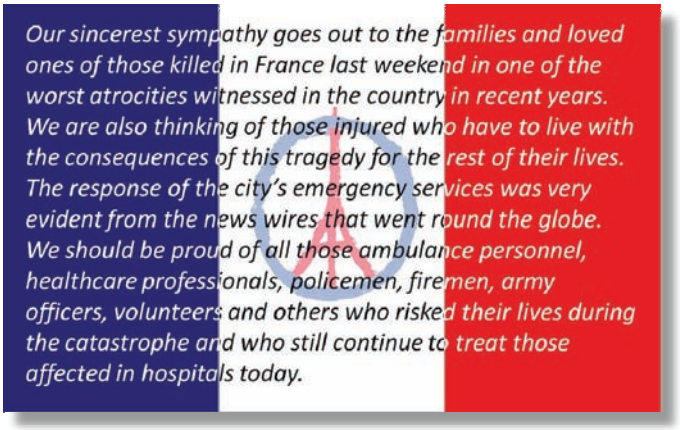
ASSOCIATION EUROPÉENNE DES DIRECTEURS D'HÔPITAUX
EUROPÄISCHE VEREINIGUNG DER KRANKENHAUSDIREKTOREN
EUROPEAN ASSOCIATION OF HOSPITAL MANAGERS

Presidential Letter

18 November 2015

Gerard O'Dwyer
President of the EAHM



The OECD data on health spending make difficult reading for hospital managers. Resources will remain tight at a time when demand for services is inexorably rising and the cost of providing each of those services is increasing. The data indicates that actual spending in 2013 is less, in real terms, than in 2009.

According to the OECD data, the rate of growth of health spending in EU countries has been in continuous decline since 2001. That is, in a century when it is widely acknowledged that healthcare will consume more and more of GDP of national economies, resources are not being made available. Managers will continue to struggle to try to balance supply and demand for the foreseeable future.

Managers in the health services are at the front-line of the challenges this dynamic brings about. Balancing the service demands against available resources is a key function of management. However a further look at data provides an interesting insight into why managers may appear not to have performed as well as their clinical peers.

Managers in the health services are at the front-line of many challenges

The most recent financial crisis has resulted in a long lasting and widely impacting economic and social crisis. In some European countries the spotlight has focused on the immediate buoyancy of the economy, but the side effects all impact on the health sector.
The economic crisis has resulted in an increase in poverty, housing problems, alcohol related issues, a rise in unemployment rates, increase in mental ill health and suicide.

There has been a double impact on health systems as an increased demand on health services coincides with cuts made to government health budgets. The demand drivers are well known and include the changing demographics of Europe. Europe's population will undergo dramatic demographic changes as the percentage of people aged 65 or over is projected to double in the next 50 years. Chronic disease management initiatives and the availability of new therapies and services will continue to drive demand and cost. Medical cost inflation continues to rise and will be driven by the demand-capacity dynamic.

It is evident from previous economic crisis in the 90s that countries that invested in health and health services performed better that those that reduced investment and prevented wider health inequalities and associated social and health problems. In contrast the private health sector continued investment while the public sector opts to cut costs as the only solution to the crisis. This approach can be viewed as a short term fix making little sense in the longer term and has a negative impact on innovation, business continuity and sustainability.

The increasing demand and the reduction in resources have resulted in a reduction in the numbers of nurses across Europe leading to concerns about quality of care and patient safety. As a result of pay cuts and salary freezes workforce attrition and recruitment remains challenging.

In addition to the financial, capacity and workforce challenges unexpected events arise that managers will have to deal with.

The influx of migrants is one such event. It was not on any agenda three years ago yet it is one challenge that Europe cannot fail on. It is not just the number of people involved with up to a million new residents expected to settle in Germany alone. As migrants from war ravaged regions, a high percentage of migrants will have medical and psychological conditions which the health services throughout Europe must reach out to support in a coordinated and equal manner.

