

A Brief History of Hospitals in the Grand Duchy of Luxembourg

2010

Roger Consbruck , Ministry of Health



Grand-Duchy of Luxembourg 2010

about the Health -System

Hospitals in Luxemburg

Chapter 1

A shortcut over
millennium history

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The millennium history of hospitals in G-D.L.

Over centuries, the institution « hospital » has known, just as elsewhere, several paradigm shifts

Chronologically documents tells us about:

- «Hostels » which provide accomodation to pilgrims,
- Hospices for the poor and the needy at the end of life,
- Leprosariums to keep away the contagious,
- Asylums to confine the insane...

but only by the end of the 20th century, hospitals arise to “temples of modern medicine”

Chap.1 **Shortcut on hospital history in Luxembourg**

The first documents mention:

- ~ 698 : the Hospice of Echternach
- 963 p.m. birth of the Duchy of Luxembourg
- ~ 1308 : the Hospice St. Jean in Luxembourg-City
- ~ 1596 : the Hospice of Wiltz (Hospital of the Holy Trinity)

Charity is always evoked as the politically correct motivation for these creations, but it is likely that hope and faith in eternal redemption was the « hard fact » argument to invest in these institutions where clergy-people did their best to fight misery

All who can afford, avoid these institutions, even for surgery and childbirth

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later on documents mention :

- ~ 1680 – 1840 : the military hospitals of the successive occupants,
- 1855 : the « Central Asylum » for insane in Ettelbruck,
= first state initiative, transformed 2005 in a national institution for psychiatric rehabilitation the CHNP,
- 1869 : the creation of an orphanage in Grevenmacher
- >1900 « in the spirit of modern times » numerous institutions are funded by religious orders and lay initiatives to meet the new needs that arose with the industrialization era

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- **1873** : Hospital of Eich (Metz-Foundation, run by Ste Elisabeth nuns)
- **1882** : Hospice in Diekirch (Nuns of the St Elisabeth-order)
- **1890** : Hospital of Clervaux (Nuns of the St François-order)
- **1894** : Hospice St. François in Luxembourg (St François-order)
- **1899** : Private hospital of Dr. Schumacher in Luxembourg, later on,
hospital of the St Elisabeth order,
- **1901** : Hospital St. Joseph in Luxemburg (order of St François)
- **1906** : Industrial infirmary, later on Hospital in Dudelange (funded by the
Arbed Company, governed later on in a joint venture with the
municipality; management subcontracted by the order of Ste. Elisabeth)

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- **1920 : Hospital in Niederkorn** (Nuns of the of Ste Therese order)
- **1924 : Ste Therese hospital in Lux-City** (Ste Therese order)
- **1927 : Ste. Mary hospital in Esch-Alzette** (order of St Elisabeth)
- **Hospital St. Louis in Ettelbruck** (Municipality, operating subcontracted run by the nuns of Ste Elisabeth)
- **1930 : Municipal hospital in Esch-Alzette** (funded and governed by the Arbed company and the municipality, operated by the order of St Elisabeth)

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~ **1920** : first plans of a lay hospital in Luxembourg –City... which shall concretein 1976 (Centre Hospitalier de Luxembourg)

All those private initiatives, contemporary to the creation of new of religious orders with cheap and devoted workforce, are neither coordinated nor elements of public health strategy.

In these times Public health focuses foremost on the fight against social poverty and community diseases like e.g tuberculosis and therefor invest in

- **the Thermal Baths at Mondorf (1927)**
- **the Sanatorium in Vianden (1929)**

Public health affairs are delegated to the « Collège médical » (1895), Hospitals release of private health affairs, left to private initiatives

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Characteristics of functioning until the xxth. century

Governance: according to the foundation status

General organisation, Nursing and Logistics: religious orders, sometimes as subcontractors, supported by less qualified lay personal

Medicine : individual agreement of doctors in liberal exercise

Financial aspects: « secrétaire-économe »

< 1920: charitable gifts, donations, legs ...

