a CULTURE OF DISEASE.

Quality and culture of health

If we aspire to elevate the population's level of health, will it be enough to do better what we are already doing? If we have disease as a focus, will we be responding to the health needs of families and communities? Will people's quality of life be improved?

Reports on meetings, analyses and studies show there is an interest in improving health systems and evaluating their efficacy and efficiency. The Director of the World Health Organization suggests performing a scientific test to evaluate them, improve the quality of data and disseminate them among the member countries.

We may also recognize and understand the role that health plays in development and well-being. The development of a country is based on human development, which means the citizen's ability to "fulfill his/her capabilities" and take full advantage of opportunities.

The above shows another perspective on health. It considers

human potential, the influence of impoverishment, humiliation, despair, the problems pertaining to the medicalization of systems and their need to respond to "people's expectations". To care for people according to their needs and not to their ability to pay.

Although these ideas are valuable and go beyond the traditional viewpoints, there is still uncertainty when actions are focused on disease, on care for damage with a biological emphasis, without considering the social context nor the primary causes that are involved. It is evident that it is not easy to go from a culture of disease to one of health, centred on life and on the promotion of actions to promote a biophilic orientation.

In this culture, health is perceived as a social phenomenon and not only a biological one. Healthy lifestyles and self-care for health are favoured; human potential is promoted to improve the life conditions of individuals and groups, so that people will not need to be hospitalized nor be users of health services, for causes that may be avoided. There is an orientation towards development and the exercise of human rights, as well as promotion of harmonious relationships in families, in their social context and their interaction with the environment.

The affirmation of life as an axis requires the development of physical, psychological and social strengths, the promotion of a culture of human rights and providing of care from the perspective of causes. In this relationship, which is life driven, all participants learn in a permanent process of development.

The vision that is centered on human nature and on seeing health as a condition where multiple causes and factors are involved, shows that there cannot be care with quality if we continue with the traditional health team, or with a unidisciplinary leadership where the treatment of diseases is dominant. Quality care, require multidisciplinary work, and leadership that responds to the needs and their causes.

Quality and strategies

To achieve a culture of health, with a life-affirming orientation, may be seen as a dream. The great advances start like this and would remain in the imagination if there were no long-term vision. For a culture of health, it is necessary to work in all social spheres. Commitment is needed, and all personnel require updating for the creation and exercise of this culture to exert continuous effort in order to carry out quality work within a new life-affirming framework.

We know that in healthcare it is important that all have an efficient participation. As in any other change, everyone needs to acquire capabilities that will allow them to have quality in their performance, in order to achieve the common objectives, contributing their work according to the functions assigned to them.

A fundamental effort is in the development of nurses' capabilities. These professional personnel have the greatest training in public health and their work conditions, characterized by direct and continuous contact with the population, every day of the year, give them the opportunity to promote healthy lifestyles and the strengths of healthy and sick individuals, of their families and in the diverse communities.

The objective is to make life the centre of our work and create a model that is not subordinated to the curing of diseases but to human development, in order to be applied to any field of human existence, with people and in groups. Nurses are the key

professionals to contribute a social force for the development of a health culture.

Participation of authorities requires joint planning, oriented towards the task of achieving change and providing support to make life a valuable event that is worth being lived.

With this perspective, we have begun in Mexico, at the National College of Nurses (*Colegio Nacional de Enfermeras*), a project of Professional Certification. This program is carried out through seminars where learning units are taught with functions and activities oriented towards a health culture. One of them is leadership and its application in healthcare and the dissemination of this culture.

Conclusions

➕ The Health System is determined by the model that has disease at its centre. Healthcare consists of curing, preventing disease and rehabilitating. Work is focused on the repairing of damage.

➕ The disease-centred focus induce people to requesting services when they are already sick or when they require prevention for some kind of disease. This orientation creates and re-creates a Culture of Disease.

➕ In the discourse on health policies, the need is acknowledged to improve the quality of services in order to improve quality of life.

➕ The health problems and life conditions of most of the population show the need to make changes that better respond to the needs of a healthy life and not only to improve on what is already being done. It is not efficient or efficacious to do more of the same, which has already shown the persistence of a problematic situation with respect to health that does not achieve a life with dignity.

➕ Change requires a perspective that is not limited to repairing the damage or to preventing some diseases.

➕ We need to create and promote a Culture of Health oriented towards: helping people recognize and use their power to achieve a healthy life with dignity; promoting the development of their potential and the exercise of their human rights; favoring the full realization of their existence, in harmony with others and with the environment.

➕ In a culture of health, the process of care is based on the affirmation of life, through an interaction where we all learn.

➕ The potential, training and characteristics of nurses and their work, are conditions that make it possible for them to create and develop a culture of health.

➕ Their performance is with healthy or sick people, at the government levels, with the training of personnel, in the development of health policies and, in general, with all the population. ❑

Sara Alicia Ponce de León Muñoz is a nurse and midwife with postgraduate courses in gender studies and a Founding Director of the School of Nursing and Obstetrics of the National Polytechnic Institute. Currently she is an academic supervisor of higher education in the same University. She has been actively participating in the Colegio Nacional de Enfermeras *from which shewas the president. She is now a member of the honour committee and the Director of the professional certification program.*

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Hospital marketing: characterization of marketing actions in private hospitals in the city of São Paulo – Brazil

EDUARDO BLAY LEIDERMAN MA, MBA,
RESEARCHER, CENTRE FOR HEALTH ECONOMICS, CPES

DR PAOLA ZUCCHI, PhD
DEPUTY DIRECTOR, CENTER FOR HEALTH ECONOMICS PAULISTA – CPES

JORGE LUIS PADOVAN
RESEARCHER OF CENTER FOR HEALTH ECONOMICS PAULISTA – CPES

ABSTRACT: Objective: Characterize the marketing actions in private hospitals in the city of São Paulo, the organizational structure of the marketing area, the target public of marketing actions and the media used. Methods: Exploratory cross-sectional study, carried out by a survey made with hospital administrators. Results: The hospitals studied were clearly divided in two groups whose differentials are statistically significant: 1. good infrastructure and equipment, with a well-defined investment policy in marketing; 2. worse infrastructure and less equipment, with lower proportional investment in marketing. Conclusions: 1. The actions most used are the evaluation of patients/caregivers satisfaction, web site and dissemination of the hospital services. 2. The hospital administrators attribute a level of significant importance to the application of hospital marketing concepts. 3. There is a marketing structure in most of the hospitals studied. 4. The hospitals consider as extremely or very important publics: patients and relatives, doctors, collaborators, health plans and community. 5. The media most used are the most simple and of lower cost. 6. There is a statistically significant correlation between the higher investment in marketing and the best infrastructure. 7. The studied hospitals apply the concept of marketing in a restricted way.

The implementation of marketing concepts arrived belatedly to the health area, at the end of the 1970s. Formally, health services marketing was recognized in 1977, the year in which the American Hospital Association, first promoted a discussion about marketing. In that year, it was also published the first book on health services marketing in the United States. It was at that same time – end of 70s, that American hospitals started organizing and structuring themselves in terms of marketing functions (Loures 2003).

Marketing is still seen with some skepticism by some administrators of the health area, who imagine that it is necessary only when the company is in a place of low competitiveness. (Wrenn 2002). The phase in which American hospitals are passing, in terms of marketing, can be characterized as "childhood" (Robbins, Kane and Sullivan 1988).

The marketing actions of the Brazilian hospital market, when they exist, are clearly orientated towards services production and towards "product" – the patient assistance process. More recently, in the last few years, the hospitals considered as "top" or "first class", started turning their marketing actions to service sales (Maya 2005).

Objectives
Main objective
1. Verify the existence and analyse the marketing actions in private hospitals in the city of São Paulo.