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Other unforeseeable events in the changing societal landscape pose significant challenges to our health care systems including; outbreaks of infectious diseases (Ebola), natural disasters and terrorism threats.

The EAHM must continue to look to the future. Managers must seek to explore options and solutions to improve access, build capacity and improve quality through partnership and engagement with broad ranging providers.

The EAHM must continue to work with our international partners and agencies to benchmark our systems with evidence based best practice. We must continue to be key players in participating and driving system reform and ensure continuous assessment of system performance to build sustainability and quality services.

We must foster innovation, support and enable research and development and ensure Academic Partnership.

It is critical that we have an opportunity to input and influence European Legislation and Directives and that our contributions are heard and included by the European Commission and Parliament. It is important that members give feedback on Directives and Legislation that are being developed including the current Cross Border Legislation. In parallel it is our responsibility to understand, communicate and ensure system compliance with European Legislation and Directives.

We have an important role in establishing the healthcare manager as a professional on an equal standing with our clinical counterparts. Our work with the IHF in developing an internationally accepted competency framework for healthcare managers is an important initiative in this regard. The preamble to the framework makes the point that the science of medicine is thousands of years old and that relatively speaking management sciences is still in its infancy.

The framework, known as "Leadership Competencies for Health Services Managers" demonstrates the broad and deep level of know-how and skills required by managers in the health services. It covers five important competency areas: Leadership; Communication and Relationship Management; Professional and Social Responsibility; Health and Healthcare environment; and, Business. The latter refers to the ability to apply business principles, including systems thinking to the healthcare environment. Having developed and adopted the framework, there is a need to have it accepted by key stakeholders and to integrate the framework into our management and development processes.

We are now looking forward to two significant events, the first one in Dusseldorf titled 'Third Joint European Hospital Conference" on 19th November 2015 and the second one our European Congress in Bologna in Italy from the 12th to 14th October 2016. The Italian conference committee have proven their mettle in planning what promises to be a most informative and enjoyable event.

Finally, at the end of my first full year as President, I would like to congratulate the members of our sub-committees on the excellent work completed during the year. I would like to thank our Director General Willy Heuschen and Jos Vanlanduyt.

On a personal level, I would like to thank all of the member organizations' for their ongoing commitment and support to patient care throughout the last year. As we say in Ireland: Go raibh mile maith agat.

Gerard O'Dwyer
President

Report
2nd IMPO Workshop
Friday 24 April 2015
Brussels

About 60 participants from 17 countries joined the 2nd IMPO workshop in Brussels. Speakers focused on main themes of the EAHM work programme while participants contributed individually and in group.

First Mr. Xavier de Bethune (ANMC) made "**Patient centerness**" concrete by demonstrating the impact of interfering in the care process on the patient experience. As the value in health care is about maximizing the (health) outcomes for patients while keeping costs under control, patients should be engaged, empowered, equipped and educated.
Mr. Eric de Roodenbeke (IHF) focused on the professionalization of the hospital manager based on a global set of core **competencies**. **Innovation** was showcased by Mr. Simon Akhtar (IBIS Biosciences), presenting the case of early recognition of life-threatening infection and rapid initiation of appropriate antimicrobial therapy while Mr. Stefan Meyer (Arcadis) presented the strategy followed to build a new hospital.

The participants contributed actively to the workshop through a discussion round in 3 work groups around 5 questions.

The reactions of participants on ***quality indicators in relation to patient outcomes*** was mixed while advice was given on development and use of indicators as well towards the hospitals as the EU.

Participants saw ***the role and required competencies for a hospital manager in assuring the delivery of quality care*** in a several ways while recommending competencies like leadership, commitment, managerial competence, empowering….

The question regarding ***the right balance of involvement of a hospital manager in steering the medical processes*** needs to be put in the larger context of hospital size, legal and structural organization of the

hospital as well as the language, cultural and information gap between the physician and the CEO. Cross-fertilisation and interdisciplinarity is needed: managers should be involvement in medical processes while physicians should be involved in the management.