> 1920: progressive contracting with the evolution of general health insurance

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1945: ephemeral Ministry of Health (Charles Marx, surgeon and resistance-fighter)

1946: Maternité Grande-Duchesse Charlotte (1st. (State) Maternity Hospital)

1956: Secretary of State for Health (R. Vouel)

Health Administration (Direction de la Santé)

Entente des Hôpitaux; first daily rate negotiations with health-assurances

Private Maternity Dr. Bohler

Clinique Sacré Cœur (private hospital of the order of St. François)

1960: Children's State hospital (Fondation Jean & Joséphine Charlotte)

As an effect of these chaotic creations, rising costs and more and more perceived unfilled needs & social inequities, questions on the role of State in public health and in hospital policy arise

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Gradually, State Administration recognizes the systemic shortcomings and undertakes action at various levels:

- **1964:** ordering of the « Sunier report » (OMS),
- **1968:** ordering of the « Aujaleu-Rösch report » (OMS),
- **1975:** ordering of the « Griffith report » (OMS)

These reports highlight the role, responsibility and the necessity of initiative taking by a modern State for the shape of it's Health-system and –organization and for pre-hospital & hospital planning

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Consequences of the Expert reports

- **1976:** Law on the Centre Hospitalier of Luxembourg
- 1.t Hospital Act and first Hospital plan
- **1986:** Act on emergency services
- **1986:** Act about the « confinement » (first accents on the patient rights)
- **1986:** Act on Health Administration (Direction de la Santé)

These reforms were overdue

.....but lacked of consistency to enable them to be proactive

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Situation at the end of 70's

- **oversupply of “acute” structures and beds and lack of long term facilities,**
- **to many and small, outdated infrastructures**
 - organization, management, security and hygienic standards of an other time,
 - lack of transparency in functioning, activities and results,
- **important changes in workforce**
 - new specialisations in medical doctors
 - the generation of nuns, devoted and cheap labor-force is overaged and retires
- **rising costs and budget problems**

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Situation at the end of the 20th century

- **Hospital legislation and hospital plan remain virtually unnoticed,**
- **Funding mechanisms are obsolete**
Hospitals which try to invest in better quality risk bankrupt
- **Continuity and quality of care are about to become of secondary interest**

**Nevertheless hospitals stay suspicious to state intervention,
but they have no choice any more,**

**At the end of the 20th Century:
a new paradigm shift is needed**

*State is required to intervene at
various levels*

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Initiatives at the eve of the new millenium

- **1990:** 1st. Law on state investment aid
- **1992:** New Act on health insurance and reform of the Health sector
- **1994:** first consistent hospital plan
(specialized medical departments, first elements on standards)

New Act (1992) on Health Insurance

Motivations

- equal treatment for all, regardless on their status
- adequate services for patients
- increased transparency in activities
- greater efficiency, better cost control

Chap.1 **Shortcut on hospital history in Luxemburg**

Initiatives at the eve of the new millenium

- **1998** : Act «ASFT» (regulation of actions in the in social-, family and therapeutic area; *long term care, nursing homes*)
- : Act on CARE-insurance
- : New Hospital Act mentions for the first time the patient, his record and his rights
- **1999**: New law about State financing for hospital infrastructures (80% participation)
- **2001**: New Hospital Plan (amended in 2009)

Hospital act of August 28th, 1998

« The reason of hospitals is the patient »

Chapter 1 : Scope and Definition

Chapter 2 : Hospital planning ("carte sanitaire"+ hospital plan)

Chapter 3 : Operating licenses

Chapter 4 : Equipments

Chapter 5 : Standards

Chapter 6 : Public aids

Chapter 7 : Special investment fund

Chapter 8 : The boards (CPH, Hospital commissioner)

Chapter 9 : Internal organisation

Chapter 10 : Patient's rights and duties

The New Hospital Act (Innovations)