Secondary objectives
2. Characterize the private hospitals in the city of São Paulo that perform marketing actions, under the following aspects:

2.1 Level of importance that hospital administrators attribute to the implementation of hospital marketing concepts.
2.2 Organizational structure of the marketing area.
2.3 Marketing actions performed.
2.4 Target public of the marketing actions performed.
2.5 Media used.

Methods
The study is a exploratory cross-sectional study, with primary data collection performed in 2007, made with hospital administrators, using a questionnaire structured type, with closed questions. Hospitals were selected by the master file of CNES – *Cadastro Nacional dos Estabelecimentos de Saúde do Ministério da Saúde do Brasil*. We included in this study the hospitals which fitted the following criteria:

✚ Hospitals located in the city of São Paulo – SP.
✚ Private for-profit and nonprofit hospitals, including the philantropic ones.
✚ Hospitals which provide healthcare to health plans and to private patients-beds "non SUS" in the terminology and

classification of CNES (at least one bed).

✚ Hospitals classified as hierarchy level 6 or 7 (median complexity), or 8 (high complexity), according to the terminology and classification of CNES.

Data are confidential and the project of the work was approved by the Ethics Committee in Research of UNIFESP.

The answers of the questionnaire were tabulated and analised from the statistical point of view, with the factorial and Cluster analysis.

Results

The sample considered was the one of 35 (30.4%) hospitais in relation to the total universe of 115 hospitals.

It was observed that the highest index of answers was in the range of hospitals with more than 200 beds: 12 (85.7%) and that the lowest index ocurred in the range of hospitals with 50 to 99 beds: 4 (14.8%).

Of the respondent hospitals, 20 (57.2%) are for-profit and 15 (42.8%) are nonprofit hospitals. Among the for-profit hospitals, 3 (8.6%) belong to a Health Agency, and all these 3 have more than 100 beds. We noticed that 26 (76.5%) are general hospitals and that from the large-sized hospitals – 200 or more beds, 11 (91.7%) are general.

When asked about the level of importance of investments of the hospitals in items and tools the success of the hospital, we observed that 33 (94.3%) of the general group of respondents attributed to the items listed, the levels "extremely important" or "very".

When this evaluation was made in relation to the processes of decision making, we observed that 31 (88.6%) of respondents of the general group of hospitals attributed to the items listed, the levels "extremely important" or "very important".

The answers to the question about to which public they direct their hospital marketing actions and the attribution of the level of importance to each one we can notice that high levels of importance were attributed to all. Considering the answers "extremely important" and "very important", to the general group of hospitals, 74.3% was attributed to community; and to the other publics, between 82.9% and 91.7%.

With reference to the media used, we can observe a higher use of more simple media, shown by the level of use in "stationery", 28 (80.0%); against 1 (2.9%) use of subscription TV.

With reference to the existence or not of a structure responsible for the hospital marketing, in the general group of hospitals, 27 (77.1%) answered that there is one. From the range of hospitals with up to 50 beds, 4 (57.1%) answered that there is such structure; and from the hospitals with more than 200 beds, 10 (83.3%) affirmed the existence of this structure.

From the answers to the question about the hierarchy level of the hospital marketing area we can observe that only in the hospitals with more than 100 beds there is a Board of Directors/ Marketing Superintendency and that prevails, with 11 (35.5%) hospitals of the general group, the Management level.

It was also questioned the subordination of the marketing area in the hospital, which showed that in only one hospital of the general group of respondents, with more than 200 beds, the marketing area is subordinated to a Management. In all the other cases, this area is subordinated to the Presidency, General Board of Directors or Board of Directors/Superintendency, with

> **Marketing is still seen with some skepticism by some administrators of the health area, who imagine that it is necessary only when the company is in a place of low competitiveness**

prevalence of 13 (48,1%) to the General Board of Directors.

The mean number of collaborators who work in the marketing area is 8. The hierarchy level with the highest mean number of collaborators, 12 (29.4%), is the one of Assistant.

It was questioned in which definitions and actions of the hospital there is one active and decisive participation of the marketing area. We noticed that the action in which this participation is more frequent is the choice and definition of the type of release and of the media used. In the budget of marketing actions, there is no participation of the marketing area in any hospital.

It was also questioned the time of existence of the hospital marketing area, observing that in hospitals with up to 50 beds, in 1 (25.0%) the area is more than 5 years old; while in hospitals with more than 200 beds, in 8 (72.7%) the area is more than 5 years old.

We have to keep in mind that 94.3% of the respondent hospitals were founded more than 5 years ago.

In the general group of respondents, 19 (67.9%) affirmed there is a budget for the hospital marketing actions. In the hospitals with up to 50 beds, 2 (50.0%) answered there is this budget; while in the ones with more than 200 beds, there were 8 (72.7%) positive answers.

With reference to the value of this budget, in relation to the billing of the hospital, the average informed by the general group of hospitals was 1.5%.

About the existence or not of a marketing plan established in a written document, the positive answers of the general group of hospitals were 17 (63.0%). In the hospitals with up to 50 beds, there were 2 (50.0%) positive answers; and in the ones with more than 200 beds, there were 6 (60.0%).

The last question of the questionnaire was: In case there is a marketing plan, this plan is or is not integrated with the values/ principles, mission, vision and objectives of the hospital? There were 17 (77.3%) positive answers in the general group of hospitals.

Discussion

The statistical data analysis showed that the hospitals researched were clearly divided in two clusters, whose differentials are statistically significant, according to the factorial analysis and to the k-means cluster analysis performed:

✚ good infrastructure and equipment, with well-defined investment policy in marketing;

✚ worse infrastructure and less equipment, with lower proportional investment in marketing.

Of the 35 respondent hospitals, 15 (42.9%) fitted in group 1; and 20 (57.1%), in group 2.

The ones which fitted in group 1, in general, are the hospitals colloquially called "first class"; on the other hand, we notice that

> The result of a well planned and well implemented marketing strategy is the attraction for new clients, which generates a higher billing, higher capacity of investment, not only in new services, infrastructure and equipment

not all the hospitals which have this differentiated image fit in group 1.

In terms of structure and service, the hospitals of group 1 significantly differentiate from the hospitals of group 2, mainly in relation to items that are not considered so essential by the market and that at the same time demand high investments, such as nuclear medicine, magnetic resonance and tomography. We should keep in mind that this type of service requires, besides the financial investment in the purchase, installation and maintenance of the equipment; investment in people and in adequacy for the physical space. Such resources are scarce for a good part of private hospitals in the city of São Paulo.

In other structural and service items, which involve lower complexity or constitute minimum necessary services for the operation of a general hospital, the differences between groups 1 and 2 are much smaller: Admission, Surgical Suite, ICU/CCU and Emergency Room.

In case of "Day hospital", this service exists in a higher proportion in hospitals of group 2, probably because it is an admission of low complexity, of lower interest from the hospitals of group 1, that invest in infrastructure, technology and skilled personnel for more complex services.

In relation to the media used, we notice significant differences in the use of media of higher cost and impact: outdoor (forbidden at the moment by a municipal law in São Paulo), newspaper, radio, open TV and subscription TV. In the most simple media, such as telemarketing, direct mail, direct emails and stationery, we do not observe this difference.

The subscription TV is used only by one hospital, that belongs to group 1. In group 2, no hospitals use TV and only 5.0 % used outside (before the prohibition by the municipal legislation), magazines and radio.

In the analysis of relationship employees/beds, group1 of hospitals showed 1.9 times the relationship of group 2.

In the relationship employees of the marketing area/ total number of employees, group 1 has 2.2 times the relationship of group 2.

In the relationship employees of the marketing area/beds, group 1 has a relationship that represents 4.1 times the one of group 2.

This shows, in any of these perspectives, that there is proportionally an investment in the structure of general personnel and, specifically in the personnel of the marketing area, significantly higher by the hospitals of group 1, when compared to the ones of group 2.