Advice on **steering the quality in hospitals** has been shared but much depends on the culture of the organization. In any case, the values, mission and objectives of the organization are important while steering the quality.

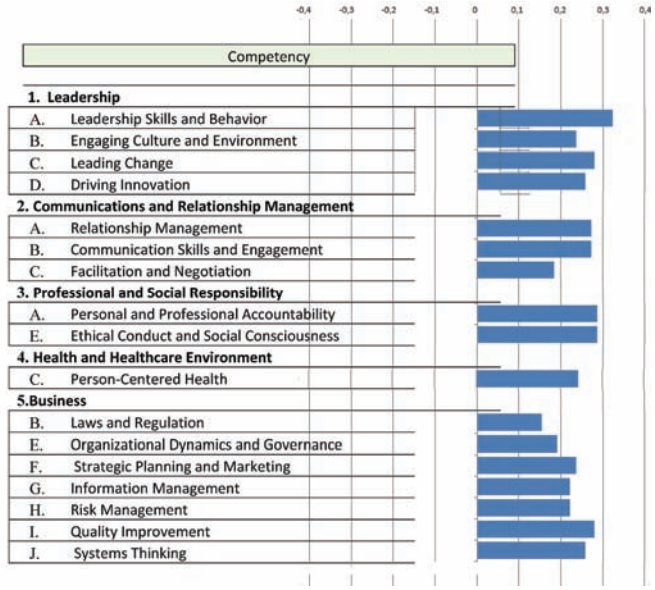
Finally **a sustainable collaboration between a hospital manager and his organization** in order to ensure patient centred outcomes and the delivery of high quality of care can be realized. On the one hand a good governance structure together with good management and leadership are critical success factors but on the other hand the organization itself, top-down, should be impregnated by these objectives.

To summarize the discussion, 3 key-words are central: participation, transparency & long-term leadership.

Participants were also presented with some questions individually. For example, they were asked to score the **importance of indicators**. The results shows that (hospital acquired) infections and readmissions get more attention of hospital directors while some classical indicators (e.g. LOS) have the tendency of getting out of the routine. From the suggested indicators, one group stands out which is focusing on the patient & outcomes, including patient satisfaction, patient experience, patient reported outcomes, adverse event reporting.

Following **competencies** from the directory of Healthcare Leadership Competencies (HLC) were found slightly more **important in assuring the delivery of high quality care**: "Leadership Skills and Behaviour", "Ethical Conduct and Social Consciousness" as well as "Quality Improvement" while "Laws and Regulation", "Facilitation and Negotiation", "Information Management" and "Risk Management" were less important.

Running a hospital is not a free ride. Hospital managers experience a lot of barriers, which was the next question. The main barriers regarding **steering medical processes** are (without giving a ranking): change resistant, communication, corporatism, conformism, professional bodies, transparency, understanding of processes, politics, integral approach and quality.



The main barriers when **dealing with external inputs / external relations** are with the unions, media, politics and funding bodies.
The main barriers when **following up and evaluating the health outcomes** concern the reliability, quality… of transmitted data and Indicators as well as the (lack of) exploitation and feedback of results and benchmarking. Furthermore the culture as logistical support is also a potential barrier.

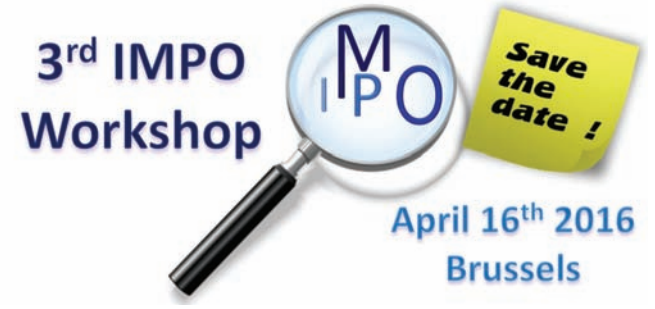
Not all hospital managers feel **comfortable with their quality management system** due to external reasons like the external influence and interventions from politicians and governments and/or due to internal reasons related to the set-up, the extent and outcomes of the system.

