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The Medical Clinic of Proximity: Business Controversies and Medical Challenges

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3.1 Introduction

Delivering universal healthcare efficiently is providing formal access to quality services, appropriate therapies, medicines and vaccines, and professionally trained staff in adequate establishments with no extra financial burden. In Europe the 2020 Strategy (2010) focuses positively on strengthening and further developing policies that support innovation, particularly for small and medium-sized enterprises (SMEs). The European medical technology industry is one of the most innovative in the world and is expected to continue its growth under solid health policies. The sector is comprised primarily of a heterogeneous group of SMEs, which make up 80% of the industry, represents a major provider of jobs, especially highly skilled jobs in research and manufacturing, employs nearly 534,000 people across Europe and has the potential to expand

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A. Thrassou et al. (eds.), *The Changing Role of SMEs in Global Business*, Palgrave Studies in Cross-disciplinary Business Research, In Association with EuroMed Academy of Business, https://doi.org/10.1007/978-3-030-45831-7_3

further; therefore SMEs are central to economic growth. Innovative healthcare SMEs are worth more than EUR 250 billion.

In Europe, delivery of healthcare is still a national competence even though a tenth of the EU's GDP is spent on healthcare and more than 17 million people are employed in this sector (Horgan et al. 2018). There is an increasing need for innovation, digitalization and accessibility in healthcare and SMEs are willing to take risks in this mission. Therefore their work needs sufficient support so that the solutions can finally reach the citizens. SMEs operate mainly at national level, as relatively few engage in cross-border business (E.C. 2017). Several categories within the health sector are of interest for SMEs, whether in healthcare services or product market, and could include medical equipment, devices, services, instruments, biotechnology, substances, medicines, diagnostics, laboratories, primary prevention, sensors, medicine development and delivery. The possibilities are expanding, especially in the era of personalized medicine (Nimmesgern et al. 2017). The revival of proximity medical services requires recognition and acceptance prior to supporting a deep-rooted health reform implementation. Accentuating the general practitioners' (GP) role and the well-functioning care philosophy, vision and structure profoundly impact the entire governing of the health sector. This sets up sound correlations between supreme values of health: life expectancy, quality of life, well-being, and corresponding political and medical management. The wise lesson from 2200 years ago to '*treat first those who are not ill yet*' (Huangdi 2011)[1] is still valid. Today, chronic diseases are mainly caused by behavioural risk factors (dietary risks, tobacco, alcohol, low physical activity), together with social disconnection (distressed societal relations, civic social media isolation, deficient management and dysfunctional institutional links, political influence). Life expectancy increases with access to education, health services, better lifestyle, less stress, cost-efficiency methods and sustainable systems. This happens when the administrative apparatus is adapted to the populations' needs through new managerial functions. For the patient, the medical act gains in quality when it is delivered closer to the home, school or

[1] The Medical Classic of the Yellow Emperor was translated by Zhu Ming, Foreign Language Press, Beijing, China in 2001, under ISBN:7-119-02664-X.

work, combined with immediate intervention, personalized treatment or preventative education. National health strategy is the core of the health policies and should offer additional medical and administrative responsibilities to the GPs, rather than burdening them with accounting-statistical activities reinforcing the primary care, with net benefits for the system. Starting with real needs, resources and applying efficient and win-win solutions could be a universal condition of success and have a real impact on health management indicators.

3.2 Health as a Holistic and Entrepreneurial Business

C.E. Winslow magnificently defined health (1920) as a *complete care model*, appropriate to the health industry, outlining the population's health management attempt and contribution: "*the science and art of preventing disease, prolonging life, and promoting health*" through holistic "*organized efforts and informed choices*" of society, establishments, public and private communities and individuals (Sadana and Petrakova 2007). Based on resources' availability and staffs' skills, governments may consider contracting with vendors, operating internal programmes or applying hybrid models of care management depending on interest, capacity to operate *in-* or *out-house* options, necessities, data programme capacity, staffs' management, monitoring programme, timeline design and evaluation capacity. Beyond this, the integrated activity of planning safety calls for identifying ways and tools to perform healthcare for everybody under criteria and time scales' settings, outlining specific responsibilities, effects or desired outcomes should result. In Butler et al. (2017) the common use of *smart concepts* refers to the "*wisdom and skills used to develop ideas and practical behaviours*" as advantages bringing about particular decisions. Health organizations nowadays need profound changes in mentality—from medical and health staff to industry, distribution, media and patients. These players are important if they are motivated to become contributors to health demands' creation and providers of best services. The relations that develop then become worthy of defining the health

paradigm instead of focusing on each player's centricity. Critical thinking is necessary to properly integrate and multilaterally improve activities, processes and operations. The switch happens through creative management and a change of behaviours (Thrassou et al. 2019) based on specific activities where solutions are difficult to find, decision makers' judgement is blurred and staffs' interactive capacity to identify risks and nonconformities is associated both with gains and losses. Good lessons spring everywhere. Statistics display increases in GDP or life expectancy, better access to health, proficient networks of health centres staffed by GPs, (non-) medical specialists, comprehensively or abusively, serving the primary care services. They look engaged in the real consolidation of relations between health and wealth, outlining the improvements (IT use, mentoring, nutrition). The society's ability translates the health knowledge into a lasting socio-medical upgrade. The organizational unbalances require attention and change: dissatisfaction with the *status quo*, perception that a better alternative always exists, inadequate transformation of the organization's structure, alterations imposed on individuals inside the organization, disadvantageous rules and relationships affecting the clarity in collaboration, the connection of good communication, the creativity and compassion, and the credibility of avoiding conflicts.