With reference to strategy and to marketing budget, the differences between the groups, as expected, are also significant, once in group 1, 13 (86.7%) of the hospitals informed a budget for the marketing area; while in group 2, 4 (20.0%) hospitals did it.

Eleven (80.0%) of the hospitals of group 1 and four (30.0%) of the hospitals of group 2 declared the existence of a documented marketing plan.

With these original findings of this work, it is demonstrated that group 1 of hospitals have a physical infrastructure (beds), technological (equipment) and of personnel significantly more advanced, in relation to the ones of group 2, or else, they are hospitals which have a better capacity of investment, what is one of the indicators of financial success. This same group shows a better defined marketing strategy, in terms of planning and with higher investment, proportionally to the hospitals of group 2.

The result of a well planned and well implemented marketing strategy is the attraction for new clients, which generates a higher billing, higher capacity of investment, not only in new services, infrastructure and equipment, but also in marketing and so on, forming a "virtuous circle" of success of the hospital enterprise; but as it was already mentioned, this is only a hypothesis to be tested in the future, once this work does not clarify this question.

The question of the questionnaire about the participation "active and decisive of the marketing area" shows that there is only this type of more intense participation, concerning the "choice and definition of the type of release and media" (68.6% of hospitals in a general sample), "evaluation of public satisfaction" and "relationship and internal and external communication" (both with 60.0%).

This shows a narrow view (or "myopic") of marketing by the side of the hospitals, that do not put into practice the concept of "marketing compound", formed by the equitable application of the 4 "Ps", as they consider the marketing area as having only the "P" of Promotion, neglecting the other "Ps", such as Pricing of products and services (20.0% of the general sample of hospitals) and the choice and definition of Products and services (28.6%).

Conclusions

✚ This hospitals, in general, make marketing actions, and the most used are the evaluation of satisfaction of patients/caregivers.

✚ The administrators attribute a significant level of importance to the application of hospital marketing concepts.

✚ With reference to the existence or not of a structure responsible for hospital marketing, in the general group of hospitals, 27 (77.1%) answered that there is this structure. In relation to the hierarchy level of the person responsible for the marketing area, prevails, with 11 (35.5%) of hospitals of the general group, the management level. None of the hospitals with less than 100 beds have a marketing director our superintendent. In hospitals with more than 100 beds, 30.4 % have this type of executive.

✚ The hospitals of the general sample consider as extremely or very important audiences: patients and relatives (91.7% of hospitals), doctors (91.4%), collaborators (85.8%), health plans (82.9%) and community (74.6%).

✚ The most used media are the most simple and of lower cost: stationery (80.0% of hospitals), direct mail (65.7%), advertisements in magazines (65.7%), direct emails (62.9%) and advertisements in newspapers (54.3%).

✚ The hospitals studied were clearly divided in two groups, whose differentials are statistically significant:

1. Good infrastructure and equipment, with well defined policy of investment in marketing.

2. Worse infrastructure and less equipment, with lower proportional investment in marketing.

There is significant statistical correlation between the higher investment in marketing and the best infrastructure. To establish the cause-effect relation of this correlation could be an issue to be developed in one next work.

✚ Although they conceptually attribute a significant level of importance to the application of hospital marketing concepts, the hospitals studied apply this concept, in practice, in a restricted way, focusing the participation of the marketing area in issues basically linked to the release (advertising and publicity), communication and evaluation of public satisfaction. ❏

Eduardo Blay Leiderman Medicine, School of Medicine – Santa Casa of São Paulo. Postgraduate degree in Business Administration. MBA and Professional Master Degree in Economics and Health Management at Federal University of São Paulo (UNIFESP). Researcher of Center for Health Economics Paulista –CPES. Associate director of Assector – health care management consulting firm.

Jorge Luis Padovan – Economist graduated at University of São Paulo (USP). Master Degree in Human Nutrition (USP). PhD in Public Health at Escola Paulista de Medicina/Federal University of São Paulo (UNIFESP) – in course. Researcher of Center for Health Economics Paulista – CPES

Paola Zucchi – Medicine, Escola Paulista de Medicina/Federal University of São Paulo (UNIFESP). Deputy Director, Center for Health Economics Paulista – CPES. PhD in Public Health School of Public Health, University of São Paulo. Specialization in Hospital Administration from the School of Business Administration from Fundação Getulio Vargas

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Improving health workers' access to HIV and TB prevention, treatment, care and support services

SOPHIA KISTING
DIRECTOR, THE ILO PROGRAMME ON HIV/AIDS AND THE
WORLD OF WORK IN THE SOCIAL PROTECTION SECTOR

SUSAN WILBURN
BSN, MPH, TECHNICAL OFFICER IN OCCUPATIONAL & ENVIRON-
MENTAL HEALTH AT THE WORLD HEALTH ORGANIZATION

MYROSLAVA PROTSIV
TECHNICAL OFFICER, HEALTH SERVICES AT SECTORAL
ACTIVITIES DEPARTMENT AT INTERNATIONAL LABOUR
ORGANIZATION

LEE-NAH HSU
TECHNICAL SPECIALIST, THE PROGRAMME ON HIV/AIDS AND
THE WORLD OF WORK OF THE INTERNATIONAL LABOUR
ORGANIZATION

ABSTRACT: The International Labour Organization (ILO) and the World Health Organization (WHO) jointly developed policy guidelines for improving health workers' access to HIV and TB prevention, treatment, care and support services. These 14-point policy guidelines support the key principles of the International Labour Standard concerning HIV and AIDS in the world of work adopted in 2010.   The joint guidelines cover issues on workers' rights, national legislation and social protection of health workers. In addition, the guidelines provide framework for workplace policies, programmes, and training. To ensure proper implementation, the guidelines also addressed issues of budget, monitoring and evaluation. Turning these policy guidelines into effective practice would require advocacy to both the health and labour sectors, as well as the recognition of the important roles of health workers, employers of health services, and that of the Ministries of Health and Ministries of Labour.

The health sector has a vital responsibility in helping realize people's fundamental rights to health. The health services employers and management must protect the health and rights of their own workers in order to ensure the public could benefit from optimal health services.

Many countries are currently facing a severe shortage in their health workforce. Increasing workloads of the personnel in healthcare facilities and resource-constrained working conditions lead to great challenges in recruitment and retention of qualified health workers. This situation is further aggravated in countries that are particularly affected by dual epidemics of Human immunodeficiency virus and Tuberculosis. The high rate of HIV-TB co-infection in these countries drives an increasing demand on health services. It also increases the HIV and TB burden on health workers who are particularly exposed to both infections on a daily basis in their work environment.

Although health workers are at the frontline of responding to HIV and TB care needs of people, they have to deal with their own fears of contracting both HIV and TB because of their work exposures. The situation is aggravated by the fact that health workers themselves often do not have adequate access to HIV and TB services. They face stigma and discrimination as well as loss of their employment, in the events they become infected.

In response to this situation, the ILO and WHO jointly developed a 14-point HIV-TB policy guidelines on how to ensure the access of all health workers to HIV and TB prevention, treatment, care and support services.

The guidelines have a solid base of evidence resulting from systematic literature reviews, studies of current practices in 21 countries, and international expert consultations organised by both the WHO and ILO.