Finally, many participants are convinced that a **sustainable cooperation between the CEO and the hospital has a positive impact on patient outcomes**.

Listening to the discussions and interventions during the workshop, it is clear that nobody has the answer to everything, conludes Mr. Gerry O'Dwyer. Therefore it is important to have people from different jurisdictions and legislations around the table, as everybody has something to offer and can reflect on the others comments.

And at the end of the day, the importance is not to focus on the patient, but to walk with the patient along the care path to a healthier and comfortable life.

For more information, ➲ *www.eahm.eu.org/impo*



Global Consortium for Healthcare Managers launch *Healthcare Leadership Competencies*

by Lucy Nugent, representative of the EAHM

Leadership matters. The evidence is convincing that the efficient and effective use of resources and the quality of healthcare services provided is improved by enhancing the management capacity of individual leaders and teams. As the healthcare portion of countries' GDP continue to increase, the pressure for enhanced management capacity will continue to grow. Yet, healthcare organisations face two key barriers to realising the benefits of professional management. The first is the lack of adequate management preparation in the training of many healthcare leaders. The second is the fact that the role of healthcare manager is not recognised as a profession in all countries.

In an attempt to address this leadership deficit, health management institutions came together to raise the recognition of professional management in healthcare by developing a core competencies directory for healthcare leaders with the input of a diverse group of multilateral healthcare organisations. The shared aim of all participants is professionalising the leadership and management of health systems to improve patient care globally. To further promote the shared aim of enhancing leadership and management practices in healthcare, a Global Consortium for Healthcare Management that is recognised and supported by International Hospital Federation members was formed.

The following organisations have participated in the consortium set up by the International Hospital Federation:

- American College of Healthcare Executives
- Australasian College of Health Service Management
- Canadian College of Health Leaders
- European Association of Hospital Managers
- Federacao Brasileira de Administradores Hospitalares
- Federacion Andina y Amazonica de Hospitales
- Federacion Latinoamericana de Hospitales
- Health Management Institute of Ireland
- Hong Kong College of Healthcare Executives
- International Health Services Group • International Hospital Federation
- Jamaican Association of Health Services
- Management Sciences for Health
- Pan American Health Organisation (PAHO)
- Taiwan College of Healthcare Managers
- Tropical Health and Education Trust – Partnership for Global Health
- University of the West Indies

The Global Consortium for Healthcare Managers formally launched the directory of Healthcare Leadership Competencies (HLC) along with a "Call to Action" at the recent International Hospital Federations 39th World congress held in Chicago, USA, October 6-8.

The directory of HLC is the result of the consortium's extensive work between January 2013 and June 2015.

All the participant from these institutions have built up a consensus to promote the foundation of healthcare management professionalisation supported by universally recognised competencies that will enhance health care to the people. In addition more than one hundred healthcare professionals and academics have contributed in the written open review process as well as by providing inputs during the presentations made at several occasions during the period 2013 – 2015. The directory represents the core competencies for healthcare managers which countries and healthcare systems can build on to reflect the needs of each country.

The Competency Directory, the competencies are categorised into five critical domains: Leadership, Communication and Relationship Management, Professional and Social Responsibility, Health and Healthcare Environment, and Business. The Definitions of the domains are as follows:

1. Leadership

The ability to inspire individual and organisational excellence, create a shared vision and successfully manage change to attain an organisation's strategic ends and successful performance. Leadership intersects with the other four domains.

2. Communication and Relationship Management

The ability to communicate clearly and concisely with internal and external customers, establish and maintain relationships, and facilitate constructive interactions with individuals and groups.

3. Professional and Social Responsibility
The ability to align personal and organisational conduct with ethical and professional standards that include a responsibility to the patient and community, a service orientation and a commitment to lifelong learning and improvement.

4. Health and the Healthcare Environment
The understanding of the healthcare system and the environment in which healthcare managers and providers function.