(Detail) Chapter 9 : Internal organisation

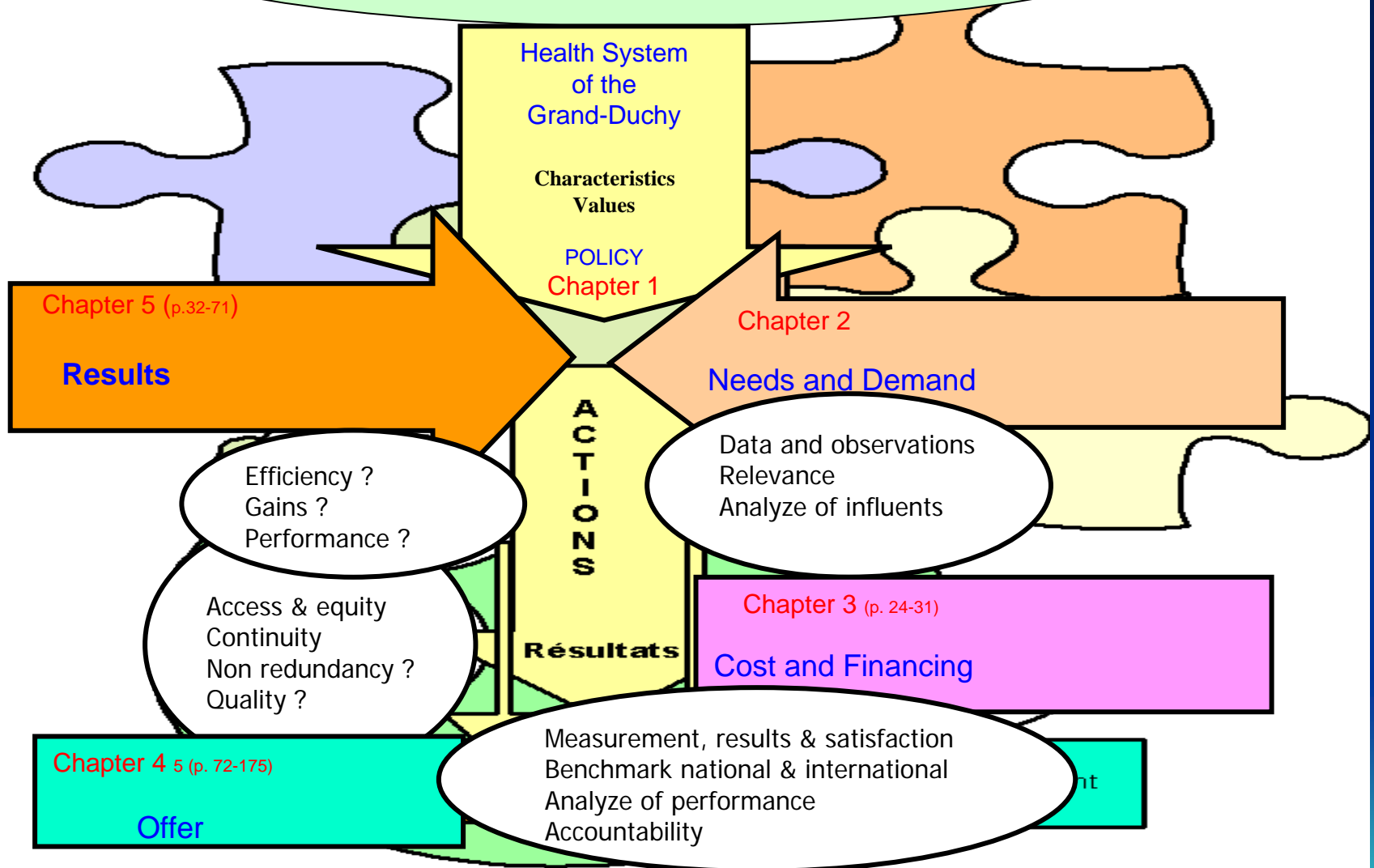
- Governance
- Management
- General requirements and authorized services
- The medical council
- The joint committee
- The patient (hospital) record

The New Hospital Act (Innovations)

(Detail) Chapter 10 : **Patient's rights and duties**

- Care, according to established scientific knowledge, must be warranted continuously
- Protection of privacy, respect of opinions and beliefs,
- Prior information and informed consent
- Equity for access and quality of care
- Internal rules of order, visiting arrangements, prior information about possible additional costs
- Palliative care and assistance
- Information on service providers
- Complaints and treatment of complaints

The « Carte sanitaire » Premise for hospital planning



The National Hospital Plan

to meet the needs of population and the requirements an efficient
functioning of hospitals (latest edition 2009)

Chapter 1	Scope, purpose and definition
Chapter 2	Hospital regions, criteria for hospital classification
Chapter 3	Needs for hospitals, services, beds and planned (heavy) equipment
Chapter 4	Patient safety and quality assurance, coordination structures
Chapter 5	Miscellaneous and final provisions

GH Luxembourg - The Health System:

The hospital sector 2010

Chapter 2:

Critical views on the evolution in the last decade

**Statements – Reflections –
Proposals**

Hospital sector: Observations ("carte sanitaire")

- **Statement (1)**

- **major changes in the hospital sector**

- separation of acute and long term care (1998)
 - decreased number of hospitals and acute care beds (5 %0 in 2001)
 - important modernization of the infrastructures
 - development of national services
 - policy of adjustments to (medical) progress

= > a modern, generously equipped sector !

