EHMA Annual Conference 2008

EHMA
European Health Management Association

MINISTRY OF HEALTH
&
SOCIAL SOLIDARITY

National School
of Public Health
Athens, GR

# the POLITICS OF health

25 • 27 June 2008, Athens, Greece

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## THURSDAY 11.00-12.30

# THEME 1: THE POLITICS OF POLICY

*The Politics of Quality and Performance*

# The political quest for quality healthcare: What's the story?

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### Research

In March 2007, the Minister of Health stated: "I think we have reached a point in time when the opportunity to focus on, and deliver, quality improvement is the best it has been for many years."

This paper is a response to that invitation to focus on quality improvement, addressing the question: "What is the evidence in the public domain that politically driven initiatives have delivered enhanced quality outcomes for stakeholders?"

### Context

The organisation of health care has undergone unprecedented politically-driven reform over the past two decades in many developed countries, where "quality" as a key strategy consistently infuses the vocabulary and management of the public health service. However, the ubiquitous presence of quality can easily become a 'given', without seeking evidence of meaning, application or outcomes.

At the same time as the political quest for quality continues its momentum, the NZ health sector has experienced unprecedented industrial action alongside a public milieu suggesting compromised quality outcomes. Questions arise about the future direction of the public health service.

### Background

First, considering how evidence of the quest for quality appears in the public domain provides current insight into how successfully the management of the quality case is being experienced by some stakeholders in the public health sector in New Zealand. Second, as work practice is shaped and normalised through the drive for enhanced quality, current issues that challenge public health sector organisations may be revealed. Thus, features of the New Zealand case may resonate with those in other countries also undergoing the political quest for quality in the public health sector.

### Theories

In New Zealand, the political focus on quality is enshrined in legislation. However, beyond government reports is the public domain consisting of individuals who have a stake in knowing that the health service is working credibly to provide a service constant with their rights. The news media provide a nexus between institutions and individuals where they can access information not available elsewhere.

In order to investigate progress in the political case for quality, using a sample of health issues in the public domain, a study was undertaken to examine relevant news items over a 6-month period, in contrast to political communication.

### Results

The results demonstrate that both users and providers are trying to navigate a seemingly impenetrable notion of what constitutes a quality service. Even reducing the quest for quality to the two fundamental questions introduced in the Health Strategy of whether individuals can access care, and whether that care is effective, the evidence is that we appear to be failing. Thus, the quest for enhanced quality in the health care service remains elusive at considerable cost.

The appeal to 'quality' is a legitimate claim, and to argue against a quality service would be perverse. However, just as the appeal of competition failed in its quest as a politically driven ideology to contain cost, might this also be the case with the appeal to quality? To 'plan' for desired quality improvement, may be necessary, but not sufficient, if underpinning assumptions suggest significant challenges to the legitimacy of the rhetoric and the reality of the case for quality. If every system is perfectly designed to get the results it gets, the results currently speak for themselves.

# Increasing importance of performance measures in the hospital sector: equity under pressure?

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### Research

The main research question is "What implications does performance measurement have on equity in hospitals?"

Four sub research questions can be derived, namely: (1) How is performance measured within the hospital sector?; (2) How is performance information used within the hospital sector?; (3) How do hospitals evaluate their performance measurement system?; (4) What are the implications of performance measurement on equity in healthcare?

### Context

In recent years, transparency and improvement of quality have became more important in hospitals. Simultaneously, hospitals are increasingly judged on their financial performance. Hospitals are thus expected to control costs without losing quality. In this context, performance measurement - with the goal to inform managers of the hospital's performance - has received more attention. However, the reliability and validity of performance indicators is often questioned, as well as the quality of measures and interpretations. Since more importance is attached to performance information at different levels within the hospital sector, performance measurement and the use of performance information need to be investigated.

### Background

In different countries, performance information gains influence in negotiating relationships at different levels within the hospital sector. On the sector level, governmental actors use performance information to determine hospitals' needs and organizing finances (cf. minimal hospital data in Belgium). On the hospital level, performance information is used to evaluate goals' achievement, decide on strategy and resources allocation, and undertake improvement actions (cf. hospital indicator project in Canada). In some countries, performance information is made public and used by patients, the local community, taxpayers, and insurers. Given the increasing importance attached to performance measures, possible side effects should be examined.

### Theories

Performance measurement was considered as an iterative, phased process, by which each phase determines the following phases. The first phase is the selection of performance indicators, ideally based on the vision, mission, and strategy of the department or hospital. The second phase is measuring performance, followed by the interpretation phase. The next phase is the hospital internal and external use of performance information, whereupon the performance measurement process can be restarted. By means of qualitative questionnaires and a case study, the fulfilment of each phase was ascertained at the departmental and hospital level in ten hospitals representing the Flemish provinces.

### Results

The study showed that the hospital management expects departmental heads to communicate their department's performance in order to outline the hospital policy. Further, the hospital management is expected to give account to the Federal Public Service Health on the hospital's performance, although feedback is often lacking. At the different levels, performance is considered as a multidimensional concept, including clinical, operational and financial performance, but the set of performance indicators does not always reflect the departmental or hospital performance. Moreover, performance measures are often incomplete or incorrect. In recent years, however, the use of performance information has only expanded. The hospital sector is moving towards more openness on performance and better cost management, but prudence is called for when making performance information public or having decisions made by external stakeholders. Some hospitals will possibly be encouraged to improve their scores instead of their performance and may even engage in the manipulation of measures and specialisation in only a few domains. Additionally, it is not inconceivable that hospitals will refuse patients who lower their scores, as adjustments for medical conditions and demographic characteristics are currently lacking. Basing decisions on invalid or unreliable information is then a danger to equity.

# The impact of corporatisation in the performance of public hospitals

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## Research

The incapability of traditional state organisations to respond to new economic, technological and social challenges and the respective emerging problems has made it necessary to adopt new methods of health management. The main hypothesis is that the adoption of business management by the hospital health care units and the implementation of quality procedures (accreditation and certification) are related to the estimated probability of one hospital being efficient.

## Context

The adoption of different modalities of management in health care institutions, in particular the corporatisation of public hospitals, is nowadays a common practice in many countries.

In this context new solutions have been developed in the health care sector. We intend to analyse the hypothesis that the probability of one hospital being efficient is related with the adoption of a managerial culture by public hospitals (corporatisation) and also with the introduction of quality procedures – accreditation and certification.

## Background

The increasing cost of health care delivery has led to different political and administrative approaches trying to preserve the core values of the welfare state. A report of the OECD (2006) states quite clearly that by 2050 most developed countries will double the health care expenditure of 2005. In order to promote cost containment many European countries have introduced the rules and principles of the New Public Management, e.g. giving managers greater autonomy and improving worker productivity. However, the New Public Management approach has well documented strengths and weaknesses in health care and the latter should be clearly regulated.

## Theories

The methodology used to identify which hospitals are efficient according to type (central, district and level 1) and according to the institutional nature was the DEA (Data Envelopment Analysis).

The hospital level of efficiency was calculated by working out two measures of efficiency. In a second stage, in order to explain the hospitals efficiency status (efficient or not efficient), we developed some regression models (Probit), by using three variables: a) the institutional nature; b) the quality dimension: b1) accreditation and, b2) certification.

## Results

Portuguese public hospitals have improved their levels of efficiency in the period of evaluation. The S.A. hospitals (corporations with managerial culture) showed better results than hospitals with traditional public management in the evaluated period.

Moreover, the institutional nature of hospitals is a variable statistically significant in the justification of the probability of one hospital being efficient. The S.A. hospitals are more likely to be efficient. Globally, all the variables considered (institutional nature of hospitals, accreditation and certification procedures) have statistical impact on the efficiency-1 and efficiency-2 measures.

To conclude, the introduction of managerial culture in the Portuguese public sector is an attempt to solve the increasing costs of health care. This study confirms that corporatisation and the implementation of quality procedures had a significant impact on the efficiency status of Portuguese public hospitals.

## THURSDAY 11.00-12.30

## THEME 1: THE POLITICS OF POLICY

***The Politics of Financing Healthcare - cost and quality***

# Rational resource use while promoting quality and ensuring an equitable access to health care. Is this possible?

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**Research**

How can a rational use of resources be encouraged while promoting the quality of care and ensuring access to care?

**Context**

In 2007 the European Commission (EC) organised a workshop on 'how social protection encourages a rational use of resources while promoting quality and ensuring equitable access to care'. Since the EC supports Member States in their attempt to modernize social protection systems in health care, reliable information about rational resource use in several Member States was needed. Recent reforms in health care areas were presented and best practices/possible solutions were identified.

**Background**

The need to ensure rational resource use in health care has been highlighted by Member States for several years. As the current growth rate of expenditure is considered to be unsustainable, the question raised is how expenditure can be curbed while the general objectives of promoting quality and ensuring access can be upheld. It is a widely shared idea that most health systems have little room for improving efficiency in their health care systems. However, areas in which health care system performance can be improved are identified in this project and appear to influence health systems in several ways.

**Theories**

A literature study was conducted, focusing on reforms such as the strengthening of primary care provision and the introduction of referral systems; care coordination programs; and policy measures for controlling pharmaceutical expenditures. These reforms were evaluated by looking at advantages, disadvantages and best practices and country comparisons were made.

During the workshop invited Member States presented their experiences of the aforementioned reforms.

**Results**

Both the literature study as well as the results from the workshop show that expenditure control and quality improvement in health care are goals that cannot be reached simultaneously, since the one goal often has negative side effects on the other goal. For example, quality improvement in health care interventions may lead to a better health situation for patients, leading to a prolongation of life, and eventually to higher health care expenditure in the near future. On the other hand, focusing on the lowering of health care expenditure may lead to a decrease in the quality of care and could endanger an equitable access to care since 'good' health care could be considered to be too expensive.

These findings lead to the conclusion that it is very difficult to implement interventions that are cost-effective, of good quality and do not endanger the access to health care. Rather, the real challenge lies in finding the 'optimal' balance between the three goals.

# Tariffs negotiations and quality bargaining in the Swiss healthcare system

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### Research

Since 1996, with the adoption of the LAMal-Law on health insurance, market principles have steered the Swiss healthcare system. There are, nevertheless, institutional characteristics limiting market diffusion. In inpatient care, supply is based mainly on public establishments. In ambulatory care, real competition is limited because of the obligation for the health insurers to reimburse all services furnished by physicians. In order to cope with this situation, the LAMal oversees incentives and self-regulation in the tariffs' definition and in the quality criteria settlement. We pose the question of how self-regulation has been implemented.

### Context

With the LAMal, new parietal institutions have emerged. Tariffs on the ambulatory domain are strongly self-regulated between physicians and health insurance associations. Similarly, in inpatient care, an association formed of providers' representatives and health insurance associations has been created to negotiate DRG tariffs in acute care. The partners have nevertheless delayed the creation of an institution for bargaining quality criteria and no coherent system exists.

### Background

The results are drawn from PhD research based on the introduction of New Public Management in the Swiss healthcare system and its repercussion for governance. More specifically, our contribution will be based on the analyses of the negotiation institutions in the tariffs' fixation and the quality criteria definition. The presentation will also consider the role of the government in its capacity to steer a coherent healthcare system

### Theories

To better analyse the negotiation mechanisms in the Swiss healthcare system we have chosen to consider the self-regulation aspect from the governance perspective and from institutional economic theory. Our research is based on a qualitative approach through two main tools:

- Study of primary sources (not systematic), officials documents (20 years debating on national parliament commissions, texts of law and bylaw), peak organisations' reports and documents;
- Semi-open interview (ca. 25 transcribed) with peak organisations' responsible (health insurers, physicians, hospitals) and civil servants acting at the national level (Swiss federal office of Public Health).

### Results

The focus on market principles and the adoption of self-regulation since 1996 has caused a radical change in the functioning of the Swiss healthcare system. In spite of the institutional limits (federalism, contract obligation), new institutions for negotiating tariff and fixing quality criteria between providers and health insurers have emerged. In contradiction to many theories, the self-regulation has not impeded conflicts rising between the partners and power dispersal, especially in the quality criteria. In all these institutions, authorities have principally an observatory status reducing their coordination power. This also raises the question of the pertinence of self-regulation and negotiation as a method to manage the healthcare system.

# Political and ethical Issues in Health Care Organisations under the National Health Insurance Programme in Taiwan

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## Research

How does political power within the present economic and management system determine the budget? What are the ethical issues?

## Context

The National Health Insurance (NHI) in Taiwan was launched in 1995 and represents 98.7% of the population. It has successfully accomplished a high satisfaction rate (76.6%) and low total health expenditure (6.2% GDP). The 23 million citizens under NHI receive good access, quality, and a low cost health service. The Bureau of NHI has reimbursed providers mainly based on the fee-for-service. In 2002, it changed to adopt the Hospitals Global Budget Payment System to control the medical cost expenditure, capped with NT$224 billion (about US$ 6.8 billion) with mild growth (5.7%) per year.

## Background

State-provided health insurance has now spread throughout much of the industrialised world and Taiwan is a good example of this trend. The current NHI environment exerts great external influences on hospital management strategies and raises both political and ethical issues in hospital administration. The hospital administrators need the ability to negotiate with hospital representatives in the Hospital Global Budget Committee under the Bureau of NHI for a bigger share of budget, and have to try significantly harder to find approaches for cost down, profit up, and market enlargement for operating hospitals.

## Theories

A phenomenological method was used to collect data. Perceptions about politics and ethical issues were drawn from interviews and focus-group discussions with a purposive sampling of 20 hospital representatives from the Hospital Global Budget Committee and National Health Insurance Supervisory Committee. “How do we distribute health care? How do we budget? How does political power within the present economical and management system determine the budget? What are the ethical issues?” were the main questions asked in the interviews and discussed within the focus-group.

## Results

Our work represents a provocative discussion of infrequently addressed ethical dimensions of health policy at both governmental and health care organisational level, which raise questions about medical, political, moral, and justice-based issues. We identify the role of different “powers” and “interests” in the establishment, administration, and distribution of health care provided by NHI. The political and ethical issues lie everywhere: no matter how enthusiastic or dedicated, hospital administrators need to deal with relationships in complex hierarchies: in particular they need to redesign physician fee systems to share the financial and reimbursement risk and to mitigate physicians’ power in medical autonomy to a certain degree, including pharmaceuticals and treatments, for better cost containment. Our observation on health provided in the NHI is that it is politically contested and that there are plenty ethical dilemmas involved. The politics of hospital management are not only between hospital and outsiders, but also between managers and health professionals. The complex and changing environment requires hospital administrators in Taiwan to understand the politics of healthcare well and to foster the ability to extensively influence different parties.

# The Gatekeeper - Medical Institution to foster Quality and contain Costs in Health care

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**Research**

Question:

Can a gatekeeper institution contribute to higher patient outcome and cost containment simultaneously?

Hypothesis:

An optimal gate keeping role can only be played by a polyclinic institution, since a general practitioner (GP) practising in a one-man-office tends to be unable to achieve the expected requirements.

**Context**

In the field of public support and pensions-research the gatekeeper approach is heavily contested. It is questionable to what extent the gatekeeper function contributes to higher medical quality and economic benefit.

Within an international study this research question was monitored. Different international gatekeeper approaches were examined in order to clarify their medical and economic consequences. The interconnection between the gate keeping function, the health insurance system and the voice of the customer in healthcare systems was analysed.

**Background**

The gatekeeper concept is a constitutive attribute of health systems which follow the principle of Managed Care in their organisational structure. It is often seen by health politicians as an optimal approach to solve the given problems of an ageing population and rising cost levels within health systems. This presentation will aim to show that the gatekeeper approach might be one possibility to manage the relationship within complex hierarchies but should not be used as a universal remedy.

**Theories**

Consensus meeting with international healthcare experts and medical professionals.

Cost-/Behaviour-Analysis focused on selected gate keeping approaches in different countries/health care systems.

**Results**

It could be observed that the gatekeeper approach leads to different outcomes in the provision of health services. It is thus important to define the real requirements a gatekeeper function has to fulfil.

Within the conference presentation recommendations are offered how to design an optimal gate keeper function in order to achieve an increase in medical quality and effectiveness.

## THURSDAY 11.00-12.30

## THEME 1: THE POLITICS OF POLICY

***Making Health Policy - decisions and drivers***

# How different are patterns of health policy innovation in tax-based and social insurance health systems?

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## Research

Are health policy innovations in higher-income countries convergent or divergent? On the one hand, we may expect similarities in types of policy innovations because all health systems are faced with the issue of how to manage limited resources, and because there are many examples of policy transfer across jurisdictions. On the other hand, agendas for policy innovation may be subject to path dependency shaped by the design of health system institutions, particularly how they are funded.

## Background

Health policy agendas are closely linked to patterns of health politics. If the nature of innovations is broadly convergent, this suggests that there is a set of political dynamics that is common to all higher-income countries. If policy agendas are divergent, this suggests that context-specific factors are more important in shaping the politics of health.

## Theories

We examine and compare the health policy agendas of three tax-based systems (Canada, Finland and New Zealand) and three social insurance systems (Israel, the Netherlands and Switzerland). Policy agendas are identified using data from Health Policy Monitor collated between 2003 and 2007. HPM identifies policy innovations in 20 countries. National health policy experts report up to 10 initiatives per year. These initiatives are categorised in terms of health system objectives (access/equity; efficiency; quality), service area, target populations, and tools for change.

## Results

The results show a mixed pattern of similarity and difference. No pattern of difference was detected in relation to the types of services addressed or the populations targeted by policy innovations. With regard to health system objectives, policy innovations addressing access and equity issues were more prevalent in tax-funded systems, whereas innovations aimed at improving efficiency were more common in social insurance systems. Innovations focusing on quality were prevalent in both types of system, but most prominent in NZ, Canada, Finland and Israel. Tax-funded systems were more likely to use additional funding as a tool for policy innovation, whereas social insurance systems tended to adopt cost-shifting mechanisms. We conclude that institutional design, particularly the funding of health systems, shapes health system objectives and tools for change, but does not have a role in shaping the types of services and target populations addressed by policy innovations.

# Elections, Health and Politics: The Turkish Case

Yildirim HH.

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**Research**

This paper seeks to explore the likely impact of electoral politics on health policy-making and health reform by dealing with the Turkish general elections which took place on 22 July 2007.

**Background**

2007 became a year of elections for Turkey, with both presidential and general elections being held. The elections are of critical importance for health policies, as in other sectors, since they influence policy preferences, priorities, and orientations. On the eve of general elections taking place on 22 July 2007, as a reflection of the dynamics in the electoral politics and investments, the Turkish government took some controversial decisions regarding health field at the expense of electoral investments.

**Theories**

Two methods are employed in this paper: literature research and observation.

**Results**

Two main political outcomes of the electoral dynamics have emerged: 1) the enforcement date of the GHI Scheme has been postponed continually, 2) by having issued a Health Implementation Communication; the obligation to follow referral system has been suspended.

The main dynamics, which influence all sectors, including health directly or indirectly, observed in the election periods can be noted as follows:

1. Pursuing electoral politics may lead to a change in priorities.

2. Change in political desire, will and support may change the effective dates of the policies.

3. Election activities gain priority.

4. Populism increases.

One of the fieriest periods in politics is during election periods. As has been described above, the policies exhibited during this period of staging may yield outcomes in the medium and long run that are hard to repair. This paper therefore argues that health and its main components and principles should be a political area that is minimally influenced by the government changes. It argues that as a main element of being a social state and as a fundamental of economic improvement and development, health should be seen as a practical field of social solidarity, equity and inclusiveness and formulated within the understanding of 'health is a right', not an area of practices which are outcomes of populism.

# Planning in the Irish Health Services: Legislative Strategy or Administrative Control?

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## Research

In Ireland the emergence of strategic planning did not occur until the 1990s, with the advent of service planning. How this strategic management of Irish health services in the form of service planning can be implemented is the focus of this presentation.

Two propositions are posited; first, that a key stumbling block to success includes the limitations of the legislation, underpinning service planning and second, that there is a lack of recognition of the complexity of the healthcare environment and the stakeholders within it in attempting to introduce service planning as a means of strategic planning.

## Context

The implementation of service planning in the Irish health services has occurred in the context of significant organisational change. One of the central mechanisms of the Strategic Management Initiative (SMI) is the devolution of accountability and responsibility from the centre to the periphery. Service planning in Ireland is seen as part of this strategic planning ethos. However, there is a need to consider the difficulties in making changes in complex institutions and these are acute in any structure of nested intentions or interests. The legislation itself has a part to play in facilitating or hindering such change.

## Background

In examining the implementation of service planning, this presentation draws on a model to account for the particular interests in services such as health care. The Street Level Public Organisation Model (McKevitt 1998) accounts for the complex interactions between government, health professionals and their associations, and the citizen, as well as analysing points of tension in these relationships and the influence of the legislation itself. It addresses the challenges raised by the conference theme of managing relationships in complex hierarchies in analysing the Irish health care sector and its current approach to planning and management.

## Theories

The propositions were addressed through analysis of the legislation and documentation as well as qualitative interviews with middle and senior management throughout the health care system. The design of this study is what Yin (2003) describes as a multiple case study. The choice was made to study the dynamics of this change in their setting by investigating a number of health boards. Service planning was examined in its implementation at the health board level as well as accounting for the wider institutional influences (other stakeholder perspectives including government and other health care organisations in the system).

## Results

This presentation narrows down the conceptual framework to two key problems; firstly, the lack of capacity built up in the Irish health care system to deal with change brought about by the service planning process and secondly, the limits of the control system, the legislation itself, in terms of its strategic intent. Using qualitative analysis of interview data. A number of core themes are identified, of which the key findings will be outlined. To conclude, the control system has resulted in the service planning process operating in the Irish health care system with a purely financial control focus. Despite the rhetoric of the National Health Strategy (2001) regarding the inclusive involvement of staff and the wider community, service planning is located within a system of top-down control. There is a need to consider the complexity of the healthcare environment in both analyzing and in implementing strategic change and McKevitt's (1998) model of the Street Level Public Organisation (SLPO) is utilised to underscore how these competing relations can be managed in the implementation of the service planning process.

# Reflection on the nature and value of research priority setting in healthcare: the POTTER project (an illustrative case study).

**Bannigan K[1], Boniface G[2], Doherty P[1], Nicol M[3], Porter-Armstrong A[4], Scudds R.[4]**

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### Research

Does research priority setting in health care need to be less consensus-oriented to ensure better investment in health?