When specific changes are identified and accepted, they precondition integration in a clear vision and common strategy. Thus, the *patient-centric model*[2] replaced the patient-centred one, identifying a few advantages. The idea of keeping the patient at the core of the medical act delivery is elevated. However, the inflexibility of the working process showed a mentality unable to tackle all providers in the process of transferring more value to patients. The recent forms of patient-centric programmes offer more opportunities for patients to encounter technology, focusing on the patients' information as a main source of development of the medical act. This is half-right until the medical act is validated inside the new relation. The move forward requires that the medical act simultaneously be identified and validated under particular criteria, by both

[2] The Patient-Centered Medical Home (PCMH) is a set of guidelines to reestablish the dominance of primary care between all actors participating in the medical action. This is more about the physician and less about the patient.

staff and patient. When information is incomplete, validation and medical act are distressing.

The partnering, as a proactive collaborative relationship between medical staff and patient, calls for attention and trust so that the medical act keys out its full identity. Once the gap between patient and GP is closed, this partnering becomes the kernel of a new managerial system. However, the trend in health policy of keeping the patient's centricity is rigid because the patient is considered a static entity while the health significance takes the societal side. This trend delineates the health resources' economic side, transmutes the values ranking and enforces advancements for the health and care service deliveries, ignoring the performing fair business side of the medical act. Démarches go beyond the basic requirements, sustaining the fundamental need for restructuring in attitude, activities and prestige, throughout the whole chain—policy, planning, organization, monitoring, assessment—to establish the rule of centric proactive and dynamic implication between the players involved. The beneficial change is pricy and laborious, as it entails application to all programmes, in all medical units, no matter the administrative levels. The change is called for as part of employees' training programmes that will be monitored long enough to germinate and develop into a new paradigm of integration. The model is appropriate when the realistic and dynamic analysis keeps within adequate limits the resources and human capital, the relationships develop and the targets are set for the best results.

The relationship spectrum in health is dominated by (a) a continuum of prevention and preventative relationships defined by the returned added value and collaborative exchanges and (b) happening or recurring relations where expectations are higher than investments. The appropriate relationships developed give to all medical and health stakeholders significant competitive advantages and benefits, inside a relational system that works similarly for all bodies involved: standardized patterns of medical provider–patient relationships; factors influencing patients' and staffs' integrated satisfaction (medical and financial); new schemes to improve the actual designed relationships; new decisive drives of relationship-satisfactory effectiveness, in the complex process of establishing, developing and maintaining a successful partnering. While activity-based

management is limited in communications and restricted in relationships between parties, the relationship management allows for mutually benefiting, long-term, cost-effective liaisons to grow practically with any potential partner (patients, medical and administrative staffs, producers and suppliers).

The health service delivery should be received as an exchange of trust, responsibility and value based on knowledge, skills and competences of specialists for confidence in medical practice, care comfort, medical subscription or paid medical treatments and services. Under such an approach, the collaborative exchange occurs when both sides' rights are respected and alternatives are few, no matter how dynamic the market is and how complex and highly appreciated the services are. The new era of medical and health sector development is dependent on managing the relationships. The relationships' core is built by values shared during the exchange process where each side gives or awaits higher quality in return. The monetary side of the deal must offer a perceived payoff of greater value to the side in need, for the medical act to occur. This is also an open door for corruption, if formal services are replaced with informal ones.

To gain collaborative advantage, special skills have to demonstrate the relationships' sustainability (Mukerji 2019) between collaborators who learn the secrets of specific high-performance activities and develop innovative schemes to build alliance partnerships. As the profit-based approach evolves, the health delivery and communication becomes a grand hub of aggregated experiences and good practices. The growing potential for creativity contributes to the institutional reputation development. The new movement doesn't ignore the existing gaps between requirements and supply, between what providers offer and what establishments deliver. The most important driver of growth relies on partnership set-ups and patients' needs and preferences. Quickly identified, they support the ICT-optimized services and accept the new devices as tools of permanent monitoring in health and care management.

