World Health Organization
REGIONAL OFFICE FOR Europe

Improving hospitals and health services delivery

Health Services Delivery Programme

By: Nigel Edwards

A report on the priorities for strengthening the hospital and health services delivery in the WHO European Region

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Division of Health Systems and Public Health

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ABSTRACT

This report examines the challenges facing hospitals and the health services delivery across the WHO European Region. There is scope for major change and improvement which is made more urgent by the many challenges being faced by hospitals as a result of changes in the population, in the practice of medicine and in the wider health system and the economies of Europe.

The report looks at the areas in which improvements and policy changes are required and identifies the areas where there is the greatest opportunity for the WHO support to Member States. We identified that there is important work to do to set out a clearer vision for the future shape of delivery systems and the role of the hospital within them, to spell out what the changes are needed in clinical services, to create tools and indicators to promote change, to develop new policy frameworks, to create and share knowledge and support country offices. Increasingly this needs to be done in collaboration with partner agencies.

Keywords

DELIVERY OF HEALTH CARE
HEALTH SYSTEMS PLANS – ORGANISATION AND ADMINISTRATION
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Introduction

There is a pressing need to improve or fundamentally change the health services delivery in many countries in the European Region. Between 35% and almost 80% of the European region's health resources are spent on hospital and outpatient care.[1]

In many countries there is a legacy of models that have been over reliant on hospitals and opportunities to reduce the large number hospitals and acute beds and high levels of hospitalisation (See Appendix 1). There is a widespread view that hospitals are often inefficient, fail to produce the quality of care that patients have a right to expect, are increasingly unsuited to deal with the changing patterns of disease and represent a significant misallocation of resources. This seems to be borne out by very significant variations in length of stay or admissions for ambulatory care sensitive conditions between countries[i]. Hospitals are also coming under pressure from a number of internal and external sources and need to fundamentally rethink their approach. Many countries are trying to deal with these issues.

This report was commissioned to:

- Explore current issues with hospitals and health care delivery systems that confront Member States
- Identify the areas in which improvement and policy changes are most urgent.
- Identify opportunities for World Health Organization (WHO) Regional Office for Europe support to Member States (MS) in this area given the resource constraints and the need for collaboration with other partners.

While the focus of this report is on hospitals they have to be seen on the context of the wider system and a key conclusion is that it no longer makes sense to plan and make policy for hospitals without understanding these connections. Plans and policy need to be for systems not just the component parts. This means that the view of hospitals as being 'the problem' and the obstacle to a patient focused and primary care based system needs to change. Hospitals need to be treated as important partners in the development of health systems and the providers of expertise and resources needed by primary care to be effective.

The report has been developed in discussion with WHO Regional Office for Europe staff in Copenhagen, Venice, Barcelona, almost all the WHO Country Offices (COs), the European Observatory and with external partners and stakeholders including the World Bank, the EIB, the European Commission, OECD and academic commentators.

Hospitals and services delivery: the need for change

There is widespread recognition that health care systems need to change to respond to the long term trends in demography and epidemiology as well as adapt to progress in medical processes

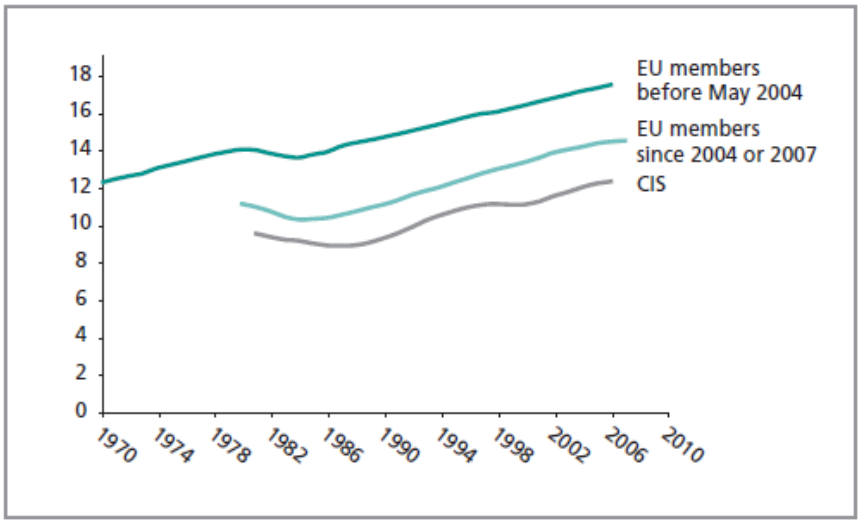
[i] Conditions that can be managed or prevented by action in primary care e.g. Influenza, pneumonia, chronic obstructive pulmonary disease, congestive heart failure, dehydration and gastroenteritis

and evolving technology that require very different delivery models from those currently in use.[2] In most of the region the impact of the financial crisis and the long term challenge of rising costs and shaky funding streams give the need for change even greater urgency while at the same time limiting the options that are available to policy makers. Hospitals are still an important part of the health services delivery but their role is changing and being challenged. This comes from several sources:

Changes in demand

All countries in Europe are experiencing an ageing of their populations, illustrated in figure 1 below, which is a trend that is projected to continue.

Figure 1: Percentage of the population aged 65+ years in Europe 1970-2006. Source: WHO[3]