### Background

Research evidence is needed to deliver improvements in health, but there are limited resources available for commissioning this research. Research commissioners have tended to use priority setting to ensure that limited resources are well targeted. In research studies, methods involving some form of consultation that are directed at achieving consensus are widely used. Considering the number of stakeholders involved in trying to achieve a consensus this is a highly political activity. It requires a range of collaborations in horizontal and vertical planes.

### Theories

This presentation will draw upon the Priorities for Occupational Therapy Research (POTTER) project commissioned by the College of Occupational Therapists (COT) in the UK. This was a collaborative project across each of the four countries in the UK. It was designed in five stages; knowledge gathering, consensus conference, survey, researchers' commentary and consultation with COT council. This study will be used as a case study to reflect upon the nature and value of research priority setting in the context of the investment in health.

### Results

The results from the POTTER project show that consensus can be achieved. The clear research priority across the whole sample (N=2661) was the effectiveness of occupational therapy. Interestingly managers (n=188) differed slightly in that they were interested in cost-effectiveness. Although the objective of consensus was achieved in the study this result is anodyne. This was the frustration expressed in the researchers' (N=15) commentary, i.e. that the priority topic was too broad and so any topic could potentially attract funding. This suggests that, in trying to ensure inclusivity and diversity so that there is a consensus across a profession, the results lack meaning. This observation fits with critiques of other research priority setting exercises which have noted a list of priorities (usually a list of specific interventions) that indicate a limited consideration of the wider healthcare context. An alternative approach to research priority setting is a criteria-based approach that takes into account demographic trends, the burden of disease, and potential benefits. Whilst consensus approaches may feel more comfortable as a strategy because they appear to promote ownership of the results it may be that criteria-based approaches deliver better investment in health in the long term. This is because criteria based approaches appear to be less susceptible to bias and more informative for directing funding, which is essential when the funds available are so limited.

## THURSDAY 11.00-12.30

## THEME 2: ORGANISATIONAL POLITICS

***Managing Inter-professional Politics***

# Managing a complex hospital organisation through diverse management teams

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### Research

A hospital organisation divides into sections and teams when its core function is divided into parts of the task. Management teams also originate in support of job division, forming in accordance with organisational charts. In this study we see management teams in different vertical and horizontal planes as links between different levels of hierarchies and organisation lines. As hospitals are moving towards process oriented way of organizing their work is it possible to manage the complex organisation through management teams which are originally formed highlighting the traditional boundaries between different hierarchical levels and organisation lines?

### Context

Researching management teams is especially important in specialised health care where organisations are large and where know-how is dispersed into several specialist fields. In this study, the research work was done in one medium size Finnish central hospital. The basic view for this study was to see hospitals as complex systems where optimizing parts does not necessarily strengthen the organisation as a whole.

### Background

In a hospital organisation the functions are dispersed into several specialties so we need tools to manage the organisation as a whole and overcome the borders between different professions and units around them. In this study we see management teams as forums of horizontal and vertical co-operation and thus as tools for reducing partial optimization. In ideal circumstances management teams could be a way to broaden out managers` view of organisations` functions and help managers to understand the effect of decisions made in their own unit to the whole hierarchical and horizontally wide organisation.

### Theories

The data were obtained by videotaping management teams and interviewing managers attending to the teams in one Finnish central hospital. There were altogether 10 management teams whose meetings were videotaped on 3 successive meetings. One of the videotaped management teams was the top management team and 6 of the management teams represented unit level. The other 3 management teams worked between the top management team and the unit level. Members of these 10 management teams were all interviewed. The interviews have been analysed with material based content analysis and video material with observation-based content analysis and ethnographic picture analysis.

### Results

The speculative results indicate that changeover for process-based teamwork has not been easy. In the literature hospitals are often described as professional bureaucracies. Finnish hospitals follow Max Weber's theory of ideal bureaucracy in that they are large, hierarchically structured and characterised by strong specialisation in accordance with job division. However contrary to Weber's theory, hospital functions are often organised as functional profit centres. This is seen to improve productivity by offering economic incentives to individual employees and profit centres, but even if this were the case functional profit centres do not encourage co-operation over unit borders and may in fact induce partial optimization inside the hospital organisation. Cutting across traditional boundaries asks for extensive changes in attitudes and operations. The speculative results also show that many important issues are discussed outside the formal management teams. This can be seen as teamwork that possibly challenges the existing boundaries and creates innovative solutions for managing the complex hospital hierarchy. On the other hand, teaming up with favourite partners in co-operation and not with others may weaken the management network as a whole.

# Transparency and trust as tools to heal a politicked organisation

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## Research

Health care organisations have traditionally relied on dual or even triple management systems: academic, nursing and general management. This creates a fruitful soil for developing a politicked organisation where much of the daily energy is used in negotiations (and fights) between different lines of management and inside each line of personnel. Often the managers and middle managers in each of the management lines are also (senior) experts in their subject area, thus adding a professional-politics dimension into this picture.

## Context

This presentation analyses the path of a clinical laboratory from a three management line politicked organisation to a modern business-like unit with one manager and one management line.

## Background

The clinical laboratory had been a complex working place for tens of years at the hospital. The personnel had worked together for years, or even decades. There were several hidden structures inside the organisation and unofficial and non-documented information and management lines even to top management level. This yielded continuous conflicts and complaints and demanded continuous supervision at the board of managers level. Our message is that change is possible, but the positive results may also be lost if you return to old models.

## Theories

The development started when the hospital adopted the European Foundation for Quality Management (EFQM) model as a tool of organisational development. The key points in the process were: Single management lines and a lean organisation; Ownership of processes; Purchasing – providing/producing negotiations inside the organisation; Management curriculum for the middle management. The presentation is an observational study presenting and analysing the experiences of this exercise and also giving recommendations for other organisations.

## Results

As a part of the general reorganising of the hospital, the clinical laboratory was moved into a single management line and a single manager model. The previous head-nurse continued to work as a senior laboratory nurse without managerial responsibilities. All the processes were now owned by the biochemist who was also responsible for the management of the personnel resources and budget of the unit. As a part of her management studies she launched:

1. A development project to reorganise the tasks and duties of the personnel
2. To build an economic model for pricing the services of clinical laboratory
3. To analyse the potential benefits and disadvantages of outsourcing some or all laboratory services.

Tasks 1 and 2 succeeded well and the working environment healed within a few months. The key factors of success were just and open communication, transparency and work sharing including circulating secretarial and chairperson duties of the weekly unit meetings.

Task 3 was less successful. The EFQM model gave soon way to more centralised management model and decision making. This decreased also the level of transparency at organisational level and moved possible outsourcing process to a political action not linked to professional expertise any more.

# Medicine and management in English primary care; a shifting balance of power?

**Sheaff R.**

*University of Plymouth, United Kingdom*



### Research

In what ways has the circular evolution of formal organisation structures in English NHS primary care from GP fund holding to PCT-based commissioning and now back again towards a new form of fund holding affected the distribution of power between managers and GPs?

### Context

English NHS organisational structures have been almost completely recycled since 1991. After a brief interlude, the governance structures of 1991 were by 2007 essentially reinstated (with some modifications and new names). Yet within these reinstated government structures, radically new managerial processes have been placed, in particular new forms of contractual management and new methods for the surveillance and control of important elements of GPs' clinical practice.

### Background

If formal governance structures alone determined the balance of power between doctors and managers, one would predict that this circular evolution would temporarily perturb the balance but in the end produced little net change. However, both NHS managers and at least a minority of GPs behave as if the balance of power has shifted in favour of management. The present paper directly examines how the media through which managerial power over doctors - and the reverse - are exercised have changed in English NHS primary care since 1991.

### Theories

Historical narrative collating primary data from a number of multiple case-study research projects in English primary health care during 1998 to 2005 and other (published) studies.

### Results

Successive formal structural changes have tended on balance to erode the centrality of the medical contribution to core NHS activity, change the character of clinical autonomy; bring increasingly wide and detailed clinical issues onto managerial agendas; and to promote the development of new professional disciplines in both management and medicine. On balance, management power over medical practice has tended to increase. The changed organisational processes within them therefore belie the similarities between the present-day NHS organisational structures and those of the 1990s, and have produced a gradual shift of power in favour of managers. Whilst these changes can be attributed to the changing of governance structures, it would be simplistic to equate different governance structures with different allocations of power. Rather, each successive re-structuring process has given managers an occasion to re-negotiate managerial and doctors' roles in primary care, and install new managerial processes of surveillance and reward. The 'churning' of governance structures is what has allowed a strengthening of the sources of managerial power. Of these changes the shifts in agenda control, professional discipline and contractual incentives – all facilitated by evidence-based medicine – have been central.

## THURSDAY 11.00-12.30

## THEME 2: ORGANISATIONAL POLITICS

***Who Decides? Power and persuasion in healthcare systems***

# Power in Health Care Organisations: Contemplation from First-line Management Perspective

Isosaari U.

*University of Vaasa, Finland*



### Research

Organisations are powerful combinations. If one kind of power is predominant then the organisation takes its shape. Sources of power in organisations are decision-making, deliberation, control of resources and control of knowledge and networks. The aim of this study is to examine 1) What power means in health care and 2) What power type health care organisations represent when looked through the first-line management perspective and what factors are connected to it? The examination is done by sources of power, revealing the organisational power configurations presented by Mintzberg (1983): instrument, closed system, meritocracy and political arena.

### Context

Public health care in Finland is facing serious challenges due to increasing demand caused by an ageing population, new expensive technology in care and more demanding customers. Health care professionals work under pressure to make service production more effective. At the same time, a workforce shortage is lurking around the corner.

### Background

In health care organisations, traditional organisational models are bureaucracy and professional organisation. New waves of result-based management has delegated tasks to unit level and put first-line management in focus. First-line management consists of managerial work done on organisational level above the lowest hierarchical level. First-line managers work on individual level and partake often in hands-on work in their units. The power position of first-line managers is essential when managing relationships in complex hierarchies. First-line managers set the tone for their units and motivate the personnel towards the joint target.

### Theories

The empirical study was executed by a survey in 10 Finnish hospital districts both in specialised and primary care. Respondents were all first-line managers and sample of staff members from internal disease, surgical and psychiatric units and outpatient and primary care units. The number of respondents was 1197. The data was analysed statistically by building sum variables and examining their values in background variable groups. Connections between variables were studied with correlation, partial correlation analysis and table elaboration.

### Results

As a result, it can be seen that certain kinds of organisational structures support generations of certain power types. Bureaucratic organisations generate instrument or closed system organisation, professional organisations generate meritocracy, but political arena and result-based organisations are also connected to political arena and meritocracy. First-line managers regarded health care organisations as instruments when staff regarded them mainly as meritocracies having features of political arena. Managers experienced their position limited by rules whereas staff members regarded their position to have lots of space and influence potential. In specialised care was found power types instrument and meritocracy whereas in primary care closed system and political arena.

The appearance of political arena can be seen as a sign of the transition stage health care organisations are facing. The pressure of efficiency and structural changes, including changes in municipal structure in Finland, causes instability in power relations. This can be an opportunity for first-line managers to have a greater impact in their organisations if they can recognize their own potential.

# The Power Game in decision making in Greek hospitals

**Balasopoulou A.**

*National School of Public Health, Greece*



**Research**

There is a need for major changes within Greek hospitals in order to improve the quality of care provided. Instead of this, a number of interventions designed for improvement have failed. The question is why these failures have occurred. Usual answers are that the problem can be identified at the middle management level or in the high political orientation of the system, but do these constitute an adequate explanation? What is the real decision-making context that influences the results? Is there room for a power game?

**Context**

The decision-making context in a hospital organisation is very complex. However, the power of the different groups is an essential part of this context, especially within the public sector. The Power Game and cycles of power are interesting and important issues, and understanding them may facilitate a further and deeper understanding of the real roots of the conflicts arising in hospitals.

**Theories**

The theory used to interpret the issue of the power game is the "three dimensions" model of power introduced by Luke, applied to the public hospital organisation, focusing on the extent of consensus building in decision making as well as on the interpretation and handling of conflict, without excluding the critique considerations. As a supplement, the "Circuits of Power" can also be used to illustrate players and their functions.

**Results**

This paper shows that decision making is based formally on the hierarchy structure but the strong political orientation of the system, which appears with several different faces, has significant impact on the final outcome of the process. Politics influences practice, particularly as the roles of the "Authority", the "Expertise" and the "Power" are often identified with different people, irrespective of their formal role. In addition, the "policy preferences", the "interests", and the "rules" –legal or practical, influence the agenda. This paper also shows how non-decision making on the one hand and easy decision making on the other hand are two extremes of the possible expressions of the power game within the hospitals. They characterize a great proportion of the decisions and have the potential to create an unstable environment, in which trust and the attempt to create consensus have disappeared, as well as managerial effectiveness. In this context conflicts are common and resistance to real change is easily developed. The analysis of the levels of power, related to the roles, the rules and the concepts above can be mapped and discussed. The reformation of the power is an important issue and may be a pre-requisite for managerial improvement. The feasibility of such a reformation is also discussed.

# Politicians and policy makers – where are managers in policy creation? An inclusive approach for Tertiary health care policy in Serbia

Katrava A[1], Jekic I[1], Boulton G[1], Rupert P[1], Christensen SB[1], Obrovacki M[1], Novak S[1], Jankovic-Vukovic T[1], Djukic V[2], Pesko P[2], Draskovic D[3], Dujmovic F[3], Trenkic S[4], Pavlovic D.[5]

*[1]EAR TA Team Sofreco, Serbia, [2]Clinical Centre of Serbia, Serbia, [3]Clinical Centre of Vojvodina, Serbia, [4]Clinical Centre Nis, Serbia, [5]Clinical Centre Kragujevac, Serbia*



## Context

Traditionally, politicians and policy makers dictate to health care institutions' managers a national strategy for service delivery. The EU/EAR Project provided to the Ministry of Health (MoH) has been charged with reforming tertiary care services and implementing an EIB loan of €200m in the beneficiary institutions: the four Clinical Centres in Belgrade, Novi Sad, Nis and Kragujevac, for their rehabilitation and strategic development. All policy decisions made at a political level and in these four out of 120 inpatient institutions will have a trickle down effect to the rest of the system - for patient care, teaching and research.

## Background

Similar to most systems in Europe, policy and decision-making in the Serbian health care system is centrally planned, regulated and managed. The EU/EAR Project's inclusive approach, linking organisational change in institutions and policy change at a national level, is endorsed by the MoH, and for the first time provides the opportunity for managers to be involved in both. In addition, for the first time, planning at a national level is service rather than institution-based and involves practitioners (managers in Tertiary Health Care (THC) institutions, Institutes for Public Health (IPH) and Health Insurance Funds (HIF)).

## Theories

The four Clinical Centres, with over 14000 employees, 220000 admissions, 120000 surgical cases and around 2.3m outpatients visits, represent one-quarter of the activity and budget of the Serbian health care system, and are leaders for change in other sectors (primary and secondary health care).

Managers of this small number of big institutions are increasingly asked to be members of policy bodies, alongside top opinion leaders in the country - and they are influencing change at many levels. THC policy and renewed service delivery model is to be implemented by managers in the four Clinical Centres.

## Results

The official mechanisms for managerial involvement include: the THC Expert Group and Task Forces mandated by Ministerial Decree; and the Clinical Centres Senior Management, Clinical Directors and Work Groups.

Areas the MoH is seeking advice on include: organisational structure of THC services; redefinition of capacity plans and capital investments (facilities and equipment) for THC institutions and redeveloped THC services, HR planning, models for financing of and contracting with THC institutions, health technology assessment (HTA), etc. Since establishment in June 2006, the THC Expert Group has developed, completed and presented most general parts of tertiary healthcare policy and now needs to address the more detailed issues to convert THC policy into strategy.

Additionally, THC service-specific Task Forces have been formed by Ministerial Decree to advise on practical issues of policy, strategy and implementation for Serbia's three population catchment areas (North, Centre and South) until mid 2008. The paper concludes that health care managers of four big university institutions and their teams are increasingly involved in THC policy development through all mentioned bodies and mechanisms.

## THURSDAY LUNCH 12:50 - 13:50

### SATELLITE SESSION:

***Equity and Health***

# Equality of access to healthcare services in the Netherlands: challenges and opportunities within a market system

**Tamsma N.**

*National Institute for Public Health and the Environment (RIVM), Netherlands*

## Research

European policy processes that focus on social protection and inclusion comprise objectives to ensure equal access to good quality health services. To facilitate these processes, the European Commission is keen to understand access barriers faced by vulnerable groups in society, how these barriers may exacerbate poverty and social exclusion, to what extent the organisation of healthcare systems may ease or reinforce access barriers, and what policy measures may be taken to ensure access and tackle inequalities.

Led by EHMA, an international consortium of researchers set out to answer the Commission's questions under the banner of 'HealthQuest'.

## Background

The European Commission has acknowledged the interaction between poverty, social exclusion and poor health. Across political systems, it supports member states to break that cycle. The HealthQuest study was to provide the Commission with more in-depth understanding of that process.

As one of the showpieces of the previous liberal-Christian coalition government, the new Dutch health system needed to balance social and market values. A closer look at health service access of people at risk of social exclusion in the Netherlands may help to understand the policy options to reconcile tension between political values.

## Theories

The efforts of the consortium included specific reports on access barriers and policy measures in eight countries, including the Netherlands. The study was built on earlier EHMA work in social exclusion and health access, the results of which informed the choice of barriers under consideration. In addition, specific health service access challenges faced by migrants, older people, and people with mental disorders were analysed. Country reports were based on existing material, including grey literature, policy reports, and interviews with stakeholders.

## Results

This presentation will present some salient findings from the Dutch report. Low socio-economic status is associated with poorer overall health status. From that perspective, people at risk of social exclusion could be a prominent client group on the now privatised market for health insurance and services. While legal safeguards seem to have been effective in ensuring broad population coverage, the system does have features that make it more suitable to assertive, well-educated and informed people. The landscape of non-coverage has shifted to include more people from low-income groups. Various access problems that exist each impact on the same population subgroups -such as older, first generation migrants- where they may accumulate.

# A comparison of the observed effects of social class and dental attendance on oral health based on the last two surveys of adult dental health in the UK.

**Gonzalez J, Wilson N, Steele J, Bower E, Donaldson N.**

*King's College London Dental Institute, United Kingdom*

## Research

Has the direct effect of social class on oral health changed between 1988 and 1998?

## Context

In a recent paper[1], we found that the association between socio-economic status (SES) and the number of sound teeth in adults in the UK is partially explained by the pathway through barriers-to-dental-attendance and the actual dental-attendance-profile, with a very significant direct effect from the SES.

[1]'The Effects of Social Class and Dental Attendance on Oral Health'. A.N. Donaldson, B. Everitt, T. Newton, J. Steele, M. Sherriff, and E. Bower. J. Dent. Res. 87(1):60-64, 2008.

## Background

Although the link between social class and oral health is well established, there are still studies that attribute the effect of socio-economic inequalities on oral health to factors that in turn affect social class as mediating that relationship. In our study we examine these relationships, to see if the pathway between socio-economic status and oral health that persisted after accounting for the mediating relationships in the 1998 survey was also supported by the 1988 survey. Discovering any trend in the sociological latent variable is very important in policy decisions.

## Theories

In this study we examine the data on 2971 participants from the 1988 survey to try to detect any structural differences in the two periods in the relation to the effect of socio-economic status (SES) on oral health, paying particular attention to differences in these mediating relationships between these two surveys.

Methods - Structural equation modelling (SEM) and meta-analysis

Materials - Data on the 1988 adult dental survey in the UK and relevant studies from the published literature

## Results

The paper will present evidence that there is a significant part of the effect of socio-economic inequalities on the number of sound teeth in adults that is not mediated by perceived barriers to attending the dentist or patterns of dental attendance in both surveys.

## THURSDAY 16.00-18.00

## THEME 1: THE POLITICS OF POLICY

*The Politics of Decentralisation*

# Political decentralisation in Health Care

Kaarakainen M.

*University of Kuopio, Finland*

## Research

This paper presents the history of decentralisation within the Finnish health system and analyses its future prospects. The research is part of a larger study, the aim of which is to identify how the role of the municipalities has changed over the last decade with regard to providing primary care services, and to demonstrate the future scenarios of Finnish municipal primary care services. The aim of this paper is to provide a new view of health care decentralisation.

## Context

The Finnish health care system is extremely decentralized. This means that each municipality has a primary health care system of its own and inside Finland there are 416 individual health care systems. However, the system has not always been so decentralised and has moved from a centralised national welfare state to decentralized autonomous municipal services.

## Background

To date, municipal primary health care remains the foundation of the Finnish health system, but there is significant pressure to restructure local government and its role in service provision. The Paras [Best] Project was launched by The Council of State in Spring 2005, and in June 2006 a proposal for the Framework Act was put forward to determine the project's policies and schedules concerning the restructuring of local government and services.

## Theories

The method used is content analysis of the political and legislative papers from 1945 to date. The historical document analysis consisted of 64 documents, including government platforms, legislation of health care and municipalities and political papers. The future aspects were studied using the Delfi method was collecting the data from municipal elected officials and primary care decision-makers. Data from the first round was gathered during Autumn 2005, and the response rate was 71% (N= 98). The second round was gathered during Autumn 2006 and the response rate for the second round was 80% (N=89).

## Results

According to this study, it seems that there has been a type of wave motion between decentralisation and centralisation of political power from the state to municipalities in Finland. The meaning of decentralisation has changed over the time and it has developed new forms and dimensions. The Delfi study also suggests that the wave motion between decentralisation and centralisation will continue in the future and it is unlikely that it will become stable.

# Autonomy and collaboration: managing local organisational relationships in the English NHS

**Exworthy M[1], Frosini F[1], Jones L.[2]**

*[1]Royal Holloway-University of London, United Kingdom, [2]London School of Hygiene and Tropical Medicine, United Kingdom*

## Research

How much autonomy (or room for manoeuvre) do local NHS organisations have in implementing national policy and reconciling local strategies?

## Background

The paper explores the local implementation of recent English health policy which has sought to decentralize power to health-care organisations as efforts are made to develop inter-organisational collaboration. Decentralisation is evident through Foundation Trusts and an activity-based funding formula (`payment by results') whilst collaboration is evident through (for example) clinical networks. Using empirical evidence from an on-going research project, this paper explores the impact of local context upon the evolution/trajectory of local inter-organisational relationships in two contrasting case-studies.

