



Research Article

Public Health Managers and Professionals: Evaluation and Appointment Graduation Criteria in an Advanced Country

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Abstract

Because Italian Public Healthcare system is one of the most advanced system in the world it is interesting to observe how are evaluated the healthcare managers inside Involved in this filed. To observe this method can be a useful instrument to be followed also for not so advanced countries. In evolution of the Italian healthcare system, a great step was the introduction by law of managerial methods as current way or organization and work. What is relevant to notice is that the MOTIVATION is a factor that contribute in success in a multiplicator way. The system is projected to guarantee uniformity and objectivity (in theory). The result of this research work is that the normative rules introduced in italy since 1992 was able to Control the similar-logarithmic expansion trend of healthcare public costs. The global results of an economic institution, even if in healthcare settings, depends also to the Abilities and knowledge of its managers (Top, medium, and of less higher level). In public Italian healthcare organization like hospital, managers are divided in Professional managers and Pure managerial career. Relevant role is played by the mechanism of recruitment of this managers as well as the progression to the upper position.

Keywords: Job description; Clinical competencies maps; Managers; Health system; Graduation; Responsibility; Privileges; Results; Budget; Economic results; Management

Introduction

We start this work with the consideration that the Italian Health Care System is one of the most advanced in the world as results for patient healthcare need (Figure 1).

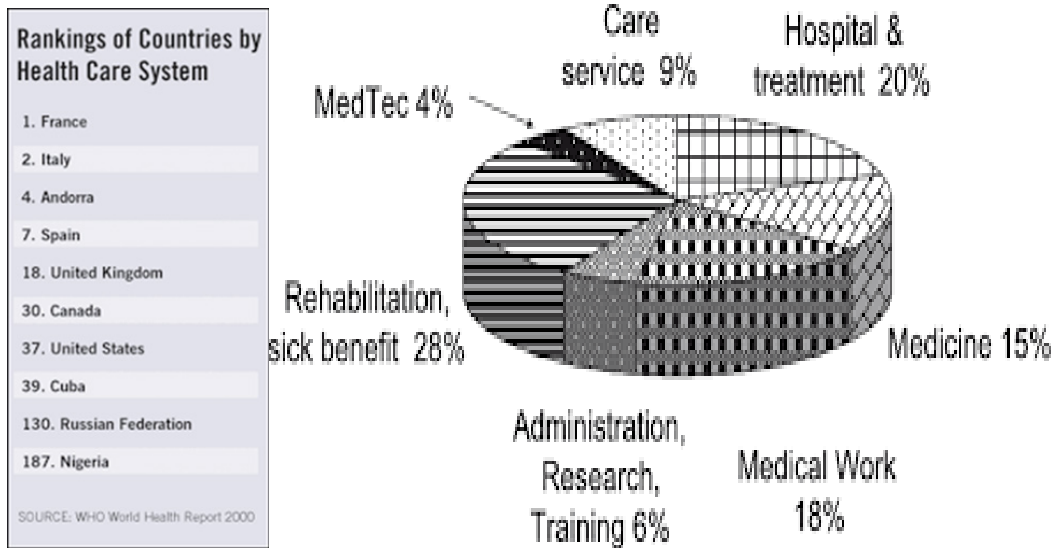


Figure n1: Health Care System.

Other fact to be taken in consideration is the trend of health care costs since from 1970:

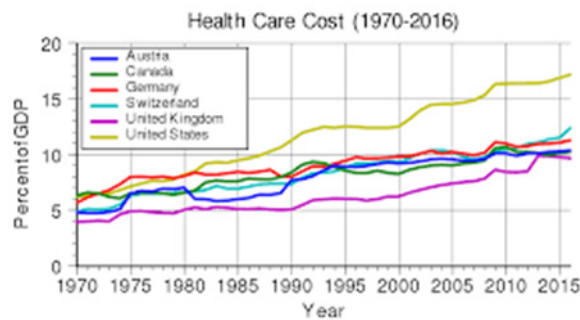


Figure n2: Health care costs since from 1970.

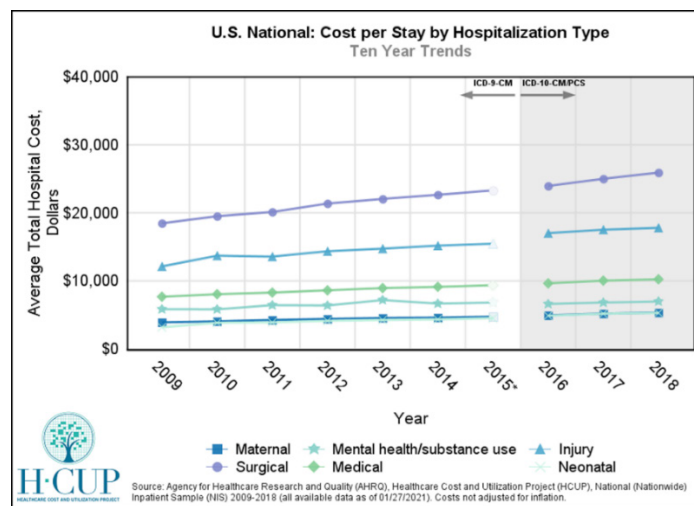


Figure n3: Cost per stay by hospitalization type.

