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CENTRUM FÜR KRANKENHAUS MANAGEMENT

Each Individual Carries Responsibility for the Good of a Nations Healthcare System

Solidarity is the corner stone of the German healthcare system. It is best obviated in its statuary health insurance and reimbursement system.
However, the demographic shift that is jolting Germany like many other nations coupled with the all pervasive perception of many Germans that theirs is still an affordable omnipotent welfare state gives one the impression that the once thought of help-for-self-help solidarity principle has degenerated into what at best can be described as an unaffordable and untenable "entitlement" solidarity.

It is cogent to couple solidarity with individual responsibility, i.e. there must be a fair balance between those that provide solidarity and those that depend on it. Otherwise those that provide will get the feeling of being taken advantage of and sooner or later seek to escape from such an obligation. Those that depend on solidarity must remember the rules of fairness in this game, i.e. they must be prepared to take their stake of individual responsibility in it.

- It is the primary task of the collective body of the insured to safeguard against existential and essential risks for the individual: no person, no family must experience social bankruptcy because illness, injury or a physical and or mental handicap has diminished the quality of life. Somebody afflicted by ill-health ought not to suffer additionally by becoming financially burdened.
- The solidarity system can only be used by those who themselves observe the rules and act according to the principles of solidarity.
- Individual risk taking (pursuit of dangerous sports), unhealthy lifestyle, ignorance of prevention are actions outside the codex of fairness and display a behaviour unworthy of solidarity in particular when others have to foot the bill for it.

Self-responsibility is an indispensable element to control a health care system.

Prof. Dr. Dr. Wilfried von Eiff

To be more appreciative of where the chinks in the armour of the solidarity system are consider the case of the passionate female amateur equestrian:

A fall from the horse causes her a complex fracture of the pelvis. After 10 months having undergone an operation, a lengthy hospital stay and a long course of physiotherapy having cost the system the princely sum of Euro 70.000 for all the treatments received she is able to resume riding again, only to break her right arm in another fall shortly afterwards.

Hence it is high time to:

- lay down clear rules about preventative measures with respect to early diagnosis of diseases in order to minimise the number of highly expensive acute treatments;
- make people who engage in high risk leisure and sporting activities pay higher health insurance premiums.

Hospitals see themselves confronted these days with ever increasing demands concerning the provision of "hotel services" which they are only able to meet if the demander is willing to pay for them.

Is it the right way to cover the costs of injuries from high risk sporting activities through the principle of solidarity?

It is also high time to do away with the ludicrous agreement of the "zero tariff policy" for prescriptive drugs. The large packaging marketing trick of the pharmaceutical industry coupled with the patients, "non-compliance" results in millions of Euros worth of prescription drugs landing on the rubbish dump each year. Introducing a co-payment for prescriptions would at least increase the awareness of value rather than sustaining an attitude of easy come, easy go. Of course, exemptions for the young, old and other social hardship cases would still apply.
The call for more customer orientation by the hospitals is quite an audible one here in Germany.

An initiative of the reform workshop "Healthcare" of the Bertelsmann Foundation and the CKM

Bertelsmann Stiftung

Though a patient is not really a customer in the strict sense like someone who with his or her own money makes a conscious decision to purchase a product like for example a car. On the contrary, patients demand care provision according to the contract drawn up by society considering it ethically theirs to make full use of its provisions, but in the process by doing so forgetting that it needs their full co-operation in order to function as intended on mutuality. Two of our best-in-class international benchmark partner hospitals, one in the US and the other in Australia, stress the need for this mutuality in their brochures. The hospitals hand them out to their patients upon admission. Here in a friendly and comprehensible language the patient is reminded of the fact that he has not only rights but that these rights are dependent and subject to the fulfilment of certain obligations by him, e.g.

- "You are responsible for following the treatment plan recommended by the treating physician and for your actions if you refuse to follow treatment."
- "You are responsible for answering questions as honestly and completely as possible."
- "It is your responsibility to be considerate of others and respect their privacy."