Hospital sector: Observations ("carte sanitaire")

- **Statement (2)**

- **a more important growth, as demography, of**
 - of the (medical) activities
 - of the recruitment (eg MD's: 976 in 2001 -> 1181 in 2006)
- **but no evidence of need or justification of effectiveness**
- **no measurements or measurable impacts**

Redundancy ? Waste ?? Abuse???

Hospital sector: Observations ("carte sanitaire")

- **Statement (3)**

- **Cost explosion** (310 m. € in 2000 -> 576 in 2006)
- **Lack of transparency**
 - insufficient flow of information
 - no standardized and interoperable patient records
 - poor exchange with MD's and low integration in the hospital organization
 - slow quality improvements
 - lack of sufficient and valid data
 - smooth policy of benchmarking,
 - no formal requirements for accountability

? Results ? Performance ?? Efficiency

Hospital sector: Observations ("carte sanitaire")

- **Summary of statements:**

The inevitable modernization of the hospital sector from the beginning of the 90s :

- has created a modern and potent high-performance tool
- but
 - goals and roles in health policy are not always clear
 - own dynamics arose with the risk of jeopardizing the sustainable development of the existing model
- the impacts of results are not measurable
- Sector characterized by
 - lack of transparency, poor data and benchmarking policy
 - inadequacy of regulatory-mechanisms and a lack of pilotability

Hospital sector: **critical analysis**

- ? Development of a vicious circle ?



Results ? Quality ? Satisfaction ? Patient-centeredness ?

Necessity and usefulness ? Effectiveness? Efficiency?

? What about « spend better, care better »

Hospital sector: **critical analysis**

- **The increasing of activities is out of control**
 - hospital governance recruits activity inducers but has no financial responsibilities in the system
 - doctors (freedom of establishment and therapy) induce activities without need of justification
 - activity make costs which are automatically financed by health-assurance
 - activity is supposed to reflect needs
 - needs stimulate capacity-planning and requires additional funding ...
- **thus cost control becomes impossible**
=> **the system**, regardless to his effectiveness or quality, **is inflationary and nearby impossibel to pilot**

Do activities really reflect needs and justify the demand?

Influence factors of demand:



Statement :

The causes of demand are known, an accountable system would and should justify its needs

- the patients: number & (easily influenced) needs,
- the prescribers: number and behavior
Rules on professional exercise & compliance to efficiency,
- the system and its values (Solidarity, justice, generosity),
- the offer and the financial incentives,
- legislation & governance i.e. responsibility & accountability for cost / results / satisfaction / service
- medical progress and his « dealers »
equipment industry and pharmaceutical-industry
- external factors: a.o. media....

Are the instruments able to steer at least the offer ?

The hospital plan and financing mechanisms as supposed regulators



Statement :
The cost evolution
can not be sufficiently
influenced by the
actual mechanisms
The system is
out of control

- **the hospital plan regulates infrastructures, structures and big (medical) equipment, but not:**
 - the (number & behavior of the) inducers of activity
 - the activity, nor it's justification or relevance
 - **financing modes decide on**
 - hospital budgets based on (historical) activity
 - payment of providers based on quantity of activity
 - the respective regulations are not coordinated for the same goals, ignore quality and accountability, have their own logics..... and sometimes bring each other down (eg hospital departments)
- = public regulatory tools are not coherent, insufficient, not pertinent to steer the offer and thus to influence the demand and cost evolution

Hospital sector: critical analysis

- Incongruence at several levels of power ?