3.3 Quality and Satisfaction Synergy in the Health Innovative Partnership

Practising medicine today goes beyond the individual diagnosis or treatment protocols. It means, above all, collective activities: mentorship, education, prevention, better general comprehension of the cause of diseases, leading to their emergence. Treatments that focused on the symptoms of diseases in the past have now become personalized targeted solutions based on genomics, proteomics, and biological or immune therapies. Innovation radically contributes to the core transformation of the entire health system, care services and pharmaceutical industry. The online environment and the digital technologies are accelerating the adoption of emerging health technologies into healthcare systems. The technological changes can sustain the advancement of health programmes. Programmatic machines are used for data, appointments, advertising and treatments' distribution replicated in real time by apps and mobiles. IT specialists' capability to deploy new elaborated framed products is possible thanks to the high technical advancements till 5D and *li-fi*. The proper identification of interventions' locations saves time and lives, increases the patients' confidence in medical specialists from afar in matters of wearable and cross-devices, and can better target and match expectations. The general biometric systems' promises cover the health market's anticipation at any time. Trends are forecast by observing physiological and behavioural nature, by technologic recognition, electronic signature and so on. The e-health is an integrative medical tool, an opportunity to make the health services' delivery more profitable, based on huge benefits of remote communication. Patients who are highly proactive are ready to learn new behaviours, use gamification, monitor their symptoms and treatment, thus choosing to live healthier lives.

To stay competitive, pharmaceutical companies share the transformation and improve social and market comportment, implement better forms of communication and collaboration, and sustain collaborative partnering. The medical devices and pharmaceutical companies rethink development as a business model to sustainably support innovation and the transformation of health delivery. The supremacy of large

corporations is diluted in front of relationships centred on cost-effectiveness and the use of new technologies making a difference where firms are unwilling to supplement or support existing pharmacological therapies. The focus is on innovative digital tools for online medical services and implementation of modern reforms inside the aggregated partnering (policymakers, contributors' players, fiscal mediators, providers, purchasers and marketers).

Individuals' uniqueness generates versatile interactions but complex perceptions as the raw material for transformation: policies, programmes and laws. Thus, the *personalized medicine* concept, based on an integrative check of the health status, sustains prevention as an upper tool allowing targeted treatments to better act against symptoms, pains and diseases. The present market context encourages the entrepreneurial efforts for growing the seeds of medical clinics of proximity: *ProxiClinic* (Mihoreanu 2018). Outdated, single regional health centres that gather patients from many surrounding districts need to be redesigned by adopting practicality principles, making access easy for the ageing patient, with continuous schedules and a variety of specialists who could be called in rapidly to assist in the clinic, remotely or in patients' homes. Medical proximity clinics are SMEs positioned and developed on local grounds, but connected within a network with the rest of the medical assistance system, intended to serve a limited number of citizens living within a specific area, combining traditional with proactive medical assistance types. These enterprises could play a vital role in increasing provisions of primary healthcare coverage, preventive services, and treatment of minor injuries, and especially in reassuring patients of their continuous availability within an overcrowded city environment or in rural, scarcely populated areas.

Applying payment ranking based on specific performance indicators for the *out-of-pocket* payment cases, the medical act could be improved and push to high performance increased. The *medical compulsory insurance* plan,[3] which introduces new notions—complications and/or

[3] Diagnosis groups system (DRS) has been replaced with a new system: per treated case (the distinction between hospitalized and treated cases represents the case mix (DRD). The system of groups of diagnosis (DRG) represents a classification of outpatients following their diagnosis and the expenses in the hospital. The groups of diagnosis have two main characteristics: the clinic homoge-

co-morbidities as additional diagnosis generating additional resources—has added advantages. A multilevel algorithm is used to generate the diseases' severity and the patients' function in terms of both diagnosis and clinical complexity. The expectations linked to payments implementation are focused on the improvement of health services supply: access, continuity, quality, efficiency; patients and diseases typology and treatment understandings; follow-up mechanism for service quality, patients' post-hospitalization and their further treatment in the most adequate medical locations; availability of limited resources for treated patients; waste and inefficiency combat; and wide access to medical and managerial information prior to taking decisions. The periodic assessments of medical actions, through surveys measuring the quality of both the medical act and patient satisfaction, keep the medical and care activities efficient, high-performing and profitable.

Scandinavian countries attained success in reforming the system starting with rebalancing the deficits: 30% of hospitals closed, half of hospital beds suppressed. The changes didn't hamper the country in developing one of the best healthcare systems in the world today, as recognized by the WHO (2016).

The essential component of the system centred on primary care as an aggregated service based on different health professionals working together: GPs, specialists, nurses, laboratory staff, psychologists and other staffs working for that city or region. Thus, a team of about 15 members manages, roughly, 1500 patients with acute, seasonal, chronic diseases, or cancer (Nolte et al. 2008). The centres avoid unnecessary referrals of patients to hospitals. For more difficult cases, the centre arranges for the appropriate type of specialist from the hospital to come for punctual visits. In such situations the specialist decides on treatment continuation. The medical decision is based on the patient's health status, but also on saving time and funds, at all levels: prioritizing needs and focusing on the most important and demanding patients, performing adequate investigations at the most convenient time of diagnosis, and monitoring treatments and patients' condition to reduce unnecessary tests.