FIGURE 1: COLLABORATION BETWEEN WHO AND ILO ON PROTECTING HEALTH WORKERS FROM OCCUPATIONAL EXPOSURE TO BIOLOGICAL HAZARDS

WHO/ILO Global Framework for National Occupational Health Programmes for Health Workers

Biological Hazards

Joint ILO/WHO guidelines on health services and HIV and AIDS, 2005

Joint WHO/ILO guidelines on post-exposure prophylaxis (PEP) to prevent HIV infection, 2008

Recommendation 200: Concerning HIV and AIDS and the World of Work, 2010

New Joint WHO-ILO policy guidelines on improving health worker access to HIV and TB prevention, treatment, care and support services
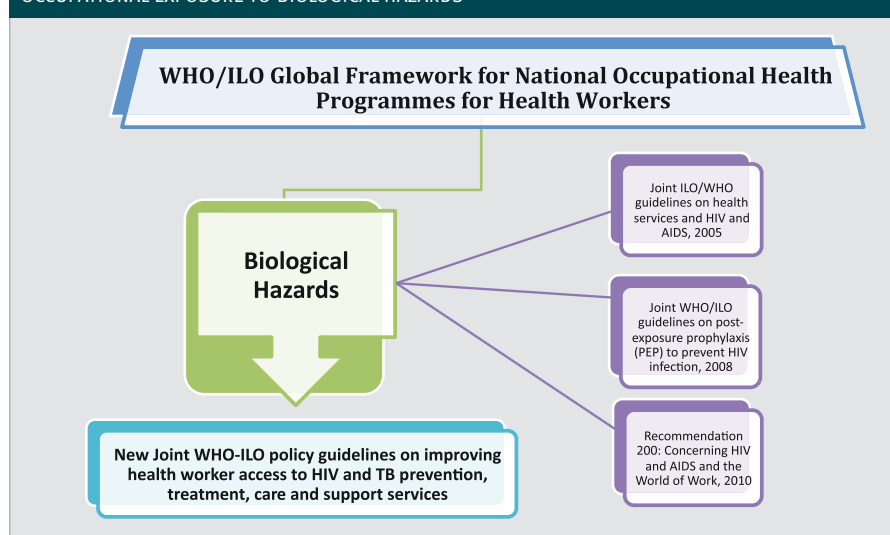
Table 1: The 14-point joint policy guidelines

Strengthening national policies, laws and strategies through TREAT

Introduce new or refine existing national policies that ensure priority access for health workers and their families to services for the prevention, treatment and care for HIV and TB.

Introduce new or reinforce existing policies that prevent discrimination against health workers with HIV or TB, and adopt interventions aimed at stigma reduction among colleagues and supervisors.

Establish schemes for reasonable accommodation and compensation, including, as appropriate, paid leave, early retirement benefits and death benefits in the event of occupationally-acquired disease.

Enhancing workplace policies, programmes and trainings

Develop, strengthen or expand existing basic occupational health services for the entire health workforce so that access to HIV and TB prevention, treatment and care can be realized.

Develop or strengthen existing infection control programmes, especially with respect to TB and HIV infection control, and collaborate with workplace health and safety programmes to ensure a safer work environment.

Develop, implement and extend programmes for regular, free, voluntary, and confidential counselling and testing of HIV, and TB screening, including addressing reproductive health issues, as well as intensified case finding in the families of health workers with TB.

Adapt and implement good practices in occupational health and the management of HIV and TB in the workplace from both public and private health care sectors, as well as other sectors.

Provide information on benefits and risks of post-exposure prophylaxis (PEP) to all staff and provide free and timely PEP for all exposed health workers, ensuring appropriate training of PEP providers.

Provide free HIV and TB treatment for health workers in need, facilitating the delivery of these services in a non-stigmatizing, gender-sensitive, confidential, and convenient setting when there is no staff clinic and/or their own facility does not offer ART, or where health workers prefer services off-site.

In the context of preventing co-morbidity, provide universal availability of a comprehensive package of prevention and care for all HIV positive health workers, including isoniazid prophylactic treatment and co-trimoxazole prophylaxis, with appropriate information on benefits and risks.

Develop and implement training programmes for all health workers: pre-service, in-service and continuing education on TB and HIV prevention, treatment and care; workers' rights and stigma reduction, integrating these into existing training programmes and including managers and worker representatives.

Budgeting, monitoring and evaluation

Establish and provide adequate financial resources for prevention, treatment, care and support programmes to prevent the occupational or non-occupational transmission of HIV and TB among health workers.

Develop and implement mechanisms for monitoring the availability of the guidelines at the national level, as well as the dissemination of these policies and their application in the healthcare setting.

Disseminate the policies related to these guidelines in the form of codes of practices and other accessible formats for application at the level of health facilities, and ensure provision of budgets for the training and material inputs to make them operational.

Table 2: How ILO and WHO work together to protect health worker

How ILO and WHO work together to protect health worker

ILO and WHO have a long-standing collaboration on HIV and AIDS responses, as co-sponsors of the UNAIDS and in occupational health.

In June 2004 the Governing Body of the ILO decided on conducting a joint tripartite meeting of experts with the WHO on HIV and AIDS in Health Sector and subsequently, in April 2005, the Joint ILO/WHO guidelines on health services and HIV and AIDS were adopted by the meeting. In September 2005, the WHO and ILO called together another joint tripartite expert consultation to develop a joint WHO/ILO guidelines on post-exposure prophylaxis to prevent HIV infection. This second joint guidelines was published in 2008.

In 2006, in response to the crisis in human resources for health, WHO, in collaboration with ILO, conducted a sequence of formal consultations with ILO constituents that includes representatives of workers, employers and governments, as well as other stakeholders and partners. The process of guidelines development also included a 21-country study on health workers' access to HIV and tuberculosis health services. This initiative originated from the Treat, Train and Retain (TREAT) strategy jointly launched by WHO, ILO and International Organization for Migration (IOM) in 2006 to support scale-up of HIV and AIDS services towards Universal Access and address the impact of HIV on the health workforce. In September 2009, an international WHO/ILO consultation on policy guidelines to improve health workers' access to prevention, treatment and care services for HIV and TB took place in Geneva. And in July 2010, a joint ILO-WHO tripartite expert consultation endorsed these policy guidelines.

The purpose of the guidelines is to give coherence to a compilation of existing clinical and policy guidelines to improve health workers' access to HIV and TB prevention, treatment, care and support services. Moreover, the new guidelines fill in the gaps of previous guidelines, for instance they address specifically need to protect health workers from contracting TB in the workplace and the need for TB infection control.

The target audience of the new policy guidelines are policy makers in the ministries of health and of labour; public and private health sector employers and senior management; occupational and infection control practitioners; all health workers, their associations or unions.

The joint guidelines cover:
- national frameworks including rights, other legislation and social protection schemes;
- workplace actions including policies, programmes and training;
- budget, monitoring and evaluation involving national and workplace coordination.

In line with the 2006 *WHO World Health Report*, the 2010 joint ILO-WHO guidelines are based on a broad definition of "health workers" which includes the providers of health services such as doctors, nurses, pharmacists, laboratory technicians, as well as management and support workers in healthcare settings such as finance officers, administrators, cooks, drivers, cleaners and security guards[1]. The policy guidelines cover health workers employed at all types of facilities, including acute-care, long-term care, community-based care, home-care and informal caregivers or providers of health services in other sectors.

The guidelines illustrate for the health sector the fundamental rights and principles contained in the ILO Recommendation concerning HIV and AIDS and the World of Work, 2010, No. 200, by promoting, among others:
- workers' rights;
- gender equity;
- the active participation of health workers, their representatives and health sector employers;

The guidelines aim to protect health workers and empower them to respond to the threat of HIV and TB infections. Implementing these guidelines could improve retention of health workers and prevent the loss of health workforce due to infection with HIV, TB or death.

The guidelines complement and reinforce guidelines previously developed by WHO and ILO on TB infection control[3] and HIV in the workplace[4,5], health-systems strengthening[6], post-exposure prophylaxis[7,8,5], clinical diagnoses and treatment for HIV and TB[10], reproductive health[11], and occupational health[12-14].

✚ the involvement of people living with HIV or TB;

✚ prevention;

✚ effectiveness and efficiency.