But this trend is also observed in USA so it is not due by a national policy (public system or private or insurance) but instead due by more elderly people and by the offer of innovative drugs and diagnostic systems of the last year. In the management of the system, it is interesting to observe the Italian health care system history: various normative rules introduced great REFORM especially since 1978. In fact In law 833/78 was introduced in Italy SSN (servizio sanitario nazionale) national health system to avoid problem produced by previous system named INSURANCE and CASSE MUTUE of workers and related economic sustainability. This was a great law for Italian people to have an unique system instead various different case MUTUE org. or ENTI MUTUALISTICI (insurance based , professional based). This organization started in 1800 in Italy. In law 502/92 second reform [1], was introduces as new concept the AZIENDALIZZAZIONE concept (also commonly called corporatization), with a more market vision. Decreto Leg.vo 502/92 introduced in public health system: concepts of EFFICIENCY, EFFICACY, ECONOMICITY AND QUALITY in order to provide adequate level in of healthcare service (quality and quantity and technical -economic efficiency). Departmental organization of hospital: aggregation of various COMPLEX unit with similar finality. In this law was introduced the mandatory of economic- financial instrument like official balance sheet and management control system. In the DL 229/99 named riforma ter this process was completed introducing concept like Appropriateness, economicity, EBM, minimum level of assistance LEA and other [2].

All this new rules changed in great way the complex healthcare system, the global cost, the clinical outcomes obtained and the general satisfaction internationally recognized. The Italian Healthcare systems in considered in the first places in the advanced world: 4th place in the 2020 (From Bloomberg). Also in D. Lgs. 27 ottobre 2009, n. 150 PUBLICH SYSTEM reform was introduced the concept of evaluation of the public manager of every level. So all this rules and other produced a great modify in the management of public economic resource for public national health care system. This system we have see was subject in last decades in a deeply process named: corporatization. In this revolution great part was due by a new managerial system of the government of the system.

Various movement was introduced: like clinical governance, EBM, risk management, HTA, HEALTHCARE ECONOMY, budget analysis, clinical competence, Total quality management, accreditation procedure Clinical audit, clinical pharmacy and many other have produced great result even in clinical outcomes but also to reduce side effect and dangers for patients but also reduce global cost (or their containment). Many economic procedures were deeply used: budget impact analysis, expenditure limits, national regulatory agency limitation, cost efficacy, cost effectiveness, cost opportunity and other. Other relevant tools currently in use in Italy healthcare organization central and local: Budgetnegotiation

from general manager of the institution and department directors Management control system, programming (introduced in health systems) by DLGS 502/92 Official balance sheet (previous year) [1], according CIVIL LAW code In recent years in Italy national collective contracts introduced the UNIQUE ROLE in health manager (in past there was 2 different level). Also in Italy various REFORM LAW introduced the management health system named “AZIENDALIZZAZIONE DELLA SANITA” (LEGGE 502/ 92 and DL 229/99) [2].

In example in specific field like the pharmaceutical department many tools was introduced

- Antimicrobial stewardship
- Clinical pharmacy
- Biosimilar drug
- Generic drug
- Central buying procedure
- Central drug agency limitation policy
- Formulary (national , regional , local)
- Personalized prescription (limitative)
- Targeted oncology therapy and companion diagnostics
- Good use of expensive drugs or blood derivatives
- Monitoring
- Evaluation of costs for drugs and medical devices or IVD
- Regulatory rules
- Risk management prescription
- ICT instruments , data analysis
- Central regional buying system
- Public buying procedure (GARE), electronic market et other And so on All this need deeply managerial-clinical knowledge and abilities.

Observing the organization of local insittution like hospital, it is possible to see various positions: apical manager’s general manager director, health officer manager director, administrative director, human resource manager director, departmental director manager

Complex unit, simple unit, departmental simple unit, pure professionals managers: different professionalism like: physicians, pharmacist, biologist, chymists and other. Administrative, ict, of economic office and many other but what is clear is that in Italy there are 2 kind of manager role:

a) Management pure role b) Pure professional management role

Management pure roles: complex unit, simple unit, departmental simple unit for covering this are requested more pure management competencies (budget assigned and other healthcare professional managed).

Professional management role: more pure professional competencies are required.