Another example of patient responsibility, in this case financial responsibility, is the "health account" operated by the healthcare system in Singapore. It works in the way that regular payments are made into his "health account" by an individual. Should an account holder need to become hospitalised he can decide which accommodation class (a total of 4 classes are available) he wants to be admitted in. In case his account funds are insufficient to pay for the class of his choice he either pays the rest out of pocket or is graded to a class fundable by his account. The "health account" system operates in a way that fees for medical treatment are served first with the residual available either for paying the charges incurred for the class level chosen or held as a deposit towards any future hospital fees. In fairness one should acknowledge the attempts made in Germany, demure though as they are, to table the subject of self-responsibility in the ongoing discussions on reform of the German healthcare system. The Stewens-commission has made here a useful start.

The conclusion:

Self-responsibility is an unrelinquishable part of the control process in a social system. Without self-responsibility the solidarity principle is not viable. Self-responsibility means that self imposed risks are entirely and solely one's own responsibility. The functionality of the collective body of the insured is only given as long as incalculable risks of the one are carried by the many in order to safeguard the individual against social bankruptcy. A system, which when drawn upon only recognises rights, when at the same time it regulates the obligations to finance itself in quite a desperate fashion cannot claim the status of being "mutual". A healthcare system that pussyfoots around and seems to be hooked on the nebulous notion of fairness by way of "zero tariff" policies only fosters the "free-ride" mentality of the population and as experience shows will inevitably have the disastrous outcome of cost escalation with the simultaneous need for rationing the care services it provides.
It is about time that these facts are recognised by all concerned and that they form the basis of the debate about healthcare reform in Germany. Simple-minded heaven-on-earth ideologies with intangible measures have absolutely nothing to do with the ethically valuable principle of solidarity.
Change starts off in the mind, but without seriously impacting the bottom line it will remain ineffective.

Six Sigma

A High Tech Methodology Leading to High Tech Quality

SIX SIGMA

The methodology Six Sigma used by service and manufacturing industries like for example Motorola, General Electric, ABB, Kodak and Nokia to obtain breakthrough levels of productivity and performance is increasingly used in the healthcare and medical fields to achieve significant levels of performance improvement.

Sigma is like a measurement, used to determine how good or bad the performance of a process is, i.e. how many mistakes a company/institution/provider makes, doing whatever it does. To reach the Six Sigma level of perfection only 3.4 defects/mistakes per a million opportunities or Defects Per Million Opportunities (DPMO) are allowed. A defect is defined as any variation from the customer requirement.

The purpose of Six Sigma is to reduce variation to achieve very small standard deviations so that almost all of the products/services supplied meet or exceed customer expectations. The statistical analysis gives you the Sigma value which reflects the overall capability of your process.

An example of the experience in implementing Six Sigma successfully in healthcare was at the Alexandra Hospital in Singapore. It was the admitting function at the hospital that benefited from this proven industry-specific application. The goal was to achieve a patient total turnaround time of 60 minutes. Although the goal was not yet totally achieved but an improvement from 1.0 to 1.7 Sigma was obtained representing an increase of 20.7 percent from 36.7 percent to 57.4 percent.

The median for registration was lowered from 11 minutes to 6 minutes and the 95th-Percentile-value was lowered from 53 minutes to 18 minutes. At the same time patient satisfaction was up by 11.4 percent with an increase in patient throughput from 64,488 to 83,038.

Cheong Choy Fong and Debanjan Sen from the Alexandra Hospital in Singapopre with Prof. Wilfried von Eiff and Wilhelm Schleibach from the CKM.

Results of the Six Sigma initative to reduce patient turnaround time at the specialist outpatient clinic at the Alexandra Hospital in Singapore.