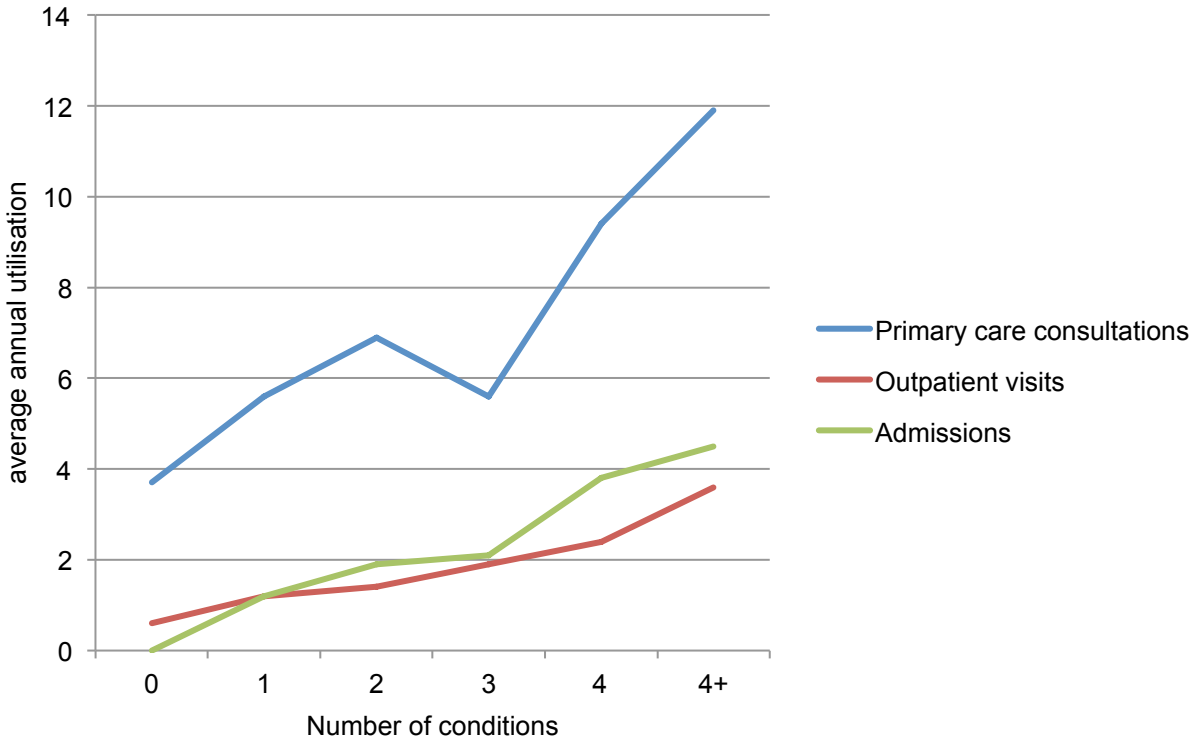


Note: CIS = Commonwealth of Independent States

Recent estimates suggest that the proportion of those aged 65+ could account for 20% of the population in the European Union by 2015, with the proportion of those aged 80+ estimated to rise from 3.9% in 1995 to 5.2% in 2015.[4] Reduced birth rates and increased life expectancy will result in dramatic changes in the age structure of the population in Europe.

As the population ages the prevalence of chronic disease will increase. There are also increases in other risk factors for chronic disease in much of the region. The prevalence of multiple chronic conditions increases with all age groups from 10% in the 0-19-year-old age group up to 78% of people aged 80 and over.[5] This poses one of the greatest challenges to service design and spiralling healthcare costs. Healthcare utilisation and costs are higher for patients with multiple chronic conditions. The addition of each chronic condition increases the number of primary care consultations, hospital out-patient visits and hospital admissions, longer stays and total health care costs, see figure 2.[6] Health costs are almost five times higher in patients with four or more chronic conditions than in those without chronic disease.

Figure 2: Health care utilisation with co-morbidities[7]



The growth of non-communicable diseases (NCDs) and patients with multiple co-existing conditions is a challenge to hospitals as they are often insufficiently co-ordinated with primary care, organized in sharply divided silos based on disease specialties and built on a model of providing individual episodes of care rather than continuity. The rise in dementia is a further challenge and this is frequently associated with patients staying in hospital longer than they usually would.

The expectations of patients about the quality of care are growing and hospitals and other parts of the delivery system will need to be much more responsive and customer focussed than has been the case in the past.

Changes in the way health is being provided

Increasing amounts of care traditionally delivered in hospital can be provided as effectively in settings that are more convenient for patients and may be less expensive. There is a trend in many countries to centralise more specialized activity where there is evidence that high volumes are associated with higher quality. Workforce shortages and restrictions on working hours are also creating pressures that make the maintenance of more specialized services in smaller hospitals increasingly difficult. This is a particular issue in rural areas.

The business and clinical models on which hospitals are based are increasingly not fit for purpose. In addition to being based on clinical silos that increasingly do not meet the needs of complex patients with multiple conditions they have also tended to rely on continued growth. The incentives in payment systems and the high proportion of fixed costs in hospitals have

tended to encourage this strategy which is increasingly unviable, not least because of the effect of the financial crisis. There are also challenges to the models in primary care and mental health which also need to adapt to meet changes in the pattern of disease, aging, increasing expectations and the need for increased co-ordination.

Technology is developing fast, particularly in the area of diagnostics; this creates both opportunities and additional costs. As with other changes it also has the overall effect of allowing further decentralisation of some work. In surgery the development of new technology assisted techniques may have the effect of increasing the number of patients able to benefit from procedures which are currently too hazardous for them. Telemedicine and information technology both offer ways to change how care is delivered and in particular to reduce the use of traditional hospital and outpatient care and allow patients to manage more of their own care.

Changes in regulation and concerns of policy makers and payers

Governments have become increasingly concerned about the performance of health systems given their share of GDP and growing spending constraints. Providers are likely to come under significant pressure to improve quality, to demonstrate that they are producing high quality services and have systems to ensure that they comply with the growing number of standards and guidelines.

There is a trend towards much greater scrutiny and accountability through inspection, the publication of data and other public reporting. There has been a growth in the amount of regulation that providers are subject to and this is likely to continue to expand. In particular, there has been a growing interest in safety with increasing requirements placed on providers to ensure not just that they have internal reporting systems but they are taking action to drive improvement.

Payers are likely to become more selective in how they contract and the growth in the use of health technology assessment is likely to continue, creating incentives for providers developing services to ensure that payers wish to purchase them. Many countries in Europe now operate some form of diagnosis related group (DRG) reimbursement system either for paying for activity or as a method of budget setting. These will continue to evolve and become more complex and it is likely that there will be a move to more pay for performance contracting, attempts to buy bundled payments, for example for chronic disease and new approaches to contracting for value, shifting attention to the whole episode of care rather than individual components.[8] Providers will need to deal with a mix of different payment systems and respond to payers who will wish to experiment with payment mechanisms more aligned to improving population health than paying for individual episodes. In a number of countries further work will be required to get better alignment between the method of paying physicians and hospitals.

The impact of these changes requires a much improved approach to management, governance, accountability and internal and external performance management.

Regional issues

In Central and Eastern Europe (CEE) and the Newly Independent States, there are a number of additional challenges that need to be addressed[9]:

- The survival of a number of old models of mono-profile institutions specializing in TB, infectious diseases and other areas is an obstacle to the development of high quality multidisciplinary care.
- The very poor state of hospital and other infrastructure.
- The over provision of hospital services generally and in capital cities in particular.
- Problems with the workforce migrating to other countries or to the private sector.