Various level: high professional appointment divided in: elevated professionalism, high professionalism, or consulting study, research, verify control (art 27 comma 1 lettera c ccnl 1998-2001) [3]:

c) incarichi di natura professionale anche di alta specializzazione, di consulenza, di studio, e ricerca, ispettivi, di verifica e di controllo and according some interna rule of hospitals regolamenti: incarichi dirigenziali di natura professionale elevata. (this are different from basis level) di alta professionalita' or of elevated copetencies technical .specialistic that produce high relevant performances for the hospital this appointent can be assigned after 5 year of role in position of basis managers.

Basis: < 5 year of working experience according ccnl 18 ottobre 2008 [4] national contract health professional managers was written that the role played by simply structure and professional role have the same relevance and dignity. And that there is the need to allineate their retribution value. Related the role of directorship of complex unit (uoc) is needed by law for the manager to follow a certification managerial course (about 6 month) with a project work in a public university to certify the managerial competences to cover the position. In this course, various topics are studied: management, economy, hr management, communication, conflict management, leadership, public organization, budget, public healthcare italy system and many other. The selective procedure between various candidates with more than 7 year of work as manager produce a list of 3 idoneous to cover the role: In this list general manager, choose the one in a discretional process after seeing the result of the selection and point assigned by the commission. General Manager can choose also not the first in list classified by curriculum and oral examination but if do this it must motivate in written way. The role is covered for 5 years for the other position like simple unit or professional role there are official procedure of selection where are valued the curriculum of the manager and their attitude to cover the specific role [5,6].

Graduation of the roles: level a complex unit director, level b simply unit responsible, level c high professional role (high specialization and study, research, verify control role), level d basis level role (less then 5 year in role)

Other role: manager not in role, free professionals, for limited time, under specialiazion schools program. in order to evaluate the

result annually of this manager it is used a weigthing procedure (what produce an effect or contribute to this and parameters to be evaluated. (criteria for evaluation)

Factors: what produce an effect parameters evaluation parameter economic factors, structural dimensional factors, technological factors, professional factors, strategic factor (by the organization), autonomy flexibility research and teaching-training activity (graduand and for specialization programs) related the payement of this manager there are 2 voices position-according national contract rules- fixed amount and variable part- according a local and decentrated agreement-related the amont of availability of money of the hospital. All this 2 voices are related the graduation of responsibility of the managers also there is an allowance for complex unit position.

Management's area: Organization, quality management, hr management, budget management

Other parameter evaluated: Autonomy-resonsability-flexibility-behavior towards innovations, use of ict, continuous formative programs activity, proactivity, teaching activity, communication skills other soft skills

Methodologies: in example using a multidimensional analisis methods or similar

Variables: individual, social, institutional, technological, organizative minimum and maximum value internal evaluation: every year and after periods of ending of an official appointment (3-5-7 year with a written report). It is interesting to say also that there is not only an evaluation of the single manager but also to the structure in witch, this works (equips evaluation). For apical manager there are also an external control of the results and by the politics governor of the region. Also for the health care mangement there is a complex system of evaluation: after 5 and 15 year under a public official committee .and every time there is an increase in official appointment is evaluated the previous one result.after every year monetary prizes goes to pay for single and equipe managers results.

Knowledge: skills and attitudes, social origin, updating courses, training, experience

Abilities: know to act, problem solving, operative abilities, relational ability

Attitudes: ability to see future opportunity, sense of responsibility

Soft Skills

Object of evaluation: what was obtained versus the objectives so it is possible to say that the manager career follow a step process after evaluation of previous results or after selective procedure for the more relevant position (like directorship of complex units)? The system is completed by apical position: general hospital manager,

health general director administrative and h resource director.

Other relevant office: ict department, innovation office, economic management office, prevention and protections service, technical office and other various ones. The hospital are organized by law in department, complex unit simply unit (inside or outside a complex unit). Every complex unit have inside various managers also whit high professionalism.

Worsening factors: every public administration in the world show various grade of corruption an family influence in selective procedure for directorship or professional role in every grade of the organization: this produces lower level of managers an lower level of results of this it must to be take in consideration.

Material and Methods

Whit an observational point of view are selected some relevant italian law related national healthcare system (creation and reform) and other that have influenced the system. After this process (historical way) are analyzed the effect in the global cost of the system in the decades from 1990 to 2020 about. This make possible to verify the change of the curve of total costs avoiding risk of non-sustainability after this reform law [7].

Results

From literature: Review Health Econ. 1993 Apr Equity and efficiency in Italian health care P Paci, A Wagstaff “Health-care finance and provision in Italy is unusual by the international standards: public financing relies heavily on both general taxation and social insurance, and although the vast majority of expenditure is publicly financed, the majority of care is provided by the private sector. The system suffers, however, from a chronic failure to control the expenditures and its record on perinatal and infant mortality is poor. Hospitals in Italy have a low bed-occupancy rate by international standards and the per diem system of reimbursing private hospitals encourages unduly long stays. Costs per inpatient day are high by international standards, but costs per admission are close to the OECD average. The Ambulatory-care costs are extremely low, but this appears to be because GPs see so many patients that their role is inevitably mainly administrative. Consumption of medicines is extremely high, but because the cost per item is low, expenditure per capita is not unduly high. Despite the emphasis on the social -insurance, the financing system appears to be progressive. There is evidence of in-equalities in health in Italy, and some evidence that health care is not provided equally to those in the same degree of need” [8].