## Theories

Theories: decentralisation, organisational dependencies, contextual influences and their impact upon performance.

Methods: qualitative

## Results

Initial results suggest four emergent themes:

1. The impact of national policies on local organisations: local organisations are affected by multiple national policies but their local impact upon decision-making seems to vary.

2. The nature of informal relations in shaping organisational culture: Local cultures can be defined organisationally, professionally, hierarchically and functionally. Despite formal arrangements, informal relations are embedded in local cultures. Local stakeholders have long-term alliances across organisations which both constrain and enable cooperation and conflict.

3. The diverse influences on performance: notions of performance can be divided into formal (which refers to official metrics (such as government targets) which has a significant impact of organisational decision-making) and informal which refers to perceptions and attitudes (e.g. trust, reputation). It also includes the concept of `dramatic performance', involving ritual. Analyses of organisational performance need to incorporate both dimensions.

4. Notions of autonomy: local autonomy is highly contingent and variable, depending on (not least), national policy, informal relations and types of performance. Evidence suggests that autonomy does not necessarily lead to innovation, but can also involve caution. Much depends on the nature of local context across organisations, in the local health economy.

# Changes in political governance structures in the Swedish county health care

Stenberg J.

*Medical Management Centre, Sweden*

## Research

The purpose is to describe the changes in political governance structures in the Swedish health care system during the period of 1998-2007. The time period covers three general elections. The specific questions are:

- How can county council political governance structures be categorised?
- How often does political governance structure change during the period?
- If there is a structural change during the period, to what structure does the political governance structure change to?
- To what extent do shifts in political majority also result in change of political governance structure?

## Context

The health care systems of the Nordic countries share notable similarities with taxed based systems and universal coverage. However, there are significant differences in structure. This observation could apply to the Swedish health care system.

This paper focuses on the organisational changes to the political domain in the county councils. As in other organisations, regardless of core mission a common used method of change is by restructuring the organisation. This is also true for the county councils, where the political domain often takes restructuring initiatives. Changes in the political organisation indicate changes in the other organisational domains: administration and the medical services.

## Background

Healthcare organisations face a number of challenges in a changing globalised world which put pressure on management abilities. A method used for organisations to respond to challenges is organisational reforms. Research has provided some explanations for and criticisms of this, but has not provided managers with many useful tools to better understand organisational structures. Indeed managerial attention to organisational restructuring has grown in health care. Organisations appear to have been matched by a corresponding decline of interest in structure in the research community.

## Theories

Document studies and research reviews on structural change.

County councils formal documents were examined classified and analysed.

Theories about structural complexity were used to operate the categorisation of the political governance structures in the Swedish county health care system.

## Results

A new classification of county councils is suggested, which enables longitudinal comparisons and descriptions of structural changes. Three main models are suggested: the empowered assembly model, the executive committee model and the split executive committee model. Each model comes with a unique set of characteristics and implications.

During 1998-2007 Sweden held three general elections. Out of 21 county councils, 13 changed their model and almost all changed towards the empowered assembly model. This paper argues that this model is historically new and raises questions about the role of the politicians in the system as well as issues about centralisation. There is no general correlation between change in political majorities and change in model. Changes most often occur during the same political majority.

Some researchers suggest that managers focus too much attention on reorganisation as the sole solution for change and argue that managers instead should pay more attention to the organisations strategic development. This paper raises the question of whether there is a need to shift the balance between reorganisation and strategic development, or whether we could do both.

# Healthcare, a balance between state and local jurisdiction, public and private sector

**Gabrilo A, Gabrilo I.**

*Association of Healthcare Employers, Croatia*

## Research

Should municipalities participate more in healthcare expenditure, although the state politicians create rules and expenditure that need to be covered? Do local politicians prefer to invest in football clubs rather than in the healthcare system? Should patients pay more for services?

## Context

- In Croatia, primary healthcare is seen as a gatekeeper, but receives only 15% of total healthcare funding
- The state budget covers only 3% of total healthcare expenditure, with 97% covered by the employers via the state fund and by patients.
- Local government refuses to participate in healthcare payment, although obligated by law.

## Background

Primary healthcare in Croatia is entirely privatised, with a majority of private practices having a contract with state fund. In their monthly fees from the Fund there are no resources for new equipment, replacement during sickness, etc. because the calculation was done for the non-profit sector before the privatization took place. Local governments should participate by the healthcare act, but they do not at present.

## Theories

- Materials from our members, private practices in healthcare, state fund, ministry of health etc.
- Responses by the municipalities and local politicians to our questions
- Our research on the subject

## Results

Our results show that there are too many municipalities in Croatia to enable them to allocate adequate resources for healthcare. The paper argues that the State budget should also increase its participation to 30% of total healthcare expenditures as in other European countries, and that local politicians should consider health as their most important concern and cooperate with each other more efficiently. The paper also argues that State funds should increase transfers to primary healthcare by at least 80% in order to organise it as the gatekeeper of the system, to acquire new equipment and educate doctors and nurses according to European standards so they could cure up to 80% of diagnosis. The results also suggest that at present, family doctors often refer patients to the secondary level of healthcare rather than treat the patients themselves, as they are not motivated and have limited resources.

# How to meet the economic and sociodemographic challenges to health systems

**Leskinen H - (*Tiri H.*)**

*Joint Authority of Kainuu Region, Finland*

### Research

Hypothesis:

Regional self-government promotes development in the Kainuu Region and strengthens its future by increasing regional self-governance and inter-municipal co-operation. By focusing the policy-making regarding municipal basic services and funding under Regional Council, the quality and attainability of services in Kainuu is secured, despite the negative population forecasts. Simultaneously, the equal changes for public services are secured for inhabitants in eight municipalities of Kainuu.

### Context

Kainuu Region is responsible for social welfare and health care services, upper secondary education, vocational education and vocational adult education. In Finland in general, municipalities are responsible for the same issues. Kainuu Region is also responsible for general industrial policy as well as planning and development of Kainuu Region. Kainuu Region started its operation at the beginning of the year 2005, and according to the Act, the experiment will go on until the end of the year 2012.

### Background

Reasons for the initiation of the self-government experiment were fivefold: a decreasing population; increase in the older age groups; declining entrepreneurial activity and employment; a weakening municipal economy; and existing administrative and budgeting practices that were not considered to provide sufficient support to the initiation of major, effective industry and business development projects in the region

### Theories

Data for this paper have been collected from the evaluation, and from annual and other reports in the organisation.

### Results

Responsibility for the specialised and primary health care, and most of social and educational services has been transferred from the municipalities to the Region, through the following means:

- Responsibility for financing remained with the municipalities
- Health-promotion and preventive services have been included in the Regional Strategy and Regional Programme
- The units promoting family welfare have been grouped into the area of family services. The goal is to secure equal services for the whole region
- The need of growth in the services for the elderly has been managed by investing on the community care and in supporting life at home
- Step have been taken to work towards a seamless co-operation between primary health care and specialised health care, decreasing institutional treatment
- Smooth data transmission between primary and hospital care
- First aid and transportation of patients has been organised regionally

And with the following results:

- Clients/patients who have used social welfare and health care services have given more positive feedback than those who have not used those services.
- Citizens have not strongly utilised the possibility to choose or change the place of treatment
- During the self-government experiment in 2005-2007 expenses of health care and social welfare increased on average 4,2 % per year, before the self-government the figure was 6,9 %.

## THURSDAY 16.00-18.00

## THEME 2: ORGANISATIONAL POLITICS

***Lean - the politics of improvement***

# Application of Lean Thinking in Health Care: Promises and Pitfalls

Mazzocato P, Brommels M, Thor J.

*Karolinska Institute, Sweden*

## Research

The study aims to investigate how the powerful theory and principles of Lean Production can be put in practice in health care organisations. The main research question focuses on whether and how the Lean Production System optimises resource use and leads to patient centred services that address patient requirements in terms of the variety, quality and quantity of services, and short waiting-times.

## Context

During the last ten years there has been an increasing interest to implement the Lean Production approach in health care. What experience shows is:

1. A limited understanding of what lean is about.
2. As a consequence, little insight of what "lean implementation" requires.

Based on the evidence available (including scientific papers, grey literature, and interviews with health care managers) the paper reflects on the potential promises and pitfalls of a "lean health care delivery system".

## Background

Health care managers are constantly seeking to develop new models to substitute the traditional "practitioner centred" model to deliver services with a "patient centred" approach. One way of doing this is to apply the Lean Production model. However, besides organisational and cultural barriers to overcome, the effectiveness of this approach it is still unproven. Health care managers and politicians are increasingly seeking to base their decisions on evidence. In line with the conference theme, this paper aims at highlighting the present evidence around Lean Health Care, which represents a new model of service delivery.

## Theories

To increase the understanding on how the lean model is being used in health care, the method chosen is a "realist review" (Pawson et al. 2005) of published reports. A realist review is a theory driven approach that aims at investigating "how" management and policy interventions work (Pawson et al. 2005). The result is a series of contextualized conclusions concerning how the intervention works in relation to the underlying mechanisms (Pawson et al. 2005)

## Results

The Lean approach is being introduced in health care organisations as an incremental approach to improve support and sub-processes, rather than cross-functional care processes. This is often consistent with the idea that starting "small and simple" (Spear 2005) facilitates the learning of employees. In a later stage they can then move to more complex processes and functions. On the other hand, this finding could be a symptom of a limited understanding of what lean is about. The Lean Method cannot be interpreted as a simple set of tools, but is rather an operations management system based on flow maximisation and waste elimination (Liker 2004). To benefit on the high-potential of lean in health care it is fundamental to understand how it works and to figure out that, as in the industrial sector, its success is "ultimately based on its ability to cultivate leadership, teams, and culture, to devise strategy, to build supplier relationships, and to maintain a learning organisation" (Liker 2004:32).

# Challenging and changing every step of the surgical pathway in an NHS Hospital

**Hemadri M, Sadowyj G, Moore P.**

*Goole and District Hospital, United Kingdom*

## Research

Is it possible to challenge and change every step of the pathway in the care delivery of elective surgical patients and run a different pathway within an existing system?

## Context

The issue was to change the surgical pathway using a bottom up approach and we report on the political lessons learnt while we made it happen.

## Background

In the NHS, elective surgical patients having intermediate problems have a pathway involving up to 6 visits to the hospital. The changes in the NHS such as 18 week delivery plan and choose and book meant that the time scales for the pathway are reduced but must be met. The NHS works the same old pathway faster.

We questioned firstly if all the visits were necessary. We changed every step of the pathway at one go, thus a revolutionary change. We trialled the pathway and now have a system in place.

## Theories

This report is based on the creation, working and results of the one stop general surgery service for elective general surgical patients which evolved over a period of 18 months and delivers a pathway which demanded 4 to 6 hospital visits to just a single day's contact with secondary care. We mainly look at the political issues from a qualitative point of view though a small element of quantitative information is presented.

## Results

Conventional pathway changed to One-stop pathway; Conventional 4 to 6 visits to secondary care reduced to one single visit. We offer the pathway for a wide range of pathologies, age groups etc.

We have challenged every step of the surgical pathway, finding that:

1. For minor and intermediate surgical patients the first consultation can take place on the day of surgical operation.
2. Telephone pre-assessment for anaesthetic purposes is adequate for minor and intermediate surgical patients.
3. Telephone pre-assessed patients needing further pre-operative tests can have it done on the day of the surgical procedure
4. Nurse led discharge is adequate for minor and intermediate surgical patients.
5. Patient generated follow up is adequate for minor and intermediate patients.

The political lessons we learnt are counter-intuitive to current thinking.

We found that:

a) It is possible to complete a project that does not directly address any specific central objective.

b) A project team with its meetings, office, budgets and reports are not always needed to run a project.

c) A loose alliance can be as effective as an official project team.

d) A rigid infrastructure can be used flexibly.

e) Bottom up leadership is possible

# Focusing on improving clinical outcomes using a patient centred approach allows you to effectively manage the challenges of healthcare economics and policy

**Middleton R, Olyslaegers Ch, Wainwright T.**

*The Royal Bournemouth Hospital, United Kingdom*

## Context

Prior to 2007, the Orthopaedic Department at the Royal Bournemouth Hospital was already one of the largest hip and knee joint replacement centres in the UK.

To date, capacity at the Trust had been sufficient. However, with pressures to meet the 18 week target, it became clear that the existing model of service delivery needed to be challenged. This need was addressed by the authors who formulated a clear vision on how to address the need for increasing capacity whilst positively influencing patient care. An entirely patient centred pathway was formulated in combination with the best available research evidence.

## Background

This case demonstrates how dramatic improvements to patient care can be made whilst negotiating the complexities of organisational politics and ensuring that health budgets are maximised.

A key component to achieving change was the engagement of committed clinicians from the start who have ensured that the traditional organisational and professional boundaries were blurred so that all members of the team worked towards a single shared goal.

By concentrating on the patient, and effectively engaging with clinicians, healthcare managers can achieve rapid change which will ensure the expectations of both the patient and wider healthcare policy can be met and surpassed.

## Theories

The patient pathway was redesigned in line with the best available evidence form current literature and based upon successful models of care utilized in high achieving orthopaedic units. The new pathway utilized guidance from the “NHS Institute for Innovation and Improvement” and also adopted procedures in accordance with the principles of “lean working”. Patients received enhanced pre-operative assessment and education and all elements of the pathway were standardised leading to greater efficiency and quality of outcomes. A robust system of audit and performance measurement was also introduced to ensure high standards of governance and immediate feedback of clinical outcomes.

## Results

Since the new pathway was introduced 5 months ago, 508 patients have been operated on and the results are extremely encouraging. The average length of stay for total hip and knee replacement patients is 4.0 days (first 496 patients). This represents a substantial clinical and economic difference to the previous average length of stay for patients in the trust, which was 7.8 days.

All 508 patients were admitted on the day of surgery and commenced surgery within 4 hours of being admitted to hospital. Previously all total hip and knee replacement patients were required to come into hospital the day before their surgery. This has been accompanied by excellent patient feedback. High patient satisfaction has been expressed with regard to the pre-operative education class and the overall in-patient experience.

The paper argues that rapid and progressive change is possible within complex organisations such as the National Health Service. However, the ability to achieve improvement is directly dependent on the drive and leadership of the healthcare managers involved to ensure that change is patient centred. Putting patients first galvanises professional groups and helps to negotiate complex organisational politics and ensures that the economic challenges to modern healthcare can be overcome.

# Day Surgery/ Day Hospital: Challenging existing models of service delivery in a transitional country

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## Context

Day Surgery/Day Hospital models of service delivery are in their early stage in Serbia. The health reform targets call for 3-5% annual increase in ambulatory services.

The EU/EAR Project provided to the Ministry of Health (MoH) has been charged with reforming tertiary care services and implementing an EIB loan of €200m in the beneficiary institutions: the Clinical Centres in Belgrade, Novi Sad, Nis and Kragujevac for their rehabilitation and strategic development.

The four largest university hospitals in Serbia have over 220,000 inpatients and 120,000 surgeries annually and rather low day surgery/day hospital cases rates.

## Background

Even when the evidence for change to clinical practice is strong and seemingly self evident, there is no guarantee that it will be adopted. This is a classic management of change issues that involves "soft" factors such as professional attitudes and "hard" factors such as data, resources and the appropriate funding system from the Health Insurance Fund (HIF) as an incentive for this change. Currently, the HIF funds the hospital based on a "hospital day" and therefore are operating budget disincentives to "shift" to day surgery because the HIF will not reimburse the hospital for a day case.

## Theories

Over the past seven years, the Clinical Centres have still been operating under unchanged legislation, models for service delivery and fixed operating budgets, representing limitation for the hospitals to respond to increasing demands of emerging ambulatory service delivery model.

The EU/EAR Project is a vehicle with capital investments providing an opportunity to restructure space for more day surgery and day hospitals, to facilitate professionals buy-in to this model of service delivery, to motivate the MoH in supporting this change due to systemic improvement in quality of care and lowering costs; and to influence the MoH and HIF to change financing models.

## Results

It is an internationally accepted standard that 70% of elective surgery cases can be undertaken in day setting. In 2008, specific annual targets for 25 selected procedures that can be done safely and effectively as day cases will be set in a step-wise fashion.

Given their magnitude and high case-load, the four largest university hospitals in Serbia offer a large area for improvement in quality of care, decreasing hospitalisation rates and ALOS, increasing patient satisfaction and decreasing cost per patient.

In each Clinical Centre Work Groups for Day Surgery / Day Hospital were formed to analyse their existing service delivery model and patient flows in order to be able to meet the MoH target of an average 3-5% annual increase in ambulatory care. Some preliminary models of financing day procedures such as chemotherapy, cataract procedures, pacemakers and cardiac catheterisations are already in place.

Specific annual percentage rates on the five year period (2008-2012) basis and an implementation plan with different targets for each of the 25 potential day cases have been done (eg. 30% of cataract extractions and 20-30% of hernia repairs as day cases in the first year), in order to secure sustainable shift towards ambulatory care model.

# Experiences from stepping down care level from normal wards to internal patient hotel as a way of providing better service delivery at lower costs

Foreland N[1], Osterman S[1], Mjos E[1], Fjeldsbraaten EM[2], Torjesen DO[2], Solvberg TA.[1]

*[1]Sorlandet hospital, Norway, [2]University of Agder, Norway*

## Research

Experiences from stepping down care level from normal wards to internal patient hotel as a way of providing better service delivery at lower costs

## Background

New and changing treatment methods, combined with a focus on cutting costs, challenges existing models of services, numbers of hospital beds and care levels. In 2006, SSHF established internal patient hotels in two hospitals as an alternative to patients needing hospital admission, but not frequent supervision, treatment and care in an ordinary ward. Ordinary hospital beds were stepped down to a patient hotel, sustaining the same medical treatment, with a 2/3 reduction of nursing costs. The service level was designed so that patients could use, to a greater extent, their own resources to promote health.

## Theories

Experiences from wards with previous reduced care levels in the hospitals of Kristiansand and Drammen were collected through interviews. In addition, experiences were gathered through interviews and field studies at the internal patient hotel in the hospitals of Karlstad (Sweden) and Harstad. Previous research reports from Arendal and Kristiansand hospitals (SSHF, 1996) were also examined. These studies and interviews were used to design the patient hotels in Arendal and Kristiansand. Cost and patient satisfaction surveys after 1.5 years of running these internal patient hotels are analysed.

## Results

Challenging existing models of service delivery gives great challenges to existing cultures and attitudes among staff. Some of the staff concerns arise from resistance to change, the traditional way being more familiar (and perhaps safer), and fears that the changes could imply staff losing control of “their own” beds or losing power. Experiences show that it is essential for the internal patient hotel to be placed inside the main building of the hospital and to have nurses available 24 hours a day whom are able to perform simple treatment. Analyses of costs, patient satisfaction surveys, and experiences from staff indicates that stepping down care level from normal wards to an internal patient hotel is a successful way of providing better service delivery at lower costs. The patient satisfaction surveys show a high satisfaction with the level of service delivery. Patients report being able to take responsibility for their own health and treatment and feeling safe. The medical treatment has been held to be at the same level and cost analyses show a reduction of costs without reducing medical activity.

## THURSDAY 16.00-18.00

## THEME 2: ORGANISATIONAL POLITICS

***The Politics of Healthcare Leadership***

# The danger of "returning boss"

**Nenonen M[1], Nenonen A[2], Pollari J[3], Aronkytö T.[4]**

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## Research

In health care organisations, it is common for the managers to collect experience and new skills by working in another organisation for a limited period of time, ranging from few months to one year. In positive cases, the returning boss may revitalise his or her organisation and speed its development to a new level of organisational expertise. In our career as consultants, managers and employees we have, however, seen many variations of this theme. In this presentation we ask what is the secret of success and what is a guarantee of failure when a boss returns to his or her organisation.

## Context

In most positive cases, we have seen the boss take the control of the situation and launch new developments within a few months after his or her return. In most negative cases, we have seen how all development stops within a few weeks after the return and the atmosphere turns highly political, with formation of parties fighting with each other (political feuds/factions). Within a few months the most talented people start to leave the organisation and all the possibilities for development are soon lost.

## Background

The variation in absenteeism of the boss has been from a few weeks sick leave to two years in another organisation and still the end result may be the same. What has been common in all the cases we have observed is the shift of focus from customers to politics inside the organisation.

## Theories

This is a qualitative study. We used observational methods and group discussions to derive the key factors of each case we studied. We tested different theories dealing with "trust" and interpersonal communication. However, we returned to a very simple model of "space and time" to explain these phenomena. This study gave support to our previous observations showing that for trust to develop at the target organisation, it is important to create and continue an interaction in which mutual experiences can be shared so that mutual values and intentions can be identified (EHMA 2007, Lyon Pollari et al.).

## Results

When you remove one of the key actors in the play, the boss changing to work at another organisation, the development continues at two different places and in two different time: the organisation either continues to develop under new and temporary management or becomes stagnant and the boss continues his or her personal development as a manager in the new position.

When the boss returns, the key question seems to be:

a) Is he or she returning (in his or her mind) to the same place and time where he or she left the organisation or

b) Is he or she returning as a different person and with different skills to an organisation which has developed often fundamentally during his or her absence.

Case "a" leads to an immediate conflict and to a fight for power. This turns the organisation highly political and stops all development since all the energy is used for internal politics. The case "b" demands a more humble approach but leads to strengthened development.

To secure the optimal results, it might be useful to plan the return of the boss already when he or she leaves the organisation.

# Leadership in professional organisations – the case of child and adolescent psychiatry

**Vikdal G.**

*Innlandet Hospital Trust, Norway*



**Research**

What roles do professional and organisational competence play for leadership, and what other requirements are essential for successful leadership?

What is the importance of professional collaboration for leadership?

What bearing has an existing or lacking shared treatment tradition have on leadership?

**Context**

Healthcare in general and psychiatric services in particular are undergoing considerable changes in Norway. Specialist services, previously part of county administration, were in 2002 transferred to government-owned hospital corporations. Generous government funds have been allocated to expand and develop mental health services. The aim of this study was to explore leadership in professional organisations, especially healthcare.

**Background**

Child and adolescent psychiatry was assessed as a fruitful specialty to study, as it brings together several professional groups and specialists, it has less medical dominance as psychiatrists for a long time have been scarce, and lacks a strong and unifying scientific knowledge base. For those reasons, it is also an example of organisational politics at work as professional relationships are complex and the power of different professional groups unclear.