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neity outlining similar expenses for similar diagnosis and the level of the possible complications (the presence of co-morbidities).

The entire activity is developed under the *reductionist principle*. For example, during pregnancy any Swedish woman can benefit from a standard schedule—one echography performed by a midwife—compared to other Europeans who have an average of three EKOs performed per specialist physician. Taking this path of monitoring the pregnant woman, embryos and patients are protected from unjustified exposures to ultrasounds with excellent results, assigning Sweden the top spot worldwide for the lowest infant and mother mortality rate. Minor injuries are also treated under the same approach. The number of medicines prescribed in Sweden is twice as low as in France. The first four visits to GPs are paid (20 Euros); then the system becomes free of charge. This policy allows GPs to grant time and attention to patients with higher needs. Funds from taxes are allocated to transparency so that patients know precisely their monetary trajectory and use for health. The influx of patients into health centres is administrated through calling offices that operate 24/7, where experienced nurses listen to patients' needs, advise them on what to do and guide them to take practical actions at their disposal. Doctors may answer the phone calls for prescription renewals, directing them to the pharmacy to avoid unnecessary on-site visits. Compared to France, results are spectacular: 12 in-centre visits, 2–3 home visits/GP, 30% increase in salaries, three times less patients, 16 hours less work per week and, overall, 200 patients satisfied daily at one single centre. Modulated home treatments follow the patients' needs. Given the high figures of Swedish seniors and funds allocated for geriatric patients, 95% among them end their life at home, while 70% of the French die in hospital. Hospitals are carefully managed and very few patients spend the night after interventions. The number of beds is one of the lowest in the world. The maximum delay between a consultation and an operation is 90 days. Thus, productivity and quality contribute to patient satisfaction, wise spending of money and social cohesion.

3.4 Societal Partnering: A Beneficial Start to Romanian Health Sector Fortification

Romania has faced continuous reform of the healthcare system during the last 30 years; disruptive efforts were made for a suitable way to get over the difficulties. The measures taken so far have always been controversial because they targeted only few or separate components: maternal and neonatal assistance; emergency medical services; countryside primary healthcare and medical services; national health and planning accounts; and project management. Recent efforts have focused on hospitals' decentralizing process and policies' harmonization of economic development and public health. Unfortunately, the legislative, institutional and administrative cleavage doesn't sustain the betterment of human resources. The vision and objectives do not reflect harmony, consistency and support of the general interest. The desire to improve the perception of the medical act or to change the mindset of local communities lacks in purpose and accountability of the community health status. The hospitals still face a copy-paste archetype in achieving objectives and fortifying the medical and managerial education. The approach is similar when strategies and policies are implemented by ignoring standards, possibilities and opportunities built on implication, tolerance, commitment, attitude and mentorship. This creates discrepancies between the initial purpose, the attitude to be adopted and the adequate action to be implemented.

Development can't be achieved without respect for the law, responsible commitment and continuous education. Practically, three types of health education—formal, non-formal and behavioural—are all in force when public health social norms promote development through educative prevention to change skills, attitudes and beliefs. The principles of health education consist in *priority* (the earlier the health education starts, the better the population's health status); *specificity and authority* (consider the higher impact of aggregated education on the sane-genetic behaviour); and *creation of an integrated workforce* to build *preventive health education* into the core objectives of the societal-sanitary policy.

The health policy in the field of quality management is aimed at providing high-quality medical services to meet the population's needs.

Efforts are diminished when final evaluations are disregarded and periodic assessments according to the last ISO standards and requirements are missed. The mission of evaluation is to accord the patients' needs with expectations, through qualitative medical services, according to the principles issued by the Strategic and Organizational Management and Clinical Management, Medical Ethics and Patient Rights standards, namely: preserve the population's health and well-being; improve the quality of health services and patients' safety measures; ensure non-discriminatory access to health services according to each patient's needs, within the limits of the mission and resources; defend the principles of ethics and deontology; respect human dignity and focus on patient medical care; promote effectiveness and efficiency; develop the concept of professional assessment through clinical audit and decision-making optimization; ensure the continuity of medical assistance within the available resources; and within the development of cultural standards, comply with legal occupational health and safety requirements to create an optimal working environment.

The medical services' quality and safety do not as yet represent the core of the entire medical and care activities. The patient is theoretically placed at the centre of attention, while the medical management is addressed on clinical and risk-free management bases. Alas, this is only a static approach of the facts bringing no benefits for longer periods of time (neither for the patients nor for the society). Real and fair communication between professionals, between medical specialists, administrative staffs and patients remains the first step of a sustainable reform on which the transformation is based. Changing the organizational culture and transforming each medical facility into a cluster of activity represents a major responsibility, a true commitment, because each organization develops a specific culture which includes a set of goals, roles, processes, values, communication practices, attitudes and assumptions that require harmonization and complete adaptation and implementation (Mukerji 2019). Harmony between entities produces balanced arrangements or relations followed by long-time stability. Hence real communication, right attitude, correctness and commitment could become the best tools for implementation and achieving the desired results. Institutions that have gone on the way of organizational culture change achieved positive results into increasing

staff engagement, attract new customers and increase revenue. Learning is individual but implementing is crucially collective.

