

Role of the Hospital

Discussion paper

This discussion paper has been approved by the Plenary Assembly of the Standing Committee of the Hospitals of the European Union during its meeting in Paris on March 26th 1996 and finalized by the Sub-Committee Coordination (SCC) in Coimbra on 12th June 1996.

The text has been prepared by a working party of the SCC, composed by N. Undritz (CH) president, E. Colaiacomo (I), G. Costargent (F), P. Garel (F), M.I. Riesgo (E), W. Heuschen (B), H. Hinterscheid (L), S. Horsley (GB), J. Hoyau (F), A.M. Lysgaard (DK), T. Mooney (IRL), T. Nilsson (S), K. Schutyser (HOPE) report, W.H. Stikkelbroeck (NL), J. Völlink (D), C. Vladu (ROUM) (host).

The working party met at Dübendorf (CH, March 18th 1994), Groningen (NL, June 18th 1994) and Geneva (CH, August 22nd 1994).

The objectives of the document

- compile a summary of the tendencies in society and the environment in general which could modify the role of the hospital
- indicate to the hospitals the resulting changes
- demonstrate the possible implications for hospital organisation
- provide an incentive for the national hospitals associations

This discussion-paper is addressed, primarily, to the management of hospitals covered by the members of the Standing Committee of the Hospitals of the European Union (HOPE) with a view to promoting the requisite changes called for by the evolution of society and secondly to the authorities, media, social insurances, insurers, patients and other partners of the hospitals and also implies a manifestation of the positive attitude of the hospital institutions.

HOPE is aware that certain hospitals already implement some of the stated propositions, but considers it helpful to present a document for guidance, information and discussion about the causes and effects of the identified changes.

The Standing Committee of the Hospitals of the European Union (HOPE)

1. considers the following social tendencies as influential in shaping the role of the hospital

- 1.1 patients become more and more educated, autonomous and conscious of their rights; they want a say in their treatment as well in the health care process.
- 1.2 the need of bio-ethical and socio-ethical reflection and consultation grows.
- 1.3 more and more emphasis is given to primary care and home care.
- 1.4 the concept of quality has implications for the health care sector and its professionals.
- 1.5 in some countries, political decisions are taken on the role of hospitals and their size or existence, e.g. forbid surgery in smaller hospitals but keep these hospitals for medicine and geriatrics, closing down beds and hospitals, versus obligation for each hospital to offer surgery.
- 1.6 centrifugal forces are oriented to a de-centralization of health services while simultaneously, centralizing forces demand accentuated institutionalization of the care of certain types of illness.
- 1.7 the rise in health care costs under current funding systems is so pronounced that society is having difficulty supporting it. The burden is becoming very heavy for families, social welfare and government budgets.
- 1.8 nevertheless, more attention is paid to health care as an economic force in the locality, the region, society (health care as an investment and not only a cost).
- 1.9 the demographic structure of society is changing (more elderly people needing health care, fewer young people to support this need).
- 1.10 life style related illnesses are increasingly impacting on the health systems (drug addiction, malnutrition etc.).
- 1.11 patient demands on the health care service increase.
- 1.12 the attitude of the health care personnel evolves. They seek more job satisfaction, shorter and more regular hours and higher salaries.
- 1.13 advances in medical technology (more possibilities and less invasive procedures are provided).

and understands

that the tendencies are due to profound sociological evolution and that the hospital, as an element of society, is directly affected and must confront them.

2. **considers the changes arising at the**

political level

- 2.1 there is a lack of co-operation throughout the health care sector and the competitive mentality is growing.
- 2.2 the Government wants to introduce new financing systems (e.g. DRG) or insurance (e.g. HMO) as an incentive for more efficiency.
- 2.3 the Government wants to introduce market systems to increase competition e.g. separation of purchasers and providers of health services.

economic level

- 2.4 rationing (e.g. block budget).
- 2.5 competition (deregulation).
- 2.6 new financing systems (e.g. all-in budgets, health schemes [HMO], diagnosis related groups [DRG], homogenous patient groups).

patient flow

- 2.7 the number of patients is increasing because of medical progress and at the same time hospital admissions are more and more "filtered" (gatekeepers, operation indications, second opinions).

new forms of hospitalisation

- 2.8 partial and very short hospitalisation (e.g. day surgery).
- 2.9 home hospitalisation.
- 2.10 network for co-ordinated care.
- 2.11 hostels.

decrease in number of beds

- 2.12 shortening of hospitalisation periods.
- 2.13 decrease in number of operating theatres.
- 2.14 reduction of number of hospital centres.
- 2.15 division between short-term, medium and long-term care.
- 2.16 concentration of high tech activities in large hospital centres and shifting to low technology hospitals and health care centres.

