"Primary Healthcare and Hospitals together responsible for good Health of Patient and Society"

Organised by the Romanian Hospital Association
In co-operation with:

the Commission for Health and Family of the Parliament of Romania,
the Romanian Residents Association,
the Romanian Institute of Health Services Management of the Ministry of Health
and the International Hospital Federation

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The Two-Way Message of Bucharest

Conclusions by Prof. K. SCHUTYSER (Secretary-General HOPE)

Within one year after the Berlin wall was broken down, HOPE started an East-West Hospital Co-operation (twinning) action during a Seminar in Berlin (1990), followed by one in Strasbourg (1992) and one in Bucharest (1994), which I called in the conclusions of 1994 one of the hearts of Central Europe. 4 years later we are back in this city and country, Romania, which became meanwhile one of the candidates (albeit of the second round) of the Euro Agenda 2000, the calendar for the enlargement of Europe.

A lot has changed during these last 4-5 years. The initial wild enthusiasm of the EU, the Member States and especially the NGOs for active partnership in bridging the East-West gap has somewhat cooled down. Especially in the health domain the PHARE and TACIS programmes lost e.g. their attention for health as a priority. Even in HOPE some weakening of the attention could be noted, which made the organisation of this Conference not so evident, but it was luckily countered by the HOPE colleagues present and their active input. The experiences and outcomes of these 2 days however certainly illustrate that if some kind of EURO Marshall plan would start towards the Central European Countries to stimulate their "renaissance", the sectors of welfare, health, education and culture should be a full part of such a plan, which could not be limited to economics and markets.

Romanian hospitals themselves also saw to it that changes happened, in implementation of the conclusions of the Bucharest seminar of 1994 to stimulate not only hospital twinning, but also twinnings between networks, regions, hospital associations and to make comparisons of national systems. So HOPE felt obliged to positively meet the request of the Romanian Hospital Association to organise this seminar on what we know yet to be a very hot issue in the present Romanian policy making in healthcare: the (renewed?) relationship between hospitals and primary healthcare.

We are grateful to the Romanian Hospital Association, the International Hospital Federation, the Romanian Institute of Health Services Management, the Romanian Residents Association and the Romanian Parliamentary Commission of Health and Family for having created the possibility of informing the stakeholders in the healthcare of Romania and of its neighbouring countries about the developments and hesitations concerning the "common responsibility for good health of patients and society", to be shared by hospitals and primary healthcare (as it is said in the title of the conference). But allow me to thank explicitly and from the bottom of my heart one person without whom this conference would never have taken place: "the indefatigable Dr. Mircea Olteanu". I hope the positive influence of this conference on the more than 200 participants and especially on the political decisions about the future of healthcare in Romania will be an immeasurable but the best possible thank to Prof. Olteanu's commitment.

Neither HOPE nor IHF have come to Bucharest to impose a single EURO-model on the primary healthcare-hospital relationship, but they tried to explain the wide range of possibilities (and hesitations) among which those responsible for Romanian healthcare will have to make their choice, taking into account the historical, socio-economic and political realities of this country and its citizens. And most of the speakers and HOPE members will surely be prepared to involve themselves or their organisations or authorities in further and deeper co-operation if approached for such further follow-up.

It is impossible and even unnecessary to try to summarise each of the more than 20 interesting communications from the 14 countries including very interesting ones from Romania itself. There was a clear and repeated inventiveness in the terminology about co-operation: co-ordination, integration, networking, (re)balancing, reversing pyramids or ratios GPs/medical specialists, redistribute the healthcare pizza or pizzas, abolishing tribal boundaries or an artificial antagonism or a bipolar system. It was also interesting to see different options or accents on primary healthcare or on GPs and on co-operation between primary healthcare and other specialized healthcare institutions (like hospitals) or between medical GPs and medical specialists. (Healthcare networks and medical networks are different realities. It is good to stress this having heard the medicalisation of Health Insurance Management in Romania.

In any case a very broad picture was given of theoretical concepts (command based or not ... yet), good practices of care and organisation (with variable command and necessary instruments (informatics, communication, control) from different countries, cultures and economic potentialities. They explain the hesitating long way it has taken and still takes many countries to evolve from a specialised medicine driven and hospital centred healthcare system (policy making, financing, management and education included) into a well balanced health and healthcare responsibility, shared between the many stakeholders in healthcare. And this gigantic change is happening during a twentieth century, balancing from a risky society, corrected by social equity, into an in fact more risky society of social exclusion, certainly if a too powerful and too less controlled global market pragmatism will continue on the eve of the third millennium, which will be a rather grey one during its first 50 years in Europe when we look at demography.