Review Health Syst Transit. 2014 Italy: health system review Francesca Ferre, Antonio Giulio de Belvis, Luca Valerio, Silvia Longhi, Agnese Lazzari, Giovanni Fattore, Walter Ricciardi, Anna Maresso “Italy is the sixth largest country in Europe and has the second highest average life expectancy, reaching 79.4 years for

men and 84.5 years for women in 2011. There are marked regional differences for both men and women in most of the health-indicators, reflecting the economic and social- imbalance between the north and south of the country. The main diseases affecting the population are circulatory diseases, malignant tumours and the respiratory -diseases. Italy’s health care system is a regionally based national health service that provides universal coverage largely free of charge at the point of delivery. The main source of financing is national and regional taxes, supplemented by co-payments for pharmaceuticals and outpatient care. In 2012, total health expenditure accounted for 9.2 percent of GDP (slightly below the EU average of 9.6 %). Public sources made up 78.2 percent of total health care spending. While the central- government provides a stewardship role, setting the fundamental principles and goals of the health system and determining the core benefit-package of the health- services available to all citizens, the regions are responsible for organizing and delivering primary, secondary and tertiary health- care services as well as preventive and health promotion services. Faced with the current economic constraints of having to contain or even reduce health expenditure, the largest challenge facing the health system is to achieve budgetary- goals without reducing the provision of health services to patients. This is related to the other key challenge of ensuring equity across the regions, where gaps in service provision and health system performance persist. Other issues include ensuring the quality of professionals managing facilities, promoting group practice and other integrated care organizational models in the primary -care, and ensuring that the concentration of organizational control by regions of health-care providers does not stifle innovation” [9].

Health Econ. 2021 May; Epub Containing costs in the Italian local healthcare market Andrea Riganti “We aim to investigate the cost -containment effects of the creation in 2005 of agencies specifically responsible for all technical and administrative services within the regional healthcare- system HS of the Tuscany region in Italy. We seek to contribute to the existing literature on the centralization and decentralization of purchases and technical services by assessing the amount of savings produced by these agencies at the intermediate level between local authorities and hospitals and the regional- administration. We use the balances of all Italian local- health authorities and hospital trusts combined with the synthetic control procedure to create from a donor pool of untreated units a weighted average of observations resembling the exposed units before and after the policy change in the 2005. The magnitude of the effect is significant as the creation of these agencies is estimated to have reduced expenditures on auxiliary-goods and contracted services by 6% in the period from 2006-2014. Moreover, we find that the cost reduction is not associated with a decrease in the provision of health-care services and procedures to the general population or in the quality or efficiency of the regional healthcare- system itself” [10].

Review Lancet. Epub 2021 Oct 22. The evolution of the Italian National Health Service Walter Ricciardi, Rosanna Tarricone “40 years ago, Italy saw the birth of a national, universal health-care system (Servizio Sanitario Nazionale SSN), which provides a full range of health-care services with a free choice of providers. The SSN is consistently rated within the Organisation for Economic Co-operation and Development among the highest countries for life expectancy and among the lowest in health-care spending as a proportion of gross domestic-product. Italy appears to be in an envious position. However, a rapidly ageing population process, increasing prevalence of the chronic diseases, rising demand, and the COVID-19 pandemic have exposed weaknesses in the system. These weaknesses are linked to the often-tumultuous history of the nation and the health-care system, in which innovation and initiative often lead to spiralling costs and difficulties, followed by austere cost-containment measures. We describe how the tenuous balance of centralised versus regional-control has shifted over time to create not one, but 20 different health systems, exacerbating differences in access to care across the regions. We explore how Italy can rise to the challenges ahead, providing recommendations for systemic-change, with emphasis on data-driven planning, prevention, and research; integrated care and technology; and investments in personnel. The evolution of the SSN is characterised by an ongoing-struggle to balance centralisation and decentralisation in a health-care system, a dilemma faced by many nations. If in times of emergency, planning, coordination, and control by the central government can guarantee uniformity of provider behaviour and access to care, during non-emergency times, we believe that a balance can be found provided that autonomy is paired with accountability in achieving certain objectives, and that the central-government develops the skills and, therefore, the legitimacy, to formulate health policies of a national nature. These processes would provide local governments with the strategic means to develop local plans and programmes, and the knowledge and tools to coordinate local initiatives for eventual transfer to the larger system” [11].