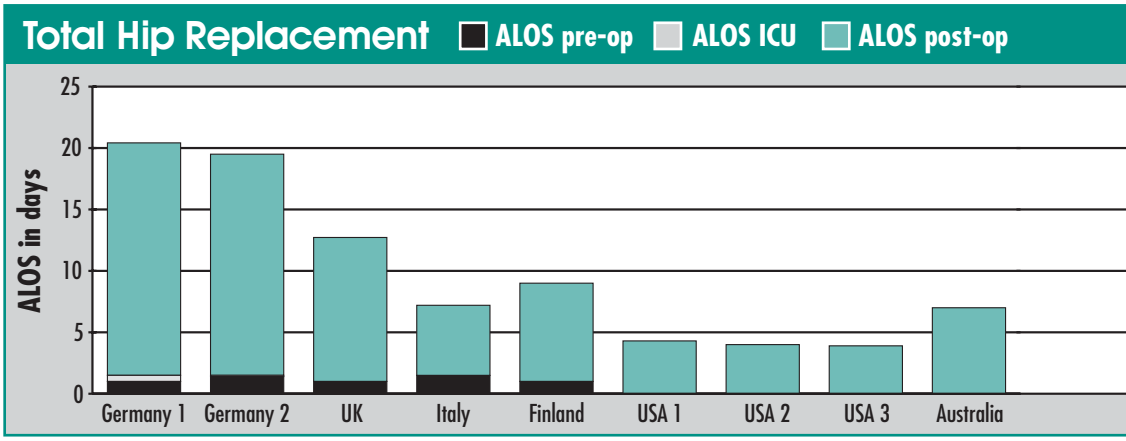
	Percentage of patients who meet TAT performance standard of 60 miutes ("Y") **(Arrival Time to Payment)**	Total Turnaround Time (min) **(Arrival Time to Payment)**		Waiting time for Doctor´s Consultation (min) **Includes Registration** (Arrival Time to Dr calls patient)		Waiting time for Doctor´s Consultation (min) **Excludes Registration** (Card delivered to Dr calls patient)		Registration Process Time (min)		Wait Time to be served for Appointment Booking and Billing (min)		Sample Size of "Y"	Total Sample Size
	%	Median	95th percentile	Median	95th percentile	Median	95th percentile	Median	95th percentile	Median	95th percentile		
Jan	35,7	75	160	47	120	31	96	11	53	6	31	704	1142
May	47,1	64	149	36	104	23	89	7	35	5	27	692	1109
Jun	43,7	67	156	38	105	23	82	9	40	5	22	766	1194
Aug	47,6	63	143	36	110	20	88	10	34	3	25	829	1281
Sep	48,3	62	127	35	90	23	81	8	27	4	25	675	1154
Oct	55,8	55	123	32	93	21	81	8	25	4	21	708	1117
Nov	57,4	54	123	30	94	22	88	6	18	5	29	751	1220
Dec	56,3	54	128	30	93	22	82	5	22	4	30	785	1231

German Hospitals with the Longest Average Length of Stay

ALOS

An international comparison shows that the average length of stay (ALOS) for elective procedures like total hip replacement, knee arthroscopy or a hysterectomy could be reduced by between 30 and 40 percent in German hospitals. German care provider organisations participating in the international comparison listed on average an ALOS of 20 days for an elective hip replacement procedure compared with the second longest ALOS of 13 days for the same procedure at the Chelsea and Westminster Hospital in London and only 4 days of Average Length of Stay at American benchmark partner hospitals.

To compare ALOSs across countries medical outcomes need to be taken into account. However, since the countries compared here all posses without exception an equally high standard of medical technology and also show hardly any differences in their respective mortality and morbidity rates it can be safely assumed that the ALOS rates in Germany are unnecessarily high. Let us take the case of total hip replacement (THR) patients who as a general rule are not ICUed after their operation in any of the other countries reviewed except in German hospitals where this is standard practice though highly questionable given the equally comparable outcomes achieved in other nations.



Abdominal and vaginal hysterectomy is another case in point. German hospitals show the longest stays with between 10 and 14 days. In comparison the ALOS for hysterectomy patients in all the other countries is only between 7 and 8 days. Re-engineering its cardio-thoracic patient care unit based on best practice evidence based medicine over a period of 3 years enabled Lakeland Regional Medical Center, Lakeland, Florida to reduce ALOSs for by-pass patients with and w/o catheterisation from 14.3 to 8.5 and from 9.5 to 5.7 days respectively. At the same time mortality rates were respectively reduced from 2.5 to 2.1 % and from 2.0 % to 0.9 %.