The objective in most systems is to develop care that is more integrated and better co-ordinated (taking less place in hospitals and other institutional settings) and where there is a step change in efficiency and quality. While there has been significant development of the family doctor system in many countries in CEE there is still more to do to develop a really effective gate-keeping system. In many countries primary care is fragmented, has limited resources and has poor access to diagnostics and specialist opinion. This is a significant obstacle to co-ordinated care. The persistence of a model of primary care which is fragmented and often consists of a single doctor with limited support is no longer fit for purpose. The Royal College of General Practitioners in the UK is encouraging the development of federal approaches to the organisation of primary care to try and overcome the disadvantages of small scale which prevents the deployment of diagnostics, specialist staff, large scale informatics and other approaches which could make a significant difference to patients and to hospital utilization.[10]

Current challenges

There are four types of change that are required – in some systems all levels will need attention:

- Redesigning the internal operation of providers, including hospitals
- Planning local health systems and how hospitals relate to other services in particular to primary care, home nursing and social services
- Planning services across hospital and provider networks – for example to rationalise the distribution of specialist services
- Rethinking the entire delivery system to meet new challenges

These all require different skills and methods. The first of these can be dealt with entirely by the management of the hospital or other providers. External assistance might be required to apply improvement techniques and project management to what can be complex inter-related activities. The other changes require action across a system, decisions by payers, regulators and policy makers, significant redesign of the delivery system and a range of policies to support this. Market mechanisms do not seem to be as effective in making these types of changes as might be expected not least because the existing providers need to fundamentally change and the incentives to do this are underpowered. These are very challenging tasks and hospitals and other providers are often not well equipped to respond for a number of reasons:

Cost structure

In Western Europe this is partly due to the often high proportion of fixed costs invested in buildings and equipment which reduces the institutional flexibility to adapt.[11] In a number of countries in east of the region the problem is different: the buildings are often of little or no value and are not fit for purpose but the shortage of capital hinders the system's capacity to change (in some cases the problems are also compounded by very high utility costs).[12] There is difficulty in accessing investment capital in many countries, and this has worsened since the economic crisis.[13] The tendency for available capital to be sliced up across schemes rather than priority projects is a further obstacle to significant change. The increasing introduction of Public Private Partnership (PPP) hospitals, with long contractual periods of operation, which "protect" funding streams for infrastructure and related costs, potentially offer less flexibility to change to the hospital and/or to contribute to hospital reconfigurations in a "corporate" way working with the wider local health system.

Workforce issues

Labour costs are often semi-variable or event quite fixed. Hospitals also have a labour force that is much less flexible than in many other sectors of the economy partly because of the highly inter-related nature of hospital work and in many cases because of legal, cultural and regulatory limits on the freedom of managers to agree flexible local terms and conditions and on whether staff can be made redundant. A number of countries have restrictions on hire and fire freedoms for employers. The planning of workforce is a serious weakness in many countries and in particular there is slow progress in the development of new roles and the devolution of tasks to nurses and other professionals.[14]

Leadership and management

In many countries hospitals and local health systems have relatively under developed leadership and management, and those responsible for the strategic oversight and direction of hospitals sometimes lack the skills, vision or experience to execute this role adequately. It is often the case that despite their size and significance hospitals are managed by individuals with little formal training in management, they have limited support from finance and management professionals and appointments are subject to political influence. Costing, performance management and other information systems are generally poorly developed. Expertise in improvement methods, process redesign, change management and other techniques for developing new approaches is rare.

There is a trend in many countries towards the further devolution of power to local hospital managers and owners (corporatization). In some cases this has been accompanied by changes in the legal status and ownership of the hospital.[15] This and the growth in more transparent reporting of important data, reflects a growing interest in ensuring organizations are well managed and that they are properly held to account and a belief that this cannot be accomplished by central control. This trend, which also often involves exposing hospitals to more commercial failure regimes for managing insolvency, is intended to be an incentive to improvement

management. This means that strengthening governance and performance management within hospitals will be even more important, as will developing better methods for holding them to account. It may also inadvertently create barriers to more integrated care or to the development of specialist centres of excellence as autonomous individual organizations may be less inclined to give up services.

Political power

The machinery to involve the public and decision makers in important questions about the future shape of the system is often not well developed. In many countries, particularly in the east of the region, there is a very hospital-centric view of health care at political level, with a bias towards high technology and tertiary services. Hospitals remain very politically powerful both nationally and locally and consequently have the ability to block change. In countries in CEE where local government is the owner of the hospitals there is a political dynamic that makes both efficiency improvement and major reconfiguration more difficult. Because of the political and economic importance of the hospital, owners have incentives to resist change but also a limited ability to hold the hospitals to account for improving quality and efficiency or challenging them to change their role. The owners are not sufficiently objective or powerful enough to exercise this power effectively. At the same time their conflicting responsibilities for a wide range of other local services have tended to mean that there is a pattern of chronic under investment in maintenance, buildings and equipment in a number of countries. In a few countries policy makers and other influential individuals are also involved in the ownership of hospitals which creates some further complications.

While the managers of hospitals and policy makers can see the need for change and may even agree on the goal, the transition path looks so difficult and the scale of change is so daunting that the first step on the journey appears to be almost impossible.

Poor integration with other services

The changing nature of the demands made on hospitals means that it is particularly important for them to work closely with other health and social care services. In many countries, hospitals have been poorly integrated with primary health care and the gate-keeping function of primary care is sometimes only partially effective. In those countries where specialist ambulatory care models exist alongside hospital and primary care the challenge of care coordination is even greater. Primary care also increasingly needs support from specialists to ensure that they remain up to date. The model of short appointments provided by small individual practices appears less appropriate for the changing demands that are faced. The internal organisation of hospitals based on clinical silos defined by the disciplines of the doctors, rather than the often complex, multiple and ill-defined needs of the patient, tends to exacerbate the lack of integration and increases the risk that the co-ordination of care will be poor, and the deliver system difficult to navigate for patients.

The separation of mental health services from both primary and hospital care is a particular concern as increasingly patients with chronic conditions and frail older people admitted to hospital are likely to have mental health co-morbidities.

Lack of staff engagement

Where major changes are to be made it is particularly important that staff are fully engaged in supporting and implementing the change. This is difficult but particularly so in countries where doctors and other staff have significant opportunities to work part time in the private system or receive a large unofficial income.