New Horiz. 1994 Aug. Cost containment: Europe. Italy G Apolone I, R Melotti, F Repetto, G Iapichino “Through prepaid compulsory insurance managed by the central government, Italy’s National Health Service provides full coverage, free accessibility, and no or limited copayment by individuals when receiving health services. Although Italy spends less than other countries on health care (< 8% of the country’s gross national product), the present NHS faces considerable difficulties, and its performance regarding quality, outcome, and spending has come under question. ICUs account for < 2% of total hospital beds, and the proportion of ICU patients is < 2.5% of all hospital patients (2.5% of all Italian hospital patients receive ICU care at some time during their hospital stay). Information from administrative-databases and epidemiologic-studies gives an interesting national picture of the situation in Italy regarding admission criteria case mix, and outcomes when

compared with data from other countries. Important changes in the financial and institutional framework of the NHS are underway, yielding an un-predictable scenario for the future. Innovations focus mostly on cost containment and quality initiatives. These innovations will likely produce a new health service in which regions will have a more important role than in the past. Actions planned in a large Italian region by the local government are used as an example to explain the potential impact of this new trend on critical-care medicine”[12].

The Prevention of Corruption as an Unavoidable Way to Ensure Healthcare System Sustainability by Pietro Previtali and Paola Cerchiello Department of Economics and Management Sciences, University of Pavia, Via San Felice 7, 27100 Pavia, Italy Sustainability 2018 “Corruption has found very fertile ground in the health sector. Many studies demonstrate the negative-relationship between sustainability and corruption. Relatively little is known at this time about how to prevent corruption in healthcare organizations (HCOs), and thus to recover the important sustainability of the entire healthcare-system. After noticing this gap in the literature, the authors’ aim in undertaking this study was twofold: 1) to analyze the current state of knowledge about how Italian HCOs adopt corruption prevention plans in compliance with the National Plan issued by the National Anti-Corruption Authority; 2) to identify some clusters of HCOs which represent different adoption patterns of corruption prevention-interventions and to classify these HCOs. For these purposes, the authors studied 68 HCOs along 13 dimensions that characterized the corruption prevention plans. The empirical results showed that the HCOs were not fully compliant with the anti-corruption legislation. At the same time, the authors identified three clusters of HCOs with different patterns of anti-corruption prevention interventions. The clusters that adopted some specific interventions seemed to be more sustainable than the others”[13].

Discussion

The global results of public health systems depends on central politics and local application. Law, rules, procedure, protocols, international guideline application, risk management principle and good Managerial behaviors. It is clear that the results in local place of health care system are related to the adding of Clinical competencies and to the managerial abilities of the managers applied. The trend of costs in Italy related hospital health show that the normative rules applied was able to contain the explosion of costs providing high level of performance and international organization in fact classify italian system as in the firsts places also in ranking. The performance measure system applied according Italian rules and law provided great part of the Results because it is undeniable that this results was obtained by the health managers that worked In this institution in the period of observation.

According EUROPEAN and national rules and laws to become a manager in ROLE in public health care systems: If needed to have a degree (medicine, pharmacy, biology, chemists and other biomedical scientific field.) > Then 4-5-6 year A SPECIALIZATION about more than 4 -5 year in university course. STATE professional examination- ABILITAZIONE PROFESSIONALE (an examination after degree to verify minimum level of professionalism to play their healthcare role). And to be selected in a PUBLIC SELECTION (various examination written ,oral, practical, informatics, English languages) Really severe examination even if some bad practice are object of jurisdictional Judge. This examination is under a COMMISSION of 4-5- member: President, commissary, secretary in a public procedure. In this selection are evaluated title, publication, year of practical experience and other of CV. To be assigned for COMPLEX UNIT MANAGEMENT is required by law an MANAGERIAL DIRECTORSHIP COURSE FOR COMPLEX UNIT certificate (about 6 month of course). Before 1992 italian healthcare system was in an increasing curve for global cost, and without any new measure, In few decades the economic resource go out the sustainability limit. Two normative rules named law 502/92 and DL. 299/99 introduced the concept named AZIENDALIZZAZIONE” with an intensive managerial approach that produced great results in the next decades making possible the sustainability of the systems. These normative rules (central and regional) and the managerial role of many healthcare professional contributed in great part to this result. Central AGENCY politics of drugs and medical devices management, regional buying AREA VASTA systems

New diagnostic procedure or surgery contributed with many other factors. ICT was a strategic tools as like as the GLOBAL HUMAN RESOURCE management.