The versatility of policies and strategies is crucial for sustainable development. To maintain an objective approach, it is necessary to involve external consultants or advisers to assess the situation and propose viable change. The *ProxiClinic* comes up as a strategic entrepreneurial innovation to better reverse the added value for society's and individuals' benefit, making all efforts more visible and individuals' expectations more satisfactory. The innovative contribution values the improved managing practice of these neighbourhood establishments, capable of saving money, time and energy, as an inevitable change and transformation for society's benefit. As a medical unit able to work in favour of all patients—chronic, disadvantaged, busy, children, seniors—it will be easily functional in all directions: preventative education, family planning, maternal, neonatal, child, and adolescent health, infectious diseases, mental health, minor surgery and health policy, as it addresses the needs and goals of classical, traditional and online medicine using even artificial intelligence among the innovative technologies aimed at improving human health.

Integrative and personalized medicine needs the support of health policies from authorities in order to change for the better the actual standards, regulations and procedures. Social media channels used extensively by patient support groups develop a relationship between doctors and patients and sustain profitability. The online dimension is giving a new hint to all medical services. Intelligent digital and artificial intelligence tools will become the foundation between consumers and health institutions supporting the medical act. One access for all appointments, records and prescriptions for a better management of chronic conditions will determine how patients can become the drivers in improving their health by using robust technology and handling their own data correctly. As the *e*-health expansion already generates consistent changes in the perception of the clinical medical act, all physicians, especially GPs, need higher recognition of their skills and better equipment to use in primary investigation, diagnostics, treatment and monitoring of their patients.

The 30-year-long awaited transformation of the Romanian society needs continuity of robust and sustainable reforms together with a solid civic education around European values. New social values will

determine new mentalities and behaviours. Evidence-based communication programmes increase knowledge, shift attitudes, update norms and produce changes. Adaptable mobile solutions are handy tools that target distinct user groups and support frontline health workers in providing community members with access to information and services and in allowing programme managers to rapidly gather data and facilitate authentic decision-making. At the European level, although health is mainly managed at the national level by policy-makers, common needs have been identified for many years now, such as increasing efficiency and resilience of health systems, finding common grounds for a better supply of new medicines and finding innovative and personalized solutions to help patients.

The formal administrative behavioural change could be slow, but SMEs in healthcare can adapt more quickly than cross-border companies to the local needs in order to deliver adapted solutions. Health budgets are not sufficient to save patients; integrative solutions must be implemented fast. Sustainable SME growth is the solution for an economy that works for people: growth from new jobs creation, more digital solutions, helping SMEs to adapt to globalization by simplifying administrative procedures and facilitating access to credits, flexibility of the work environment and facilitating access to new competences (E.C. 2010).

A time-bound commitment is the key to implementation. Political and managerial intervention is considered befittingly achieved once people are responsible and dedicated, after a realistic and complete internal evaluation and audit of resources, operations and processes, as a continuing process appreciating and respecting freedom of understanding and deciding to implement it at all levels. Redefining prevention as a lifelong interactive activity emulates a national return-value-based business model, bringing incentives and awards for desired outcomes to all health players, centred on improvements in access, common solutions upriver and increase of healthy-life years, and not only healthcare quality and treating the sick, but care management when just a few things can be repaired. "*Salience is the most important modification*" made to standard analyses of incentives (Thaler et al. 2008). The secret lies in "*incorporating the concepts of health and well-being*" into every economic and societal decision (Tyson 2017) as the choice architect has the responsibility for

organizing the "*context in which people make decisions salience*" (Thaler et al. 2008).

Clear and simple laws, decisions and regulations are easier to implement when the focus is on pain reduction, saving lives and money, and building a healthier society. Beyond the compulsory nuance, any law should express the obligation of the State support and the value of long-term plans and strategies in all fields of activity. Disinformation about any executive measure has serious consequences. Governments need to closely monitor public perceptions, counteract misinformation and promote the benefits of all programmes adopted. For example, immunization is one of the most important and cost-effective public health achievements in modern times and should be proactively promoted.

Comprehensive medical assistance is a responsibility-based relation between patient, medical team and healthcare institution. For better health outcomes, patients should understand their illness, acknowledge prevention education, comply with the treatment and discuss concerns with the medical staff. Coping with the challenges and finding appropriate solutions rely on commitment to knowledge, prevention and health safety as the highest societal priority. The disparities in health equity call for an extended definition of prevention: better conditions of living in communities, whose role should be reconsidered within society, participation in the local decision-making system and involving stakeholders in building and formulating adequate solutions.