**Theories**

A strategic sample of eleven leaders of Norwegian child and adolescent psychiatry units were interviewed. Interviewees represented different professional backgrounds, unit sizes and parts of the country. Interviews were transcribed verbatim and content analysis was performed.

**Results**

Norwegian leaders in child and adolescent psychiatry have, regardless of background, a strong professional identity as clinicians and are driven by professional ambitions. The leadership task is valued lower than clinical activities. The leaders are extremely staff focused and take on a ”self-sacrificing” role. They see their role as complex and their responsibilities as unclear. Professional competence, long working experience, formal leader position and personal authority were important factors strengthening the leaders’ legitimacy. Many clinical competences and a variety of experience, typical of child and adolescent psychiatry, are seen as positive features by the interviewees, but those also encourage the protection of professional territories and lack of clarity about the relations between professional groups. The discipline has a weak research tradition, but the different professional groups have relatively uniform treatment practices internally. Clinicians have a high degree of autonomy as to the choice of treatment. Goal congruence is reached by establishing a shared ”ideology” of multi-professional collaboration. Leaders usually do not control clinical activities but focus on administrative and organisational tasks. Many leaders make the active choice of focusing on their own unit and experience a conflict between their goal of improving services to patients and what is required by the hospital corporation.

# Health care executives as binding outsiders in politicised organisations

**Stoopendaal A.**

*Erasmus University, Netherlands*



### Research

Health care executives govern large, complex and often fragmented organisations in which the distance between policy and practice is often huge. An important effect is that - in some way - health care executives have become remote from their own organisations. In this study I focus on the question 'What strategies do executives develop in order to deal with these complexities, while being detached outsiders themselves?'

### Context

The complexity of governing health care organisations is based firstly on the variety of social/medical work, secondly on the fragmented way in which health care organisations are organised, and thirdly on the autonomy of the professionals which always creates a gap between policy and practice (Lipsky,1980). Constructed by ongoing specialisation processes and growing scales, the organisations became fragmented in layers and isles. The distances between this layers and isles are inherent to internal political games.

### Background

The aim of this presentation is to reflect on how health care executives deal with the complexities and processes in the distancing and fragmentation that take place in their organisations.

### Theories

This paper is based on the results of the PhD study 'Care at a distance', which focuses on how health care executives in large care organisations structure the twofold task of remote management on the one hand, and being involved with patients, personnel and primary processes on the other. The empirical data have been gathered by three ethnographic case studies (interviews, observation, documents) in different sectors of Dutch health care.

### Results

In order to cope with the fragmented order of health care organisations, it is in the first place necessary for executives to notice the ongoing construction work with respect to distance and involvement that takes place everywhere in the organisation. Layers, for example, can sometimes work in a connecting way through cascading and translation, but they can also turn out to be barriers. And between the islands (departments and locations) bridged rivers or defended walls can be found. Where processes of distance and involvement get stuck, there is a special task for the executive.

Secondly executives can make use of four specific methods to govern distance:

- Governing by extension
- Governing by connection
- Governing by meeting places
- Governing by boundaries

Thirdly, executives play a special role because of their detached position. This position can be a strength instead of a weakness. Health care executives can be bridge builders, strangers or representatives. In a politicised organisation, they can be a binding outsider.

# Clinical focus at Board level in English NHS Trusts

Endacott R, Sheaff R, Jones R, Woodward V.

*University of Plymouth, United Kingdom*

## Research

The aims of the study were to:

1. Refine methods for measuring the concept of clinical focus
2. Examine the effects of differences in Trust Board membership on clinical focus
3. Examine relationships between clinical focus and organisational culture
4. Examine relationships between clinical focus and service outcomes

## Background

UK governments since 1990 have favoured the 'public firm' model for the organisational structure and management practices of public service providers. One consequence has been the creation of a distinctive Board membership and structure for NHS hospitals. NHS Trust Boards are held accountable to higher NHS bodies both by performance management and contestability. Trust Boards are also intended to provide a conduit for clinical issues to influence managerial decisions. Further, the implementation of national standards of care (e.g. National Service Frameworks) presupposes that Trust Boards can exercise a strong leadership role in the clinical domain.

## Theories

Study aims were addressed through a two phase design:

Phase 1: Analysis of publicly available data (Board meeting minutes, biographies of Board members, n= 92 Boards)

Phase 2: Observation during Board meetings (n=10 Boards)

## Results

There was considerable variation in the ease with which 'publicly available' data could be accessed from the Trust websites.

Distinction was made during analysis between clinical focus arising from clinical and non-clinical agenda items. The processes by which clinical matters were raised at the board varied between Trusts, specifically between acute (hospital) Trusts with varying clinical governance processes and primary care Trusts that commonly had a formal committee process to debate and manage clinical issues. Hence the Board role in governing clinical matters could be quite different. The next phase of the study will comprise a survey of Board members, analysis of publicly available service outcome data and organisational measures to examine relationships between Board membership, clinical focus, organisational culture and service outcomes (n=92 Boards).

## THURSDAY 16.00-18.00

# THEME 3: HEALTH POLITICS AND THE COMMUNITY

*Working Across Organisational Boundaries*

# Mentally disordered offenders - the need for integration and "smart" design of services

**Kristiansson M.**

*Clinical Neuroscience, Karolinska institute, Sweden*



**Research**

Integration of medical/forensic psychiatric and social services and collaboration between psychiatry, community services and housing facilities may be beneficial in the rehabilitation process for mentally disordered offenders.

**Context**

In the present paper a model for "smart" design of services to mentally disordered offenders will be discussed. The need for integration of services and environments from the high security hospital to special outpatient and housing facilities in the community will be described. The concept of a "forensic hostel" will be introduced.

**Background**

During the last decades, many mental hospitals in Europe have been closed. This has created a need for new management approaches for patients with mental illness. Mentally disordered offenders present a special challenge since security measures must be integrated in the caring process in hospitals as well as in outpatient services and special housing facilities. In the rehabilitation process, patients will gradually move from security hospitals out in community. This process is complex and requires integration and collaboration between various services.

**Theories**

In the present paper, an example of integration of services in a special housing facility will be described. The organisational prerequisites for beneficial outcome will be discussed. Implications in allocation of resources will also be described.

**Results**

Management of services to mentally disordered offenders must change and ought to include a long-term perspective. Many of the services provided by old mental hospitals are today delivered by the community. This creates a need for the design of new caring processes and environments in order to reduce the risk of relapse in criminal behaviour.

# Managing Partnerships for Improving Health & Wellbeing: Learning from a 'Brave New World'

**Mackinnon J, Fischbacher M, Pate J.**

*University of Glasgow, United Kingdom*

### Research

How can health and social care organisations work together in partnership to improve the delivery of health care services?

What measures of effective partnership management can enhance and demonstrate the performance of integrated health and social care services?

What local, organisational and professional factors have helped and hindered the early development of the Community Health and Care partnership?

### Context

The Scottish Government has recently integrated health and social care organisations through newly formed Community Health Partnerships (CHPs). The CHP model has been interpreted in various ways across Scotland. One Health Board, Greater Glasgow and Clyde, has created a fully integrated, inter-agency model. We have evaluated the impact of the new model on inter-organisational and inter-professional relationships, CHP performance, and organisational change. A range of findings have emerged, with important implications for managers and policy makers. CHP senior managers have already responded by incorporating the findings within organisational development plans and further research is underway.

### Background

CHPs require unified management structures governing activities across and between these organisations. They challenge traditional resource flows, patterns of service delivery, and the role of and interface between the various professional groups involved in the design and delivery of care. Accountability to politically elected members of the public adds a further layer of complexity to organising and managing care in light of external stakeholder interests.

### Theories

This paper draws on theories of partnerships/networks, organisational change, and identity. The paper includes findings from a mixed-method study conducted over a 2-year period. The paper includes material from a staff survey (N=389), and one to one interviews with senior and middle managers, and professional representatives (N=36) as well as one to one interviews in four service areas within the CHP (N=74). The case studies allow analysis across strategic and operational levels of organisational integration, and enable comparison of staff experiences around the realities of service integration at various stages in the integration process.

### Results

The way in which organisations and services are brought together is a source of considerable anxiety for staff. Issues include changing staff roles and referral patterns, approaches to service delivery, concerns around patient/client safety, relocating staff, the resources required for change and the capacity for change whilst ensuring ongoing service delivery. It is both notable and significant therefore, that parties at present have little sense of inter-dependence – commonly considered fundamental to successful partnership working and essential to ensuring a momentum for change. A particular barrier to change and to partnership working concerns the perceived 'erosion' of professional identity. It is therefore important that the CHP moves towards a focus on service outcomes rather than continued focus on structures or organisational processes, if staffs are to be convinced of the value of ongoing change and organisational development. It is also essential that policy makers and managers identify demonstrable measures of partnership success that provide evidence of the merits of integration in the short and long term if external and internal stakeholders are to continue to support partnership working. Moreover, such measures need to take account of the variable starting points and differing rates of change within each partner organisation.

# Relationship picking: the experience of Italian mental healthcare managers with working across organisations

**Compagni A, Gerzeli S, Bergamaschi M.**

*CERGAS, Universita' Bocconi, Italy*

## Research

In the field of mental healthcare (MH), working in networks with a cross-sectoral and multidisciplinary approach is considered the optimal solution to face issues that are often complex and multi-causal. This translates in the need for MH professionals and managers to handle a complex network of relationships with internal and external stakeholders. The objective of the present study was to map and analyse the network of relationships established by managers in charge of MH services in Italy, their strength and nature, and their relevance in the everyday management of MH organisations

## Context

In Italy, all public MH services are part of one organisational entity: Departments of Mental Health (DMH), of which 205 exist overall. DMHs are complex organisations that include general hospital psychiatric wards, community-based services, day centres, semi-residential and residential services. DMHs are managed by a board and a Head of Department, a senior psychiatrist. Heads of DMH negotiate budgets, coordinate service provision and hire the workforce. The mandate of the DMH is to guarantee service coordination across care settings and integrate the different approaches to MH contributed by diverse actors in the healthcare and social sectors

## Background

MH represents an area in which management can be expected to deal constantly with establishing and facilitating collaborative relationships within the MH organisation itself and with external stakeholders different for approaches, economic resources and power. Inter-organisational links can be based on informal relationships or be formalised, see management involvement and result in resource sharing and joint planning.

The aim of the study was to understand how diffused this idea of management is among Heads of DMHs, what levers they have put in place to promote internal and external networks of relationships, and the difficulties they encounter in doing this.

## Theories

We conducted a postal survey addressing all Heads of DMH in Italy. The questionnaire enquired about: (1) the level of coordination among the different DMH service units; (2) the level of external network with some stakeholders in the healthcare sector (GPs, substance abuse services, child/adolescence MH services etc.) and social sector (local authorities responsible for social services, non-profit and voluntary organisations). For each stakeholder, we asked about the nature of the relationship with that organisation, frequency of meetings at management level, topics of discussion, level of participation of other DMH members, main difficulties encountered in managing these relationships.

## Results

Analysis of the survey responses (53) revealed that coordination of services among DMH units is mainly predicated upon the joint revision of clinical cases and supported by information sharing through IT systems. More organisational tools, such as clinical pathways, that would formalise the linkages between different DMH units, are still rarely used. Creating an intra-organisational network, therefore, appears to be the responsibility of MH professionals rather than of management.

A strong selectivity transpires in the external stakeholders preferred by DMH Heads. The weakest linkage is with organisations providing substance-abuse services and collaboration is mainly left to the initiative of single MH professionals. On the contrary, the strongest and liveliest relationships are those created with local authorities responsible for social services and, especially, with non-profit/voluntary organisations. Not only these organisations offer services jointly with the DMH but their representatives often sit in the management board of the DMH and have frequent exchanges directly with the DMH Head.

DMH Heads might prefer nurturing the relationship with one stakeholder instead of another based on issues of visibility, convenience and strength of the counterpart, and not necessarily according to the patient's need that ought to be satisfied.

# Purchaser-Provider Systems in Psychiatric Care in Sweden – Models and Experiences

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### Research

How do managers in Swedish health services describe the reasons for the recent development and implementation of purchaser-provider (PP) models in psychiatric care in Sweden? What are the characteristics of the PP models used? What is the experience so far from using PP models in Swedish psychiatry?

### Context

This paper discusses the introduction and application of purchaser-provider (PP) models in psychiatric care in Swedish health services. Those models have only been in use for the past five years and experience is now gradually being gained on their use. This experience is of general interest to health care managers and policy makers in European countries.

### Background

As PP models gradually get integrated in regular management of health services in Sweden they are also being introduced in psychiatry. This presentation identifies present reasons for the introduction of PP models in psychiatric care in Swedish county councils as expressed by managers and describe some of the characteristics of the PP models. Also, some early conclusions on the effects of the PP models are presented.

### Theories

Document reviews, auditing and evaluation reports, interviews with health care managers and discussions with implementers of PP in psychiatry were used as sources of information.

### Results

The reason for the introduction of PP in psychiatry was stated to be a need to reorient services to new modes of work and case management, and the impression of low efficiency and quality of public sector psychiatry. PPs were also introduced to meet an increasing need and demand for services. General health policy changes were also important as health services are gradually reorganised towards a purchaser-provider system and contracts and agreements providers varied between purchasers of psychiatric care, like reimbursement mechanisms. Several of the PP models were documented to have had an impact on provider performance in terms of productivity and other measures of performance. It is concluded that purchaser-provider models should be further tried in management of psychiatric services. PP relations serve a purpose to strengthen the clarity around objectives of services and expectations on providers. They also provide a powerful tool, the reimbursement mechanism, through which production can be quickly steered towards desired outputs.

## THURSDAY 16.00-18.00

## THEME 3: HEALTH POLITICS AND THE COMMUNITY

***Upstream Action: engaging the public***

# National community-based project for increased physical activity and healthy eating among children in Iceland.

Heimisdóttir J, Gylfason HF, Jónsson SH.

*Public Health Institute of Iceland, Iceland*

## Context

The prevalence of obesity has increased dramatically in the last decades. Changes in physical activity and eating behaviour are factors that are related to the increase of body weight among children in Iceland. “Everything affects us, especially ourselves” is a mutual development project of the Public Health Institute of Iceland and 25 municipalities with the goal of promoting healthy lifestyles of children and their families by emphasising increased physical activity and improved diet. The project started formally in the autumn of 2005; the first part of the project concluded in 2007 and the second part in 2010.

## Background

The circumstances of children and young people are shaped by society as a whole. If the plan is to improve the lifestyle of young people, cooperation is the keyword. The participating municipalities formulate their own policy and action plans for physical activity and nutrition. In each municipality, an interdisciplinary task force is formed to keep track of implementation of the project. In this respect, the municipalities’ administration, politicians, educational institutions, the healthcare service, sports clubs and parents associations participate in each task force.

## Theories

The project is based on a multi-factorial, population-based, primary prevention strategy, making an effort to increase people's knowledge of the relevant, influencing factors, in addition to promoting better facilities for public health improvement. The target groups are children, adolescents and their families in participating municipalities. The Public Health Institute of Iceland is involved in the project through consultation and instruction. Indicators have been defined that are considered the Critical Success Factors (CSFs) in successfully reaching the goal of the program. The CSFs are contained within three levels; (1) structure, (2) process and (3) impact.

## Results

The Public Health Institute is responsible for the evaluation of the project. The baseline was taken in the spring of 2005 and a status assessment was done in 2007 and will be done again in 2010. During the last two years, the municipalities participating in the program have been responding well. Increased knowledge and changing attitudes by all involved has led to more strategic focus on physical activity and nutrition.

(1) Structure:

Municipal administration.

Agencies and associations within the municipality.

Primary Health care sector

Co-operation between the National Public Health Institute, the primary health care sector, and local government officials

(2) Process:

Municipality’s policy and action plan regarding children’s lifestyle emphasising physical activity and nutrition

Framework for involving parents in healthy family lifestyle.

Framework in Health Education for school children regarding healthy lifestyles.

(3) Impact:

More health-orientated environment in municipalities, schools and kindergartens regarding nutrition

Different factors for each CSFs are outlined for the planning and objectives for the evaluation of the project until the year 2010. Available now are assessment from 2005 and 2007.

The project has also drawn attention to the importance of comprehensive actions for curbing the obesity epidemic, even in non-participating municipalities

# Engaging the Public in Health Science: You and Your Body

**Hamer S.**

*University of Leeds, United Kingdom*



### Research

Can enabling the public to ask questions about health science and find answers in a supported setting have an effect on their perceptions of the value of science.

### Context

The last ten years have seen a growing emphasis in health policy on the importance of "engaging" with the public in order to address a perceived democratic deficit and to embed concepts such as individual responsibility and choice. What has received less attention has been the need to actively engage the public in order to address sensitive areas of scientific and technological policy. It is possible see examples of how greater public/patient engagement have created real tensions in health policy. The public's confidence and understanding of science is critical for advances in health technology to be adopted appropriately.

### Background

This project engaged the local community of the University of Leeds and the Leeds Teaching Hospitals NHS Trust in a series of workshops and events designed to help improve public understanding of health science. Each event had a theme (e.g. You and Your Heart) and content was supplied by a partnership of scientists, clinicians and voluntary groups.

The objectives for the events were:

- To enable the public to ask good questions.
- To inform the public about the latest thinking in health
- To encourage the public to be involved in future research.
- To make science fun and engaging.
- Identify possible partners for future work.

### Theories

Each event combined a series of short talks, hands on exhibits and opportunities for the audience to talk to speakers and exhibitors in an informal way. The events focused on how the body works, what can go wrong, how it can be fixed and how to keep healthy. Exhibits included the opportunity to see new inventions demonstrated and try out interactive learning packages (keyhole surgery). A café style area was set aside where medical students helped people find answers to their questions using online resources.

All events were evaluated using a range of methods, including questionnaires, interviews and focus groups.

### Results

Each event attracted between 120-200 members of the public. On evaluation the audiences' response was very positive with a high percentage of attendees asking questions and enjoying the day. The project also produced some unexpected outcomes, one of which was finding that many people do not see the relationship between science and clinical medicine, science being viewed as an abstract subject. Doctors were not viewed as connected to science and research. We also found that many people continue to have preconceptions that medical experts are unapproachable, communicate poorly and do not wish to engage with "ordinary people". These events went some way to challenging this view. The University was also viewed by the public as unwelcoming and remote.

What next? The public are often well informed and their interest in science is high, however engaging with them appropriately does need care and good partnership working. We have continued to hold more events and are investigating ways of actively involving the public in forming biomedical research agendas. We are working with our new generation of doctors and researchers to make sure they understand the importance of this knowledge transfer activity.

# Health Literacy in Athens: Exploring Sources of Health Information in Adults

**Kondilis-Petropoulos B[1], Akrivos PD[1], Falagas M.[2]**

*[1]Hellenic American University, Greece, [2]Alfa Institute of Biomedical Sciences, Greece, [3]Tufts University School of Medicine, Department of Medicine, United States*

## Research

Health literacy is a relatively new concept in health promotion and in Greece. People dealing with their health have to face the challenge of processing complex medical information, underlying the need for accurate and understandable written and verbal information from various sources on various health issues. Patient's lack of understanding of individual health problems and treatment results in possible higher health care expenditures and worse health outcomes than those patients with higher literacy or health literacy levels. This research addresses the sources of health information, including pamphlets, and patient-provider communication for adult patients in greater Attica of Greece.

## Context

Past research seems to indicate that people with low literacy have a difficulty in understanding written instructions and self-care advice. Patients can neither adequately understand instructions on medicine bottles, nor comprehend standard informed consent forms. The lower the understanding of information, the lower the probability of the individual changing their behaviour in accordance to the information received. This also may lead to a lack of understanding of individual health problems and treatment, resulting in possible higher health care expenditures and worse health outcomes than those patients with full literacy.

## Background

On the whole, persons with low literacy including low health literacy have an increased likelihood for hospitalisation and experience medication errors, leading to important cost implications. Combating the adverse effects of literacy on health care is an important issue to health care policy and management.

## Theories

A questionnaire was developed for adults based on existing journals publications and comprised of five sections including demographics, reasons for visiting the physician, source and type of health information received, use of health related pamphlets by patients, and patient-provider communication.

The questionnaire was distributed from March until October 2007 through a private hospital, a university, private physicians practice and general practice patients, and a convenience sample of other sources. The target population was adults who visited a physician within the last 6 months. Correlations were performed including information sources by age, gender and education.

## Results

N=100, ages 18 to 65+. 95% participants declared their ethnicity as Greek, 57% of the sample was female. 64% of participants came from an outpatient unit of Henry Dunant Hospital; 13% from the Hellenic American University, 9% from private practice, and 14% from other sources. 50% of participants had a university education, 21.9% had secondary school education, 21.9 % had technical school education, while 6.3% had primary school education.

Overall, health information sources indicated that the internet is not a major source for health information. (59.1 % "rarely" to "never" use the Internet for health info). Other possible health info sources such as magazines; television, pamphlets, friends, family and pharmacist had an average cumulative percentage 82.9% for "not at all" to "sometimes". This indicates that either the participants did not use these sources of health information, or use various sources of health information to make health decisions. 57.2 % of respondents will "often" to "always" ask their physician for health information. Out of the 14% who "often" or "always" use pamphlets as a source of information, there was no significant correlation with age, gender or education levels.

The research also found a positive relationship (p-value significant at 0.01 level) between education level and obtaining information through the internet, and a negative correlation (p-value significant at 0.05 level) between age and obtaining information from one's family.

# How can local programs affect population health? Health impact assessment (HIA) a valid evaluation tool.

Falconeri D[1], Frazzica RG[1], Di Mattia P[1], Blangiardi F[2], Tebaide A.[2]

*[1]CEFPAS, Italy, [2]LHO of Ragusa, Italy*

**Research**

Do the politicians/administrators take into consideration the health of the population in all their political decisions? Do citizens participate in this process?

**Context**

CEFPAS, the centre for training and research in public health of the Sicilian Region, has implemented a HIA initiative in the Province of Ragusa, Sicily. This two year project evaluated province and town determinations that may have had an impact on local population's health. The project focused on the integration of individual and public health interventions and used operational platforms placed at community level which became "natural" bases for alliance negotiation and synergy development.