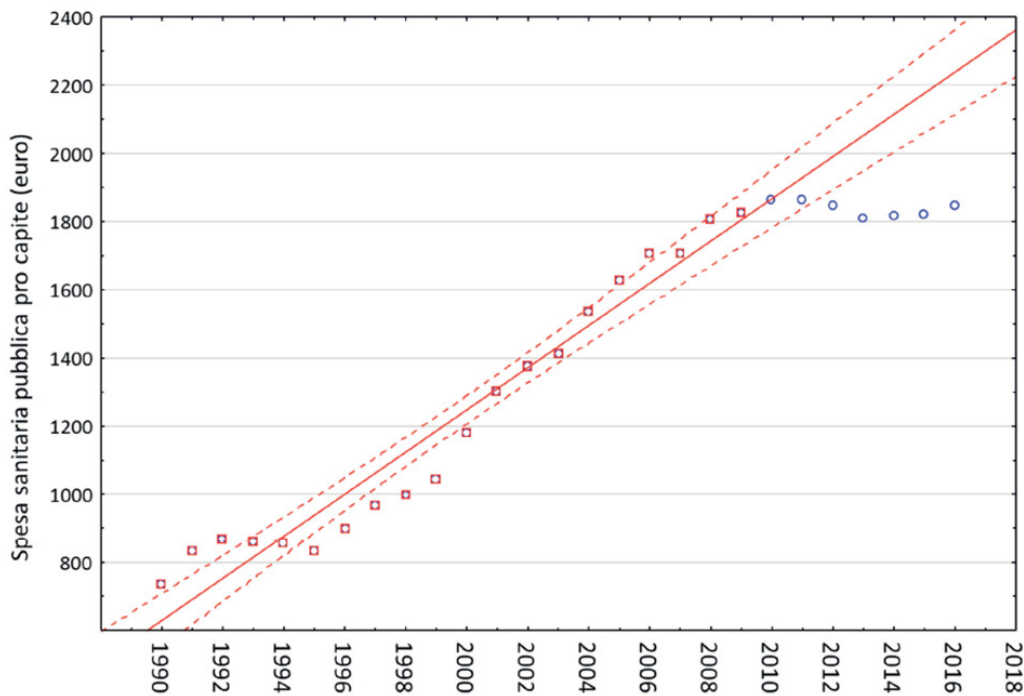


Figure 1: Serie storica della spesa sanitaria pubblica pro capite nazionale da 1990 a 2016, a valuta corrente e proiezione- tendenziale (e intervallo di confidenza al 95%) sulla base dei dati fino al 2010. (6) After this economic analysis as conclusion the authors think that this approach: the manager’s evaluation systems in use in Italy can be a useful instrument to be translated also in other countries to get

The same results. (in advanced or not advanced countries).

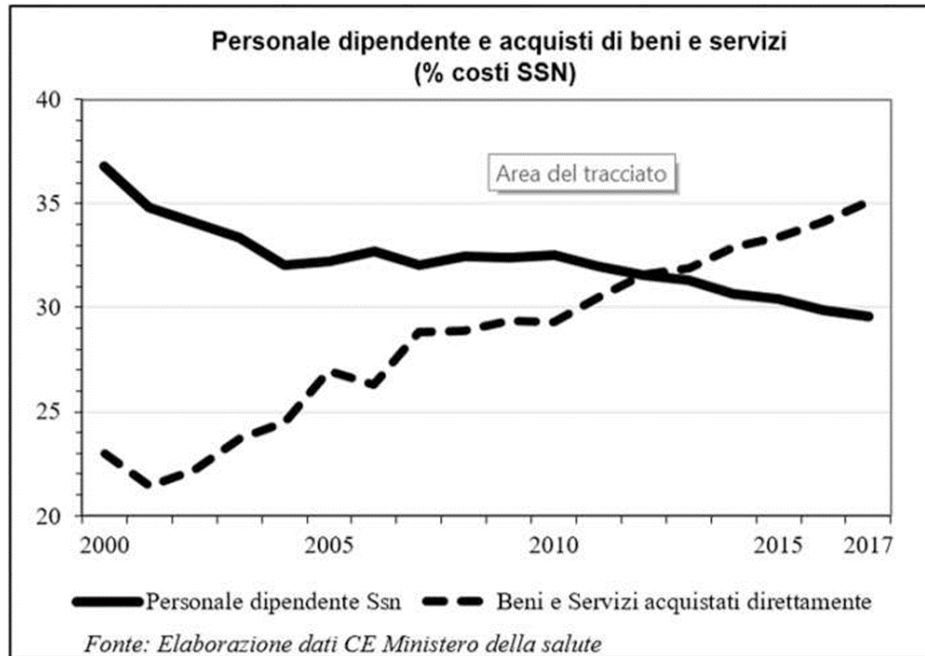


Figure 2: Direct healthcare professional cost in role in public healthcare systems and costs for services and healthcare goods.