Issues with policy frameworks

The wider policy framework is often not supportive of the changes that are required. Although many countries have now moved away from historically based and centrally set line item budgets to a variety of activity based payment methods there is still much to do. For many chronic conditions payment systems that re-enforce an episodic model of care, pay individual providers rather than for a pathway or year of care and incentivize additional activity are not appropriate. Progress towards more bundled payment has been slow, not least because of the formidable challenges in designing these new models.

DRG based payment methods may encourage improved efficiency and reduced hospital stays but have limitations given that they rarely cross the hospital boundary to cover community settings. The payment methods in many countries often serves to cement the divisions in the system with primary care often being paid on a capitation basis and hospitals being paid on a DRG basis or by negotiation of budgets for the institution.[16] [17] DRG payments are not particularly powerful as mechanisms to change the shape of the hospital system, although they can be used to persuade providers to stop or start particular activities.[18] Strategic change requires decisions to be taken at a political level, by the payers or by the providers themselves. For all the reasons listed above this has proved difficult.

Often there is relatively little done to articulate the vision for the future role of the hospital or the shape of the wider delivery system. Some countries have developed hospital master-plans but these tend to focus on the distribution of facilities and tend to say little about major redesign of the wider delivery system. Sometimes there is even a lack of acknowledgement that there are problems or that the area requires attention. There may not even be a clear locus for policy leadership on health care delivery systems within ministries or elsewhere.

Evidence and expertise

The difficulty for policy makers is compounded by problems with the evidence base for planning hospitals and delivery systems. There are significant gaps in our knowledge or areas where the evidence is contested or context dependent:

- What is possible / desirable in rural areas?

- Geographical distribution – for which condition or in which circumstance does travel time matter?
- What should be the content of different types of hospital and which services need to be located together?
- The extent to which there are economies of scope and scale, diseconomies of size or complexity and the trade-offs involved in these.
- Safe and effective models for different types of services, for example, maternity care, emergency response, internal or general medicine.
- The distribution of specialist services and which should be centralised.
- The balance between specialization and the ability to deal with multiple pathologies.
- The criteria that should be used to judge investment in hospitals or major equipment
- Staffing levels
- Effective implementation
- The documented benefits of previous reconfigurations

WHO Regional Office response

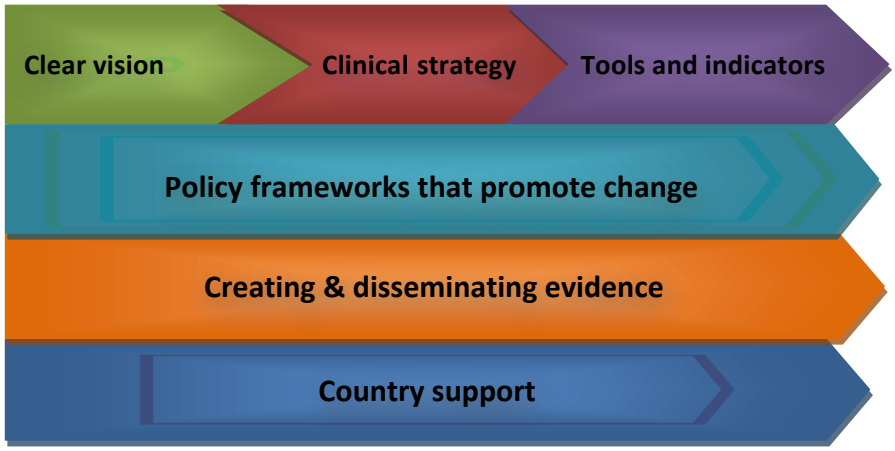
It is very clear, given the scale and urgency of this agenda and the importance of hospitals and the wider system to health outcomes, that there is a strong case for WHO to be very active in this area. The country offices and the other stakeholders welcomed the suggestion that WHO was intending to increase its activity and were very clear that they believed that it has an important role to play. There was a strong view amongst a number of stakeholders that there are well defined areas in which WHO is uniquely positioned to provide support to member states and to the wider discussion on the future shape of health services.

The analysis above provides a high level view of the main issues and it is obvious that the scale of the change that is required and the number of difficult issues that need to be addressed is extremely large. The approach to this question therefore needs to consider:

- Which areas are priorities?
- What is the unique contribution that WHO can bring?
- What is the balance between in-country work as opposed to regional or sub-regional work?
- How can WHO develop partnerships and ways of working that increase the power of its contribution?

There are several areas where WHO can be most effective building on its power to convene different parties, its credibility in the area of clinical and health care issues and its links to 53 countries and all the learning and experience that this provides access to. The identified components of work on hospitals and delivery systems are presented by the diagram (Figure 3) and explored in detail below:

Figure 3. Areas for WHO intervention and support



Author's own illustration

Developing a clear vision for health services delivery and hospitals

There is a need for a very compelling case for change to be made and for this to be heard by policy makers. But there also needs for a much better articulated positive vision for the delivery system and the role of hospitals within it. While the detail of this will need to be adapted to reflect the highly diverse nature of the European Region there are some common features of such a vision and a shared direction of travel. The most challenging aspect of this is that while there is a clear consensus amongst experts in this area that the hospital and the wide systems of care need to change, there is much less clarity about what new models are needed.

WHO is uniquely positioned to challenge policy makers, hospital directors, clinicians and others engaged in health care to think differently about the systems they work in, to help them redefine what good services look like, and to make them aspire to make changes to their system. Working with partners WHO can help these actors set aspirations for access, efficiency, quality, care coordination, the use of evidence, continuous improvement, patient engagement and other characteristics of high performing health services delivery. In doing this however the focus is expected to be on defining the characteristics of systems and showing that there are different ways in which these can be achieved.

In previous attempts to set out the direction for health systems there has sometimes been an unfortunate perception that WHO has taken an adversarial position towards hospitals. This might have been counterproductive as failing to provide a positive vision to such an important part of the system may have created more opposition than was necessary. It is also worth noting that a language of shifting care from hospitals may also be unhelpful – particularly in those systems that historically have not had a high quality primary care system. Instead, it would be better to focus discussion on strengthening overall delivery systems and integration of care. Furthermore, in some cases more hospitalisation may be needed in particular where access (especially financial access) is weak, and hence the issue is more complicated than simply shifting care out of the hospitals.