**Background**

Politicians and administrators generally proclaim that citizens and their well-being are at the heart of their work but often this is not the case. HIA offers an innovative approach for evaluating policies and programs based on scientific evidence and congruent with the population comprehensive health needs regardless of the sectors they originate from. HIA assesses decisions' influence on the health and on the quality of life of the target population. The population representatives had a proactive role in the management of the assessment process and in the use of its results.

**Theories**

The multidisciplinary team was composed of politicians, economists, GPs, hygienists, specialists, veterinarians, farmers, environmentalists, representatives of citizens groups and CEFPAS personnel.

The project was composed of 5 main stages:

> **screening:** creation of the instrument; **scoping:** definition of the assessment process; **assessing:** evaluation was carried out; **reporting:** elaboration of the recommendations; **monitoring:** evaluation of HIA. How it influenced on the decision making process and in its sustainability.

A preliminary stage was carried out in order to flowchart in details the steps used to approve the determinations. The instrument of analysis was tested and validated through retrospective assessments.

**Results**

A set of instruments was developed/tested/validated and was used to carry out the first retrospective assessment. A retrospective evaluation was then carried out on two deliberations dealing with waste disposal and the purchase of an electronic mixer. A document with recommendations was produced and presented to the mayor concerning the waste disposal. It was suggested that a safe system to store the special waste laying near the industrial sheds was necessary as the one currently used was considered unhealthy. The purchase of an electronic mixer to substitute the existing one in the city purification plant received a positive note from the HIA team because the municipality prevented possible negative effects to the environment/population health. The mayor welcomed with enthusiasm the initiative and committed himself to continue to support this co-operation asking the HIA team to undertake prospective evaluations on emerging issues.

Furthermore:

- Politicians and administrators start now to appreciate the possibility of carrying out evidence-based decision-making putting the health of the population at the centre of their work.
- Health professionals were enthusiastic to take part in preventive efforts in their communities.
- The population starts to recognise the benefit of evidence-based information for possible lobbying purposes, to protect their personal as well as their community's health.

## THURSDAY 16:00 - 18:00

### WORKSHOP

***Patient mobility and Cross-Border Care***

# The Politics of Trade in Healthcare: The case of 'Medical Tourism'

Lunt N[1], Carrera P.[2]

[1]York Management School, United Kingdom, [2]Management Centre Innsbruck, Austria

## Research

From their inception, healthcare services and other aspects of the welfare state have been largely funded by public and private contributions and delivered to the national population. As such, health analysts have typically viewed healthcare policy, organisation and delivery within the confines of nation-state boundaries. Significant economic, social and political changes occurring at the global level are however, challenging this national focus across a range of policy and service delivery areas including healthcare.

## Context

The case of healthcare in the age of globalisation is most significant as the processes of globalisation bear on the principle of territoriality governing healthcare systems, whereby delivery and access to healthcare are confined to territorial boundaries. Unfortunately, how processes of globalisation are eroding traditional categories of production and consumption of healthcare - and, suggesting new ones - are little understood. This engenders a less than ideal response to the globalisation of healthcare.

## Background

Globalisation, defined as growing interconnections (political, economic, social, and technical), has contributed towards radical shifts in the nature, frequency and intensity of cross-border processes and transactions including people, products, capital and ideas. Changes in economic production, migration, and emerging communication and travel technologies have revolutionised contemporary living. "Medical tourism" as one aspect of the globalisation of healthcare offers challenges and opportunities to health systems.

## Theories

This workshop explores some broad developments of medical tourism focusing on Europe. It also surveys the advantages and challenges of medical tourism at the healthcare system level. Finally, it offers a preliminary sketch of the policy issues that need to be addressed for the further development of medical tourism in Europe.

## Results

The export of healthcare offers the opportunity of harnessing excess capacity into productive use. Importing healthcare, in the meantime, can be a means of overcoming shortages of physical and human resources given the requirements of a changing demographic structure and changes in the disease structure of the population. Cross-border cooperation along with complementarity in the supply of healthcare not only offers the possibility of improving the efficiency of healthcare systems but also broaden the scope of treatment for the patient. To be sure, there are also potential risks and challenges inherent in such developments including patient safety, secure patient records, and the sustainability of the funding system.

## FRIDAY 9.00-10.30

## THEME 1: THE POLITICS OF POLICY

***The Politics of Financing Healthcare - cost and coverage***

# Politics, Values and Interests in Policy Making: The Case of Supplemental Insurance in Israel

Gross R[1], Brammli-Greenberg S.[2]

*[1]Bar Ilan University, Israel, [2]Myers-JDC-Brookdale Institute, Israel*

**Research**

This paper aims to analyse the politics affecting changes in the role of supplemental insurance (SI) in the Israeli health care system.

**Context**

Over time, there has been a change in the content of SI benefits. Originally SI offered mainly "nice to have" extra services. Over time a high proportion of the services that were added to the SI plans were of clinical value. This development in the role of SI challenges existing models of service delivery in the public system. It represents a shift from a predominantly centrally defined health basket, to a situation in which the health plans, through SI, exercise growing discretion and initiative in expanding services to those who want better coverage and can afford to pay for it.

**Background**

SI was introduced as part of the 1995 National Health Insurance legislation, allowing health plans to provide services beyond those included in the mandatory benefits package, for an additional fee. Each health plan may now offer a standard SI package in return for a premium that varies by age group only, regardless of personal risk. Since 1998, the health plans have been obligated to accept all applicants, regardless of health status, to promote equality. SI was perceived as a tool for encouraging competition and responding to consumer demands for the expansion of services despite the growing constraints on public funding.

**Theories**

The study employed multiple research tools: a) Population surveys conducted periodically between 1995 and 2005 to assess the rates of SI ownership; b) Comparison of services covered by the SI plans of each health plan in 1996 and in 2006, to examine changes in their content over time; c) Interviews with key policymakers and analysis of published documents to understand the political processes affecting changes in the SI plans.

**Results**

The rates of SI ownership rose from 35% in 1995 to 79% in 2005. Originally, SI offered benefits attractive chiefly to the young and healthy. Between 1996 and 2006, all the health plans expanded their SI coverage, adding some 130 new services and numerous medications of clinical value, which are particularly relevant for the ill and elderly. This fundamental change in health plan strategy was reinforced in 2007, when the plans expanded SI coverage to include life-saving and life-extending medications not included in the mandatory benefits package.

The new character of SI challenges the value of equity and solidarity in the system and undermines the ability of the Ministry of Finance to constrain national health care expenditures. Consequently, this initiative has been vehemently opposed by the government and social advocacy groups. Commercial health insurance companies joined them in opposing the Health Plans' new initiative, which threatened their market share.

The debate was framed as an ideological value-based confrontation defining the future of the public health care system. However, a political analysis of the process reveals the underlying role of organisational interests and power struggles among stakeholders to be crucial in shaping health care policy.

# Regulating and financing health technologies: a comparison between Italy and Spain

**Cappellaro G[2], Fattore G[1], Aleksandra T.[2]**

*[1]Bocconi University, Italy, [2]The European Institute of Health Technology Socio-Economic Research, Belgium*



## Research

All health care systems are under pressure to control expenditure while maintaining universal access to effective and cost-effectives services. Health technologies are increasingly targeted by cost containment policies in Europe but such policies are not fully investigated, particularly in cross-country studies. We investigated how 6 specific health technologies are regulated and funded in the Italian and Spanish health care systems.

## Background

The two healthcare systems are similar as they are based upon a National Health Service undergoing a profound decentralisation process. In both systems there has been a shift of political powers from the national to the regional level. In such a new context the national tier maintain the role of guarantor of national citizen rights (stated by Constitution Charts) but the regional/comunidad tier has wide autonomy in funding and managing health services.

## Theories

For both countries we reviewed published material and grey literature, accessed through Internet to national and regional legislations and interviewed about 20 experts from the government and the industry. We collected information according to a pre-defined grid to describe how technologies are regulated in general and how in practice incontinence pads, implantable cardiac defibrillators, knee prostheses, wound care, coronary stents and laparoscopic gastroenterology are regulated and funded in Italy and Spain.

## Results

Both healthcare systems are making the content of public system coverage more explicit. The use of a health basket, as a device to clarify national health rights and to keep regions accountable is apparent in both countries. Nevertheless, relevant differences emerge when specific technologies are investigated. The Spanish legislation appears more explicit than the Italian one as health technologies are often explicitly listed. However, in both countries a major issue is whether providers have enough resources to actually deliver what they promise. In both countries, funding systems cannot automatically guarantee that additional resources are made available to new health technologies. In Spain, where providers generally operate under a global budget, managers and clinicians face a general financial constraint and can make choices across specialties and areas of care. Instead, in Italy providers often compare revenues and costs for specific cases thus highlighting the impact of new health technologies on costs and margins. Therefore, in Italy the fee structure is an important determinant of the diffusion of health technologies.

If politics has the final say about coverage in public systems, both decisions about the content of health basket (whether the technology is covered) and reimbursement system (resources available to cover the actual deliver of the technology) need to be appropriately governed.

# The Economic Costs of Ageing – A Review of the Situation in the German speaking countries (Austria, Germany, Switzerland)

**Güntert B, Gruber S.**

*University for Health Sciences. Medical Informatics and Technology, Austria*



**Research**

The demographic shift in our population requires fundamental reforms of the health care and social security systems and their financing mechanisms. Several strategies are under discussion in the three German speaking countries. The question is, which strategy or which combination of strategies will (i) be able to cope with the challenges of the demographic shift and (ii) be politically enforceable.

**Context**

In German speaking countries we find quite a lot of similarities, and in all three countries there is an ongoing debate on the reform of the social security and health insurance systems. Reform trends are (i) increase of the retirement age, (ii) increase of the social and health insurance contributions, (iii) decrease of pensions and benefits, (iv) extension of the contribution basis, (v) introduction of an additional long term care insurance, (vi) forcing people to take more individual responsibility by promoting privately financed insurance plans, (vii) stimulation of prevention and health promotion (viii), a combination of several strategies.

**Theories**

Based a variety of recent studies of Central European Countries (especially Austria, Germany, Switzerland), we are investigating the economic challenges of ageing societies (analysis of secondary literature and studies).

The focus of our research is put on public social security (pensions) and especially the health insurance systems of these countries. Since these two sectors are strongly interrelated, both of them have to be considered.

**Results**

The following results will be presented:

1. A systematic overview on (i) the already implemented strategies, (ii) the strategies discussed within the formal political processes with the pros and cons, (iii) the strategies discussed within the scientific communities.
2. A systematic evaluation of the different strategies based on secondary literature and studies and an estimation of the effects on the societies and the national economies.
3. Recommendations for political decision makers from an economical an financial point of view.

# New financial institutions in German Statutory Health Insurance: are they consistent with its overall goal?

**Nebling T.**

*Techniker Krankenkasse, Germany*



### Research

In early 2007, important plans for reforming the German Statutory Health Insurance (SHI) passed the Bundestag - the German legislative. Those plans include heavily discussed new institutions reorganizing the financial structures. The question is whether or not those new financial institutions are consistent with SHI's overall goal.

### Context

Until now, each sickness fund has decided on its contribution rate autonomously and collects contribution payments from its members and their employers. This practice will be replaced by a central health fund collecting contribution payments from all SHI members at a central government-fixed contribution rate. Then, the central health fund will pay capitation lump sums for each of their members to the sickness funds. Included in this health fund is a morbidity-related risk structure adjustment (M-RSA). Those sickness funds with higher levels of morbidity receive higher surcharges unlike those sickness funds with lower levels of morbidity within their insured.

### Background

This paper focuses on the incentives of health politics for investing in healthcare and disease management programmes to achieve a better health status of SHI members. Health politics heavily determines if it is economically worthwhile for sickness funds to invest.

### Theories

The overall goal of SHI is defined in § 1 Social Code Book V as "to maintain, recover or improve people's health". To achieve this aim, investments in developing and offering healthcare and disease management programmes are needed. By using property-rights theory, it can be analysed if there are enough and the right incentives for sickness funds to invest in those programmes. Property-rights theory suggests that investments will be made if there is a satisfying return on investment (ROI) for the investor.

### Results

If a sickness fund invests in establishing successful healthcare and disease management programmes and achieves reducing morbidity of its members, e.g. they need less hospital stays or less pharmaceuticals, the result will be lower payments from the central health fund due to its morbidity-related risk structure adjustment (M-RSA). Therefore, it is very doubtful if a construction like the institution of M-RSA is the right incentive to follow the overall goal of SHI. New financial institutions pay for the status quo of high morbidity levels, not taking into account efforts needed to maintain, recover or improve people's health status. ROI can be expected to be very low or even impossible. Instead, there should be financial institutions established, rewarding investments in people's health status: the more morbidity level of insured decreases, the more payments a sickness fund should receive and not the other way round.

## FRIDAY 9.00-10.30

## THEME 2: ORGANISATIONAL POLITICS

***Decentralisation, Hospitals and Community Care - shifting the balance of power***

# Allocation of Authority in European Health Policy

Greer S[1], Massard da Fonseca E.[1]

[1]University of Michigan, United States, [2]University of Edinburgh, United Kingdom



## Research

The efficiency and effectiveness of health policy depends in large part on the level of government carrying out the policy. This paper tests two broad theories of authority allocation. The economic theory suggests that rational governments will concentrate information-intensive operations such as primary care planning at lower levels, and redistributive and regulatory functions such as health financing and pharmaceuticals at higher levels. The political theory, by contrast, suggests that all governments will concentrate in areas where they can reap public credit, and will all avoid areas that have a high concentration of blame (such as service reconfiguration).

## Background

Our interest stems from the persistent confusion about decentralisation in health care and what it is supposed to do. Is it about democracy, or retrenchment, or better service design? How does it fit with privatization and regional politics? The question matters not just because so many health care systems are caught in endless cycles of de- and re-centralisation, but also because the cycles promise all sorts of benefits.

We approach the question by explaining authority in health care systems. There are many theories of why a given policy should be at a given level, but what explains what happens?

## Theories

We focus on the general dimensions of the health policy (primary, secondary and tertiary care, public health and pharmaceuticals) in the 27 EU member states. We will try to identify the deviant countries and why they differ from the others according to the four theoretical propositions presented on the previous section.

The information has been be collected from the Health in Transition (HiT) series of country profiles produced by the European Observatory on Health Systems and Policies, cross-checked with the recent scientific literature available for health policy, EuroHealth bulletins and expert surveys for a small number of countries.

## Results

We find that the allocation of powers does broadly follow the precepts of fiscal federalism, with redistribution and regulation at the highest levels of government, acute care at the regional level, and primary predominantly local.

Where it does not follow the precepts of fiscal federalism, it is because of overarching constitutional politics, as with Germany's entrenched federalism or the powers of stateless nations such as Scotland and the Basque Country.

# Incentives and Change in Primary Care: implications for tomorrow's leaders

**Williams S.**

*Cardiff University, United Kingdom*



### Research

Health policy initiatives extol the benefits of devolving power and authority to local levels, but organisational structures often inhibit the implementation of these aims. What incentives are needed to promote these changes? What leader behaviours are needed to effect the desired changes? And what leadership development strategies can best promote system change?

### Context

Devolving power and authority to local level has been a key tenet of health policy across the UK since 1990. Local Health Groups – the precursors of Local Health Boards in Wales – were set up in 1999 as the first organisational wave of this policy. This study traced the experience of the 22 Chairmen charged with responsibility for leading the new organisations created to implement this new policy. The findings from this study of the three years of local health group experience highlight the tensions experienced by these leaders and identify behaviours which contributed to the creation of successful innovative organisations

### Background

This ethnographic study identifies specific tensions and contradictions that emerged as obstacles to be managed in the complex new relationships arising from structural reorganisations across the health system in Wales between 1999 and 2003. The findings have important implications for leader behaviour and the strategies appropriate for leadership and organisational development in future.

### Theories

The study was based on observation and individual interviews with 22 LHG Chairmen over the three-year period of their tenure in office. Analysis of the qualitative data was supported by documentary analysis and observation. Analysis of interview data was validated by participants. The study forms the basis of a doctoral submission to Cardiff University in 2008.

### Results

The results indicate the extent to which system characteristics combine to maintain the status quo, despite organisational re-structuring. The study illustrates the need for leaders who can work from within to create innovative organisational identities and capabilities. The findings identify specific leadership behaviours that can promote organisational receptivity to change (and those that inhibit it). The study findings also point to leadership development strategies for the future.

# Diffusion across contested institutional terrains: a study of family medicine-centred primary healthcare reforms in Europe

**Kyratsis I.**

*Imperial College London, United Kingdom*



### Research

How do complex, systemic in nature, healthcare innovations diffuse within health systems?

How do divergent institutional environments and dissimilar health systems affect the diffusion process of a complex organisational innovation?

### Context

During the last two decades, the transition countries in Europe and Central Asia (ECA) have experienced extensive political, economic and societal transformation. These events impacted on the health sectors and created considerable challenges for these countries. Fundamental structural changes in the health systems of the ECA countries were needed to address these challenges. Although the transition countries in the ECA region have pursued different health system reform approaches to meet these challenges, they have all attempted to strengthen their PHC level by introducing, to varied degrees, innovative organisational models based on family medicine (FM) principles.

### Background

The empirical study analyses the adoption and diffusion of an organisational, systemic innovation encompassing family medicine-centred primary care reforms in the health systems of four European countries in transition, namely: Slovenia, Estonia, Moldova and Bosnia & Herzegovina. Organisations and health systems are political arenas in which struggles over diverging interests take place and where adoption of a specific practice may have significant consequences regarding the allocation of power and resources.

### Theories

To retain the holistic and meaningful characteristics of real-life events, a multiple case design with embedded units of analysis has been employed, fostering the application of replication logic across cases. The above design was also selected as being sensitive in exploring the influence of contextual factors.

Primary data collection resulted in 210 semi-structured interviews (with additional notes taken during fieldwork) with a multi-level, multi-stakeholder, purposive sample of key informants in the 4 countries studied. Documentary and archival data, including legislation and relevant policy documents, and complementary statistical quantitative data were also used as secondary data sources.

### Results

Results highlight the importance of specifying the ways in which the constituent elements of the innovation are perceived by actors. This perception is contingent on the institutional and health systems contexts within which the process of diffusion occurs. The dynamic interplay between the innovation and the actors and societal entities who adopt it was constantly evolving in conjunction with changing organisational structures, practices and institutional conditions. This interplay affected the organisational fields' characteristics that further facilitated or inhibited change.

Initially, in all countries studied, the introduction of the innovative reforms was resisted by the inter-organisational macro-culture, as represented by the dominant belief systems and interests of the major health institutions and the interpretative schemes of the key actors in the organisational field that favoured a specialist led model of health care.

The importing of the reforms attempted to overcome the barrier of the inert-organisational macro-culture and it carried three coexisting logics of legitimation: efficiency, equity and quality based logics. Analysis of the results revealed the pursuit for organisational legitimacy as part of the dynamic impetus behind the diffusion of the innovation. Adoption of the reforms is shown to be partly a legitimating exercise.

# From hospital based to community based services

Tiri H.

*Joint Authority of Kainuu Region, Finland*

**Research**

What has the change from hospital based care into community care meant in practice?

**Context**

For the author's thesis, data were collected in Greece in 1997 and in Finland. After this, an exchange program was arranged in 2000 – 2003 between the Institute of Psychiatry and Neurology in Warsaw, Poland; Dromokaiteio hospital in Athens, Greece; and Kainuu hospital district in Finland. The development program was continued for three more years 2005 – 2007 between Dromokaiteio hospital and Kainuu hospital district. Altogether 72 nurses, nursing managers and occupational therapists travelled to another country for a two week period and wrote their reports from what they were told and what they had seen.

**Theories**

For this paper data from the reports of the participant groups in the exchange program were analysed for descriptions concerning the organisation of care in Dromokaiteio hospital and Kainuu hospital district

**Results**

The analysis showed the following results:

The number of hospital beds in Dromokaiteio has decreased during last twenty years from about 880 to 350. In Kainuu hospital the amount of 297 beds on the highest has decreased to 67.

The amount of short time treatment periods in the hospitals has increased. The number of rehabilitation and service homes and hostels has increased. Workers from he hospitals have been moved to work in the outpatient services. In Kainuu there are also several private service homes. Purpose of the rehabilitation programs is to change the activities of the hospital to be outpatient care oriented.

The phases in the treatment of the mentally ill have been similar in both countries: isolation, medical treatment, work and other activities, psychotherapies and nowadays patient-oriented combination of all the methods. The aims are well-being and functional abilities of the client/patient and his/her relatives, service ability and economy.

Doctors' role as the leader of treatment is significant. Medical care, professional skills of the staff, the patient's family and the society in question, and availability of both outpatient and inpatient treatment have been emphasized. The results also suggest that attitudes towards mentally ill people change in the society little by little.

## FRIDAY 9.00-10.30

# THEME 2: ORGANISATIONAL POLITICS

*The Politics of Medical Management*

# A new role for the doctor-manager? About the changing role of the medical hospital director in a more competitive and politicised environment.

**van der Scheer W, Putters K.**

*Erasmus University, Netherlands*



### Research

How important is the medical background of executives for governing hospitals?

### Context

In 2007 the Dutch Association of Medical Directors initiated a study about the specific role and position of medical directors (executives with a medical background). The main reasons were: 1) health care delivery has become a multi-disciplinary task and organisations are no longer organised in a functional way; 2) the health care system and health care organisations have changed. More emphasis is put on output management, transparency and patient empowerment. What effect does this trend have on the relationships between doctors and managers? What is the added value of a medical background of executives in this new context?

### Background

In the Netherlands, changes in the health care system have lead to a displacement of politics from the national level to the local level of service delivery. Supported by a policy of regulated competition, hospitals are held accountable for realising both good quality of care and efficient and effective services. The role of government concentrates on setting goals and monitoring outcomes. Negotiations over means and ends are left to insurers, doctors, managers and patients. This pressurizes the often already tense relationship between doctors and managers. Consequently, the role and position of medical directors in hospitals is changing.

### Theories

A literature study was conducted for a better understanding of the historical and actual context of the relationship between managers and doctors in hospitals.

The outcomes of a large scale survey were studied to find out whether executives with and without a medical background interpret their role and function differently. The survey was set out among hospital executives in 2000 and repeated in 2005.

To get a better understanding of the role and function of medical directors in daily practices, interviews were held with executive searchers, hospital directors, members of supervision boards and doctors (chair of the medical staff).