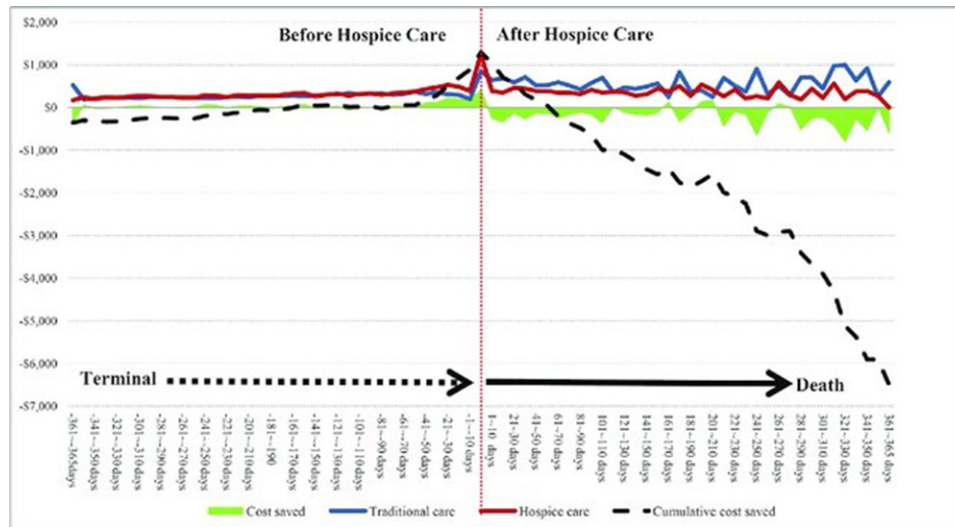


Figure 3: Trends in medical- costs before and after hospice care in the year before death. The vertical dashed red- line represents the day of receiving hospice care (point zero). The left- side of the dashed red -line represents the number of days from the beginning of the end of life to the day before accepting hospice care, and the right- side of the dashed red line represents the number of days from accepting hospice care to death. The cumulative- total cost for the last year was calculated regardless of the length of hospice care exposure time (terminal patients started receiving hospice care 30 days before death, while the date of death was pushed back 30 days in the traditional group for matching, and the medical- cost for the 2 groups of patients started to accumulate to death from 335 days before receiving hospice care/ treatment). 1 US dollar = 31 Taiwan dollars. From OPEN ACCESS PEER-REVIEWED RESEARCH ARTICLE Differences in medical costs for end-of-life patients receiving traditional care and those receiving hospice care: A retrospective study Ya-Ting Huang ,Ying-Wei Wang,Chou-Wen Chi,Wen-Yu Hu,Rung Lin Jr,Chih-Chung Shiao,Woung-Ru Tang Published: February 20, 2020.

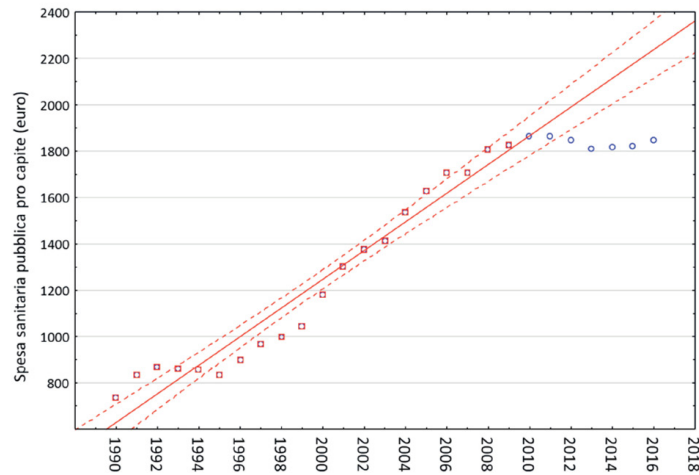


Figure 4: Mostra la spesa- sanitaria pubblica pro capite nazionale dal 1990 al 2016, a valuta corrente. L’andamento dei dati evidenzia una flessione della spesa pro- capite dal 1993 al 1995, imputabile a vicende giudiziarie che in quel periodo coinvolsero diversi settori dello Stato, compreso la sanità. Inoltre, si registra una rilevante stabilizzazione della spesa pro- capite pubblica dopo il 2010, verosimilmente in conseguenza degli effetti che la crisi finanziaria internazionale (international financialy crisis) ha avuto sui conti pubblici dello Stato. In termini di spesa sanitaria pro capite, la riduzione media annuale avuta dopo il 2010 è stata del -13,2%, corrispondente ad un valore pro- capite nel 2016 di 1.846 euro, anziché di 2.232,6 euro di spesa pubblica. Nel complesso, la serie- storica della spesa sanitaria pubblica pro capite- annuale (a valuta corrente) cresce linearmente (R-quadro 0,93; p<0,001), con una crescita media di 51,5 euro pro capite all’anno (95% IC: 45,6-57,4). In Tab 1 (ved. Original article) , sono riportati i dati annuali e la variazione- cumulativa della spesa- sanitaria pubblica pro- capite nazionale, prima e dopo l’attualizzazione della spesa alla valuta del 2017. La variazione cumulativa in 25 anni della spesa sanitaria pubblica pro capite è stata di +1.112,4 euro (+471,8 euro alla valuta del 2017), corrispondente ad una crescita del 152% rispetto al 1990 (+33,8% sulla base della serie a valuta 2017 from 19 Marzo 2019 GIHTAD (2019) Il valore della spesa sanitaria in Italia dal 1990 al 2016 The value of healthcare expenditure in Italy, 1990 – 2016 Pierluigi Russo, Tommaso Staniscia, Ferdinando Romano. This figure show how economic crisis can act on the management of the systems in order to contain costs in efficiency way.