pressures on the services of long term or chronically ill

- 2.17 de-medicalisation and simultaneously shifting to more care by nurses.
- 2.18 better linking to social services.
- 2.19 economic pressure because of increasing number of chronically ill and at the same time limited financial resources.

public health

- 2.20 creation of health promotion programmes.
- 2.21 development of health out-come indicators.
- 2.22 health education.

new types of illnesses and the reappearance of former diseases

- 2.23 drug-addiction.
- 2.24 diseases caused by malnutrition.
- 2.25 diseases caused by pollution.
- 2.26 infectious diseases.
- 2.27 therapy resistant micro-organisms are increasing (thus e.g. more tuberculosis again).
- 2.28 iatrogenesis growing with increasing health care.

human resources

- 2.29 more mobility.
- 2.30 more flexibility.
- 2.31 better training to guard against unemployment.
- 2.32 emergence of new professions.
- 2.33 increased specialisation among doctors and nurses and at the same time more emphasis on the role of the general practitioner.

3. considers the following hospital objectives

- 3.1 hospital care focuses, with a wide view of health, on the entire human being who puts his/her trust in the provision of care and also expects respect for his/her autonomy, involvement in his/her recovery process and clear information.
- 3.2 it is a social mission for the hospital system to meet the needs of the individuals without excluding them on account of their beliefs or financial or other reason.
- 3.3 patients needs will be met by highly qualified medical-specialist, nursing and paramedical care, supported by modern technology, in an optimal environment and with warm human support.
- 3.4 active participation if possible in concrete initiatives in the sphere of health education, illness prevention and protection of the environment for the population, in order to improve the health status of the population and of the patients. Hospital care is strategically situated within the overall Health care policy for care of the population.

4. proposes to the hospitals of Europe that the following considerations be taken into account where necessary

- 4.1 to provide medical services, which are
- highly competent
 - of high quality
 - comprehensive (preventive, curative, somatic, psychiatric, rehabilitative with or without hospitalisation).
- 4.2 to provide therefore
- comprehensive technical equipment
 - highly motivated personnel, particularly well qualified and with continuing training
 - a management which anticipates and implements changes
 - a clear understanding of need of the population and to respond to those needs
 - valid social economic and particularly epidemiological data
 - good information and communication systems.
- 4.3 to enhance the quality of hospital services to the patient, which will play a decisive role in permitting the hospital unit to be efficient. Evaluation systems for the outcome of hospital services will need to be in operation.
- 4.4 to encourage the patients own involvement in the health care process.
- 4.5 try to identify the participants in health promotion and to work in networks with them. In this context they should try as well to appreciate their own role of health promoting agents (e.g. by organising nutrition information and specific actions of health education and information for the patients and the general public).
- 4.6 to pay a particular attention to issues such as the practice of health promotion for their patients and visitors (e.g. healthy food), for their personnel (e.g. safe and healthy working conditions) and for the community (e.g. correct treatment of hospital waste).
- 4.7 to activate networking between various types of hospital facilities (psychiatry, acute care, specialties, preventive and curative services etc.) as well as with other health services to meet the patients need for co-ordinated care.
- 4.8 to anticipate closely developments in medical technology, to evaluate and provide where appropriate such technologies and foresee repercussions for the hospital etc.
- 4.9 to include in annual reports and press conferences health outcome indicators which report on the quality of life and the improvement in the state of health gained by the patients by virtue of its care. These indicators will have to be further developed (e.g. number of years gained, lack of handicaps etc.).
- 4.10 to be prepared for new types of illness, particularly infectious diseases (AIDS, tuberculosis) or diseases of the immune system.
- 4.11 to take into account the treatment of lifestyle related illness.

- 4.12 to reorient the traditional role of research in the major hospital centers to concentrate on new forms of care, hospitalisation, medical technology, health care system organisation and systems for enhancement of quality in public health.
- 4.13 to concern itself with training of its personnel so that it can cope with the changes.
- 4.14 to meet these changes it is essential that medical, nursing and administrative staff have a common vision of the mission of their hospital to its patients and society.

5. concludes

that the profound change comprises the transformation of the "bed-centered" hospital to a health centre as part of a wider health care network.

6. suggests to it's members

- 6.1 to participate in defining the objectives of the health system and the role of hospitals in achieving these objectives.
- 6.2 to stimulate hospitals to become agents of change in the areas indicated above by way of seminars, exchange of experience or documentation centres.
- 6.3 to collect information so that the hospitals can evaluate their activities and their outcomes.
- 6.4 to develop strategic thinking.
- 6.5 to update education and continuing training policy to meet the changes.
- 6.6 to develop and diffuse information, for example in the fields of quality indicators, good practice, standards, legislation and ethical issues.

therefore

the member organisations are invited to continue the discussion on the issues raised and to report at the next Plenary Assembly.