5. Business
The ability to apply business principles, including systems thinking, to the healthcare environment.

As well as launching the HLC directory the Consortium called for the congress attendees' commitment in the professionalisation of healthcare management through four main areas:

- The adoption of the Leadership Competencies for Healthcare Services Managers to train and align healthcare management development at all levels of health systems.
- Formal recognition at the national level of healthcare management as a profession that requires training and the development of specific competencies.
- Implementation of merit-based career advancement along with a career path of healthcare managers.
- Recognition of healthcare managers' professional associations as key stakeholders for policy dialogue related to leadership and management and for the advancement of the profession.

Following the HLC launch, a well-attended session with presentations by Dr Reynaldo, Pan American Health Organisation/World Health Organisation, Ray Raclette, Canadian College of Health Leaders Association and Lucy Nugent, Health Management Institute of Ireland (also representing the European Association of Hospital Managers) was followed by a lively debate moderated by Deborah J. Bowen, American College of Healthcare Executives, which looked at way of incorporating the

HLC into healthcare systems which included:

- Recruitment including competency based interviews
- Continuous Professional Development
- Education and training -Review course content to reflect directory
- Professionalisation of Healthcare Managers including credentialing

For further information, please contact Lucy Nugent
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CERCLE SENS & SANTÉ

deuxième édition du colloque

Comment développer le service aux patients à l'hôpital ?

Mardi, 1er décembre 2015 de 9h à 17h

à l'Institut National des Jeunes Sourds, 254 rue Saint-Jacques, Paris 5è

en présence de nombreuse personnalités dont Jean-Louis Touraine, professeur de médecine, député du Rhône, Hervé Gaymard, ancien ministre, député de Savoie, Michel Cremadez, professeur émérite à HEC

L'hôpital aujourd'hui vit des mutations majeures, qu'elles soient technologiques, économiques ou politiques. Dans le même temps, le patient devient un consommateur avisé, qui, au-delà du soin, demande toujours plus de services.
Ces évolutions transforment le schéma classique de la relation praticien-patient-hôpital pour envisager d'autres espaces de réflexion.
Par d'appréhender les bonnes pratiques et de s'engager dans une réflexion prospective sur les moyens d'allier la qualité et la permanence des soins, un suivi médical personnalisé et optimisé des patients avant, pendant et après leur hospitalisation, ainsi qu'une vie meilleure à l'hôpital, pour tous.

Pour plus d'information, ➲ *www.cerclesensetsante.com*

From Competition to Collaboration
A call for Impatient Leadership

In April 2015 the Subcommittee for Mental Health, one of the four subcommittees in European Association of Hospital Managers, was gathered in the lovely coastal town of Kinsale outside Cork, for a visit to Irish mental health services and to conduct our Spring meeting.

The Lord Mayor of Cork received the Subcommittee and Irish hosts in the beautiful Cork City Hall. Left, top row: Members, Adrian Ahern - our hosting member, Pierre Wesner, Beda Meyer, Vesna Šendula Jengić , Nicole Demeter, Klaus Kupfer (Vice President), Doris Gillig. Left, first row: Gerry O'Dwyer, EAHM President, Cllr. Tony Fitzgerald, Presiding Lord Mayor, Inger Kari Nerheim, President, and Derek Greene, HMI President.

Minister of State Kathleen Lynch joined the group for two sessions, here to the right with Professor Geraldine McCarthy in the back row; as well as Derek Greene, Gerry O'Dwyer, Klaus Kupfer and Inger Kari Nerheim. Not present were Marc Graas, John Simpson, Alberto Appicciafuoco, Holger Höhmann, Joseph Halos, and Niels Aagaard Nielsen.

The Subcommittee has 13 members from 11 European countries, and it is a group of impatient leaders, who wish to contribute to service development. The countries currently represented in the Subcommittee are Ireland, UK/Northern Ireland, Germany, France, Belgium, Switzerland, Croatia, Norway, Denmark, Italy and Luxembourg.