However, to achieve ALOS reductions of that magnitude requires that certain conditions are being met, namely

- an incentive scheme that is not limited to one specific provider segment only in the respective care chain but that allows a payment per case right across all of the involved care chain segments,
- and that there is a seamless care chain continuum beyond the hospital with post hospital community care.

Enviable results can also be achieved in Germany as demonstrated by a German benchmark partner which specialises in short term elective surgical procedures where through good organisation ALOS are significantly lower than those of other German hospitals. For example the ALOS for a laparoscopic cholecystectomy and an inguinal hernia procedure at the hospital is only 3 days compared with between 7 and 8 days elsewhere in Germany.

Learning from Disaster
The "Baby-Switch" Case in Virginia

LEARNING

Professor Thomas Massaro, Chief of Staff at the University of Virginia Health System, Charlottesville, Virginia, showed extreme courage by stepping up onto the stage at the 6th International Hospital Benchmarking Forum in Berlin to give the audience his account of a 'switching babies' incident that seemingly occurred at the University Medical Center in the summer of 1995 and which made copy and headline news for weeks right across America when it was discovered by chance in 1998.

By way of taking her partner to court to enforce the $75-a-week child support payment he owed and a subsequent court ordered DNA test because of denying paternity the mother discovered that the University of Virginia Medical Center had sent her home three years earlier with the wrong newborn. Complicating matters even further, the couple mistakenly given her baby girl had just died in an automobile accident, unaware of the switch. Their daughter was being raised by grieving grandparents who learned the terrifying news from their television set. The mother Paula K. Johnson filed a $ 31 million malpractice lawsuit against the University Medical Center for suffering emotional distress and physical injury.

Once the story hit the papers Thomas Massaro as Medical Chief of Staff became a spokesman of the top hospital officials dealing with the case. They would imply that the switch had been a criminal act, insisting they were '99.9 percent certain' that it could not have been an accident or honest mistake because of the many safeguards the hospital had in place.

However, the siege mentality and the line of defence that was taking hold at the UVA Medical Center was interpreted and perceived by the public as arrogant and displaying a lack of accountability. Realising the downside of their stance and the negative long-term implications such a negative image could have on the Center for years to come the administrators sought professional advice on how to change their communication strategy.

The best preparation for handling crises: Regularly run

- **Near Miss-Analyses** and
- **What-if-Scenario-Analyses**

and distinguish between the three phases of behaviour and communication:

Phase 1:	Prior to news of crisis
Phase 2:	At the peak of the crisis
Phase 3:	Post crisis: the storm has abated

From there on they became much more open, showing compassion and the willingness to immediately help by offering compensation figures that were regarded by the public as 'fair'. The openness with which they now sought to communicate trying to understand from only fading memories and cursory logs and seeking to reconstruct who might have handled which baby, if even for a few moments, on a busy but unremarkable day some three years past helped a great deal in avoiding further damaging negative press. On the contrary their change in the way they communicated with the public was essential in slowly regaining their public image and standing with the public.

Prof. Massaro openly admits that at first they were struggling to cope with handling the news. That Medical Center had no contingency planning or crisis management in place for what had happened. At first we did not know how to react in a professional sense to the bad news that hit us. In a way we went through what the auto maker Audi experienced in 1986 in the USA when it was claimed Audi cars had some inherent construction fault in one of its models. Despite such a claim could never be proven the company nevertheless suffered for years from it through significantly reduced sales and loss of image simply by adopting the wrong communication strategy in a crisis. Top hospital officials at the University Medical Center have learned from their mistakes. Their mistake was less in switching the babies than not knowing how to cope and react with such bad news. Mentoring, training programmes and appropriate organisational changes that have been made since have prepared them to deal much better and more appropriate with crisis in the future.

According to Prof. Thomas Massaro, University of Virginia Health Systems, Charlottesville, VA, USA, the success factors for crisis management are:

1. The organisation for a crisis management must be in place prior to any crisis occurring
2. Communication, Communication, Communication and
3. Say "I am sorry".

Project Initiative

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