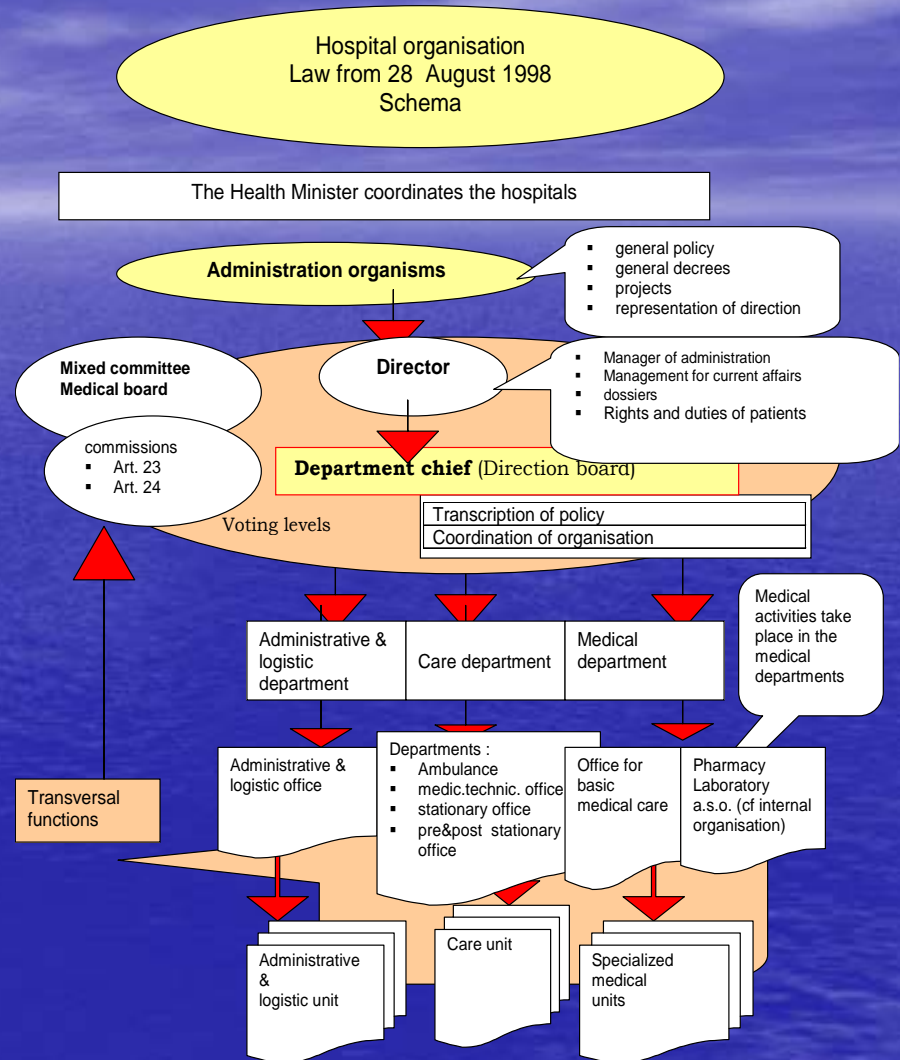
- Ministry
- Hospital Governance
 - Hospital director
 - Accredited physicians