The joint policy guidelines have been agreed to by the tripartite constituents of ILO and approved by the *Guidelines Review Committee* of WHO. The guidelines were adopted by the Governing Body of the ILO in November 2010. They are officially launched as part of the World AIDS Day celebration 2010. WHO and ILO encourage all their global partners to disseminate and implement this set of guidelines. For instance, to incorporate the joint ILO-WHO policy guidelines for health workers into the International Hospital Federations' Positive Practice Environment campaign.

Sophia Kisting, MD is the Director of the ILO Programme on HIV/AIDS and the World of Work in the Social Protection Sector. She is an occupational medical specialist with extensive experience in workplace tripartite structure, occupational health and compensation issues. She has numerous publications. The Journal of Epidemiology and Community Health *recognized her as one of ten influential women internationally in occupational health and safety. kisting@ilo.org at ILO, Geneva, Switzerland*

Susan Wilburn, BSN, MPH is a technical officer in occupational & environmental health at the World Health Organization responsible for health worker occupational health and "greening" the health sector. Ms. Wilburn, the past coordinator of the Centre for Occupational & Environmental Health at the American Nurses Association, is the author of numerous articles on protecting health workers from occupational hazards. wilburns@who.int, at WHO, Geneva, Switzerland

Lee-Nah Hsu, DSc, JD is a technical specialist at the Programme on HIV/AIDS and the World of Work of the International Labour Organization responsible for health sector issues. She is a specialist in health systems strengthening and previously served on Technical Review Panel of the Global Fund to fight AIDS, TB and Malaria and GAVI health systems strengthening review committee. hsul@ilo.org, at ILO, Geneva, Switzerland

Myroslava Protsiv, BSW, MPH is a technical officer on health services at Sectoral Activities Department at International Labour Organization. A recent graduate of Global Health master programme at Karolinska Institute, she has practical and research experience in human resources for HIV prevention and AIDS control. g4sector@ilo.org at ILO, Geneva, Switzerland

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QUALITE ET CULTURE DE LA SANTE

Les services de santé ont pour cadre une culture de la maladie qui émane essentiellement de la biologie, et consistent à diagnostiquer, guérir et réadapter. Les problèmes de santé montrent que les efforts déployés et les progrès réalisés dans le domaine de la médecine ne suffisent pas. Perfectionner les actions au sein de cette même culture paraît inefficace. Des changements sont nécessaires pour créer une culture de la santé. Les caractéristiques et le potentiel du travail infirmier ouvrent des perspectives pour améliorer la qualité des soins, au cœur de la VIE.

TROUVER UN EQUILIBRE ENTRE INTERETS NATIONAUX ET BESOINS DES PATIENTS : DES PROJETS SANS FRONTIERES QUI FONT FACE AUX DEFIS EUROPEENS

Cet article est consacré aux nouvelles possibilités qui s'offrent aux citoyens des Etats-membres de l'UE d'aller à l'étranger pour un traitement médical. La Court de Justice européenne a facilité l'accès aux traitements médicaux dans d'autres Etats-membres par les citoyens de l'UE. Cette mesure inquiète les gouvernements nationaux qui craignent de perdre le contrôle de leurs systèmes de santé. Le projet inter-frontières "Healthacross" entre l'Autriche et la République Tchèque démontre néanmoins comment les autorités peuvent répondre aux besoins des patients dans deux pays différents. Toutefois, il faudra résoudre une pléthore de problèmes pratiques ou administratifs pour permettre une coopération internationale pour la délivrance de soins de santé.

LES SOINS CENTRES SUR LE PATIENT : BIEN PLUS QUE LA SOMME DES PARTIES - PROGRAMME PLANETREE DE DESIGNATION DES HOPITAUX CENTRES SUR LES PATIENTS

Bon nombre d'hôpitaux aspirent à être mieux centrés sur les patients, maintenant que ce concept commence à attirer l'attention, notamment sous l'aspect d'un sondage de consommateurs disponible au public et une législation nationale de réforme des soins de santé comportant des incitations financières. Dans son programme de désignation, l'objectif de Planetree est de faire des soins centrés sur le patient une notion moins ambiguë et un objectif plus accessible. Le programme de désignation fournit un cadre d'évaluation des systèmes et procédures d'un hôpital, basé sur les trois décennies de recherche de Planetree, et plus particulièrement sur les données réunies auprès des panels de consommateurs. En partant de ces perspectives, Planetree a défini 50 critères en 11 catégories.

CONCEPTION HOSPITALIERE PRE- ET POST-SOVIETIQUE EN UKRAINE ET EN MOLDAVIE

Cet article examine le développement de la conception hospitalière post-soviétique par une analyse de récentes modernisations en Moldavie et en Ukraine. Il se compose de deux parties. D'abord, je rappelle la définition de la conception hospitalière et de ses caractéristiques principales sous le régime soviétique. Ensuite, je présente deux exemples de modernisations d'hôpitaux en Ukraine et en Moldavie. Aux fins de comparaison, je présente les acteurs de ces changements, les difficultés de modernisation d'un hôpital dues aux règlementations léguées par les gouvernements antérieurs, ainsi que les solutions proposées pour instaurer les changements. Une introduction à la conception hospitalière en Moldavie et en Ukraine permettra de mener une étude approfondie sur l'implication des acteurs internationaux dans les transformations post-communistes.

FACILITER L'ACCES DES AGENTS DE SANTE AUX SERVICES DE PREVENTION, TRAITEMENT, SOINS ET SOUTIEN CONTRE LE VIH ET LA TUBERCULOSE

L'Organisation internationale du travail (OIT) et l'Organisation mondiale de la santé (OMS) ont élaboré ensemble des lignes directrices destinées à faciliter l'accès des agents de santé aux services de prévention, de traitements, de soins et de soutien contre le VIH et la tuberculose. Ces directives en 14 points s'appuient les principes de base des Normes Internationales du Travail relatives au VIH et au sida dans le monde du travail adoptées en 2010. Ces directives communes portent sur des questions de droit des travailleurs, de législations nationales et de protection sociale des agents de santé. En outre, les directives définissent le cadre des politiques, programmes et formations sur les lieux de travail. Pour assurer une mise en œuvre correcte, les directives examinent également les questions de budget, de suivi et d'évaluation. L'application de ces directives dans le quotidien nécessitera de plaidoyer dans les secteurs de la santé et du travail, et la reconnaissance des rôles importants des agents de santé, du patronat de services de santé et des ministères de la santé et du travail.

PREPARATIONS AUX SITUATIONS D'URGENCE, GESTION DES CRISES ET CAPACITE OPERATIONNELLE : LES HOPITAUX PUBLIQUES D'IRAN

Les situations d'urgence qui se sont déclarés au cours des dernières décennies montrent que l'état de préparation des organisations permettant de prévoir et de répondre aux catastrophes est directement proportionnel à leur niveau de capacité et de préparation à la gestion des crises. A cet égard, par rapport à d'autres organisations, les hôpitaux sont mieux armés pour faire face à une catastrophe. Cette étude examine les capacités opérationnelle d'hôpitaux publics et leur capacité de réponse aux situations d'urgence possibles. Les réponses des directeurs et gestionnaires d'hôpitaux montrent que la plupart d'entre eux ne sont pas familiarisés avec la gestion des crises, bien que la plupart d'entre eux aient déclaré qu'ils avaient un plan et un comité de gestion des urgences dans leur hôpital. Par

ailleurs, la plupart des interviewés pensaient qu'en cas de crise au sein de l'hôpital, les patients, le personnel et les documents seraient les premières victimes de la crise. L'étude montre également qu'avoir un plan et un comité de crise sans bien connaître la gestion des crises ne sera d'aucune utilité pour aider les gestionnaires à faire face aux situations d'urgence. Par ailleurs, les corrélations montrent que les gestionnaires plus âgés connaissent mieux les expériences de gestion de crise hors de leur pays, et que des responsabilités bien définies facilitent la mise sur pied de comités de crises, et la capacité de prendre au sérieux les situations d'urgence.