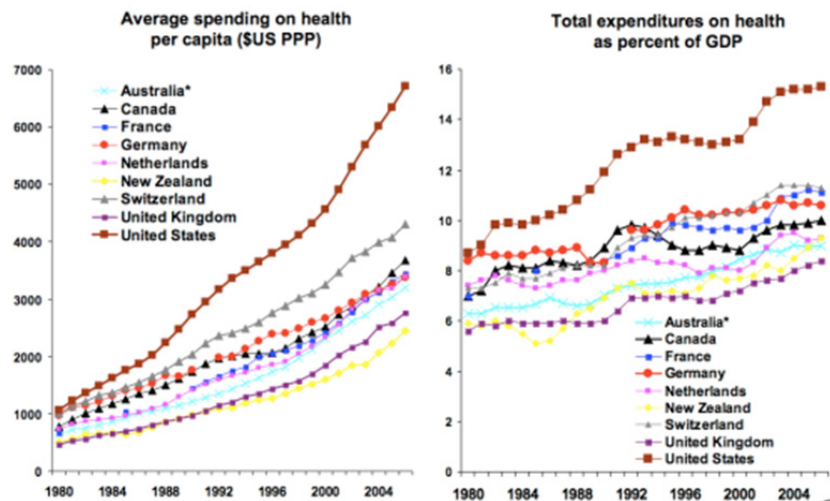


Figure 5: Observing this graph it is possible to verify that the organization of a public health system can be responsible of the management cost globally (private or insurance vs public system): so it is possible to Say that the management of the system can be more efficacy regulated. (In central or local way). The global sustainability is the final endpoint for an equal opportunity, accessibility, universalistic and Cost effectiveness management.

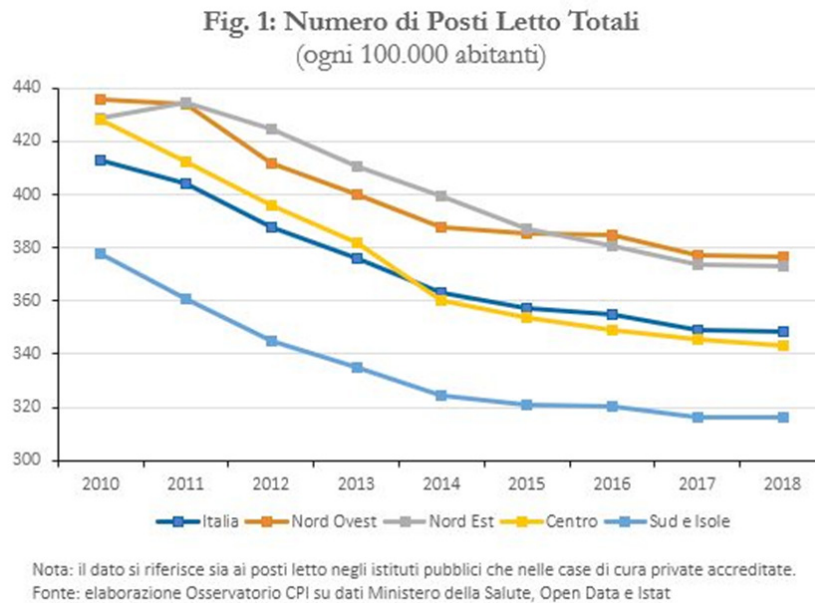


Figure 6: From La sanità in Italia: cosa è cambiato nell'ultimo decennio di Beatrice Bonini e Francesco Tucci 11 maggio 2020.

Conclusion

Observing the literature reported in this work, the law introduced in Italy after 1978 and the figure related health care cost trend in last decades make possible to produce a global conclusion: Not only EBM or clinical and risk government, but also A REAL PURE MANAGERIAL SYSTEM help to get this kind of results in a scenario of increased health demand and with an increased chronic pathology population and the evaluation system of the Italian public health managers contributed (and the selection procedure for career progression) in a relevant way. ICT, big data analysis and new instrument like professional social media or the new communication systems or simply sharing of the KNOWLEDGE increase the efficiency of the system. The Actual Pandemia also increased all activity of communication on distance and this can be an interesting opportunity also for future. So, after this works and evidence submitted, it is possible to say that: The economic and clinical results of an health care systems depends on the organization model choosed in heavy way.

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