**CONCEPTUALIZING A MODEL FOR EUROPEAN HEALTH SYSTEMS:**
**THE INSTITUTIONAL FRAMEWORK**

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**Background**

Recently forced into the spotlight throughout the world because of the Covid-19 pandemic, health care is a milestone for all developed nations. Tightly related in all settings to health professions, the management of a health system is also a matter of economics and administration because of the costs induced by goods and services provided. Consequently, health care has always been a highly debated subject in politics too, open to misleading ideologies and demagogies in every nation.

This is the first of a mini-series of commentaries, in which we try to put order in the endless debate on health care from the policy point of view. The final goal of our effort is to launch the proposal for a single model of health system in the European countries, supported by a few but solid theoretical principles. Here, we try to figure out the institutional framework of the virtual model, while in the next commentaries we will try to list the rules of the game to manage it, and finally to depict an ideal network of community and hospital services.

**The contestable concepts of demand and supply**

Economic theory teaches us that the positive effects induced by competition in free markets cannot be expected in health care, by definition [1]. According to economics, health care is a classic example of market failure from both the key-concepts of demand and supply.

From the demand side, patients cannot be considered the common consumers described in economics, who shop around to buy the most convenient goods at the lowest cost [2]. Not being fully informed in health care, by definition, patients fill their information gap by devolving to physicians the decision on what goods and/or services to use. Furthermore, patients can neither be considered rational consumers, since the (real or perceived) illness makes them weak and vulnerable, thus potentially prone to financial blackmailing by healthcare providers. That is why health is classified in economics as a 'merit good' rather than a 'consumer good'.

From the supply side, real competition requires a reasonable number of competitors offering the same products or services and operating in similar conditions [3]. Besides the widespread evidence that these necessary conditions are nowadays scant in a lot of markets − justifying the recent boom of anti-trust agencies in highly developed countries − the unlikely presence of these conditions in health care could even reflect an abnormal situation at local level (e.g., some similar hospitals located in the same low-populated area).

In the light of these insurmountable hurdles against market competition from both the demand and supply sides, the logical consequence is that prices cannot come from naturally matching them in health care. Even though prices are fixed ex ante – as it happens in many European countries for hospital admissions through tariffs based on diagnosis, derived from the Diagnosis Related Groups (DRGs) originated in the US health care system [4] – setting prices artificially is necessarily an arbitrary exercise, which eventually leads to financial distortions and irrational allocation of resources among healthcare players in the long run [5]. Last but not least, by requiring a periodic update of the tariffs values and a systematic audit on how healthcare providers use them, fee-for-service systems dramatically increase administrative costs as a negative effect.

**The suitable concepts of funding and provision**

The most suitable key-concepts to reference for managing a health system are funding and provision. While the rational solution for the first variable is quite easy to find out, the second one requires a deeper understanding.

The most logical criterion to apply for funding a health system at macro level is universal coverage through general taxation. In principle, the State is the best insurer to cover the illness risks of its citizens, being able to spread the

total risks on the whole population regardless of the kind of tax systems adopted. So, Beveridge-type public health services should be privileged for funding [1].

The concept of provision is obviously related to the costs induced for delivering healthcare services, with providers that are generally a mix of public and private bodies in the vast majority of European countries. At the micro level, the discipline to refer for managing health care organizations is business administration, in particular planning and budgeting. The key-concepts of business administration can be applied to any kind of employer, including public administration, with the aim of enhancing efficiency in organizing labour such as in a private company. While it is pretty obvious to opt for a public health system for funding health care, the choice between public and private actors for providing health care is less straightforward. In principle, a private company must make profit (especially the for-profit ones) or cover costs at worst. Therefore, it is not surprising if, for example, private hospitals usually focus on the most profitable ('cream skimming') and/or least costly ('cherry-picking') treatments [6]. On the other hand, it is fair to recognize that public organizations are usually prone to strong political pressure in taking their decisions and slowed down in their administrative procedures by the stiff bureaucracy that generally permeates the public sector [7].