ADDENDUM

During the same Plenary Assembly held in Paris on March 26th 1996 an applied discussion document prepared by the Sub-Committee on Economics and Planning (SCEP) on achieving a better balance of hospital and ambulatory care services has been approved as well.

Consideration and Recommendations for achieving a better balance of Hospital and Ambulatory Care Services.

During recent decades important changes in our society, as well as in medicine and healthcare systems, have challenged the supply and demand patterns of health services, that emerged during the sixties and seventies reflecting the medical progress of that time.

These changes have influenced especially the role of the Hospital which has shifted from an institution centred around inpatient areas, towards an impressive development of its specialized diagnostic and treatment services. As a consequence, modern hospitals no longer have inpatient care as their main role, rather they are increasingly becoming centres for specialized diagnostic and treatment of conditions which, only a decade ago, involved a considerable number of inpatient stays.

Scientific and technological achievements, together with the social progress in living standards, educational and economic improvements, are making it possible for many conditions that previously required long inpatient services, to be treated entirely on an outpatient basis, or with a much shorter stay in the hospital, or with a combination of the two.

The use of information technology and telematics applied to medicine is allowing now (and much more in the future) the development of communication networks for the transfer of complex graphic information. This will give to patients in remote areas or small healthcare facilities, and even at home, access in real time to referrals to institutions of the highest level of specialization

On the other hand, within healthcare systems, hospitals have become centres employing thousands of workers, with costly and complex management systems, their budgets are hardly affordable by national economies confronted with other priorities and in consequence pressures on expenditure control and efficiency improvements have increased.

In summary, many factors point to the need for change in present healthcare patterns which, not so long ago, were considered the most suitable:

- society, now with better economic and living standards, higher cultural level and increased citizen's participation, demands equitable access to healthcare of high quality (both technical and humane), delivered without delay and with the best prospects of fast recovery;
- scientific and technological advances, both in medicine and in other fields, make it now much more feasible to meet these demands of our modern societies;
- the need for cost control in healthcare expenditure is forcing policymakers to consider new alternatives for improving health service quality, yet being less of a burden for public budgets ;
- finally, the frequently observed difficulty of large service organisations to respond to users' expectations regarding personal aspects of their services, also favours the tendency towards care alternatives that are closer to the citizen and his environment.

As a consequence, the shift of hospitals towards patterns of care based on more outpatient, home and short stay services is a change that will also open new possibilities of innovative fields for the hospital itself and for the healthcare system.

Among these new patterns of care the following have special importance:

1. Major Ambulatory Surgery.
2. Day Hospital Services, for performing diagnostic tests as well as for medical (oncology, rehabilitation, psychiatry ..) and surgical treatments (ambulatory surgery).
3. The so-called "hospital at home" services.

All these new services, if adequately provided, are safe, effective and beneficial for patients. Besides, they may have lower unitary costs than inpatient care, and are likely to have a positive impact on the efficiency of hospital organisations and the management of health systems.

In fact, these new services, if adopted within the appropriate social and cultural environment, will be of benefit to:

- patients, through higher quality care, provided faster and with better prospects for recovery;
- health professionals, through better co-ordination and communication between hospital doctors and providers in ambulatory care;
- hospitals, through the reduction of inpatient days, and the possibility of placing hospital technology and medical specialists closer to the community;
- health systems, through overall greater efficiency in the use of resources.

However, in Europe the expectation regarding the potential of these new services

is greater than the actual advances in their implementation. This could be happening because the implementation of these changes often clashes with:

- existing patterns of hospital financing, often designed to pay for items like 'number of beds', 'length of stay', rather than for the cases treated ;
- difficulties existing in some countries in co-ordinating and/or opening hospitals to specialist and generalist working in private out of hospital practice;
- nursing organisation which may present difficulties in the development of ambulatory care when hospital guidelines have to be used in the home care setting;
- the implementation of these new patterns of services which is not always easily accompanied by the reduction of acute hospital beds (which could be reoriented towards the needs of chronic and palliative care whose demand is growing), and therefore the potential for cost cutting is not achieved;
- the lack of social and welfare services which are required to supplement hospital care from within their own resources ;
- the basic and continuing education of health professionals, which does not prepare them for change.

In view of the above considerations, the Standing Committee of the Hospitals of the European Union, wishes to make the following three recommendations:

1. hospitals should encourage and lead a shift towards increasing ambulatory care services, such as Ambulatory Surgery and other similar procedures, Day Hospital facilities and more home care.
2. This process must include the development of innovative health policymaking and of new management and financial instruments for hospitals, as required for the implementation of these new services in each healthcare setting.
3. The same shift towards increasing ambulatory care services and short stay formulas should be applied in the social and welfare sector, especially towards the growing very old age population.