Similarly, there is a need for a change in the way that WHO and other agencies talk about hospital capacity as in some countries simply closing beds will release few resources for reinvestment due to the virtually zero value of the buildings and low levels of staff. The focus needs to be on designing more clinically effective systems bearing in mind that these will have different effects depending on the starting point of the country. The high-level analysis of hospitalization conceals the fact that while some countries may appear to be close to or higher than the European average for hospital admission, many of these admissions are for ambulatory care sensitive conditions and other diagnoses that would not be admitted in many other countries. (e.g. hypotension which is a common diagnosis in Germany and consumes large resources, while in other countries, the condition is not recognized). By contrast, access to hospital care for surgical procedures and interventions which have a relatively low cost per quality adjusted life year and which are important for returning people to productive work (e.g. hip replacement) may be very poor. Focusing on the effectiveness and value added by hospital admission would produce a very different answer in Moldova compared with Croatia or the Netherlands. Country offices (CO) report that there is still a very strong demand for norms to be set for numbers of beds and specialist at different levels of hospital.

A message that needs to be continually emphasized is that it is the capacity of the system to provide appropriate and cost effective care that is the key question, and not the institutions or number of beds in a particular institution or area. This is a very different way of thinking about healthcare and capacity planning from that still very common in many countries which is very focussed on beds. Any strategy for hospital care has to be closely linked to primary care, specialist outpatient services as well as primary and secondary prevention supporting a system that will improve population health, reduce mortality and morbidity (particularly from NCDs), and improve access, value and experience for patients and staff. Changing the approach will take some time and will be challenging for many of those involved in it.

This vision needs to include a strong reference to sustainability and in particular to carbon reduction. Healthcare systems and hospitals in particular are major carbon producers and consumers of other resources. They have a key role in contributing to the wider sustainability of the communities they serve. This important aspect of their role seems to be neglected, and WHO needs to ensure that this responsibility is recognized.

The advocates of reform – often somewhat in a minority – would find the statement of a strong vision for the future of the system very helpful. Creating a consensus at the level of government and politicians that change is necessary is a very important first step in a change program. WHO with the European Observatory can bring a systems perspective to the issue of service delivery and start an important dialogue on the high level vision for health services delivery.

Developing a clinical strategy that underpins the vision

Implementing the vision for the care system, developing the practical measures needed to improve outcomes and the other steps necessary to reform of the health care delivery system and

reduce the relative size of the hospital sector require very significant changes in clinical practice; for example in the management of infectious diseases and in the role of primary care in preventing admissions for chronic conditions. WHO is well placed to support the development of clinical strategies that will drive the change specified in master plans and other reforms and to link this to the wider European strategy in the area of NCDs.

It will be important that any clinical strategy should make strong statements about the place that mental health services have as part of the overall health services delivery. As noted above, with the growth of NCDs it is increasingly likely that many patients with physical illness will have mental health co-morbidity. There is a need for much better integration of mental health services with primary care in a number of countries, particularly in the east of the region. General hospitals will equally need to have a competence in the management of patients with mental health problems.

End of life is an important area where improved clinical strategies will have significant benefits for patients and their families. WHO has already published useful material for care at the end of life which is an example of the type of strategy proposed here[19].

Similarly, there is an opportunity to set out a clinical strategy for conditions which currently are often treated in mono-profile hospitals. Not only does this frequently require patients to make long journeys for treatment but it is also an obstacle to high quality multidisciplinary care. A strong statement about the future of different types of single specialty hospitals would be very helpful.

When talking about service delivery, WHO is expected to focus on underpinning clinical models and patient pathways in the continuum of a health system, rather than thinking in a fragmented way about different service levels, as some of the old distinctions are now unhelpful.

The components of a strategy in this area will include policy development in a number of complementary areas:

- The redesign and improvement of pathways and clinical systems incorporating evidence based medicine.
- The development of high quality systems for care coordination between providers, effective gate keeping and the systematic management of non-communicable diseases.
- The concept of patient activation, self management and of shared decision making is expected to become a key principle for healthcare. There are ethical, financial and clinical reasons why these should be the case which are well explored elsewhere.[20] [21] Patients with multiple conditions may have goals for their care that are quite different from the biomedical outcomes generally used to define success. This is particularly true for patients with multiple conditions where there are trade-offs to be made between treatment and lifestyle, but this may be true also at the end of life and for a number of elective surgical procedures. Health systems have to develop a whole new set of competences for understanding these needs, providing information and support to patients to help them in managing their own care and in

connecting them to other patients. The cultural shift involved cannot be underestimated and WHO role in articulating this could be significant.
- Developing guidelines, decision tools, policy and payment systems to underpin these changes.
- Understanding the impact that these changes will have on providers and the wider system.
- Medical and other clinical education and training to ensure that there are staff with the appropriate skills to operate the more complex systems required for coordinating care for chronic disease. Giving professionals the skills to share decision making and to work with empowered patients will require major changes to many existing training and education programmes.
- Measurement and indicators to track progress.

A number of CO and a number of organizations responsible for infrastructure investment are keen to get guidance in a detailed form on the content of different levels of hospitals, the level of provision required for different types of population, staffing levels, investment appraisal criteria and other quite detailed advice. This is neither possible nor desirable. The region is too diverse, the evidence is insufficiently strong and there is a very serious risk of locking in a particular model of practice and stifling innovation for this to be a practical or useful contribution. What would be useful is the development of broad design rules that set out general principles of how effective models of care can be created and some of the options for how the delivery of these can be configured.

Developing tools and indicators

Tools such as WHO Performance Assessment Tool for Hospitals (PATH) [22] and collaborations such as Health Promoting Hospitals and the Pharmaceutical Health Information Network appear to be valued, and the current proposal to develop tools to support health systems strengthening is valued by countries and stakeholders. The use of assessment tools and other methods that foster collaboration, peer-to-peer learning or fill in knowledge gaps are particularly useful in those countries with relatively underdeveloped hospital management or external regulation. The question of where and how WHO might focus its efforts in the development of tools needs further discussion but the following areas seem to reflect a common need in many Member States:

- Care co-ordination between different parts of the system.
- Clinical pathways and guideline implementation.
- Hospital efficiency and quality improvement. There are a number of well-established methodologies for quality and efficiency improvement. A number of these do require a culture of devolved management within hospitals. Promoting measures that advance a supportive environment for these improvements is an important role for WHO.
- The autonomous hospital - including issues such as ownership structures, governance, internal management systems and failure and insolvency regime.
- Investment appraisal, particularly in relation to hospital construction and high-cost diagnostics. These do already exist and the question might be how to get them more into use.
- Policy measures, regulation, payment systems and bundled payment that would support these changes.

