A EUROPEAN NATIONAL HEALTH AND SOCIAL SERVICE MODEL: A FEW RULES OF THE GAME

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Striving to figure out a conceptual model for a European health system, we have recently concluded that a National Health and Social Service (NHSS) should be recommended as a blueprint for each European country after having analysed the main pros and cons. However, the experience of the existing NHSs in Europe has undeniably raised the issues of political influence and administrative bureaucracy as often inter-related major concerns. Here, we consider the potential remedies to mitigate these threats, specifically highlighting the negative experiences of the British (B)NHS (the most widely recognized public health care system in the world) and the Italian (I)NHS (born in 1978 in the wake of the BNHS) with the goal to provide a few relevant examples in real practice.

Democracy necessarily entails the impact of political governments on health as in any other domain, through policies and laws that can be influenced by dominant ideologies. So, alternate governments of opposite parties can inject inconsistent changes into health systems, which may often be superficial, but occasionally radical and thus deeply altering their functioning. A classical example of radical reform inducing dramatic changes was the inclusion at the end of the last millennium in the BNHS of the so called 'internal market' to foster competition among healthcare providers [1].

When local governments enjoy institutional autonomy, political influence can also undermine the organizational consistency of a health system at the local level. This happened to a limited extent in the BNHS because of the four nations (e.g. Scotland and Wales) and to a larger extent in the INHS owing to the twenty regions (e.g. Lombardy, Tuscany, Sicily) [1]. Financial autonomy has allowed regionally elected politicians to develop substantially different healthcare strategies in the INHS, with no need of national endorsement. When the cost item of health represents by far the major share of local budgets (as for the INHS), health necessarily becomes a major topic for local elections. Local autonomy also facilitates the purposeful appointment of health managers who are often politically affiliated with the current political leaderships [1]. Ultimately, this devolution can gradually transform a public NHS within the same country into several uneven local ones, undermining central governance in the long run.

Bureaucracy had a laudable goal in its original purpose, aiming at delimiting administrative responsibilities and tasks in the frame of large-scale organizations [2]. In principle, by ruling out any influence of personal relationships by standardizing functioning rules, administrative bureaucracy is expected to be a most rational system for managing organizations efficiently. However, bureaucracy has become a negative term, especially in the field of public administration.

Nowadays bureaucracy is increasingly associated with unnecessary administrative activities lacking evidence of benefit and mainly fostering the bureaucratization of health systems. Being designed to be inherently impersonal and rewarding only adherence to the rules, bureaucracies may demoralize and penalize health professionals who, working hard for patients, may be unable to fully respect these rules [2]. By gaming metrics and filling in survey forms explicitly designed to formulate rules and routines for managerial control, bureaucracies multiply themselves requiring more and more administrative staff.

Paradoxically, bureaucracy is prone to financial conflicts of interest, which are ubiquitous in medicine, especially for professionals who often deal with private commercial companies [3]. Indeed, bureaucracy barely requires the disclosure of financial conflicts of interest as a barrier to prevent them. A well-known example is the sponsorship of events approved for continuous medical education by pharmaceutical companies and medical devices manufacturers. Since the primary goal of industrial managers is to promote their products and/or services, they may hardly be expected to pay for activities which go against their financial interests.

In the light of the major weaknesses described above, herewith we figure out a tentative list of synergic rules of the game aimed at constraining the negative effects of political influence and administrative bureaucracy on our model of virtual NHSS.

First, political governments should not be allowed to modify the baseline institutional framework of the NHSS, neither for funding nor for provision of public health care services. Since the only welcome innovations in health should be scientific and technological, laws and bills concerning health policy and economics should be submitted to a sort of 'safeguard clause', e.g. to be approved by a majority of two-thirds at least. Further, employers and citizens subscribing additional health insurance schemes should not benefit from any tax discount, in order to avoid financial distortions undermining the NHSS funding. At the same time, co-payments by patients should be excluded out within the NHSS to make services fully free of charge at the point of delivery.

Second, the NHSS total budget should be anchored to the gross domestic product in order to ensure its consistency over time. Then, the national budget should be allocated at the local level through clear-cut formulas based on local populations weighed per class of age as major criterion, and its planning and control should be managed only centrally, with no interference on local budgets by politics. The local borders of the NHSS should be rationally designed and not necessarily coincide with those of political jurisdictions. Consistently, the essential levels of health

and social care guaranteed by the NHSS should be clearly set centrally and made available all over the country, providing services in due time and close to where people live, thus discouraging the cross-boundary flow of patients within each country.

Third, post-graduate education should be mandatory for top managers appointed by the NHSS, in order to strengthen their management skills in the health care field. This education could be provided by a national school of health and should make all candidates fully aware that patients are the primary interest of health professionals, eventually helping them to recoup time with patients without recurring to financial incentives. Managers should consistently foster collaborative rather than competitive professional relationships, and encourage job rotation of the health professionals among the provided services in order to enhance integrated care.

Fourth, the domestic number of scientific societies and associations of health professionals should be drastically reduced by allowing NHSS employees to become members only of their national professional associations. More, company sponsorships of educational events aimed at fulfilling the continuous education required to health professionals should be banned, being necessarily biased by commerce and marketing. Rather than external e-learning courses and events, internal meetings inside health care facilities (e.g. clinical clubs), personal activities (like reading and writing) and exchange schemes between professionals of different levels of care (e.g. hospital consultants and GPs) should be encouraged.

Fifth, the salaries of the main types of health professionals should be generous enough for living with dignity in the society. In fact, after having banned dual practice in the NHSS [3], salaries should be the only source of income of its employees. Domestic wages should be anchored to a common parameter (e.g. the national average income per employee) throughout the whole Europe, in order to discourage the movement of health professionals across national borders merely for financial advantages. More, the NHSS should formally indemnify health professionals for legal expenses in case of lawsuits for medical negligence [4].

Finally, the NHSS procurement of goods should be distinguished between health goods (e.g. drugs and medical devices) and common goods (e.g. food and drink for canteens). Since the former cannot be traced back to the rules of free markets and are all marketed by private industry in European countries, the related purchasing strategies should switch from irrational pricing to rational budgeting [5]. Once decided which health goods are eligible for reimbursement only according to their efficacy and their established need for population health, national authorities could reimburse pharmaceutical companies and medical devices manufacturers for the volumes

prescribed during the year through standardized unit costs per therapeutic class. This should help to manage this type of expenses, which has become almost untenable in the last few decades in many European countries owing to increasing prices, especially for pharmaceuticals.

To sum up, we are confident that a safeguard clause to restrict the meddling by national politicians on the matters of health economy and policy, the thorough exclusion of local politicians from the management of health care, and the introduction of a national school for mandatorily educating the NHSS potential managers on health care should be three important deterrents able to constrain the influence of politics at all tiers in our virtual NHSS. In addition, a drastic reduction of professional lobbies inside the NHSS, the reference to national economic parameters for setting fair salaries to health professionals exclusively contracted as civil servants, and the adoption of reasonable strategies for purchasing health goods within a context of market failure should help to constrain administrative bureaucracy and control expenses in the NHSS, as well as financial conflicts of interest and thus potential corruption.

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