Rencontre de la télémedicine, des dossiers cliniques électroniques et des échanges d'informations médicales. Des initiatives pour les communautés rurales

La rencontre de diverses innovations a conduit à des changements radicaux du système de santé américain et la convergence de la télé-santé, des dossiers cliniques électroniques et des échanges d'informations médicales.

Cet article examine les nouvelles tendances et les difficultés récemment rencontrées ainsi que les opportunités qu'elles présentent en termes de progrès des solutions médicales basées sur les télécommunications et les infrastructures de haut débit rendues disponibles par les réseaux de télémédecine. Il examine également de façon approfondie les diverses applications de la télé-santé et les modèles de services de télémédicine les plus courants, ainsi que le rôle du réseau télémédical et des Centres de Ressources Télémédicales (Telehealth Resource Centers,TRC) dans le développement de ces initiatives cruciales et de leurs possibilités d'accès pour les communautés isolées. Il s'appuie notamment sur l'exemple du REACH Montana Telehealth Network.

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Resumen en Espanol

LA CALIDAD Y LA CULTURA EN MATERIA DE SALUD

Los cuidados de salud tienen como marco una cultura de enfermedades que se basan principalmente en la biología y que sirven para: diagnosticar, curar, prevenir y rehabilitar. Los problemas de la salud ponen de relieve que ni los esfuerzos ni los grandes adelantos de la medicina son suficientes. El mejorar las medidas dentro de esta misma cultura no parece dar resultado alguno, es necesario introducir una reforma con el fin de crear una cultura en materia de salud. Las características de la labor del personal de enfermería y su potencial abren nuevas oportunidades para mejorar la calidad de los cuidados de salud, teniendo por centro la VIDA.

COMO LOGRAR UN EQUILIBRIO ENTRE LOS INTERESES NACIONALES Y LAS NECESIDADES DEL PACIENTE: PROYECTOS TRANSFRONTERIZOS QUE HACEN FRENTE A LOS RETOS EUROPEOS

Este artículo trata de las nuevas oportunidades para los ciudadanos de los estados miembros europeos para trasladarse a otro país con el fin de recibir tratamiento médico. El Tribunal de Justicia Europeo ha facilitado el acceso al tratamiento médico para los ciudadanos de un estado europeo en otro de la misma Unión. Esta norma es motivo de preocupación entre los distintos gobiernos puesto que temen que representará una reducción del control que ejercen sobre su propio sistema de salud. El proyecto transfronterizo denominado "healthacross" (salud en todas partes) entre Austria y la República Checa es un ejemplo de la manera en la que las autoridades pueden responder a las necesidades del paciente en dos países distintos. No obstante, hay toda una serie de problemas de carácter administrativo y práctico que solucionar para este proyecto transfronterizo de cooperación en la prestación

de la salud funcione.

ASISTENCIA CENTRADA EN EL PACIENTE: ALGO MAS QUE LA SUMA DE TODAS SUS PARTES – EL PROGRAMA PLANETREE PARA DESIGNAR A UN HOSPITAL COMO ESTABLECIMIENTO CENTRADO EN EL PACIENTE

Conforme el concepto de la asistencia centrada en el paciente recibe mayor atención, hay numerosos hospitales que aspiran a adoptar este sistema, especialmente en lo que respecta a una encuesta de mercado disponible públicamente y a la legislación sobre las reformas de la seguridad social, además de los incentivos financieros. El objetivo del programa Planetree, destinado a nombrar a un hospital como establecimiento centrado en el paciente, consiste en conseguir que el concepto deje de ser tan ambiguo y pase a convertirse en un objetivo más fácil de conseguir. Este programa sirve de marco para evaluar los sistemas y procedimientos de los hospitales y se trata de un proyecto basado en las tres décadas que Planetree lleva dedicado a esta labor y especialmente a la información recopilada entre una serie de grupos específicos. Haciendo uso de estas perspectivas, Planetree formuló 50 criterios dentro de 11 categorías.

TRANSFERENCIA INSTITUCIONAL DE LAS PRACTICAS EUROPEAS A UCRANIA Y MOLDAVIA: EL CASO DEL DISEÑO HOSPITALARIO

Este artículo examina el curso del diseño hospitalario en la época postsoviética mediante un análisis de la reciente modernización de Moldavia y Ucrania. El informe consta de dos partes. En primer lugar, una definición del diseño hospitalario y sus principales características durante la época soviética. En segundo, el ejemplo de dos modernizaciones hospitalarias en Ucrania y Moldavia.

Dentro de una perspectiva comparativa, hago una presentación de los actores implicados en el caso, las dificultades en cuanto a la modernización del hospital en lo que respecta al reglamento anterior, así como las soluciones avanzadas con el fin de poner en práctica ese cambio. Una introducción al diseño hospitalario en Moldavia y Ucrania permitirá llevar a cabo un estudio a fondo de la implicación de actores internacionales en las transformaciones postcomunistas.

COMO MEJORAR EL ACCESO DEL PERSONAL SANITARIO A LA PREVENCION, EL TRATAMIENTO, LOS CUIDADOS Y LOS SERVICIOS DE APOYO DEL VIH Y LA TUBERCULOSIS

La Organización Internacional del Trabajo (OIT) y la Organización Mundial de la Salud (OMS), han redactado conjuntamente una serie de normas de política con miras a mejorar el acceso del personal sanitario a la prevención, el tratamiento, los cuidados y los servicios de apoyo del VIH y la tuberculosis. Se trata de 14 normas de apoyo a los principios más destacados de las Pautas de la Organización Internacional en cuanto al VIH y el SIDA, en la esfera laboral, adoptadas en 2010. Estas normas conjuntas comprenden asuntos relativos a los derechos de los empleados, la legislación nacional y la protección social del personal sanitario. Por otro lado, las pautas constituyen un marco para las políticas, programas y formación en el lugar de trabajo. Con el fin de garantizar una puesta en práctica adecuada, las normas tratan además otras cuestiones relacionadas con los presupuestos, el seguimiento y la evaluación. Para convertir estas normas en una práctica eficaz se requiere el apoyo, tanto hacia la esfera de la salud como la laboral, además del reconocimiento del papel tan importante que desempeñan los empleados de la salud, el personal de los servicios sanitarios en general y el de los Ministerios de Sanidad y Trabajo.

CONTROL DE EMERGENCIAS, APTITUDES Y ESTADO DE PREPARACION: EL CASO DE LOS HOSPITALES PUBLICOS DE IRAN

Los desastres ocurridos en las últimas décadas indican que el estado de preparación de las organizaciones para predecir y reaccionar ante ciertos problemas inesperados está directamente relacionado con el nivel de sus aptitudes y el estado de preparación para controlar las emergencias. En este sentido, en comparación con otras organizaciones, son los hospitales los que pueden sufrir más daños cuando se produce un desastre. Este informe investiga el nivel de aptitudes y estado de preparación de los hospitales públicos para manejar los desastres. De las respuestas de los gerentes y directores de los hospitales se desprende que si bien muchos de ellos no están familiarizados con el control de emergencias, la gran mayoría admiten que sus hospitales cuentan con un programa y un comité para el control de emergencias. Lo que es más, la mayoría de los cuestionados opinan que en el caso de ocurrir un desastre en el hospital, los pacientes, el personal y los documentos serían los primeros en sufrir las consecuencias. Los resultados del informe demuestran además que el contar con un programa de emergencias o un comité de crisis sin estar familiarizado con conocimientos para el control de emergencias no ayuda a los gerentes a hacer frente a una situación de crisis. Además, la correlación demuestra que los gerentes con más experiencia están más familiarizados con experiencias sobre el control de emergencias en el extranjero y destacan que las responsabilidades contribuyen para el establecimiento de los comités de crisis y para tomar las situaciones de crisis con mayor seriedad.?