The meetings bring us to visit different countries' mental health services, with a view to learn from each other. Each host country presents its best research contributions, and invites the others to share current policy discussions, in order to instigate collaboration and quality improvement across borders. The last visit, in September, was to the mental health services in Croatia, which also was very inspiring.

The sensory gardens and art therapy at Rab Psychiatric *Hospital*

Integration of somatic and mental health services? Consequences for patients?

The EAHM leadership is currently working together with the Subcommittee to make mental health services better integrated in the hospital managers' organization. The message from the Subcommittee is that there is a definite need for a more holistic view on illness and wellness in our hospitals, and that a development in this direction will support both the "somatic" and the "psychiatric" patient as we categorize them today. We have seen in our services that the patients and their family and networks can benefit greatly when the somatic and mental health services work together. We have to begin at the leadership level – the professionals need the support of their leaders to make this change.

Ass. Professor and Hospital director Vesna Šendula Jengić , Klaus Kupfer, Vice President of SCMH.

Why do people with mental health problems have a lower life expectancy than the rest of the population?

One of the issues which the Mental Health Subcommittee finds it important to address jointly in the European setting, are the well documented findings that persons who have a severe mental illness have a life expectancy rate of between 16 and 30 years lower than the general population. The numbers have been found in replicated studies all over Europe and internationally.

Patients with a mental health disorder are to a great extent invisible in our services when they as all others contract cardiovascular disease, diabetes, lung disease, or present with metabolic syndrome. In addition, many of the medicines have debilitating effects and need to be monitored closely. The sedentary daily routines in many of our treatment facilities have not increased the wellness potential of the service users, to put it mildly. Appalling and shocking are words that will be used when the next generation looks back on these statistics, indeed, that is how we as leaders and professionals reacted.

There are many reasons, but no excuses for not resolving this now: in most countries hospital services for people with mental health problems are part of the general hospitals, and should have had good routines for ordinary somatic health diagnostics and treatment for people who are experiencing mental distress. The secondary health services have been integrated on the organizational level only, not on the clinical level.

When the wake-up call came on the life expectancy rates, many mental health services were already looking for better collaboration across services and across the primary health and secondary care divide. Through EAHM the Subcommittee hopes to contribute to setting this issue on the agenda. The time for a decisive change is now. To achieve this aim, we need to come together on all levels, in politics, the professionals who are working out procedures and treatment plans, financial departments who define the funding scope, and through all this, speed through impatient leadership.

The recovery movement – a philosophy, and an ethical force

In 2011 the Subcommittee made a commitment to support the international work on personal recovery in mental health and addiction services. Patient autonomy and dignity are central values in this reorientation of services, which is getting an increasing momentum, especially in the English-speaking world. In Berlin 2014 the EAHM biannual leadership conference featured a keynote talk by professor Geoff Shepherd from the UK NHS organization Implementing Recovery through Organizational Change, IMROC. The keynote was followed by a workshop on recovery projects in Europe.

Member countries in the EAHM are increasingly planning projects and making vision statements which support services in joining forces with patients in creating self-directed care systems. The recovery philosophy brings a stronger focus on the "social" part of the treatment specter in what often is called the "biopsychosocial" model of mental health. Respect for the individuals' right to make their own life decisions, even in periods of mental distress must go hand in hand with the best, evidence based treatment and thorough and complete diagnostic procedures.

Quality improvement – a results focus in services

What are the results for the patients after weeks or years in mental health and addiction services? The governments have asked services to report on a number of parameters like persons treated per staff, number of overnight stays, number of acute admissions, length of stay, costs per day, cost per intervention even, but rarely on the rate of return on different treatment options and hardly ever on improvement in the persons quality of life.

There is great need for routine data gathering on how the patients we treat, actually are faring, and which treatments are actually working. Use of therapies in Primary Care services could possibly play a part in preventing unnecessary hospital admissions – as of today, there is little we as leaders can do to instigate the necessary processes across service levels that could facilitate change. What we measure, can, however, be decided by ourselves, and through better collaboration we can find good quality measures. The Subcommittee will work through EAHM's IMPO project with themes like these.

