A EUROPEAN NATIONAL HEALTH AND SOCIAL SERVICE MODEL: IMAGINING A RATIONAL PHILOSOPHY FOR HEALTH CARE ORGANIZATIONS

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DISCLOSURES

Funding: No specific sources of funding were used to conduct this study or prepare this manuscript.

Ethical approval: No information on individual patients was included in this manuscript.

Conflict of interest: Livio Garattini, Marco Badinella Martini, Nick Freemantle, Alessandro Nobili and Pier Mannuccio Mannucci have no conflicts of interest relevant to this article.

Data availability: not applicable to this manuscript

Human and animal rights
This article does not contain any studies with human participants or animals performed by any of the authors.

Informed consent
Not applicable.

After having figured out a rational network of health care services designed to enhance seamless and continuous care for patients in a model for a European National Health and Social Service (NHSS), here we try to imagine a rational philosophy that should characterize health care organizations in order to face the main challenges of modern medicine. In particular, three main issues highly debated in the literature will be considered: the endless perception of medicine oscillating between science or art, the potential involvement of patients in decisions regarding their health and the peculiar characteristics of job organization in healthcare workplaces.

In general, the debate on health care organizations is influenced by the broader one on the perception of medicine, which varies from the extreme of a still imperfect art of probability to that of a perfect science endowed with evidence-based certainty [1]. The former approach argues that only uncertainty is sure and that in medicine certainty is an illusion starting from diagnosis, so each disease can vary widely depending on the individual, his context of life and socio-economic determinants. Accordingly, since the personal physician-patient relationship is still crucial, physicians should always assess their patients case by case. The latter approach of perfect science is well described by the 'body-as-machine' metaphor, in which the machine is the patient's body and the doctor its mechanical engineer in case of failure. Thanks to scientific progress, physicians can always make the right diagnosis and provide the right therapy when available,

so almost any illness seems potentially curable and thus any complication arouses suspicion of clinical error. By overestimating potential benefits for patients, this approach would somehow justify defensive medicine as a logical reaction to limit physicians' liability.

Another quite recent and highly debated subject in literature that indirectly affects health care organizations concerns the attitude of patients towards physicians [2]. According to a multidisciplinary approach, patients should empower themselves and challenge the traditional paternalistic attitude of physicians, which makes the former fully dependent on the latter and ignores personal preferences, thus shifting toward true patient-centred care. This cultural change would imply a redistribution of power from clinicians towards patients, with their direct involvement in taking decisions on their health. The ensuing challenge for clinicians would be to ascertain the wishes of their patients, in order to understand which role they want to play for their health, keeping in mind that power can only be taken but cannot be given by default. The concept of patient empowerment ultimately raises an ethical dilemma between patients' rights to self-determination and clinicians' responsibilities. In fact, although clinicians are required to act in the best interest of their patients, it might happen that patients jeopardize their health by rejecting their recommendations. This dangerous behavior has been recently magnified by the modern Internet technology, which has shifted

power in our society broadly [3], with health care being particularly affected as clearly emerged during the recent COVID-19 pandemic.

Going more straightforwardly into practical issues, it is worth noting that a vast multidisciplinary literature supports the views that the workforce organization is somewhat peculiar in health care. The main reason is the greater influence that health care professionals placed at the delivery of care have over daily decision-making [4]. Although this influence is a common finding in organizational surveys, it seems particularly strong in health care organizations on account of the stronger professional discretion in performing the work. Therefore, organizational changes in clinical practice are more likely to succeed when health care professionals have the chance to share them through bottom-up incremental strategies rather than by top-down hierarchical directives. An indirect consequence of the workforce influence is that outcome measures and empirical results of trials designed to prove the effectiveness of new organizational interventions compared to usual care are all weak and uncertain, as well as all the economic trade-offs between additional costs and potential savings estimated around them.

In the light of the uncertain scenario surrounding health care organizations in modern societies, herewith we figure out some general proposals to strengthen the holistic approach which should characterize the present model of NHSS.

First, the NHSS (employer) should legally protect its health care professionals (employees) in case of lawsuits for medical negligence. In parallel, the NHSS should build up a permanent observatory to compare the healthcare consumption patterns and health outcomes of clinicians and their families with those of the general population. Assuming that clinicians are the most informed patients when they (or their close relatives) fall ill and feel the same emotions as any other patient, the periodic dissemination of this information should contribute to discourage the endless debate among experts on whether medicine is an art or a science, eventually contributing to make more realistic the general expectations of common people toward health care. Moreover, this should also limit in the long run the expensive (and sometimes risky for patients) phenomenon of defensive medicine.

Second, a workforce organisation inspired by collective collaboration and integration should contribute to decrease the plea for patient empowerment, likely more nourished by ideological than practical issues. Rather, there should be scope for modifying some still diffused practical habits in order to really enhance patient-centred care in health care organisations. For instance, an apparently trivial change (whilst actually epochal in many European countries) would be to adapt the time schedules of meals in hospitals to common lifestyles of people rather than to health care staff conveniences. At the same

time, physicians should not spend nights periodically in their workplaces, but rather be called at home in case of real need.

Finally, it is quite evident that a hierarchical approach 'army-styled' is not recommended for health care services (hospitals included), which conversely need collaboration and integration among health professionals starting from clinicians [5]. In addition to supporting junior colleagues in their professional growth, senior medical staff should be on an equal status and subdivide among them the patients in their health care facilities, each one taking decisions on the diagnostic and therapeutic patterns of the patients of whom they are clinically responsible. In turn, nurses should manage all the health care practices needed by patients, recurring when necessary to the help of supporting professions (e.g. dieticians, physiotherapists, psychologists). Thanks to their intermediate clinical role, nurses should be the best positioned to boost teamwork in multi-professional teams. In general, sharing inter-professional knowledge and multi-professional team building should be the main organisational strategies to be pursued in order to improve the quality of health care services provided in the NHSS workplaces. All the professions should be fully involved in this modern approach to integrated care. Consistently, job rotation of health care professionals among community and local hospital services should be implemented as much as possible in order to favour horizontal integration (emergency services included). This organizational approach should also contribute

to limit the negative aspects of professional burnout and discomfort, which are currently dramatically increasing, especially among hospital clinicians. Safeguarding the mental health of health care professionals should be a must for a truly modern and advanced health service. Therefore, the NHSS should offer assistance on demand as well as training on skills aimed at coping with professional distress.

To conclude, the ideal philosophy which should permeate the NHSS model would be based upon a full collaboration among all health care professionals, a positive approach which should permanently become a corporate strength of the NHSS. Once acknowledged that medicine is firstly a mission aimed at serving patients, working together in integrated workplaces not excessively affected by the behaviour of single individuals should be a far more productive and fulfilling strategy for health care professionals than working alone in isolated silos.

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