➤ everyone can hide behind the other and does so,

➤ systematic irresponsibility

⇒ **Statement:**

Misconceptions with a cascade of undesirable consequences



Hospital sector: critical analysis

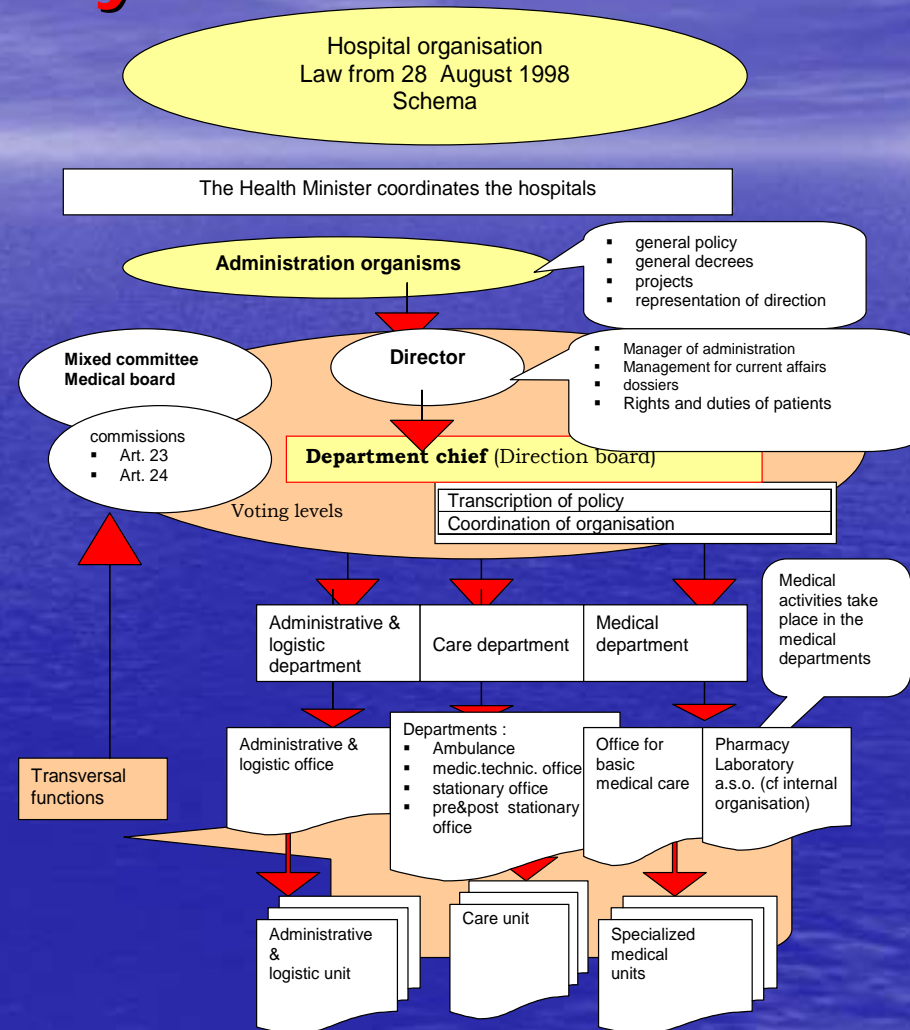
= Absence /Inadequacy

- governing concept,
- clear targets at each level,
- valid & sufficient data
- coherent information flow
- steering boards
- mandatory accountability

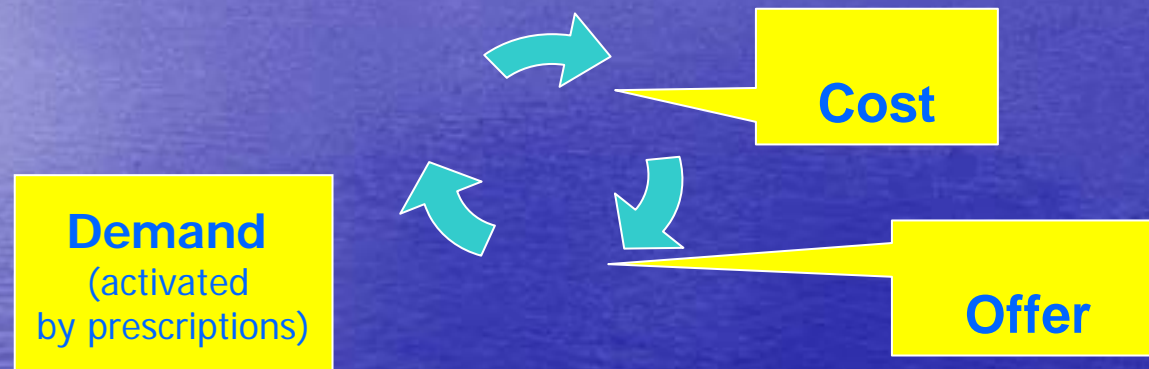
= impossibility to

- steer properly
- justify evolution
- be accountable for results
- take responsibility
- induce continuous, targeted improvement

= > bottleneck



Statement: The more an un-invited crisis spreads and seriously worsens the situation and the perspectives,



Admitted principals "*Activity = need = justified demand*" are of weak evidence.
The hospital has become the focus of interests of many actors,
but is the (futur of the) patient (still) in the focus ?

Break the vicious circle

To get out of this vicious circle,
the existing regulatory instruments are
far from being sufficient.