How should mental health services be funded?

The Subcommittee finds questions of activity based funding of great importance. Several of the members have worked on this issue in their respective countries. The way our services are funded clearly has an effect on how we deliver services. The last 15 years have seen activity based funding giving a boost to somatic services, while mental health and addiction services have lagged behind. A change is needed, but the difficulty in defining care levels for our patient groups must be taken into account. Trials in Switzerland have shown that the level of care and treatment needed for an individual patient does not follow diagnostic categories. Indeed, with the dimensional view of mental health problems, the diagnosis has already become redundant as a sole marker for care delivered, or resource use. A new system must assure that the patient is secured optimal, individually tailored treatment, and not lose out in sub-optimal or random categorization.

EAHM and mental health services

Through EAHM conferences, the IMPO project for a new lease on effective hospital organizations, through gathering of people across professional and national borders, working on projects, bringing forth the issues for debate, we aim to collaborate with somatic services to create an integrated service with better results for our patients. Help must be available as soon as possible and as close to the ordinary daily activities of the person in distress as possible, and to accomplish this, there must be a strong focus on what service users and their families and workplaces actually want and need. In order to succeed, the user organizations on European and national levels must be a partner in this endeavor, and the Subcommittee is looking for ways to improve our collaboration with the users' voice in mental health and addiction in Europe.

Inger Kari Nerheim
President
EAHM Subcommittee for Mental health (SCMH)

Sustainable and future oriented Health Care needs our responsibility and competence

Given the many challenges our society and also health care is facing, there is a strong need to move forward to a sustainable and future oriented health care. This call is not new and as many visions exist on this theme, a selection of the most important vision will be presented together with the impact this might have on the society.

But to realize this, we as hospital managers have to take up our responsibility and we need to do this on different level like quality of health care, finance, human resources but even on the ethical level.

But to be on the front-line, hospital managers must show they have an added value in this process. Therefore the congress will look into ways how to prepare us and, through examples, how to realize this.

Looking forward to welcome you in Bologna !

➲ *http://www.eahm.eu.org/26thcongress*

EU-newsflash

- **Patients' rights in cross-border healthcare: state of play of transposition**: The transposition deadline for the Directive was 25 October 2013. Infringement proceedings were launched against 26 Member States on the grounds of late or incomplete notification of such measures. As of 1 July 2015, four infringement proceedings remained open, concerned had made firm commitments to address the outstanding issues.
  The Commission implementation report of the Directive, adopted 4 September 2015, captures the current state of play of transposition with particular emphasis on the use of prior authorization, the level of patient mobility, reimbursement practices, patient flows, information to patients and cross-border cooperation. Regarding ERNs, the first Networks will be established in 2016, and will then need to be evaluated. More information on
  ➲ *ec.europa.eu/health/cross_border_care/policy/*
- **see more news on our website…**
  ➲ *http://www.eahm.eu.org/news*

Calendar

By November 25th 2015

	November 2015
30	Akademie Leipzig (DE)
	December 2015
1	Conférence ' Sens et Santé', Paris (FR)
11-12	Board, Vienna (AT)
	January 2016
12	Scientific Subcommittee, Brussels (BE)
22	Subcommittee European Affairs, Luxembourg (LU)
	February 2016
	Board: to be fixed
10-11	IT Entscheiderfabrik, Düsseldorf (DE)
	March 2016
4	Executive Committee, Brussels (BE)
24-25	24eme Journées ADH, Paris (FR)
	April 2016
15/04	EAHM Core Partner meeting, Brussels (BE)
16/04	Extraordinary General Assembly, Brussels (BE)
16/04	3rd IMPO Workshop, Brussels (BE)
	October 2016
13-14	26th EAHM Congress, Bologna (IT)
	September 2017
27-29	27th EAHM Congress, Belfast (UK)

Please check ➲ *http://www.eahm.eu.org/events*
for details and updates