### Results

The study shows how internal and external politics affect the relationship between management and medical staff and affect the role and position of medical directors.

It appears that the medical background of health care executives is still very important for hospital governance, but the reasons have changed. Initially the main task of the medical director was to coordinate medical affairs and support doctors. Later the main focus was to manage the relationship between hospital and doctors. Medical directors themselves, however, feel primarily responsible for realising good quality of care and services and not just managing the management-doctor relationship. It requires, besides attention for professional affairs, serious attention for the patient's point of view. In a competitive setting the role of patients is in fact crucial.

To patients, quality of care focuses on medical treatment, but also involves feeling 'at home'. We conclude this requires a broader interpretation of the task of the medical director, with more attention for all parties involved in the delivery of care. National health care policy and politics support this turn and several examples from daily practices show how relationships between doctors and managers are already starting to change accordingly.

# Doctors' Involvement in the Management of Quality

**Scrivens E.**

*Keele University, United Kingdom*

## Research

Research has demonstrated that clinicians are reluctant to become involved in external reviews of quality assurance. This paper examines the research evidence on the methods used to promote the involvement of clinicians in the management of quality in health care and discusses the reasons why these have failed. The paper also briefly presents an approach to involve clinicians in a national quality initiative.

## Context

There is a serious implication of the lack of involvement in quality assurance on the part of clinicians. Lack of team development, poor inter-professional communication, lack of co-ordination and lack of standardised care processes are claimed to be associated with higher hospital mortality (Ward 2005, p.391).

## Theories

North Staffordshire Combined Health Care NHS Trust developed an approach to address the engagement of clinicians with national standards. Three mental health teams were invited to develop indicators using a methodology based on best practice in indicator development, to test their compliance with national standards in relation to a selected task. Using a 6-point scale (scarcely if at all, somewhat, substantially, strongly, fully), teams rated to what extent the indicators they had designed were met by their team. The teams were also asked to appraise the level of influence they had been able to exert through this process to improve their compliance (6-point scale: none, marginal, some, de facto, strong, full).

## Results

Significantly, the medical clinicians reported that the process of developing and using task based indicators related to standards had helped them to engage with the standards. This research therefore suggests that to improve clinical engagement with national standards, policy makers designing standards need to reflect on how national standards can be incorporated into the day to day tasks of clinicians.

# Doctors' power in transition country academic hospitals: waxing or waning? Are they mutually exclusive?

**Jekic I[1], Katrava A[1], Obrovacki M[1], Novak S[1], Djukic V[2], Pesko P[2], Draskovic D[3], Dujmovic F[3], Trenkic S[4], Pavlovic D.[5]**

*[1]EAR TA Team Sofreco, Serbia, [2]Clinical Centre of Serbia, Serbia, [3]Clinical Centre of Vojvodina, Serbia, [4]Clinical Centre Nis, Serbia, [5]Clinical Centre Kragujevac, Serbia*

## Context

Health care reforms in transitional countries affect numerous functions/processes within health institutions.

The EU/EAR Project provided to the Ministry of Health (MoH) has been charged with reforming tertiary care services and implementing an EIB loan of €200m in the beneficiary institutions: the four Clinical Centres in Belgrade, Novi Sad, Nis and Kragujevac, for their rehabilitation and strategic development. It represents an opportunity for innovative approaches in hospital organisation and to ensure physician buy-in. Looking into the "soul" of the physician to create a "win-win" situation is the challenge.

## Background

There are over 2600 doctors and 800 University affiliated staff in Serbia's four Clinical Centres. This paper argues that waxing and waning are processes, and are hence not mutually exclusive. The power of the classical doctor focused on individualism and sole, predominantly medical, decision making is waning, particularly in transition countries, whereas the power of decision-makers, politicians and doctors-managers/opinion leaders focused on a team approach for collaborative decision-making at the national, local and institutional level is waxing. If change is to be affected in institutions with over 14,000 employees, the buy-in of important opinion leaders/doctors is essential.

## Theories

The Tertiary Health Care (THC) Expert Group (national level) and Work Groups (WG) (hospital level) were formed to "wax" doctors' new combined professional and managerial roles for them to be part of the decision making process and planning the future of the Serbian health care system.

In this context, doctors are social leaders and the role of the medical profession in health care reform in Serbia is paramount. They are essential for their professional input in the areas of: care and standards, research and development, patient advocacy, shaping policy and cost-effectiveness.

## Results

In June 2006, the MoH established the THC Expert Group to provide advice on future tertiary health care policy and strategy. Members include Minister of Health, Directors of the four Clinical Centres, representatives of major medical and nursing associations, Schools of Medicine, Health Insurance Fund-HIF and the EU/EAR Project, being the "elite" of the Serbian medical profession.

As of January 2007, over 200 mid-managers (approx. 1,5 % of employees) have participated in the first circle of WG training in the four Clinical Centres. Two-thirds are mid career doctors chosen by their professional, ethical and managerial merits. They are likely to be the future leaders of the Serbian HC system.

The THC Expert Group has developed and presented general parts of the THC policy and now needs to address more detailed issues to convert THC policy into strategy. Furthermore, THC service-specific Task Forces have been formed by MoH to advise on practical issues of THC policy, strategy and implementation until mid 2008.

The WG have completed their first cycle of training in change management and have significantly contributed to the development of their institution's 5-year Business Plan, specifically improvement action operational plans to be implemented in 2008.

# Doctors' power, neither waxing nor waning: The changing power of the omnipresent group.

**Hemadri M[1], Purva M.[2]**

*[1]Northern Lincolnshire and Goole Hospitals NHS Foundation Trust, United Kingdom, [2]Hull and East Yorkshire Hospitals NHS Trust, United Kingdom*

**Research**

The expert power of doctors places them in a unique position to control many segments of the health care industry.

**Context**

In the context of a very dominant NHS the healthcare industry in UK is unique in itself. The consultant doctors in the NHS as the main deliverers of secondary care have certain advantages rarely available to equivalent groups in other health economies.

**Background**

Changes in the political, economical, social, technological, legal and environmental areas have meant that many of the powers of doctors have changed. While the doctors generally perceive that their powers have reduced there still remains an overall perception that doctors are still very powerful. We explore the dichotomy in perceptions.

**Theories**

We use Porter's five forces model for industry analysis as a template to look at the power of UK doctors at Consultant level. We do not embark on an analysis of the healthcare industry but look at how a single factor, namely the power of consultants, impact on the healthcare sector in UK.

**Results**

We argue that doctors, especially at the Consultant level in UK form an important component of all the five forces. We also argue that consultant doctors not only are part of the five forces but to a great extent control the way in which the five forces impact on the healthcare sector. We see this as a rather unique phenomenon rarely seen in other industries.

We find that many of the powers have changed and many have reduced but the ability to control the way in which these powers seem to remain unchanged.

## FRIDAY 9.00-10.30

## THEME 3: HEALTH POLITICS AND THE COMMUNITY

*The Politics of Patient Power*

# Putting patients at the heart of change – the challenge in transitional countries

**Katrava A[1], Jekic I[1], Obrovacki M[1], Milojkovic A[1], Andrejevic V[1], Djukic V[2], Pesko P[2], Dmitrovic T[2], Draskovic D[3], Dujmovic F[3], Trenkic S[4], Pavlovic D.[5]**

*[1]EAR/TA Team Sofreco, Serbia, [2]Clinical Centre of Serbia, Serbia, [3]Clinical Centre of Vojvodina, Serbia, [4]Clinical Centre Nis, Serbia, [5]Clinical Centre Kragujevac, Serbia*

## Context

The EU/EAR Project provided to the Ministry of Health (MoH) has been charged with reforming tertiary care services and implementing an EIB loan of €200m in the beneficiary institutions: the four Clinical Centres in Belgrade, Novi Sad, Nis and Kragujevac, for their rehabilitation and strategic development.

The essence of the EU/EAR Project is to promote the patient as the centre of care. This has been accomplished at an institution level by creating Business Planning Work Groups around main patient flows (Emergency, Outpatient, Inpatient, Day Surgery/Care, Operating Rooms and ICUs).

## Background

In South-eastern Europe countries in transition, health systems are mainly physician-centred and are gradually moving to patient-centred care. This is a long and cumbersome process mainly due to a tradition that clearly sets the dividing line between patients and professionals, and in many instances patients are not fully ready to be an active partner in the process. As market forces are introduced into health care services "choice and competition" will be a better answer than "command and control" thus giving patients a right to decide where to be treated.

## Theories

The Clinical Centres have already embarked on the Business Planning process. Continuing to develop excellence and set the standard for patient-centred care in Serbia will require further evolution along four dimensions;

- Measurement: Identify and manage against performance-based measures of service and outcome
- Interdepartmental Cooperation: Eliminate barriers between departments that hinder the delivery of care and services; enhance statistical process control skills to identify significant opportunities
- Management Skills: Reward "taking risks" to improve service/outcomes
- Reporting: Develop status reports and information systems to support the management of quality improvement

## Results

At a system level, the project is facilitating collaboration vertically between network partners in primary health care (including first aid), secondary and tertiary care and horizontally with all key stakeholders including the Institute for Public Health (IPH), the National Health Insurance Fund (HIF) and other Clinical Centres.

At an institutional level, four Clinical Centres, due to their central regional/national role could provide a forum for the practical application and implementation of a patient-centred care model. Pilot projects with primary healthcare, HIF and patient associations are underway.

The Work Groups (WG) consistently support Clinical Centres' service focus on the needs of the patient and family.

Seven (out of 28) strategic recommendations emerged in the Clinical Centres' 5-year Business Plan:

- Patients and their families need to participate actively in the care process (1-3)
- Each patient's care will be coordinated, in Clinical Centres and across the network (4-5)
- The setting will foster the well-being of the patient and family (6-7)

Flows for Emergency, Inpatient and Outpatients developed by responsible working groups in all Clinical Centres, combined with data survey results represent a basis on which to make operational improvements, in particular patient flow, putting them at the centre of care.

# Views on culture and culture change in the English NHS: a national study of professional and patient perspectives

**Konteh F, Mannion R, Davies H.**

*University of St Andrews, United Kingdom*

## Research

The degree of convergence between the perspectives of clinical governance managers on culture and culture change, particularly around patient safety cultures.

## Context

We recently carried out a nation-wide study among acute and primary care trusts in England in which we elicited the perceptions and views of clinical governance managers and patient representatives on culture and culture change in the NHS. This paper presents the specific study findings around safety and patient-centredness as key among the cultural domains of interest to stakeholders.

## Background

In England, as in the US, there is a growing interest in basic organisational values, beliefs, assumptions and behaviour as they relate to health service delivery. To this end there is quest for better understanding about the nature of organisational culture, how it can be assessed, and how to integrate assessments into beneficial programmes of change. The perspectives of clinical governance and patient representatives on culture/culture change, especially with respect to patient safety and quality healthcare are increasingly important.

## Theories

The theory, embedded in management literature, of a relationship between culture and performance has been gaining prominence, reflecting growing interest on the part of healthcare professionals, policy makers and researchers in the notion that organisational culture change can be a lever for improved performance and quality health service delivery (Mannion et al. 2005). We conducted a national study (involving postal survey and a few semi-structured interviews) of heads of governance and patient representatives in English NHS organisations. The quantitative and qualitative data were entered and analysed using SPSS and atlas ti, respectively.

## Results

On the basis of our study results, both clinical governance managers and patient representatives view quality and safety improvement in cultural terms and acknowledge the importance of culture to performance in healthcare. Both sets of respondents expect clinical governance to try and understand the local organisational culture and clinical governance managers agree that it is within their purview to influence their organisation's culture toward desirable outcomes. Most clinical governance managers are amenable to the assessment of local culture by using appropriate measuring instrument(s). However, only a few NHS trusts (33%) have used any culture assessment instrument and almost all the tools used to assess culture focus wholly or in part on the assessment of safety cultures. Patient representative's views on the most important cultural attributes for high quality care were remarkably similar to those of clinical governance managers. The most important culture components considered by both sets of respondents for assessment and improved healthcare performance include: 'patient centredness', 'senior management commitment', 'a quality focus', 'clear governance/accountability', 'safety awareness' 'prioritization of choice', public service ethos, 'focus on cost effectiveness', and 'standardisation of care'. Each of these attributes has a patient focus, directly or indirectly. In the interviews patient representatives were critical about the culture of their organisation whereby managers sometimes failed to consider patient perspectives when planning, undertaking and assessing organisational change.

# The role of patients in Dutch healthcare politics: towards a patient centred governance

Den Breejen E, Putters K.

*Erasmus University Rotterdam, Institute of Health Policy and Management, Netherlands*



**Research**

How is the role and influence of patients being strengthened within organisational politics in Dutch healthcare?

**Context**

Regulated competition was introduced in the Dutch healthcare system in 2006 (the Health Insurance Act). Next to arguments of efficiency and effectiveness, the improvement of the quality of health services and the empowerment of patients were important arguments. The proposition was that patients will get more choice and influence in financing (e.g. vouchers, personal budgets), organising (e.g. through participation in patient platforms) and delivering healthcare services (e.g. through possibilities for choosing healthcare providers, professionals of your choice and types of services). This paper questions whether such a patient-centred health care governance is being developed in practice.

**Background**

The Dutch healthcare system is characterised by a mixture of steering mechanisms: from government steering, to professional/clinical and self-governance, and the market mechanism. Most organisations in this context can be characterised as hybrid organisations that have to deal with a variety of steering mechanisms. Patients also take different roles and positions in each of the different domains: patients, citizens, clients/consumers. This raises that question of how health care organisations cope with this variety of roles and what this means for organisational politics.

**Theories**

The paper is based on research conducted for the Dutch Federation of Patient and Consumer Organisations (NPCF). The materials we have used are transcripts from interviews, expert meetings and documents from archives. In addition, we studied relevant literature and policy documents. The theories we combine are the democratic, economic and participative perspectives on the role and influence of patients and consumers within healthcare. The methodology being used is the comparative research design. We compare different cases of patient involvement in different sectors of healthcare.

**Results**

The results of the research focus on the different instruments for patient empowerment in sub sectors of healthcare. We clarify the role and influence of patients within organisational politics by studying the use of three instruments: communication, consultation and co-production. These are being studied on the individual and the collective level. This means that we focus on the patient position itself, as well as on their relationship with the other stakeholders in the organisation and direct environment. On the basis of the results we will develop a typology of patient centred governance in a context of regulated competition. The discussion we want to raise is whether and to what extent the introduction of market principles within the hybrid context of Dutch healthcare leads to a more patient centred healthcare governance. Finally we will suggest different ways of strengthening the role and position of patients in the organisational politics of healthcare.

# Interesting Value Added Services in Health Service Organisations

**Wagner U.**

*Bern University of Applied Science, Switzerland*

### Research

Are there industries comparable to "value added services" in a service branch like health care? Do they have the same or similar value(s)? How can this value be defined? How can these services be defined and managed? Can these services on the one hand be useful for the single institutions to reach economic goals and secure its own existence? On the other hand, how can these services be useful in a public health perspective and add value to the system as a whole?

### Context

Identical services are difficult to position in a market economy. The health sectors in German speaking countries are more and more developing towards a market approach and the services are more or less identical with relatively unknown quality. Until there are valid and reliable quality data available and also more or less equal quality, the competition can be fought through other services. This is well-recognised in industry, which uses such "value added services" to promote their goods. These are offered voluntarily and help to sell the main product. This paper asks if there are similar services in the health service.

### Background

The research found that "value added services" as defined in this research project, which targets clearly the management of health, have one main impact and different side effects (wished and welcomed). The main impact of value-added services is to challenge existing models of service delivery, which have concentrated up to now mainly on core services. Side effects are seen principally through the implementation of an integral customer approach, which is also useful and necessary for process delivery of the main services. Secondly, these services help the stakeholder "politician" to legitimize the money spent on the system.

### Theories

Based on theories used in the profit / industry setting, hypothesises were developed and tested in a deductive approach. Examples from all German speaking countries were explored.

### Results

A practical definition of "value added services" was developed. It was found that these services reach far over the traditional service categories and are used to position health enterprises in the health market. The development and implementation of these services are usually used to set up a culture that is based on an external and internal customer approach. So the patient is a starting point of the change that then typically follows.

## FRIDAY LUNCH 12:50 - 13:50

### SATELLITE SESSION

*E-Health*

# Lessons from the limited success of implementing a telehomecare program

**Boonstra A, van Offenbeek M.**

*University of Groningen, Netherlands*

## Research

Through which mechanisms does the interaction of technology, stakeholders and institutional properties influence telehomecare implementation effectiveness?

## Context

In this case study three organisations co-operated in implementing telehomecare technology for approximately 450 clients. The main objectives of this program were to substitute traditional home care tasks and to learn how care can be provided to more people using the same resources. Since the Dutch government has outlined targets for large scale telecare provision, the project was funded by national innovation programs. The case shows how differences and changes in orientation among the key stakeholders influenced the implementation process and outcomes. Lessons are derived from this study that may be applied and tested elsewhere in e-health implementation.

## Background

Many homecare providers are attempting to implement telecare services. Telehomecare is the use of ICT to facilitate a range of health care services to be delivered to clients in their own homes. While previous studies suggest that telehomecare offers a potentially efficient method of service delivery, they offer little insight into the organisational questions that arise in implementing telehomecare. Such applications are complex in nature. Moreover, unscheduled health care delivery crosses professional and organisational boundaries. New ways of partnership working have to be established and trust must be developed. Consequently, telehomecare is inherently political in nature and difficult to implement.

## Theories

In our analysis we draw on a structuralist model of telecare implementation, which shows how technology, stakeholders and institutional factors interact. The implementation can be seen as the product of this interaction that determines the organisational outcomes. The researchers mainly took an interpretive approach, assuming that the various actors view the telehomecare initiative in the light of their own context and interests. The research was longitudinal. Data collection took place over an 18 month period (October 2006 – March 2008) and combined qualitative and quantitative methods. This enabled to capture policy changes, effects and changes in attitudes and strategies of actors.

## Results

Our design enabled us to capture policy changes, effects and changes in actors' attitudes and strategies. In line with existing models of change, the outcome of this ICT–enabled change could best be understood as a product of the interaction of technology and people over an extended period within overlapping organisational and institutional contexts. In this case different groups of actors and technologies ‘met’ and in their interaction over time worked their way through often colliding realities, e.g. the cognitions and norms of the technology provider did not match the client group behaviour. In some respects colliding realities led to new ways of working and integrating each other’s knowledge and norms, in others they restricted the stakeholders´ goal attainment.

The discussion focuses on drawing out the path–dependent choices and dilemmas in telehomecare implementation, including generating volume versus content, and reliable performance versus experiential learning. Subsequently, ways are discussed in which the implementation approach can facilitate the alignment of the professionals’, the clients’ and the organisations’ interests. The implementation should take into account the technology; telecare’s implications for the institutional and organisational contexts; the experienced effects on care delivery; and the changing roles and responsibilities for health professionals involved.

# Effects of a telephone-based medical advice centre on the use of the traditional health care system

**Klein S, Jochem M, Nebling T.**

*Techniker Krankenkasse, Germany*

### Research

Can a telephone-based medical advice centre influence decision of the patients to go to a doctor or to a hospital?

### Context

The Techniker Krankenkasse (TK), one of Germany's biggest health insurers, supplies its clients with a doctors only telephone-based medical advice centre on a 24/7 basis. In the annual customer satisfaction survey, the users of the medical advice centre not only reported a high level of support for the service, but also a broad range of effects on the use of general practitioners, pharmaceuticals and even hospitals.

### Background

With its medical advice centre, Techniker Krankenkasse is challenging the existing model of service delivery. Although doctors in Germany are not allowed to diagnose and to treat via the telephone, there are significant effects on the demand for the traditional system.

### Theories

The paper is based on a survey of approximately 6000 TK clients who used the medical advice centre.

### Results

Where relevant, every fourth user of the medical advice centre reported a change to the doctor treating the illness. This coincides with a change of tests and/or treatment methods other than planned by the first doctor. Cancellations of visits to doctors (8 per cent) and even hospitals (5 per cent) were also recorded. There were similar effects with regard pharmaceutical treatments.

## FRIDAY 14.00-15.30

## THEME 3: HEALTH POLITICS AND THE COMMUNITY

*The Politics of Public Health*

# Public health policy of Stockholm county council – shifting focus from cure to prevention and health promotion

**Liljegren M.**

*Centre for Public Health, Sweden*



### Context

Stockholm County Council (SCC) regularly conducts public health reports in order to keep track of epidemiology within the region. Based on this knowledge, in 2005, we developed a new public health policy. The public health policy is based on the idea that health determinants can be identified and addressed. The SCC Centre for Public Health was commissioned by the County Council to manage the implementation process. The strategy is to work in close cooperation with mediators such as SCC departments, politicians and decision makers, health planners, care units, schools, NGOs, the media and others.

### Background

Stockholm County Council (SCC) is the largest health and dental care provider in Sweden. Stockholm County has a population of about 1.9 million inhabitants and has the second largest political board in Sweden next to the national assembly. The development of SCC's public health policy was led by a parliamentary group of politicians. The two main strategies of the public health policy/plan are to develop a more health-promoting health care and to cooperate with other actors in the region.

### Theories

In order to implement the policy we are working with several different methods such as:

Upgrading public policy – The public sectors normally use several governing documents and many plans and policies in different areas that can be acknowledged as influencing health determinants and thus help to reach public health goals.

Health promoting health care – Leading the reorientation of the health care sector, starting with a documentation of public health work at SCC hospitals.

Engagement with communities - Building alliances with municipalities, (who have the responsibility for social services, school, and elderly care) and strengthening local health promotion action.

### Results

The political decision to approve a public health policy of SCC put the issue of prevention and health promotion on the daily agenda of both administrators and politicians. The policy has led to more active communication, actual efforts and a greater understanding of the matter.

In the latest election 2006 there was a shift in the political majority and this has led to a development of the management of the public health policy. The policy was established as a long term policy document and an action plan for the term of office (2008-2010) is now being created.

We can see that entering of the public health policy into the administrative/political system has led to regular need to make decisions and to follow up ongoing efforts. The existence of the policy itself has led to closer cooperation between politicians and administrators. So far it is also our experience that management and decisions put into effect is in constant development, as shown by the development of the action plan.