Reengineering, simultaneously on various
levels, is required
with focus on the sense of (hospital) activity
within the targeted frame given by the system.

A systematic approach is needed

Equation for a solution:

Need of consensus for hardly compatible wishes

Ambitions: Equity, Effectiveness , Quality, performance, transparency, absence of waiting lists, Efficiency, « cost-containment », satisfaction, humanism

Values : Solidarity, generosity, free choices, free exercise, mandatory "all round" health assurance, attractive conditions....

Context: Deficit in financing, economical crises, incongruent governance and insufficient steering possibilities

How to get out of the bottleneck?

Answer preliminary questions :

What are the aims and specific missions of the hospital within the given health system?

What do we really need and what can we afford?

Which policy, governance- and steering- tools do we need therefore?

Which results and which accountability e.g for the patient & which level of competitiveness are wanted ?

What are the pitfalls and how avoid them ?

How to get out of the bottleneck?

AXIOM: The only reason of the hospital is the patient

- 1) The patient is in the focus of the efforts of all the actors.
- 2) The results and the added value for the future of the patient are measurable and benchmarked.
- 3) There is a constant challenge for the research of best practices, coordination of approaches and concern for continuous improvement and sustainable development.
- 4) The system, entirely funded by public solidarity, requires accountability and the necessary flexibility to adapt to always new challenges.

How to get out of the bottleneck?

Set or confirm the frame of values

- **First no harm**
 - Efficient, relevant and coordinated actions and (branches in the) care
 - Patient-safety (Management of the undesirable events, risk-management, learn by experience, no fault)
- **Advantage**
 - Results, quality, satisfaction, justified by similar measures and assessments + improvement measures
- **Justice-Fairness:** Rights and obligations of each one, cooperation and coordinated approaches to explicit and shared goals, with clear division of tasks and responsibilities, etc

=> Check fundamentals of health and hospital legislations

How to get out of the bottleneck?

Give the hospital a role and enable it to play this role

- pillar of the health system
- focused on to the becoming of the patient
- relevant enterprise for health services
- transparency, good results, accountability
- efficiency, sustainable development
- etc...

reconsider financing, legislation and planning

How to get out of the bottleneck?

Align the elements: share-& stake holders

❖ **Policy-concepts**

- Health
- Social Security-health assurance

❖ **Governance** (Roles and accountability)

❖ **Management**

❖ **Health providers**

=> review the afferent legislations

How to get out of the bottleneck?

Align the elements: conceptualize steering instruments
enable effective action for regulation of the

- demand
- offer
- the systemic coherence of health and social security policies and their instruments

**and foremost be aware that the financing modes
are finally the most effective steering instruments**

**=> Study the impacts of the modes in use for coherence with
the policy targets**

Get out of the bottleneck

Intelligent financing should
not focus exclusively on quantity,
to assure the income of providers
and the budgets of hospitals,
otherwise
it stimulates inevitably production
instead of results and added value for the
patient and the health system

How to get out of the bottleneck?

enable steering: get instruments

- 1) (recognized) **measuring instruments** for:
 - results, quality, effects for the patient
 - the validity of the concept, the competitiveness of the system,
- 2) **an electronic, interoperable patient record with integrated data-base**
- 3) **a coherent information flow**
- 4) **steering-boards & approach by benchmark**
- 5) **accountability & continuous sustainable develop**

Critical views on the last decade (Summary)

The modernization of the hospital sector has allowed the development of its potential but highlights conceptual weaknesses in the (health care & assurance) system.

The crisis impact brutally enhances structural deficits and urges to act.

Non-intervention cannot redress the situation but is likely to worsen it rapidly.

Critical views on the last decade (Summary)

- the diagnosis has been established and is known,
- the therapy needs a coordinated & multi-level approach and urgent actions,
- many proposals for action have already been made.

(Intermediate) Conclusions:

The hospital of tomorrow will necessarily be different, its evolution depends on :

- ☐ economic constraints
- ☐ scientific progress
- ☐ societal values (Politics, Ethics)
- ☐ wise policy and a wise leadership

The recent experiences and the 'crisis' make now an exhaustive reform inescapable which the "lethargy of comfort" allowed to postpone as long as economy flourished.

Discussion

Thank you