Recommendations suggest using two levels of health service delivery platforms and a potential specific intervention, including any avoidable burden, especially for the low and middle incomes per inhabitants and households, "*cost-effectiveness, implementation cost per person, and feasibility of scale-up*" (Jamison et al. 2013):

- *The entrance level, centred on the GPs' responsibility and attributions*; the interventions are delivered as *basic packages* via primary care and GP clinic specialists' network/platform and then hospitals. The basic packages refer to (a) the cardiovascular set of treatments as an essential one, high blood pressure and acute heart attacks; (b) the pulmonary set of treatments concerning the treatment of asthma and chronic obstructive pulmonary disease with inhaled corticosteroids and ß-2 agonists;

(c) the mental health set, treating pricy chronic diseases with long-term therapies; (d) the neurological package that contains some highly cost-effective interventions to be delivered in special resourceless circumstances: need for anti-epileptic or older antipsychotic medicines, generic antidepressants and lithium, short-term treatment and therapy for depression; and (e) the cancer set of treatments. More elaborate treatments, for all mentioned groups, are delivered by the specialists affiliated to the GPs' platform and neighbourhood.

- *The second level, centred on the hospitals' platforms*, provides basic packages for accepted patients with emergency requirements for (a) basic injury requiring surgical interventions, (b) severe cases of cardiovascular diseases, or (c) a set of treatments for severe situations of cancer.

The clinics of proximity managed by GPs and their cluster of specialists should play the most important role in delivering health and medical services. The proximity assistance counts on community support for prenatal care, immunization and vaccination, multidrug treatments and rehabilitation, educational prevention programmes, cardio, pulmonary, cancer incipient screening and treatments, minor burns and other complicated emergent surgery. Such a clear demarcation between practical situations, attributions and responsible engagement of all health and care market players would more easily designate the path towards progressive universal health coverage implementation by financing the population, the realistic policies and the innovative research. This is, by far, the most efficient and profitable way to reach peoples' health and financial protection, to achieve the convergence of the health sector and societal benefits.

3.5 *ProxiClinic* Environment: The Core Synergy of the Healthcare Sector

The *ProxiClinics*' activities go round the electronic medical records. Good records assist the real-time information delivery, avoid duplication of efforts, identify missing records, replace illegible and altered data, help conceiving better plans of care by integrating all specialized registrars,

accelerating diagnosis and serviceable care (Dengleri et al. 2019). At an executive level, more tools and time are available for managing assets and liabilities, abiding by norms and regulations, increasing operational security, improving the working environment, operational techniques, competitive skills and financial results. Crafting the right way to save added value and use it to motivate patients to make the best choice is crucial. To acquire and important position the health sector needs to reposition itself as "*primus inter pares*" inside the society (Clift 2013). To be successful, the approach will address the educated and motivated people; the rest will follow. Turning away from the *sclerotic and stiff bureaucracy* (Clift 2013) requires expertise to restructure, a deep change in attitude to create new behaviours, to eliminate *the antiquated management* vision and *senior managers' ill-advice* (Clift 2013), to remember the ambitious objective that WHO has had since 1948 and that medical establishments have forgotten along the way—*attainment by all people of the highest possible level of health*.

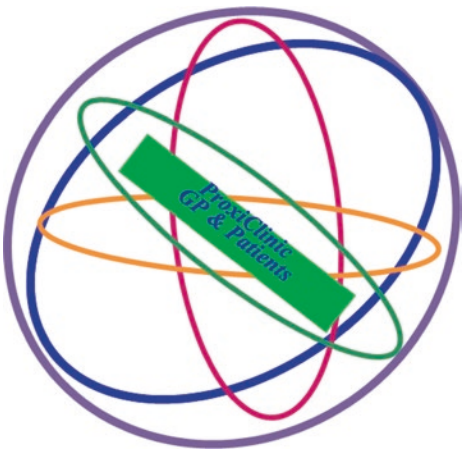
Innovation in medical technology has the power to increase the efficiency and effectiveness of care, either by revolutionary steps in medical prevention, diagnosis and treatment or by the application of innovative technology that is able to do more with less. New technologies like voice and natural language processing will make important changes such as improving caregivers' workflows. Adapting the technology to the need and particularly to the characteristics of the patient will be essential for success. The model proposed here, channelled along three major axioms,[4] is recognized as a dynamic, complex, multilayered structure, with interactions and feedback inside networks, using critical thinking pathways to change attitudes, rules, technologies and assessments. Behaviour will then become the main pillar built on attitude. Consequently, rules and regulations will be derived; ICT and evaluations will use all the feedback received to implement changes for the better. Successful delivery of

[4] 1. Health is a holistic sector with a mechanism composed of relations, operations, activities and flows.
2. Health has a pricy value that determines its synergistic quality and satisfaction.
3. Dominance is developed based on the relation between any human being (patient, employer, employee, partner, collaborator, decision-maker) and the medical service establishment supported by mentoring educative prevention anchored in a new culture and style of life where attitude forms the new behaviours.

medical activities from the early identification of diseases to stabilization or full cure, capturing timely intelligence, assessing opportunities and follow-up prospects together with other medical specialists, collating feedback and ensuring that the lessons learnt are appropriately disseminated and acted on will help in the strengthening of the profit-based medical development procedures and the creation of demand-driven teams able to develop strong relationships and kind communication with everybody, including those involved in activities of governance, security and justice, profit-based medical growth practice and in/out technical specialists. The way the GPs get connected becomes the core of preventive personalized health maintenance. GPs work together with a medical registrar, a nurse/midwife, a mentor and residents to reinforce the GP cells and their value, and to eliminate the manipulative addressing only to GPs for medicines, medical leave and specialist referrals. This way, the *ProxiClinic* can finds its way to the core of a new system.