# The challenge of reducing health inequalities in East Lancashire

**Peat D.**

*East Lancashire Teaching Primary Care Trust, NHS, United Kingdom*

## Research

East Lancashire Teaching Primary Care Trust commissions and provides health care to 382,000 people in North West England. Four of its five municipalities are amongst the most deprived in the UK. The research and evidence was based on the following references:

- Comparison of standardised mortality ratios (Source: Compendium of clinical and health indicators)
- Determinants of Health and Wellbeing (Source: determinants model - Dahlgren and Whitehead)
- Trends in infant mortality (Source: Office for National statistics)
- Alcohol related conditions (Source: North West Public Health Observatory)

## Context

The Primary Care Trust (PCT) has embarked upon a strategy to save 1 million years of life in four years, i.e. to halve the gap in life expectancy, by addressing: infant mortality; coronary heart disease; mental health problems including drug and alcohol misuse; targeted localities and populations.

## Background

There is an increased recognition that fundamental determinants of healthcare are not medical but social and economic, and that the management of these requires negotiation across health and social boundaries at all levels. In addition, an ageing population and rising levels of chronic disease poses particular challenges, both in the delivery of services and resources available.

## Theories

Principles to be adopted to tackle inequalities:-

- Evidence based practice
- Partnership working - to allow joined up thinking and action
- Public involvement - to raise the expectations of the community
- Communications - to ensure the right messages are given and received
- Demonstrable benefits and targeted monitoring of the four priority areas

## Results

The PCT hosted a Health and Wellbeing Equality Summit in October 2007. The keynote speech at this high level summit was delivered by NHS Chief Executive David Nicholson. Sir David Henshaw, Chair of NHS North West also addressed the audience. Summit delegates were invited to sign up to a statement of intent, committing their organisation to working in partnership in order to reduce health inequalities, making measurable improvements and raising aspirations in the local community. Since the Summit, the PCT has engaged:

- Other public services - social services; education; police; probation; housing; leisure.
- The private sector
- Higher/further education
- The general public

These organisations now meet within a structured framework. Their objectives involve setting and sharing targets; defining accountabilities; social marketing, and addressing new ways of service delivery.

# Developing and implementing health targets in Carinthia (Austria)

**Offermanns G.**

*University of Klagenfurt, Austria*



### Research

The paper presents the development of the Carinthian health policy framework and the derived health targets. It also describe critical factors for success in the cooperation between the project group and different levels of politics in Carinthia. One of the success factors was to include health and social professionals in the process and professionals from different political sectors with a strong relationship to health, according to the concept of "Health in all policies".

### Context

Austria is a federal state composed of nine Länder. Carinthia is one of the eight Länder and is situated in the south part of Austria. The direct neighbours of Carinthia are Slovenia and Italy. The Austrian health care system has historically emphasised free access, high numbers of providers and technological equipment more than cost effectiveness and cost containment. Another big problem of the system is to guarantee good quality of health care in the different sectors and to introduce concepts of public health, e.g. prevention and health promotion.

### Background

Traditionally, the provisions of social insurance law in Austria are strongly orientated towards a curative approach, whereas the tasks of the public health service were essentially limited to sanitary supervision and providing specialist advice to authorities, or linked to individual preventive programmes. The resulting vacuum with regard to modern concepts for health promotion and prevention was countered with the aid of a series of legislative initiatives. Until now these initiatives had no direct impact on the relationships or health status between citizens, patients and health professionals.

### Theories

To face these essential challenges, the Carinthian government decided to develop a special health policy framework and health targets to advance the change process. The whole process was scientifically based by the University of Klagenfurt. The policy framework and the targets were viewed as a means of defining and setting new priorities in Carinthian health care, creating high-level political and administrative commitment to particular outputs, and providing a basis for follow-up, continuous management and evaluation. One of the global targets of the project was to support the change process from a curative based to a preventive driven system.

### Results

The vision to introduce a new view to the health system in Carinthia has required the development of a vision for health, a policy framework for all sectors, a process of target formulation that incorporates widespread stakeholder involvement, the creation of appropriate incentives and intelligence gathering. The field of prevention and health promotion is a "cross-sectional issue". This paper also shows how the transfer of the targets in the different sectors takes place in the political districts and the local communities or boroughs. In addition, a special tool will support the allocation of resources for projects in prevention and health promotion linked to the developed health policy framework.

## FRIDAY 14.00-15.30

# WORKFORCE SIG

# Skill-mix change and workforce planning in Italy

**De Pietro C.**

*Bocconi University, Milano, Italy*

## Research

In recent years Italy has undergone major changes in professional regulation of healthcare professions. The aim of this proposal is to analyze the extent to which changes in the regulation of healthcare professions have led to a similar professional composition in national health service organizations

## Background

In heavily regulated professional systems, legal monopolies imply no substitutability between different professional groups. If this is true, similar activities should be performed by employed staff characterized by similar professional composition. However, organizations of the Italian NHS seem not to follow that rule. In fact, also when providing similar services, they use different professional composition for their staffs. Recent skill-mix changes occurred in the Italian healthcare legislation – notably with the increased professionalization of nurses, midwives, lab technicians, rehab technicians, etc. – provide a new scenario for multi-disciplinary working and HR planning. This requires a new and better understanding of determinants of professional distribution.

## Theories

The study is based on the so called “Conto Annuale” of public service employees, a database yearly released by the Ministry of Economy. The analysis covers years 2002-2006 and uses standard descriptive statistics techniques. The “Conto annuale” database describes quali-quantitative features of the staff of each Local Health Authority and Hospital Trust of the Italian NHS (around 300 organizations in total). Data are provided for each of the 134 “roles/professional families” in which the NHS staff is divided.

## Results

The main goal is to answer to the initial research question.

Secondly, the paper will analyse the pattern of recent trends in staff composition in different Regions and aim to elucidate similarities between different types of organizations (ex. big, medium or small hospitals).

Third, results will be discussed for their consequences on regional and State-level HR planning

# Cefpas' experience in multidisciplinary training

**Frazzica RG, Giambelluca SE, Falconeri MD, Greco D, Livolsi P.**

*Centre for Training and Research in Public Health, Caltanissetta, Italy*

## Research

This paper presents a case study on training courses based on a multidisciplinary approach and compares them with those based on a monoprofessional focus. It points out the challenges posed by this approach and describes the strategies followed to overcome them.

## Context

CEFPAS, the Centre for Training and Research in Public Health of the Sicilian Region, is located in Caltanissetta, in the heart of Sicily. From its beginning in 1996, the Centre has organized numerous training programs on human resources development with the aim to improve the quality of healthcare service in the region, and has focused particularly on multidisciplinary training.

## Background

The general characteristics of Cefpas' training courses include:

- Multidisciplinary or mono professional settings
- Experiential, interactive and problem based learning
- A focus on trainees and on learning
- Small work groups
- An extensive evaluation system

Key advantages of multidisciplinary courses can be the exchange of experiences and the interactivity among different professionals. Furthermore, in courses where a high degree of creativity and problem-solving ability is used, a heterogeneous group is generally the most effective.

However, there are also some critical issues in multidisciplinary training, namely:

- the involvement of participants from different disciplines with diverse cultural backgrounds, competences and aims which could generate problems.
- the effort that participants must make in learning to adapt their communication skills and transmit technical information to other trainees not familiar with their professional field.

The main challenges are to maintain the individuality and the learning needs of each professional and to build, at the same time, a solid teamwork experience.

## Theories

The strategy used by Cefpas to overcome these critical issues related to the multidisciplinary training is based on the conviction that teamwork is fostered when group members are geared for a common goal. One way of accomplishing this is to involve trainees in the definition of the goal and, at the same time, to let leadership emerge spontaneously within the group. In order to implement this strategy, Cefpas adopts interactive training methodologies such as problem solving, simulations and small group work.

## Results

Multidisciplinary courses represent approximately 70% of Cefpas courses. The comparison of the results of the final evaluation questionnaires for the two typologies of courses, mono professional and multidisciplinary, shows no significant difference between them. However, Cefpas will continue investing in multidisciplinary training because of the importance of diminishing fragmentation and establishing a common language and a shared approach among professionals and services for a more global and sustainable development of our health organisations.

# Helping hands? The Allied Health Professions (AHPs) and European policy development

**Petchey R, Needle J.**

*Centre for AHP Research, City University, United Kingdom*

**Research**

In this paper, we present a high level overview of the Allied Health Professionals across Europe, including key reflections on recent and upcoming European policy initiatives.

**Context**

The Allied Health Professionals (AHPs) consist of such professions as occupational therapy and physiotherapy, speech and language therapy, radiography, dietetics and the like. They thus represent an important component of the European health workforce, with regard not just to their numbers but also to their contribution which is set to expand through the development of extended scope practice of various kinds. Despite this, by comparison with medicine and nursing they remain an under-researched and largely under-recognised group of professions. This is particularly true at the European level, where little attention has been paid to the implications for them of European enlargement and policy development. As a significantly more heterogeneous group of professions, the AHPs constitute a special problem for comparative health policy and are likely to pose particular difficulties for any attempts at harmonisation.

**Results**

In this paper, we will present the following:

- An overview of the Allied Health Professionals across Europe, including
  - Their key demographic characteristics
  - The legal and administrative framework(s) within which they function
  - Their current professional status (including their relationship with the medical and nursing professions)
  - Their current scope of practice in terms of their professional roles and responsibilities, initiatives to develop extended scope practice, and institutional or other barriers to extension
- An analysis of the main cross-border flows of AHPs within Europe
- A critical analysis of recent and current European policy initiatives (such as the Bologna process, freedom of movement of professions and services, recognition of qualifications, etc.) and their implications for the AHPs.

## THURSDAY 15:30 - 16:00

# POSTERS I

# Mapping the politics of health: A framework for analysing the dynamics of power across the variety of health policy contexts

Tenbensel T.

*University of Auckland, New Zealand*

**Research**

Politics is a ubiquitous feature of health policy, but the political dynamics of health policy vary widely according to the context of particular issues. Governments, private industry, and the medical profession have significant leverage in some areas but not in others. However, existing frameworks for understanding power in health policy are frequently tied too closely to particular contexts (e.g. hospital reform) to be applied across the range of health policy contexts. This paper develops an analytical framework, firmly grounded in policy studies and social science literature that can be used to map the variety of particular health policy issues.

**Context**

Three disparate examples of prominent health policy issues in New Zealand over the past 15 years are drawn upon to illustrate the variety of political dynamics:

(i) prioritisation of pharmaceutical expenditure - governments have successfully controlled the growth in public expenditure on pharmaceuticals

(ii) primary health care reform – governments have moved to reduce barriers to access, and enhance community engagement by changing the organisational basis of primary health care

(iii) dealing with the obesity epidemic – governments have attempted to stimulate broad-based prevention, detection and treatment programs but have stopped short of regulating or taxing the food industry.

**Background**

The objective of the paper is to provide a framework for identifying and comparing different health policy political dynamics. The examples chosen also are relevant to a number of sub-themes including the politics of investment in health, doctors' power and engagement with communities.

**Theories**

The framework for analysing policy dynamics is adapted from the 'modes of governance' literature which identifies hierarchies, markets, networks and communities as alternative 'ideal types' of co-ordination. The metaphor of suits in a card game is used to denote the different power types:

♠ = hierarchical power of the state; ♦ = market/purchasing power; ♣ = provider power; ♥ = community power

Each of these types of power can be used by policy actors in their efforts to advance or resist policy changes. Each case study is analysed in terms of combinations of types of power marshalled by policy actors.

**Results**

The case studies illustrate quite different configurations of power, which produce quite different power dynamics. In the pharmaceutical example, ♠ and ♦ power have been used by the NZ government to discipline pharmaceutical expenditure, encountering resistance from doctors, the pharmaceutical industry and the public (♣ and ♥) power. In the primary care example, the government drew upon ♠ and ♥ power in redesigning the primary care system to be more accessible and responsive to high needs populations, but the policy has raised concerns among many general practitioners regarding restrictions on their autonomy and the viability of their businesses (♣ and ♦ power). In the obesity example, policymakers draw on ♠ and ♣ power, but their efforts are constrained by ♦ and ♥ power.

This paper demonstrates that it is possible to map different 'power environments' for different health policy issues using a common conceptual framework. By identifying types of power government does not have in particular contexts, it raises the question of whether these types of power are to be neutralised or fostered. This has practical importance for policy actors because it can help them formulate more robust strategies for policy change.

# A theoretical framework explaining the relationship between health politics and health policy

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**Research**

Different languages treat the concepts of 'health politics' and 'health policy' in a different way. Some, like English, use two different terms (politics and policy) but others like Finnish have only one term with two different meanings (politiikka).

**Context**

This theoretical exercise tries to derive these concepts from the three basic elements steering the health service systems: need of services, demand of services and provision of services and to build a model which makes these terms understandable despite linguistic limitations.

**Background**

This exercise develops further the model presented by e.g. Liss P-E. (Health Care Need. Newcastle upon Tyne: Avebury Ashgate Publishing Limited; 1993) and Wright J, Williams.R, & Wilkinson J. (The development and importance of health needs assessment. In: Wright J, editor. Health Needs Assessment in Practice. Plymouth: BMJ Books; 1998. p. 1-11).

**Theories**

Into this model we have added three factors regulating the relationships of these circles. 'Health policy' deals with needs of services and provision of services. For us it is the strategic and visionary work setting great lines of organising health care services, co-payment schemes etc. for years or tens of years. It rises from the basic health needs of the whole population and keeps eye on equity and social acceptability. It also tries to influence the health determinants of the population by providing health care services aimed at, for example, diminishing obesity, smoking and promoting physical activity.

'Health politics' organises health care services so, that demands of services are fulfilled and population is satisfied. It is more rapidly reacting, changing from day to day and influenced by needs of every-day politics. In 'health politics' common themes for debate are: waiting lists, need for out-of hours services and patient fees. The scope of health politics reaches no longer than to next elections.

'Health education' is third factor in this picture. It has most important role of all three. It influences health determinants of population and increases consciousness of their health needs. In the future people demand services for their basic health determinants, like obesity and smoking in stead of acute and random demand of contacts with health care professionals.

**Results**

This model visualises how we need all three elements to develop health care. It also makes it easier to set the reforms and new initiatives in their right context. Thus it places, for example, actions targeted to reduce long waiting lists into the field of health politics. If we want to tackle some risk factors to health and thus decrease the need of some operations (leading to shorter waiting times) we are doing health policy.

# Effectiveness in political-administrative decision making in Finnish health care

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**Research**

1. In what contexts does the concept of effectiveness occur in the council and board meeting documents of specialised health care?
2. To what purpose is the concept of effectiveness used in the subject contents of political-administrative decision-making?
3. Is the effectiveness concept used differently in different university hospital districts?

**Context**

In this study, we examined political-administrative decision making in specialised health care. The objective was to analyse the subject contents and contexts in which the concept of effectiveness was used in board and council meetings documents. The results will be useful when care effectiveness knowledge is reported for decision-making purposes.

**Background**

Knowledge on the effectiveness of patient care is crucial for making decisions in health care. Effectiveness knowledge enables decisions which will improve the focus of general funds and permit comparisons of patient care between hospital districts. In the Finnish political-administrative healthcare system, decisions are prepared by officials and hence the chances for the trusted persons to influence the contents of issues pending a decision are small.

**Theories**

The occurrence and use of the concept of effectiveness was investigated using the meeting documents of the boards and councils of five university hospital districts during two years, 2001 and 2006. The meeting documents (public) (n=190) included 160 board and 30 council minutes. Altogether 2754 decisions were made during the meetings. There were 2018 meeting appendices, of these 156 were publicly available. The material was gathered from the internet pages of the hospital districts and analysed using qualitative and quantitative content analyses.

**Results**

In the board and council meeting documents, the concept of effectiveness was found in connection with service activities and matters related to professional skills, especially regarding the planning, organisation and assessment of service activities and for research and development work. In the political-administrative decision making of health care, the concept of effectiveness is used to define and justify various activities. Effectiveness is used in administrative rhetoric, which is appealed to. Issues can also be justified with effectiveness and a generally desirable direction for activity can be highlighted. It seems that the use of effectiveness concept reflects an effort to reach for generally acceptable ideals.

In this study, the decisions were made neither with the aim to prove effectiveness nor were they founded on proven effectiveness. The hospital districts give special support for effectiveness research to provide knowledge of care effectiveness. Utilisation of such knowledge in political-administrative decision-making is, however, poor, especially in small hospital districts. The use of the effectiveness concept has increased from the year 2001 especially in large university hospital districts, which typically are leaders of the research and development work in health care.

In the future, the use of care effectiveness knowledge will increase its role as a supportive element in decision-making. Consequently, there is a distinct need to focus the data collection and systematic follow-up efforts accordingly. In order that care effectiveness knowledge can be utilised in decision-making, it needs to be presented in such a form as to allow easy applicability.

# Do top down changes in occupational structure on dental hygienists' scope of practice affect task distribution in local dental care organisations?

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## Research

To what extent does the top-down implementation of an extended professional domain for dental hygienists lead to a local task distribution that changes Dutch dental healthcare delivery, in the following ways:

- Are practically assigned tasks and responsibilities consistent with formally trained competencies?
- Does dental hygienists' scope of practice differ significantly with the traditionally trained dental hygienists?
- How can we explain the variety among the developed scopes of practice?

## Context

Stakeholders intend to improve Dutch dental care organisation, both to solve capacity problems and to answer to higher expectations in care demanded. Task redistribution from dentists to dental hygienists has been put forward as part of the solution. While the dentists' own scarcity has sometimes already led to task delegation, the recently implemented legal and educational changes enable further and formal task redistribution between the dentist and dental hygienist professions. According to earlier findings, the willingness of Dutch dentists to delegate tasks depends on their professional philosophy, their preventive inclination, and the perceived quality of care delivered by dental hygienists.

## Background

A new dental hygiene curriculum and the legal changes allowing patients to consult a dental hygienist without a dentist's referral, offers good prospects for task redistribution between dentists and dental hygienists. The main objection was the expected loss of dental hygienists' preventive attitude. In contrast, the dental hygienist association takes the following position: "The dental hygienists' core task is prevention, but now we can offer treatment in case prevention fails". Given the political nature of the institutional changes and the dependence on the dentist's willingness to delegate tasks it is interesting to look at the emerging forms of local appropriation.

## Theories

The contextual approach of Abbot (1988) is used to describe the relationship between dentists and dental hygienists. By way of two surveys, organisational and personal factors, dental hygienists' scope of practice, experienced job complexity, and dentists' supervision were measured. The first group consists of traditional trained dental hygienists educated within the old curriculum (n=800), these data are collected in 2006. For the second survey data were collected in 2007 and this sample consists of dental hygienists who graduated in the new extended curriculum (n=104).

## Results

The response of the surveys was 40% (2006) and 66% (2007). We encountered a high variety in local task division, supervision practices and task complexity. Only 13% of the new dental hygienists do not perform the tasks implemented in the new curriculum. According to the figures from the first survey, 20% of dental hygienists educated within the old curriculum perform these extended competences; even when they were not part of their initial curriculum.

Based on the patterns and clusters found, the discussion may focus on the local conditions (organisation, interaction, actor characteristics) under which the top down implementation of such a new curriculum may enable innovative organisational forms in dental practices, like more team-based care. The size of dental practices is increasing, demanding more managerial and entrepreneurial competencies. It is envisioned that teamwork and closer cooperation between dentists, dental hygienists and assistants is needed to meet a high standard of dental care.

# Management teams as management arenas and tools in specialised health care

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## Research

This study investigates management teams in specialised health care and their role as management tools on various management levels in hospitals. This study aims to answer the following questions:

1. What is the significance and role of management teams for the management functions on the different levels of specialised health care?
2. Do management teams implement shared leadership in their activities?
3. How do management teams recognise human resources, and what are the meanings of human resources in the management team work and subsequently in the management of the hospital?

## Context

Large healthcare organisations are regarded as expert organisations, distinguished by complicated hierarchical structures, organisation cultures characterised by professions, strictly functional division of labour and mechanical and machine-like way of action. Teamwork management has a remarkable role as the coordinating and leadership tool across the fragmented entity of healthcare organisations. International business literature shows that, at its best, teamwork management expands participants' views on organisational activities and decision-making while deepening their understanding of the organisational core task. A well-functioning management team participates in the implementation and follow-up of organisational strategy and thus increases organisational innovation.

## Background

This study is draws on the discourse of complex, adaptive organisations, such as specialised healthcare organisations. Studies from the UK and USA point out that the formal and informal interaction seen between organisational actors in complex healthcare organisations enhances their adaptive capacity.

## Theories

Altogether, 50 interviews were conducted between 2005 and 2008 among middle and top management of five hospital districts regarding management and evaluation of organisational activity. 65 interviews were conducted in 2007-2008 among activity area and unit-level managers in one hospital district regarding the functions of management teams and other teams considered relevant for work. The study was also based on videotaped materials of management teamwork on different management levels in one hospital district and supportive materials consisting of agendas and minutes of management team meetings. The interviews were analysed using theory-based content analysis and videotapes with ethnographic image analysis.

## Results

The preliminary results indicate that, from a single manager's perspective, working in management teams supported the manager's work and made him commit to the organisation. The manager's perception of organisational activity broadened. Managers often represented only their own profession in the management team.

When analysing whole management teams, their most important tasks turned out to be transmission of knowledge, financial surveillance, distribution of tasks and agreement on mutual interests.

Strategic issues and organisation as a whole received little attention. The actions of management teams can be described as passive, formal and producing few ideas.

Research and development of management teams is especially important in specialised health care, which incorporates several management levels and where know-how is divided between several professions and specialities. Knowledge on well-functioning and ill-functioning management teams is useful when intensifying organisational activities in specialised health care.

# Performance Appraisal: What Do We Want From It and What Do We Get?

**Williams S.**

*Cardiff University, United Kingdom*

## Research

Human resource management theory postulates that performance appraisal is an important tool in every manager's portfolio, because appraisal provides a mechanism for regularly setting employee goals, reviewing performance and identifying professional development needs that will enhance future performance. This empirical study tests the extent to which the appraisal process is delivering the objectives of improving performance among general practitioners in Wales.

## Context

The GP Section of the PGMDE School at Cardiff University pioneered a system for improving GP performance through a structured system of annual appraisals in 2003. Since then 75 GPs have been trained as GP appraisers, and 8 as Appraisal Coordinators. These teams carry out annual appraisals amongst the 2300 registered GPs practising in Wales.