The relatively under-developed state of hospital and health care management is an issue where some action has been taken but there is more to be done to encourage the development of better hospital management and governance e.g. changing management practice to support the changes in clinical practice. WHO could have a valuable role in promoting good practice and, resources allowing, the development of specific programmes such as PATH to support improved management.

The current indicators used in the WHO health system performance assessment framework to examine the changes to the hospital system do not fully reflect the change of emphasis that this new strategy requires but they are a good start and in many cases are all that are available. As noted above, focusing on the number of beds or hospitals fails to capture important aspect of how the system operates. New indicators are required to supplement existing measures such as length of stay and ambulatory care sensitive admissions to hospital. It may be worth considering developing indicators for management and governance given the crucial importance of these to the changes in the system that are required. Some frameworks for examining these questions already exist and could be adapted for use as a self-assessment tool or to be used in a more formal performance management role. There may be some high level indicators that could be used at system level that are a proxy for this – for example: extent of budget delegation and autonomy, hospital director turnover, political influence in appointments, powers, make up and knowledge of supervisory boards.

Developing policy frameworks that promote change

There are a number of examples where the policies in place are failing to help support the process of reform or where they may actively undermine it; for example some aspects of DRG payment systems, global budgets and the promulgation of regulations that specify in detail bed or staffing norms that lock in the current model. Most countries have now developed the capacity in their ministries, health insurance bodies and other public institutions to be able to write appropriate policy but there are particular countries or areas of policy where there is a need for external support and guidance, both at a technical level and at more macro level where there are apparent contradictions between policies. The European Observatory could provide background support on this, but more practical implementation work would require a dedicated programme. It is possible that building on the experience of countries further ahead with reform programmes - acting as "beacons" - could be a productive way of spreading good practice.

Creating and disseminating evidence

There are a number of areas where policy makers, hospital managers, insurance funds and CO need access to evidence and advice. Some represent traditional areas in which WHO has been very effective in raising standards. A number relate to the creation of a clear vision and an underpinning set of strategies. They include:

Clinical issues:

- The development and implementation of clinical guidelines and embedding an evidence-based medicine approach in care delivery;
- Evidence on how to create effective care coordination between different providers including the creation and management of network models;
- Improving the management of NCDs and in particular admissions for ambulatory care sensitive conditions;

- Creating evidence on variation in practice;
- Policy and tools for patient empowerment and shared decision making.

Hospital configuration questions:

- Evidence about the levels of clinical support required for the safe operation of some crucial services where a critical mass of expertise or 24-hour cover is required, for example, cancer, obstetrics or paediatrics;
- Options for different models of hospital systems and advice on levels of hospital (with the caveats above that WHO should take care not to be to appearing to set planning norms);
- Operating and staffing hospitals in rural areas.

Policy questions:

- The development of effective payment methods, including bundled payments which will incentivise care coordination and improve efficiency;
- Creating effective regulation mechanisms;
- Developing effective health technology assessment ;
- Evidence on creating effective autonomous hospitals;
- Assessing the performance of hospitals and other components of the health services delivery;
- The relationship with autonomous hospitals and private providers;
- Sustainability and carbon use in health.

Management and governance

- How to create high-quality management and governance of hospitals;
- The skills and capabilities needed for effective hospital management;
- Strategies and methodologies for efficiency improvement;
- Performance management;
- Effective quality and safety systems;
- Information systems;
- Corporate social responsibility and sustainability;
- Other technical issues.

Workforce questions:

- Human resource management and reward strategies;
- Professional development and education, workforce flexibility and roll substitution;
- Workforce planning and preparing for / dealing with shortages;
- Workforce solutions for rural areas.

There are many areas where the evidence does not exist, is uncertain or where its interpretation will be highly context dependent - for example special solutions are needed for rural areas, or where there are skills shortages, etc. WHO can play a valuable role in identifying where there are gaps in the evidence, as suggested above, identifying countries that have attempted to find solutions in these areas of uncertainty and disseminating this knowledge along with an understanding of the context, so that it can be properly interpreted.

Support to WHO Country Offices

Detailed feedback was collected from Country Offices (COs) about the support that they need. There were a number of broad themes and approaches that they require

- Access to expert advice - mostly in the short term to give advice plans or provide some validation. Some support to implementation and longer term attachments to build capacity were mentioned but this is less common. The areas identified are the same as those listed above where there is a high demand for the creation and dissemination of evidence.
- Access to knowledge on the areas identified. This could be access to evidence, expert opinion, sign-posting to good practice or experience in other countries in the region.
- Capacity building in hospital management and policy making. There is some debate about the best method of delivery and design – Are problem oriented learning opportunities needed rather than courses aimed at improving theoretical understanding?
- Advice on change management.
- A number of COs wanted more international comparisons and benchmarks that will help policy makers and planners produce more rational decisions.
- Policy dialogues and follow-up projects to ensure that the conclusions of these are developed and implemented.
- In addition there may be opportunities for individual CO to act as the co-ordinator of donor or lender activities – providing advice and being an 'honest broker', which may require technical support from WHO.

Given the limited resources available to WHO and the huge demand for assistance in this area there is a need to decide which countries to target and in what way. While this needs f***u***rther exploration, a pragmatic approach has been taken which classifies countries as follows:

Current position	Action required	Examples (at the time of writing)
Requirement for major change, need to increase local capability and responsiveness 1.	Work at a political level, observe contextual opportunity	Albania, Azerbaijan, Belarus, Bosnia and Herzegovina, Georgia, Kosovo, Russian Federation, Tajikistan, Turkmenistan
Requirement for major change, willingness to deliver	In country support, peer learning mechanisms, benchmarking for progress	Armenia, Czech republic, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Montenegro, Moldova, Poland, Romania, Uzbekistan
Less requirement for major change but ambition to move forward	Use as a resource to support others and to develop and test tools and techniques 2.	Estonia, Hungary, Croatia, Slovenia, Slovakia, Turkey

Further work is required to define these criteria and to ensure that there is a consensus over which parts of the region should be targeted and in which way.

Delivery mechanisms

There are some very effective ways of delivering this work already in use. But, there are some unresolved questions about the most effective methods for delivering support to Member States (MS).