LA ENCRUCIJADA DE LA TELE-SALUD, LAS HISTORIAS CLINICAS ELECTRONICAS Y EL INTERCAMBIO DE INFORMACION SANITARIA. LA PLANIFICACION DE LAS COMUNIDADES RURALES

Hay una serie de circunstancias que está dando lugar a una reforma radical del sistema de salud de los Estados Unidos y produciendo una convergencia de tele-salud, historias clínicas electrónicas (en inglés EHRs) e intercambio de información sanitaria (en inglés HIE).

Este artículo examina las tendencias emergentes, así como los aspectos perjudiciales y estudia las oportunidades que ofrecen para el avance de las soluciones sanitarias basadas en las telecomunicaciones y la infraestructura de banda ancha disponible a través de las redes de tele-salud. También hace un examen minucioso de los distintos usos de la tele-salud y los ejemplos más corrientes de prestación de la tele-medicina, así como el papel que desempeña el sistema de la tele-salud y los Centros de Recursos Tele-sanitarios (en inglés TRCs) para ampliar el alcance de estas iniciativas tan importantes. El informe pone de relieve la Red tele-sanitaria REACH Montana.

Company profiles

ARAMARK

is a global leader in professional services, providing award-winning food services, management of facilities, assets, and clinical technology, and uniform/career apparel to health care institutions and other businesses. In FORTUNE magazine's 2010 list of "World's Most Admired Companies," ARAMARK ranks number one in its industry, consistently ranking since 1998 as one of the top three most admired companies in its industry. ARAMARK seeks to responsibly address key issues by focusing on employee advocacy, environmental stewardship, health and wellness, and community involvement. Headquartered in Philadelphia, Pennsylvania (USA), ARAMARK's 255,000 employees serve clients in 22 countries.
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The success of this innovative business model has led to Bionexo for Latin America and Europe, where also attained leadership in addition to export technology and implement a new concept in commercial transactions of organizations. Everything happened in a short time, just like businesses are made between the companies that integrate our platforms. This makes Bionexo the largest core of the hospital sector in Brazil. Pioneering and innovation, helping thousands of companies and hospitals.
www.bionexo.com.br

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is the world leader in GIS technology. On any given day, more than one million people around the world use ESRI geographic information system (GIS) software to improve the way their organizations conduct business. ESRI GIS solutions are becoming an integral component of health organizations in addition to nearly every other type of business and government service.
By adding a geographic component to data and analysis, ESRI software promotes exploring, analyzing and visualizing massive amounts of information according to spatial relationships. Since most health and human service problems facing the world today exist in a location-based context, geography can play a major role in helping health professionals understand health dynamics and the spread of disease. Health surveillance systems are used to gather, integrate and analyze health data; interpret disease transmission and spread; and monitor the capabilities of health systems. GIS is the enabling technology to spatially relate much of the information, making it a powerful tool for identifying, tracking and responding to disease patterns and health service needs.
 ESRI software is extensively used by health organizations throughout the world, including the US Centers for Disease Control and Prevention (CDC), the World Health Organization (WHO), 112 national health ministries, and over 500 hospitals.
www.esri.com/health

HCA
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owns the Capital's six leading private hospitals all based in central London and each with an international reputation for the highest standards of care. They are: The Wellington – the largest private hospital in Europe, The London Bridge Hospital, The Harley Street Clinic, The Portland Hospital for Women and Children, The Lister Hospital and The Princess Grace Hospital. HCA also has four outpatient and diagnostic centres – soon to be six – a blood and bone cancer treatment joint venture with the NHS at University College Hospital, The London Gamma Knife Centre, another joint venture with the NHS at St Bartholomew's Hospital and Harley Street at Queen's, a private patient cancer centre at the NHS Queen's Hospital in Romford.

The six HCA hospitals treat around 300,000 patients per year. They also specialise in the most complex medical procedures including cardiac care, liver transplantation, inter cranial surgery and complex cancer care. The HCA CancerCare network, for example, is the largest provider of cancer care in the UK outside the NHS. Uniquely, HCA has its own clinical trials unit based in Harley Street in central London. Medical teams in HCA are involved in research programmes aimed at finding new treatments in areas such as heart disease and cancer. In recent years HCA has invested around £250 million in capital expenditure including new diagnostic and treatment technology. As an example, HCA has recently installed at The Harley Street Clinic, the revolutionary CyberKnife robotic radiotherapy machine, which is able to target previously untreatable tumours. It is the first machine of its kind in the UK.
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As the Inter-national division of Joint Commission Resources, Joint Commission International (JCI) has been working with health care organizations, ministries of health, and global organizations in over 80 countries since 1994.

Our focus is on improving the safety of patient care through the provision of accreditation and certification services as well as through advisory and educational services aimed at helping organizations implement practical and sustainable solutions.

In fact, the world's first World Health Organization (WHO) Collaborating Centre, dedicated exclusively to patient safety solutions, is a joint partnership between the WHO, The Joint Commission, and JCI. We recently celebrated our tenth anniversary of the first hospital accredited by JCI, Hospital Israelita Albert Einstein, a private, non-profit, non-governmental facility in Sao Paulo, Brazil. Since then, more than 300 public and private health care organizations in 39 countries have been accredited by JCI. JCI provides accreditation for hospitals, ambulatory care facilities, clinical laboratories, care continuum services, medical transport organizations, and primary care services, as well as certification for disease or condition specific care. JCI Consulting provides education and advisory services to health care organizations, ministries of health, accrediting bodies, and other entities outside of the United States. We provide practical solutions to help develop clinical services, improve the quality of care, enhance patient safety, reduce and manage risk, and achieve international standards. JCI currently has regional offices serving Asia Pacific, Europe and the Middle East.
www.jointcommissioninternational.org

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

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

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THE EXECUTIVE COMMITTEE

President
Dr JOSE CARLOS DE SOUZA ABRAHAO
President
CONFEDERACAO NACIONAL DE SAUDE (CNS)
SRTVIS Quadra 701, Conjunto E
Edificio Palacio do Radio 1
Brasilia DF, CEP 70340-906
BRAZIL
Tel: +55 61 3321 0240
Fax: +55 61 3321 0250
Email: cns@cns.org.br

President-Designate
Mr THOMAS C DOLAN
CEO
AMERICAN COLLEGE OF HEALTHCARE EXECUTIVES
One North Franklin Street
Suite 1700
Chicago, Illinois 60606-3491
UNITED STATES OF AMERICA
Tel: +1 312 424 9365
Fax: +1 312 424 0023
E-mail: tdolan@ache.org

Immediate Past Presidents
Dr IBRAHIM A AL ABDULHADI
Assistant Undersecretary for Health Insurance Affairs
MINISTRY OF HEALTH
State of Kuwait
PO Box 5, PIN Code 13001
KUWAIT
Tel: +965 2486 5415 / 3699
Fax: +965 2486 3524
E-mail: drhadi@moh.gov.kw

Mr GERARD VINCENT
Délégué Général
FEDERATION HOSPITALIERE DE FRANCE
1 bis Rue Cabanis
75014 Paris
FRANCE
Tel: +33 1 44 06 84 42 / 44
Fax: +331 44 06 84 45
E-mail: g.vincent@fhf.fr / l.maute@fhf.fr

Treasurer
Dr LEKE PITAN
Former Commissioner for Health – Lagos State
House G40C, Road 2
Victoria Garden City, Lagos
NIGERIA
Tel: +234 1 775 4544 / +234 803 7787834 / +44 7785 764 692
 Email: drlekepitan@yahoo.com