The process itself is subject to continuous review and improvement. A formal external evaluation of the system was conducted last year. The present study arises from this review process, and focuses on the impact of the appraisal process on GPs as individual service providers.

## Background

Improving performance at system, organisation and individual levels is a key aspect of quality assurance in the British health care system. But in terms of health politics and policy, to what extent can health care professionals be seen to be engaging with this agenda? The findings of our study indicate that GPs value autonomy and self-direction very highly, and tend to resist externally-derived measures to improve or change their behaviour. This study explores the impact of using appraisal as a mechanism for stimulating –and implementing - changes in performance.

## Theories

An initial literature review was completed in October 2007. Focus groups with GP Appraisers and Appraisal Coordinators were held in November. The data from these sources informed a questionnaire survey to be administered online in January and March 2008. The questionnaire will elicit GPs' own views of the impact that participating in the appraisal process has had on them, on their motivation, on their insight into their own performance, on their intentions to change their own behaviour, and the extent to which they have been able to implement any changes to their own practice and services to patients.

## Results

Initial results indicate that appraisal has a significant impact on Appraisers' behaviour, in terms of their commitment, motivation and intention to change their own practice. There are also indications that participating in appraisal has had an impact on GPs' behaviour over time. Changes identified include increased participation in audit, and in more targeted continuing professional development activities.

The survey will shed more light on these preliminary findings, enabling us to quantify them more accurately. Issues about the extent to which Appraiser behaviour affects motivation and intention to change have also been highlighted from early findings.

# Cost and Practise Patterns of Arthroplasty in European Countries

**von Eiff W, Henke, V.**

*University of Muenster /CKM, Germany*

## Research

Is there a "gold standard" in diagnosis and treatment of patients who need a total hip replacement (THR)?

Hypothesis:

a) There is no "gold standard" pertaining to diagnosis and treatment of THR European-wide.

b) The variation of the indicators describing medical quality and economic issues of THR procedures is stunningly high between different European orthopaedic centres.

## Context

Arthroplasty is one of the most frequent surgical procedures in European countries. Within a European wide survey, research was undertaken in respect of diagnosis, interventional methods and cost structures within selected European countries (Germany, United Kingdom, France, Italy). It was questioned if differences within these three fields could be observed between the chosen countries and possible reasons were detected.

## Background

As a result of the demographic development, it is expected that the number of hip replacements will increase continuously. This will not only have a short-term impact on costs for the health institutions, but also for the health system itself. For effective health management it is important to understand the differences that might occur between different countries for one diagnosis. The understanding of whether a significant cause-and-effect interconnection between costs and patient-outcome exists might support a more effective management outcome on a micro-level and a more effective outcome on a health system level.

## Theories

Questionnaires containing medical (e.g. type of procedure), organisational (e.g. LOS) and economical (e.g. costs of stay/ procedure) queries have been distributed to 26 European orthopaedic centres that are recommended to represent best-in-class performance. Based on the results of the analysis of the questionnaire activity a consensus meeting has been carried out in which evidence based recommendations could be agreed on.

## Results

It could be found out that significant differences in diagnosis, interventional methods and cost structures exist for arthroplasty in different European countries. One of the main goals of this conference presentation is to clarify the different approaches that have led to the given results and to develop recommendations.

Furthermore, the following subject areas should be discussed:

1. Are there common patterns pertaining to procedure technique, patient flow organisation, equipment and treatment plan that can be identified in all (some) European countries?
2. Which are the critical cost drivers of arthroplasty and do they influence medical treatment decisions?
3. Is it possible to create standards of arthroplasty procedure performance regardless the different practices we can find in Europe?
4. What is a standard cost calculation for arthroplasty?

# Freedom in Choosing Healthcare Providers in Turkey: A Situational Analysis

Yildirim HH[1], Yildirim T.[1]

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**Research**

The main objective of this study is to explore putting patients at the heart of change by analysing the Turkish case with regard to patient choice, and to provide the information, data and knowledge about patient choice in the Turkish health care system.

In order to realize this objective we:

1. Examine the pressures for patient choice
2. Analyse the current policy context for patient choice in the Turkish health care system
3. Consider whether patient can make rationale choice
4. Investigate patient choice implications for stakeholders
5. Develop recommendations on policy and practice for patient choice

**Background**

The phenomenon of "empowering patients" became a current issue in Turkey for the first time in 1998 when the Patient Rights Regulations went into effect. However, putting patients at the heart of change in the Turkish health policy gained priority and found the area of implementation with the Health Transformation Program (HTP), which was initiated in early 2003 and has been endeavoured to be implemented since then. One of the main principles of the HTP is to be "human-centrist." To this end, the implementation of the "right to choose a doctor" is now applied in 400 hospitals.

**Theories**

This analysis is based on a review of the literature and data obtained from secondary sources, including government reports, epidemiological data, academic publications, and policy reports. Published and grey literature were identified using database, manual and internet searches.

**Results**

Although patients have freedom to choose the doctor theoretically and legally, this does not mean that they may use this right in an unlimited and rational manner. The first reason arises from the nature of health services and the second one from the health system in the country under discussion. As is well-known, there are market failures in health services, of which information asymmetry is particularly important , and which in turn results in agency relationship in health services.

In health services, the patient can choose his/her doctor in a healthy and rational manner provided that he/she

1. Is aware of his/her health problem and need;
2. Has alternatives;
3. Has knowledge on alternatives;
4. Has opportunities to compare the alternatives; and
5. Has financial possibilities, time, etc. to make selection.

However, this paper argues that the patient is not fully equipped in the above because of the two main reasons mentioned. Therefore, the ability of the patient to choose and, more importantly, to make rational selection is an area that has limitations in practice. Furthermore, the use of this freedom has not much influence on the main objective of the health policy, that is improving health status.

## FRIDAY 10:30 - 11:00

# POSTERS II

# The use of ultrasonic dissector vs. conventional surgery in thyroidectomy: a cost-effectiveness comparison

**Cicchetti A[3], Lombardi CP[2], Marchetti M[1], Raffaelli M[2], Di Bidino R[1], Ruggeri M[1], Velleca M.[1]**

*[1]HTA Unit - A.Gemelli University Hospital, Italy, [2]Endocrine Surgery Department - A.Gemelli University Hospital, Italy, [3]Faculty of Economics - University Cattolica del Sacro Cuore, Italy*

## Research

The aim of the study is a cost-effectiveness comparison between patients undergoing traditional thyroidectomy non video-assisted with (HS) and without (nHS) ultrasonic dissector (or harmonic scalpel). Patients with >30 mm wounds are randomized in two treatment options and followed for three months after surgery. The primary objective is to collect hospital costs related to admissions and Quality of Life (QoL) of patients undergoing to thyroidectomy until three months after surgery. A secondary end point is to assess the efficiency at hospital level focusing on surgery room time, time management and length of stay (LOS).

## Context

Patients were enrolled at the time of admission for total thyroidectomy. A baseline and follow-up diaries were filled in by patient to obtained data on diagnostic exams, visits, drugs, complications and QoL before the surgery and up to 3 months after the admission. During the admission, clinical and management information was collected as well as QoL and pain scales at 6-24-48 hours after the surgery.

## Background

This is the first attempt of a cost-effectiveness evaluation in Italy for the ultrasonic dissector. Similar experience focused only on the hospitalisation phase was conduced in Spain in 2001-2002 providing significant results in reducing operating time with harmonic scalpel. Meanwhile other studies provide data on the QoL but not related to the costs.

This project collected costs and QoL data in order to provide an overall picture of the real impact of the use of the harmonic scalpel in thryoidectomy, from an hospital and societal perspective.

## Theories

From March 2007 till February 2008 patients admitted to Endocrine Surgery Department of A.Gemelli Hospital of Rome for a total thyroidectomy were enrolled. The sample size was 200 patients: 100 patients for every treatment solutions available. In order to perform a cost-effectiveness study, clinical efficacy and related costs are assessed. At the moment the analysis is related only to inpatient resource consumption, since follow up data collection is ongoing. Further analysis will be performed at the end of the study. Incremental costs and incremental benefits will allow to estimate the ICER of thyroidectomy with harmonic scalpel.

## Results

Up to the end of 2007 168 patients were enrolled, 84 (50%) of them were treated with the harmonic scalpel (HS group). The two treatment groups were similar in age, sex, diagnosis, type of anaesthesia and of surgical intervention.

Mean ± SD operative time was significantly shorter in the HS group compared with the nHS group (52 ± 21 vs 69 ± 30 minutes, p-value 0.000). The reduced operative time in HS group led to a significant difference in personnel cost in surgical room (329 vs 442 Euro, p-value=0.000).

LOS was similar in both groups (5.76 vs. 5.97 days, p-value 0.947).

Other health resources consumption analysis is ongoing.

For QoL and pain perception a different time trend emerges between the groups. The HS group had a more immediate regain of QoL and lower pain levels (40 vs 44 after 6 hours, in a scale 0-100 of increasing pain). At the end of the stay, pain and QoL were almost similar, but 1-3 months after the intervention the HS group improved their QoL.

Scar perception was significantly better for the HS group at 3 months (8.5 vs 7.7, p-value 0.038) follow-up.

# Managing relationships in complex hierarchies – Project management: Moving from consensus-building to decision-making in transitional country' hospital restructuring project.

**Jekic I[1], Katrava A[1], Boulton G[1], Obrovacki M[1], Andrejevic V[1], Novak S[1], Milojkovic A[1], Koumpis N[1], Djukic V[2], Pesko P[2], Dmitrovic T[2], Draskovic D[3], Dujmovic F[3], Trenkic S[4], Pavlovic D.[5]**

*[1]EAR/TA Team Sofreco, Serbia, [2]Clinical Centre of Serbia, Serbia, [3]Clinical Centre of Vojvodina, Serbia, [4]Clinical Centre Nis, Serbia, [5]Clinical Centre Kragujevac, Serbia*

## Context

The EU/EAR Project provided to the Ministry of Health (MoH) has been charged with reforming tertiary care services and implementing an EIB loan of €200m in the beneficiary institutions: the four Clinical Centres in Belgrade, Novi Sad, Nis and Kragujevac, for their rehabilitation and strategic development. These university hospitals represent the four largest and most specialised state hospitals in Serbia with over 14.000 employees and 2.5m patients annually, accounting for one-quarter of healthcare system activity and costs.

## Background

Managing relationships in complex hierarchies at the national, local and institutional level in a project of this scope and magnitude requires different organisational models for the planning phase (consensus-building), the implementation phase (decision-making), and a transitional model of a matrix structure allowing the project to move rapidly into implementation mode in 2008, while important planning work continues. Preparing different groups of professionals to work in new physical settings, parallel to creating a momentum of change towards international evidence-based care and services standards represent complex tasks for healthcare change management policy in any environment, particularly in transition countries.

## Theories

The project consists of the three interrelated components: hospital infrastructure modernization, tertiary care policy development and business planning. Within this framework, the role of the EAR Technical Assistance Team has been to coordinate multiple stakeholders from the MoH, the Tertiary Health Care Expert Group, Clinical Centers' top management, Working Groups (WG) structured around main patient flows, the Project Implementation Unit, D&S Consultants and national and international financing authorities.

Processes and procedures are required to facilitate shift from planning towards implementation of the strategic development of the four Clinical Centres including overall site (re-)development (facilities, infrastructure, equipment), and an efficient and effective service delivery model.

## Results

To date, the scope of project for the planning is centred on consensus-building and therefore structured around committees (at a national level) and work groups (at the hospital level).

In 2008, this will require a gradual evolution from a "bottom-up" approach to more "top down" implementation. A transitional structure where both models are employed to achieve the ultimate objective of an integrated "project management organisation" that recognizes the reality of ongoing planning activities and the formative stages of the overall Project.

Health care management in transition countries is complex due to the only emergent practice of management, an inappropriate legislative framework, a system of health financing still not based on outputs, professionals-centrism, etc.

Therefore, a framework for this integrated "project management organisation" – together with a description of its work processes and schedule of activities – is key in the politics of health management and complex negotiating relationships in the project of this scope and magnitude.

# Sources of funding for the rural public primary health care in Greece. Which is the most valuable?

**Tsakountakis N[1], Vasilopoulos T[2], Lironis I[1], Apostolakis Ch.[1]**

*[1]Kastelli Health Centre, Greece, [2]Ag Varvara Health Centre, Greece*

## Research

We investigated various primary care settings in Crete, Greece to discover the major sources of funding and which were the most reliable and valuable among these

## Background

The transformation of the rural surgeries of Greece into well equipped primary health care centres requires a lot of funding from more than one source. The public health system is not relying on the State's health budgets only, but seems to engage with local communities in various ways.

## Theories

Eleven primary care health centres were chosen among 50 practices. The inclusion criteria were that the surgeries should be located in towns over 1000 inhabitants with a town hall, and that at least one general practitioner should have been in service for the last three years constantly.

## Results

Recorded sources of funding were: a) the hospital – the state, b) the local authorities (municipalities mostly), c) citizens' associations specially created in order to support the surgery d) other associations, e) individuals' donations. The state provided all the dispensable medical material needed for everyday clinical practice and the wages of the personnel. It contributed to cover the needs for more expensive medical equipment on a yearly planned basis but the whole procedure was too time consuming and bureaucratic. Local authorities covered the rent (wherever necessary) and they paid for cleaning and secretariat services on two occasions. Local supporters' associations were not uncommon and seem to be enabled in funding really expensive medical equipment (e.g. ultrasound etc). The contribution of the other sources was circumstantial although sometimes quite remarkable. It is therefore difficult to consider which source of funding is the most valuable. It seems that the first three sources mentioned above played the most important and complementary role for the proper and constant progress and development of primary health care settings in rural Crete.

# Evolving local customs as a funding source of a primary care practice

Tsakountakis N[1], Vasilopoulos T[2], Lironis I[1], Fthenakis A[1], Kastrinakis I[1], Apostolakis Ch.[1]

*[1]Kastelli Health Centre, Greece, [2]Ag Varvara Health Centre, Greece*

## Context

One of the major problems that delay the constant development of primary health care services is underfunding by the state. These disharmonies between will and act by the state have led local communities to search for other funding sources. We present how local customs and ethics could be directed towards a very remarkable funding source for the local public primary practice.

## Background

Death in each community is associated with many social and religious traditions. In Cretan society, people who attend the funeral of a beloved member of the community make donations mainly to public institutes and services to support their aims and proper function. Local public primary care surgeries seem to have a really good chance to benefit by these donations but a big concern is to find out what is the most effective and legitimate way to turn to advantage this custom.

## Theories

Malia Surgery is a primary care health centre in which this funding source has been applied for five years. A local formal association of distinguished citizens was created in order to collect and administer the donations. None of the surgery's staff or any other professional (such as pharmacists) who could have any conflicting interest can become a member of the association. Nevertheless, the staff of the surgery takes part in the advisory committee. Its purpose is to assess and record the needs and demands for health services of the local people and then to make suggestions to the board.

## Results

As a result, in the five years of the existence of this association a great amount of money has been gathered. These funds were spent not only on expensive medical equipment (e.g. ambulatory blood pressure monitor, electrocardiographs, defibrillators, doppler, etc) but also on the reestablishment of the surgery in a better and bigger building.

In conclusion, a well-organised community can contribute to the advance of its primary care health services by its own means. Customs of civil life could be the opportunity for this engagement of the local society into public health policy. These budgets could help local public primary care surgeries to improve their facilities, to expand their health services by employing more medical or other personnel and to get more advanced and expensive medical equipment. If this tactic could have an impact on better health indicators inside the community is a question that should be answered in future.

# Understanding informed consent: An Athenian Sample of Surgery Patients

**Kondilis-Petropoulos B[1], Akrivos PD[1], Falagas M.[2]**

*[1]Hellenic American University, Greece, [2]Alfa Institute of Biomedical Sciences, Greece, [3]Tufts University School of Medicine, Department of Medicine, United States*

## Research

Physicians have an ethical and legal responsibility to ensure patient comprehension of informed consent. Despite this responsibility, many patients are still not aware of important aspects concerning their surgery. As past research has shown, half of all patients forget most information within minutes of their consultation. Moreover, due to rapid advances in the field of medical research, yielding a greater variety of treatment options and legal concerns, informed consent documents have increasingly become more complicated. This leads us to question whether informed consent actually fulfils its requirements of "informing" the patient which this research seeks to explore.

## Context

Informed consent has come to replace the old paternalistic notion of the "doctor knows best", with a more collaborative picture. Patients expect to be informed of the risk of a surgical intervention. A truly successful informed consent process implies that the patient or clinical trial participant understands the procedure and their rights and responsibilities. On the other hand it seems that even though patients welcome the collaborative spirit, they would prefer the physician to be the primary decision maker. A key component in informed consent is the physician-client relationship and their communication.

## Background

Cordoza stated in 1914 that "every human being of adult years and sound mind has the right to determine what shall be done with his body, and a surgeon who performs an operation without the patient's consent commits an assault for which he is liable in damages" (Langdon, Hardin & Learmonth, 2002). However, the obtaining and giving of informed consent has become a central issue in clinical research and biomedical ethics.

## Theories

A questionnaire was developed for adults based on existing journals publications and comprised of four sections including demographics, knowledge of the reason for surgery, knowledge of patient rights and the client-physician relationship and communication.

The questionnaire was distributed from October 2007 until January 2008 to patients of three surgeons in Athens, Greece. Surveys were given to adult patients one day after their surgery.

## Results

Approximately 50 surveys have been collected to date. Content is being analysed but preliminary findings indicate that 41% answered "no", 36% answered "yes", 8% "not sure", 6% "not needed", and 9% left the question blank, regarding changing their mind once they give their consent. The average rating for how "easy" they found the survey was 4 (0-5 scale; 0 being "not at all easy" to 5 being "very easy").

This is the first of such a study done in Greece. The research team faced most difficulties in recruiting physicians to perform such a study and the limitations of the sample may be the sampling of doctors already "invested" in providing informed consent, possibly biasing the sample population results.

# A systematic review of settings-based oral health promotion in the UK

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## Research

Tooth decay is the most prevalent chronic childhood disease (Watchyourmouth.org, 2007). In New Hampshire, over half of the third graders have experienced tooth decay (Watchyourmouth.org, 2007). The present study presents a very thorough review of the oral health promotions with the aim to inform policy. We summarise current settings-based oral health promotion strategies in the UK, applicable to school or child care settings, and outline future steps that can be taken to improve oral health promotion.

## Context

Disabilities derived from impaired oral health status cause millions of school and work hours to be lost the world over. Prevention of cavities through oral health promotion is the most cost effective. Settings-based health promotion refers to the use of pre-existing environmental settings being used by target populations for the planning, implementation and evaluation of specialised initiatives. The settings-based approach to health promotion has its roots in the first international conference on health promotion on 21 November, 1986 (Ottawa Charter for Health Promotion, 2007). The charter produced from this conference recognizes that health is heavily affected by people's own behaviour, their environment and that attaining good health cannot be ensured by the health sector alone. The World Health Organisation (WHO) later published a report highlighting the great advantages schools have in promoting oral health: an established learning infrastructure, a contained environment, and good relationships with students and influential peers (Kwan, et al., 2005).

## Theories

A collection of published papers were used as reference material for this paper. A series of government publications, official government websites and policy reports provided the most valuable guidance.

## Results

Beyond the Sure Start programme, and other oral health promotion initiatives described along the paper (eg Brushing for Life) there was limited evidence of other activity. This picture portrays inconsistent and unsystematic oral health promotion across the UK. While some healthy schools are promoting oral health, others are not. While some regions are assessing the need for fluoridated, others are not. There is essentially no standardised national oral health promotion scheme capable of reaching all children and ensuring preventative oral health diseases and, therefore, the benefits of successful oral health programmes are not being achieved.

While some local councils and health trusts have taken action to ensure their communities have appropriate oral health knowledge and access to oral health services, there does not seem to be a standardised oral health promotion programme in the UK that reaches all children. Evidence-based oral health promotion programme that impacts all citizens and future generations need to be in place. There does not appear to be a single nation-wide standardized oral health promotion focused programme capable of impacting all children in the UK. This continues to leave parents educating their children on oral hygiene and teaching them how to develop healthy oral hygiene habits. Special initiatives, including Sure Start, need to be firmly in place to help those parents less able to support their children in this way. Good oral hygiene habits need to be embedded into the nation from an early age – Sure Start targets children early, but is not available for all preschoolers and in any case only targets particularly disadvantaged groups. There needs to be adoption of the principles of oral health promotion in schools across the board.

# Reaching across organisational, sectoral and geographical boundaries: exploring the learning potential of an EC cross border project

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**Research**

This paper outlines some of the key findings from an evaluation of the project and demonstrates that EC funded projects such as this, which seek to promote cross border collaboration and understanding (i.e. across organisational, sectoral and geographical boundaries) offer considerable learning potential – not least about variances in health politics across different communities. However, for this learning to be realised a comprehensive system of knowledge management needs to be an integral part of project planning alongside a system for sustaining embryonic professional networks. The concept of managing relationships was also a key part of the projects success. Executing a project funded by the EU demands the development of complex organisational skills to negotiate all the administrative challenges en route to successful completion and this project in particular relied for its success on the development of social relationships of trust and mutual respect across national, professional and social boundaries.

**Context**

A three–year European Commission funded project designed to exchange a wide range of staff (professional, semi-professional and voluntary staff in health and social care) project led by the University of Greenwich (UK) and the Université Catholique de Lille, France was completed this year (February 2008). The project was complex because it involved working in different national contexts, was multi-disciplinary, and demanded the negotiation of multiple boundaries.

**Theories**

A mixed method evaluation including written reports gathered immediately after each exchange visit and a post hoc series of individual interviews and focus groups was conducted in order to gain qualitative information (from the participants perspective) on their experiences and to identify any learning gained.

**Results**

Analysis of the data provided evidence of learning on a number of levels; personally, inter and intra professionally and organisationally as well as across sectors and also from a project management perspective. The learning crystallised around the extent of the differences noted by the participants between the UK and the French health and social care systems despite geographical proximity, common membership of the EU and many shared challenges in health and social care. The extent of these differences, noted at every level from policy to practice proved a rich source for reflection on organisational philosophies, ways of working, distribution of resources, professional roles and autonomy and professional registration and mobility - in short on health politics at ‘macro’ and ‘micro’ levels.