ProxiClinic grows as a combination of GPs' office and a polyclinic, a field office and a mobile one, with an activity based on the proximal community's social function, on people's awareness, responsible engagement and devotion to change life and work for the better. The advantages are linked to distances and time-saving while looking for specialists' intervention and necessary institutions (administration, churches, NGOs, schools, voluntaries, trainers ready to help). The fact that GPs permanently connect to medical stations (as seen in Fig. 3.1.) where specialists are ready for further investigations of local patients, thus dissipating the burden from the hospitals and leaving them to treat the more difficult cases, allows a better use of medical assets and shares with patients the right resources they need. It is possible to eliminate supplementary burdens on budgets and misuse of resources without scientific arguments on a standardized medical scale of evaluation.

Patients and staff work together to answer efficiently the needs, implement the best options to full satisfaction and promote holistic and personalized healthcare as the new standard of care. The access to online health platforms empowers patients who expect solutions from biology, genomics, socio-economics and lifestyle/behavioural changes for a better outcome. BIG data analysis, health education and mentorship for better prevention and compliance with the right treatments develop patients'



LEGEND

Healthy living and working bodies: decision making, laws and regulation implementation, evaluation and assessment.

Establishments: Minister of Health, Minister of Education, Minister of Research and others, medical authorities, Town Halls, Schools, Churches, NGOs, Associations, Volunteers, Families.

***ProxiClinic*:** GP, Assistant, Nurse, Registrar, Treatment cells (Kinetics, Speech-Language Pathologist Speech Therapist, Autism, Eye, Ear and Post-surgery treatments, ECG, Opticians Dispensing, Laboratory for regular analysis, Neighborly specialists.

Higher Specialized Medical Entities : Metropolitan Hospitals, Specialized Hospitals and University Clinics, Pharmaceuticals, Chemists.

Environment: Natural gardens and playgrounds

Fig. 3.1 ProxiClinic environment

awareness of their responsibilities in maintaining their health status. Within the presented model, new competitive trends are rising, and more chances are available to avoid risks and to find answers to old problems. Changing behaviours is a multistep process and determination, and engaged education, training, mentoring, tailoring new patterns and accepting the need for self-knowledge are only few ingredients for success.

The GPs' station remains the core of the model and of its functioning: evidence, diagnosis, education, training to sustain prevention, a decrease in the number of inpatients and sick people, better allocations of operational diagnosis in all phases, consolidation of border special activities and auxiliary checking. All those employing self-development take a good lesson from evidence-proved and profit-based experiences. Larger communities share the good lessons to multiply the values. Such a model can be franchised so that more successful experiences will be shared in the Medicare sector. Strategies and policies could be improved for the benefit of all partners. The new engineering design spurs the cognitive and epistemological development of partners by transcending the power and influence to a large partnering portal, where ministries, health funds, medical professional bodies and other authorities or corporates recognize each other's responsible engagement in this common project.

3.6 Conclusions

The subjective perception of the reality and the erroneous understanding of the universal goals of health undermine the implementation of a sound reform in the health sector because of inadequate decisions. When policy-makers' decisions are not realistic, the funds' allocations don't follow the needs, the specialists emigrate and the health sector governance is suffers acutely, triggering health risks. To avoid this, the transformation is a requisite in order to build the governing and managing sides of the health sector for societal benefit. Rights and obligations are on both the sides. Their analysis can't ignore patients, medical teams or health institutions. They belong to an integrated health and well-being conglomerate of vision, mission, rules, policy and burden and affect nation, individuals and budgets. Therefore, rights, responsibilities and indebtedness are to be learned, acknowledged and acted out accordingly as a robust set of pillars and rules to follow in the greatest game of life. The rules give the players the possibility of benefiting from a safe environment ensuring the population's physical condition, mental health and future well-being. Their entanglement in the decision's process linked to health matters, treatment, rehabilitation or emergency care and facilities remains crucial to yield the fundamental values and tools that serve the whole system from a societal perspective: accurate diagnostics, relevant treatment, mentoring and educative prevention, counselling for rehabilitation procedures, organ donation, conditions for free or paid services provided, and medical records arrangements. The conscious recognition of the controversial issues will help the dialogue and understanding of matters in order to advance according to norms, standards and best general practices. This perspective will frame Winslow's words into a more complete definition. Healthcare is the science, technique and art of learning and applying the prevention of disease, which involves patients to assist in prolonging their own life and promote health through aggregated, formal and informal, individual and collective efforts, to choose the best decisions to fully satisfy their true needs at appropriate times and places.