The main conclusion of this catalogue of opinions, systems and techniques seems to be the need to reconsider the basic opinion which hitherto, underlies too often - sometimes visibly, sometimes in a hidden way - the discussions about the relationship between primary healthcare and hospitals. It is an antithetic one, a kind of white and black Minstrel show: the white being the hospital for a while, which should be replaced (substituted) by an alternative white having been the black primary healthcare before, thus turning the hospital into the black (sheep). Why not replace this antithetic thinking by a synthetic or better synergetic model of reciprocal positive relationship? In its article one, the first

French hospital law of 1893, specified textually for every French patient the right to medical assistance at home or if it would be impossible to care for him appropriately at home, to do this in a hospital. Prof. Pequinot once observed remarkably about this law: "It seems to me that the hospital of all times has but been an alternative to home care" ("l'hôpital de tout temps me paraît n'avoir jamais été qu'une alternative aux soins à domicile").

Substitution gives a first impression of affecting absolutely, completely, rather artificially (as a prosthesis) than naturally, thus more as a kind of allotherapy than of homeotherapy. Of course in healthcare there are clear examples of absolute and complete substitution in the case of closing sanatoria. But in most cases we are confronted with complementarity and thus with the question of the right balance between the substituted and the substituting. Sometimes what is called substitution is even nothing more than a real "restitution". So instead of only concentrating on the substitutes as primary healthcare e.g., however important this may be, planners, executors and evaluators of changes and reforms as well as "charter designers" should also pay some attention and energy to the substituted actors such as hospitals. Especially their remaining changed roles and potentialities and the co-operation and positive interaction within the more and more complicated jigsaw of professionals, services and institutions, which in the best hypothesis can be or become a really reengineered network, should be highlighted. It is e.g. evident that every existing hospital (bed) hasn’t a life guarantee, but hospitals will continue to play an important role in the future within the new networks between primary healthcare and hospitals and between the health care and the social sector and other ones as well... And the brakes and the brakers, the obstacles and competition traditions in the tricky processes of change should be carefully watched. It should not be forgotten that substitution is possible as well within existing entities of such networks (e.g. day hospitalisation within the hospital and short stay within the social institutional care for elderly people). Substitution is moreover also advisable within the regulation of certain entities (e.g. should the costs of parking and garden of hospitals be better defrayed than the care costs for the elderly, or should the banker continue to charge the same interests for the social sector as for really risky investment or treasury operations?).

This synergetic model of two-way thinking (D), which was even illustrated for the human nervous system, emerged in suggestions such as integrated care or disease management, seamless care, managed clinical networks, interaction between system components, common therapeutic protocols or responsibility. But it has to be enlarged towards the " sectors other than therapeutic healthcare": prevention and health promotion, social care and welfare, housing, food, transport, environment, which where many times mentioned here. It is even applicable to the changes in the roles of the different healthcare professionals in multidisciplinary teams, as illustrated by the nurse in the new "why why why" relationship with medical doctors. It can be used as well in the very important relation between healthcare and education and research and certainly in the too antithetic disputes between care and management and between quality/health outcome and costs. Quality shouldn't be a must because of (cost-reducing) financial reasons. Nor is it an a priori guaranteed white sheep: production of unnecessary quality is the most costly waste which may be produced both in rich and in less rich healthcare systems.

This synergetic model can even be applied at the demand side, and in a new relation between offer and demand. Putting the empowered patient at the centre of the healthcare system, should not be done to provide him with an autonomous superego, but to make of him a social human being prepared to participate actively in personal and community health and to enter into partnership when he needs healthcare and real health gain.

With this general and positive two-way message of Bucharest between European healthcare colleagues, I would like to close this co-operation seminar inviting you all to Finland next June where we will continue discussing the theme of SEAMLESS CARE and to Sevilla for AGORA V in October next year. And allow me to specially thank the very performing translators, one of these professions that are absolutely necessary to enable co-operative international synergy, as I hope all of you could experience these days.