Dr JUAN CARLOS LINARES
Director
CAMARA ARGENTINA DE EMPRESAS DE SALUD (CAES)
Tucuman 1668, 2 Piso
Buenos Aires C.P. 1050
ARGENTINA
Tel: +54 11 4372 5915 / 5762
Fax: +54 11 4372 3229
Email: linaresjcarlos@yahoo.com.ar

Prof HELEN LAPSLEY
Research Professor
CENTRE OF NATIONAL RESEARCH ON DISABILITY & REHABILITATION MEDICINE
University of Queensland
3 Keston Avenue
Mosman, Sydney NSW 2088
AUSTRALIA
Tel: +612 99 692 346
Fax: +612 99 684 987
Email: cliveh@ip.net.au

Prof GUY DURANT
Administrateur général
CLINIQUES UNIVERSITAIRES SAINT-LUC
Avenue Hippocrate 10
B - 1200 Bruxelles
BELGIUM
Tel: +32 2 764 15 22
Fax: +32 2 764 15 25
Email: durant@hosp.ucl.ac.be

Dr GEORG BAUM
Chief Executive
GERMAN HOSPITAL FEDERATION
Wegelystrasse 3
10623 Berlin
GERMANY
Tel: +49 30 398 011 001
Fax:+4930 398 013 011
Email: g.baum@dkgev.de

Dr LAWRENCE LAI
Senior Advisor
HONG KONG HOSPITAL AUTHORITY
Room 1003, Administration Block
Queen Mary Hospital
102 Pokfulam Road
HONG KONG (SAR)
Tel: +852 2255 3253
Fax: +852 2504 2784
E-mail: laifm@ha.org.hk

Dr MUKI REKSOPRODJO
International Relations
INDONESIAN HOSPITAL ASSOCIATION (IHA) -
PERHIMPUNAN RUMAH SAKIT SELURUH INDONESIA (PERSI)
c/o Jl.H.R.Rasuna Said Kav.C-21
Kuningan Jakarta Selatan 12940
INDONESIA
Tel: +6221 72791383
Fax: +6221 7252026
Email: reksoprodjo7muki@gmail.com

Dr TSUNEO SAKAI
President
JAPAN HOSPITAL ASSOCIATION
13-3 Ichibancho, Chiyodaku, Tokyo
JAPAN
Tel: +813 32 650 077
Fax: +813 32 38 6789
Email: ouchi@hospital.or.jp

Dr TAI-CHUN YOO
President
KOREAN HOSPITAL ASSOCIATION
35-1, Mapo-Dong, Mapo-Gu, Seoul
KOREA
Tel: +822 718 754 Ext 183
Fax: +822 718 7522
Email: intlaffairs@kha.or.kr

Dr ERIK KREYBERG NORMANN
Project Director
Department of Hospital Services
NORWEGIAN DIRECTORATE OF HEALTH
P.O.Box 7000 St. Olavs plass, N-0130
OSLO, NORWAY
Tel: +47 24 163 000 / 47 24 163 201
 Fax: +47 22 22 66 88
Email: erik.normann@helsedir.no

Prof CARLOS PEREIRA ALVES
Vice Chair
ASSOCIACAO PORTUGUESA PARA O DESENVOLVIMENTO HOSPITALAR
(Portuguese Association for the Hospital Development)
Av. António Augusto de Aguiar, 32-4º
1050-016 Lisboa
PORTUGAL
Tel: +351 217 92 5 823 / 5666
Mob: +351 963 668 745
Fax: +351 217 925 594
Email: apdh.mail@gmail.com

Dr THABO LEKALAKALA
Director - Hospital Management and Planning
DEPARTMENT OF HEALTH
Street Hallmark Building
231 Proes Street
001 Pretoria
SOUTH AFRICA
Tel: +27 12 312 0930
Fax: +27 12 312 3388
Email: thabang.lekalakala@gmail.com

Dr DELON WU
President
TAIWAN HOSPITAL ASSOCIATION
25F, No29-5
Sec. 2, Jung jeng E. Road
Danshuei Township, Taipei County
TAIWAN
Tel: +886 22 808 3300
Fax: +886 22 808 3304
Email: hatw@hatw.org.tw

Mrs ALISON KANTARAMA
President
UGANDA NATIONAL ASSOCIATION OF HOSPITAL ADMINISTRATORS (UNAHA)
Mulago Hospital
PO Box 7051, Kampala
UGANDA
Tel: +256 414 554 748
Fax: +256 414 532 591
Email: alisonkantarama@yahoo.com

Mr ABDUL SALAM AL-MADANI
President
INDEX HOLDING
Dubai Healthcare City
Block B, Offices 203 – 303
P.O.Box 13636, Dubai
UNITED ARAB EMIRATES
Tel: +97 14 362 4717
Fax: +97 14 362 4718
Email: index@emirates.net.ae

SIR KEITH PEARSON
Chairman
NHS CONFEDERATION
29, Bressenden Place
London SW1E 5DD
UNITED KINGDOM
Tel: +44 (0) 207 074 3200
Fax: +44 (0) 844 774 4319
Email: keith.pearson@nhsconfed.org

Dates for your diary

2011

Switzerland
November – H+ Les Hôpitaux de Suisse
National Association congress
Bern, Switzerland
Tel: +41 (0) 31 335 11 33
reinhard.voegele@hplus.ch
www.hplus.ch / http://www.ihf-fih.org

8-10 November 2011
Dubai, Unites Arab Emirates
37th IHF World Hospital Congress*
info@ihf-fih.org
http://www.ihfdubai.ae/ http://www.ihf-fih.org

Events marked* are interpreted into English, French and Spanish. All other events will be in English/host country language only. IHF members will automatically receive brochures and registration forms on all the above events approximately 6 months before the start date. IHF members will be entitled to a discount on IHF Congresses, pan-regional conferences and field study courses.

For further details contact the: *International Hospital Federation*, Immeuble JB Say, 13 Chemin du Levant, 01210 Ferney Voltaire, France; E-Mail: info@ihf-fih.org
Or visit the IHF website: http://www.ihf-fih.org
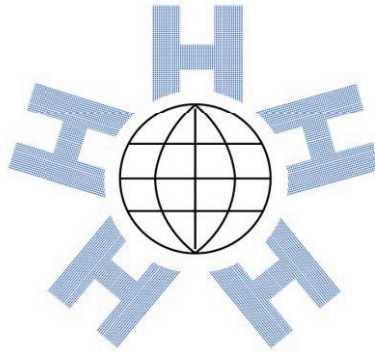
Corporate Partnership Program

Supporting collaboration, ideas and innovation
in global healthcare

What Is the Corporate Partnership Program?

An opportunity offered to major corporations who seek to join with IHF members to work to improve hospital performance around the world. The Program is run by World Hospital (WH), a company owned by the International Hospital Federation (IHF) and dedicated to supporting IHF goals through collaborative events and publications.

The program is open to a limited number of corporations that are fully engaged in the global health sector and have a good reputation as providers.

Benefits include:

- Year-long access to decision makers from around the world.
- Exclusive opportunity for relationship building and sharing ideas and experiences between corporate leaders and executives in the hospital sector.
- Access to IHF policy and advocacy communications
- Interaction with actual and potential clients through a "one-stop shop" approach.
- Advertising and marketing opportunities

Corporate Partnership Package

Please contact Sheila Anazonwu (sheila@ihf-fih.org) at the **IHF Secretariat** for more details and a corporate package information

It's All About Hospitals !

DUBAI
IHF 2011
37th World Hospital Congress

"Healthcare in a Changing World : Overcoming the Challenges"

8 - 10 November 2011 — DATE

ATLANTIS The Palm, Dubai — VENUE

World class exhibits await all visitors — EXHIBITION

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