Case studies and peer to peer consultation and learning appear to be increasingly popular and are often seen as more appropriate than using external consultants. Creating networks and techniques to support and document this learning would be very valuable. The policy dialogue approach involving other countries dealing with similar problems is also seen as a highly cost-effective method of helping policymakers understand the options available to them and raising issues which may be avoided in some of the policy discourse within countries.

The European Observatory has an excellent record in analytical work, being recognized as a key resource for knowledge on policies, system design and very useful comparative information. It is highly regarded and the policy dialogues that it runs are thought to be particularly useful. However, the European Observatory does not generally provide information or expertise about implementing large-scale change in complex systems, particularly at the meso or micro level of systems where some of the most difficult implementation problems tend to occur. This is perhaps the most important gap in the knowledge available to MS in this area. The knowledge of what needs to be done is available through a number of high-quality sources but advice about how it can be achieved is scarcer. It is very difficult to see how this gap can easily be filled as these skills can generally only be acquired by experience. Thought should be given to how to support MS in the area and the development of a body of knowledge, case studies and if possible a group of practitioners able to provide mentoring and supervision rather than undertaking the work themselves.

Multi-stakeholder partnership

There needs to be some discussion with partners about the most effective way of working. WHO works with both national and international stakeholders as well as supportive political and technical networks. A number of partner organizations have significant resources to deploy and give careful consideration to the potential of making unwise investment decisions as a result of the limited evidence that is available about new models of service delivery and the sometimes difficult context in which investments are being made.

Following the informal ministerial meeting and the Hungarian EU presidency (Gödöllő) there is an increased interest in service delivery questions and in particular care coordination and the role of the hospital. There is now considerable support for undertaking a reflection process on health services delivery. The change is the result of the serious nature of fiscal pressures on many systems and the expected increase in cross border patient mobility following the recent EU

Directive. DG SANCO is supporting the Council Reflection Process on "modern, responsive and sustainable health systems" aiming to identify effective ways of investing in health. Five thematic working groups were set up and one of them covers the area of "Integrated care models and better hospital management", led by Poland. The Group is still in the phase of defining its scope and objectives, and the outcomes of the WHO-EC mapping exercise on integrated care models would perfectly feed in that process. The first deliverables of the Working Group are expected for October 2012 and WHO is already coordinating work in the roadmap development.
Cohesion (or regional) policy provides a framework for financing projects and investments with the aim of encouraging economic growth in EU member states and their regions. Structural Funds[2] and Cohesion Funds[3] are instruments established to implement EU cohesion policy.

Furthermore, the cross border directive and the work on the mobility of professionals and the recognition of qualifications both have profound implications for those MS that are also EU members, as well as for the ones with or considering EU accession status.

The World Bank is active in a number of countries in the region with a range of projects, and a partner in the Observatory. There are already good examples of joint work and the COs often played an important role in ensuring that projects are integrated with other WB activities. This collaborative work is expected to further benefit with WHO providing a strong message about the need for change, challenging policymakers, and providing insight into clinical strategy. The WB is the major multilateral active in the Central and Eastern part of the region. However, there is also the Council of Europe Development Bank, together with the bilateral donors such as UK Department for International Development (DfID) and German KfW Forderbank der Wirtschaft und Entwicklungsbank fur die Transformations-und Entwicklungslander. Such organizations may usefully be part of a changed health policy and implementation architecture alongside WHO.

The OECD is a valuable partner for the WHO. Besides the constantly developing collaboration on indicator alignment, update and improved data collection exercises, the importance of promoting evidence based policy and medicine, and setting up the infrastructure to promote this has been confirmed. OECD is also aiming for a more sophisticated and powerful vision for the future of the delivery system being articulated.

There appear to be some quite good relationships with other agencies at CO level but more needs to be done to develop a very clear and shared understanding of the respective responsibilities of the different actors working in the area of health care delivery across Europe.

[2] Structural Funds are made up of the European Development Fund (ERDF) and the European Social Fund. Together with the Common Agricultural Fund (CAP), the Structural Funds and the Cohesion Fund make up the great bulk of EU funding, and the majority of total EU spending.
[3] For the 2007-2013 period, the Cohesion Fund concerns Bulgaria, Cyprus, the Czech Republic, Estonia, Greece, Hungary, Latvia, Lithuania, Malta, Poland, Portugal, Romania, Slovakia and Slovenia. Spain is eligible only for a phase-out fund as its GNI per inhabitant is less than the EU-15 average.

Recommendations

In reviewing the sector it is very clear that the WHO Regional Office for Europe has a potentially very important role to play and that there is support for a more active programme of work in this area.

Based on the analysis presented, it is recommended that WHO focuses on the following areas.

1) Making a compelling case for change and developing a clear and positive vision for the future of health services delivery and hospitals which helps MS rethink their systems and encourages them to deal with some of the difficult issues they face.
2) Supporting the development of clinical strategy about the improvement of care to patients, the application of evidence - focus on changing the nature of the whole system not simply closing beds on hospitals. The co-ordination of care is a key aspect of this.
3) Creating tools and indicators to help policy makers and managers make changes and measure the impact of the steps they take.
4) Helping policy makers to create policy frameworks, incentives, regulations and other measures that promote the changes that are needed.
5) Creating and disseminating evidence about policy options, care delivery, management and implementation.
6) Providing support to COs with the type of input provided based on an assessment of their needs and the potential for progress in the country.

In doing this WHO will be expected to work at different levels and use its convening power to bring a wide range of actors together to support these actions, and build partnerships where possible.

At the national and supra-national level there is a key role in making the argument for change and providing a powerful vision of the future, or at least a number of scenarios.

With national policy makers and leaders of the system there are important questions about the direction of reform and the design of effective policy.