References

Butler, H. A., Pentoney, C., & Bong, M. P. (2017). Predicting real-world outcomes: Critical thinking ability is a better predictor of life decisions than intelligence. *Thinking Skills and Creativity, 25*, 38–46.

Clift, C. (2013). *The role of the World Health Organization in the international system*. Centre on Global Health Security, WG papers, Chatham House, London.

Dengleri, K., Lois, P., Thrassou, A., & Repousis, S. (2019). Industry application of assessment and forecasting theories through comparative financial analysis: The case of Greek pharmaceutical industries under crisis conditions. In A. Thrassou, D. Vrontis, Y. Weber, S. M. R. Shams, & E. Tsoukatos (Eds.), *The synergy of business theory and practice advancing the practical application of scholarly research* (Palgrave Macmillan, Palgrave studies in cross-disciplinary business research, in association with Euromed Academy of Business, Chapt. 8) (pp. 175–198). https://doi.org/10.1007/978-3-030-17523-8.

European Commission. (2010). Emanuel Barrosso (coord), Europe 2020, A European strategy for smart, sustainable and inclusive growth, Brussels, 3.3.2010, COM(2010) 2020.

European Commission. (2017). *Annual report on European SMEs* 2016/2017.

Horgan, D., van Kranen, H. J., & Morré, S. A. (2018). Optimising SME potential in modern healthcare systems: Challenges, opportunities and policy recommendations. *Public Health Genomics, 21*, 1–17.

Huangdi, N. (2011). *An annotated translation of Huang Di's inner classic—Basic questions* (P. Unschuld, H. Tessenow, & Z. Jinsheng, Ed.). Berkeley: California University Press. http://www.biblio.nhat-nam.ru/Huang_Di_Nei_Jing_Su_Wen-Unschuld-Tessenow-1-2.pdf

Jamison, D. T., Summers, L. H., Alleyne, G. A., Kenneth, J. B., Seth Binagwaho, A., Bustreo, F., Evans, D., Feachem, R. G. A., Frenk, J., Ghosh, G., Goldie, S. J., Guo, Y., Gupta, S., Horton, R., Kruk, M. E., Mahmoud, A., Mohohlo, L. K., Ncube, M., Pablos-Mendez, A., Srinath, R. K., Saxenian, H., Soucat, A., Ulltveit-Moe, K. H., & Yamey, G. (2013). Global health 2035: A world converging within a generation. *The Lancet, 382*, 1898–1955, The Lancet Commission.

Mihoreanu, L. (2018). PhD thesis on *Empowering the structural reform in the health sector: An innovative synergistic and business masterminded approach*, ASE Bucharest. http://www.doctorat.ase.ro/Media/Default/sustineri%20

teze%20doctorat/documente%20doctoranzi/anunt_sustinere_mihoreanularisa.pdf

Mukerji, D. (2019). Sustainability in project management: Advancing the synergy of practice and theory. In A. Thrassou, D. Vrontis, Y. Weber, S. M. R. Shams, & E. Tsoukatos (Eds.), *The synergy of business theory and practice advancing the practical application of scholarly research* (Palgrave Macmillan, Palgrave studies in cross-disciplinary business research, in association with Euromed Academy of Business, Chapt. 13) (pp. 285–310). Cham: Verlag—Springer International Publishing, Springer Professional "Wirtschaft+Technik", Springer Professional "Wirtschaft".

Nimmesgern, E., Benediktsson, I., & Norstedt, I. (2017). Personalized medicine in Europe. *Clinical and Translational Science, 10*, 61–63.

Nolte, E., Knai, C., & McKee, M. (2008). *Managing chronic conditions. Experience in eight countries.* European observatory on health systems and policies, Observatory studies series no 15, ISBN 978 92 890 4294 9.

Sadana, R., & Petrakova, A. (2007). Shaping public health education around the world to address health challenges in the coming decades. *WHO Bulletin, 85*(12), 901–980. http://www.who.int/bulletin/volumes/85/12/07-046110/en/

Thaler, R. H., Sunstein, C. P., & Balz, J. P. (2008). *Choice architecture.* https://www.sas.upenn.edu/~baron/475/choice.architecture.pdf

Thrassou, A, Orfanos, D., & Tsoukatos, E. (2019). Linking motivational leadership with creativity. In D. Vrontis, Y. Weber, A. Thrassou, S. M. Riad Shams, & E. Tsoukatos (Eds.), *Innovation and capacity building cross-disciplinary management theories for practical applications* (Chpt. 5, pp. 77–108). Palgrave Macmillan. https://link.springer.com/book/10.1007%2F978-3-319-90945-5

Tyson, B. J. (2017). Redefining 'health' for the 21st century. *QJM, 110*(4), 203–205. https://doi.org/10.1093/qjmed/hcw189.

World Health Statistics 2016: Monitoring health for the SDGs, https://www.who.int/gho/publications/world_health_statistics/2016/en/