**An opportunity for integrated care**

Integrated care (IC) is a concept of common sense that emerged in the literature at the beginning of the new millennium and has undoubtedly laudable aims for patients [8]. Striving for combining parts to form a whole, IC implies a systemic collaboration among all professionals and organisations involved in modern health and social services, in order to struggle against the widespread fragmentation of services provided. The increasing plea for IC reflects the ever growing need induced by chronic diseases of aging and multi-morbid patients living in community with both physical and mental problems, the major challenge of the European health systems at present.

IC is the modern approach that better supports the choice in favour of the public sector for health care provision too. IC is certainly favoured by a (necessarily public) single employer, being the presence of several (public and/or private) actors antithetic to IC by definition [9]. In fact, the existence of multiple providers discourages integration, since any player is naturally orientated to follow its own financial interests in the long run. Also, consistently to the IC approach, the provision of health and social services should be merged nowadays in order to enhance both horizontal and vertical integration [10], eventually surmounting all the organizational boundaries to pursue seamless and continuous care. It is worth noting that IC is particularly important for long-term chronic illnesses associated with high levels of disability, where the mix of health and social services needed in primary and secondary care can be very complex. Indeed, the growing number of community-dwelling patients with multiple physical and mental health needs is the major challenge for the European health systems at present.

**The threat of dual practice**

The combination of both public and private practices legally allowed for health professionals − called dual practice (DP) in literature [11] − is historically widespread in the Western European countries [12]. DP is a major threat for health care employers, inevitably raising financial conflicts of interest for their employees and potentially undermining integration within and among healthcare organizations. In general, any form of DP legally allowed in a health system can only mix up business and medical ethics, eventually undermining the patients' fiduciary relationship with health professionals [13]. In particular, an almost paradoxical form of DP is when public employers directly encourage private activity in their healthcare facilities – e.g., the so called *intra moenia* activity in Italian hospitals [14]. Such an extreme form has been associated to the ethical concept of institutional corruption [15],

potentially thwarting the ability of public organizations to achieve their primary goals. The ban of any form of DP is strongly supported by business administration [16]. It would be very odd for an employer to allow its employees to work contemporarily for other competitors, and even stranger to allow them to make private business with its clients in their free time, as often happens for physicians with DP.

Accordingly, an exclusive contract of employment for civil servants should be the *sine qua non* for providing public services. At the same time, even though medicine is first a mission aimed at serving patients, this should not imply limitless sacrifice for health professionals, who would deserve a quite generous wage in a civilised society. Last but not least, once DP is forbidden, also the widespread claim among health professionals to make their public employers accountable for legal expenses in case of lawsuits for medical negligence – an ever growing phenomenon in the European health systems [17] − would be much more justifiable.

**Proposal**

In the light of this theoretical exercise focused on the attempt to figure out a European health system, we can conclude that a public National Health and Social Service (NHSS) should be the most indicated model for both funding and providing health and social services in modern European societies [18], which increasingly need to bring the two types of services closer together for fulfilling the health needs of ageing populations. All health and social professionals should be employees of the NHSSs, so as to help manage their activity more effectively and plan at best the organization of services delivered in a perspective of IC. As to the private sector, of course it can exist in healthcare, like in any other domain, probably exploiting the requests of wealthier citizens. We just argue that private and public actors can co-exist in health care, but separately and without any overlapping. Eventually, where and when it is (temporarily) necessary, the NHSS might recourse to private providers for local catchment areas where public services are not able to cover the essential needs of resident people in due time. However, these unfulfilled needs should be estimated in advance and financed through specific budgets, and not fee-for-service tariffs, to avoid undermining coordination and synergies among the NHSS healthcare services.

In conclusion, we fully share the idea that an organisational culture rooted in teamwork and collaboration among colleagues, instead of a competitive one driven by financial interests, should fit much better to manage health and social services. Striving to enhance patients' health as the primary interest of health and social services, the organization of the NHSS should be inspired by a culture of systemic collaboration and coordination among health and social professionals. The big challenge of the ideal model of public health system here envisaged would be to limit the negative influences of politics and bureaucracy. Potential remedies aimed at constraining these two major motivation-killing threats of public sectors will be analysed in the next commentary.

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