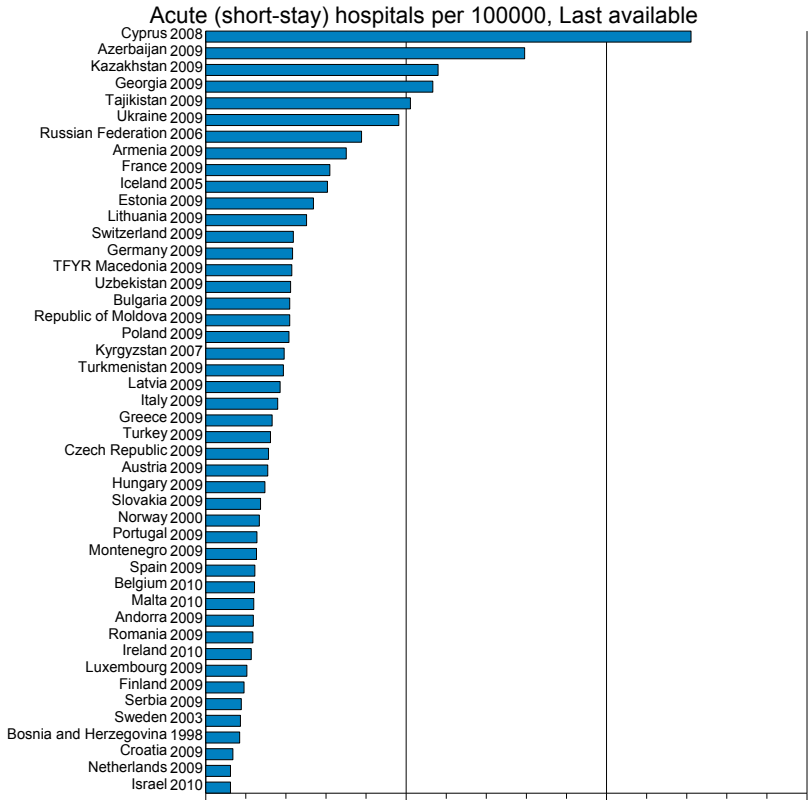
In local health systems and individual providers there is a need to improve the organization and management of health care and the quality, safety and effectiveness of clinical practice.

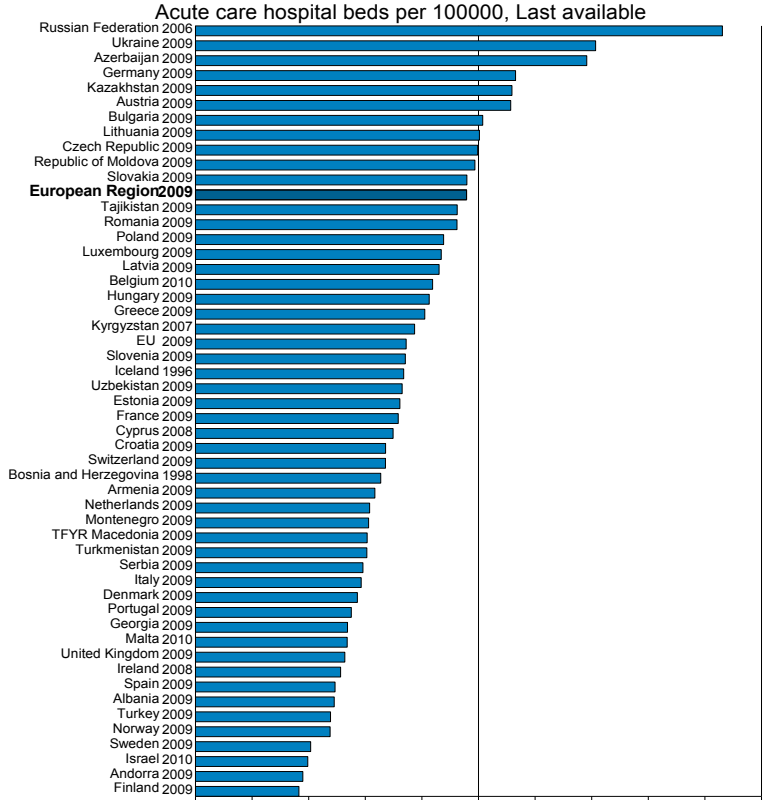
It should be possible to create a single narrative which describes how these interconnected interventions work together, based on a vision of how clinical care needs to change and its effect on patients and professionals. Moving away from talking about institutions and beds, towards coordination and continuum of care thinking is probably the most effective way of doing this.

Conclusion

There is a large agenda and some very intractable problems in some Member States where progress has been frustratingly slow. The pressures that hospital systems will be experiencing in the next few years means that there may be more opportunities to create change than in the last few years of comparative economic prosperity. WHO is well positioned to act in this area and all those interviews for this report were keen to see it do so.

Annex


Acute (short-stay) hospitals per 100000, Last available
Cyprus 2008
Azerbaijan 2009
Kazakhstan 2009
Georgia 2009
Tajikistan 2009
Ukraine 2009
Russian Federation 2006
Armenia 2009
France 2009
Iceland 2005
Estonia 2009
Lithuania 2009
Switzerland 2009
Germany 2009
TFYR Macedonia 2009
Uzbekistan 2009
Bulgaria 2009
Republic of Moldova 2009
Poland 2009
Kyrgyzstan 2007
Turkmenistan 2009
Latvia 2009
Italy 2009
Greece 2009
Turkey 2009
Czech Republic 2009
Austria 2009
Hungary 2009
Slovakia 2009
Norway 2000
Portugal 2009
Montenegro 2009
Spain 2009
Belgium 2010
Malta 2010
Andorra 2009
Romania 2009
Ireland 2010
Luxembourg 2009
Finland 2009
Serbia 2009
Sweden 2003
Bosnia and Herzegovina 1998
Croatia 2009
Netherlands 2009
Israel 2010


Acute care hospital beds per 100000, Last available
Russian Federation 2006
Ukraine 2009
Azerbaijan 2009
Germany 2009
Kazakhstan 2009
Austria 2009
Bulgaria 2009
Lithuania 2009
Czech Republic 2009
Republic of Moldova 2009
Slovakia 2009
European Region 2009
Tajikistan 2009
Romania 2009
Poland 2009
Luxembourg 2009
Latvia 2009
Belgium 2010
Hungary 2009
Greece 2009
Kyrgyzstan 2007
EU 2009
Slovenia 2009
Iceland 1996
Uzbekistan 2009
Estonia 2009
France 2009
Cyprus 2008
Croatia 2009
Switzerland 2009
Bosnia and Herzegovina 1998
Armenia 2009
Netherlands 2009
Montenegro 2009
TFYR Macedonia 2009
Turkmenistan 2009
Serbia 2009
Italy 2009
Denmark 2009
Portugal 2009
Georgia 2009
Malta 2010
United Kingdom 2009
Ireland 2008
Spain 2009
Albania 2009
Turkey 2009
Norway 2009
Sweden 2009
Israel 2010
Andorra 2009
Finland 2009

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