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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)

Other fact to be taken in consideration is the trend of health care costs since from 1970 (Figures 2 and 3)

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 a 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, was introduces as new concept the Aziendalizzazione concept (also commonly called corporatization), with a more market vision.

Decreto Leg introduced in public health system: concepts of Efficiency, Efficacy, Economicity and Quality in order to provide adeguate level in of healthcare service (quality and quantity and technical-economical efficiency).

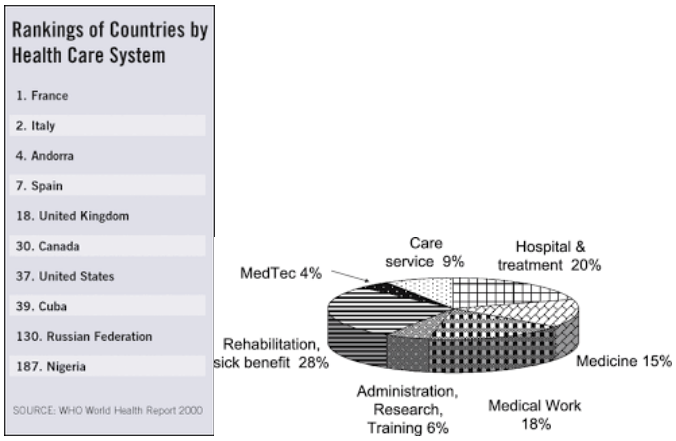

Figure 1. Ranking of countries by health care system.

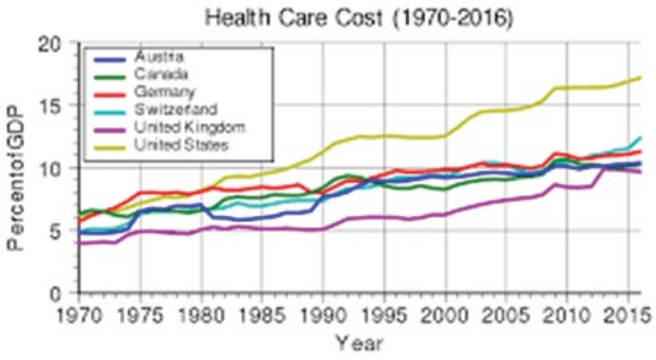

Figure 2. Health care cost (1970-2016).

Departmental organization of hospital: aggregation of various complex units with similar finality. In this law was introduced the mandatory of economic-financiary instrument like official balance sheet and management control system. And In the DL 229/99 named riformater this process was completed

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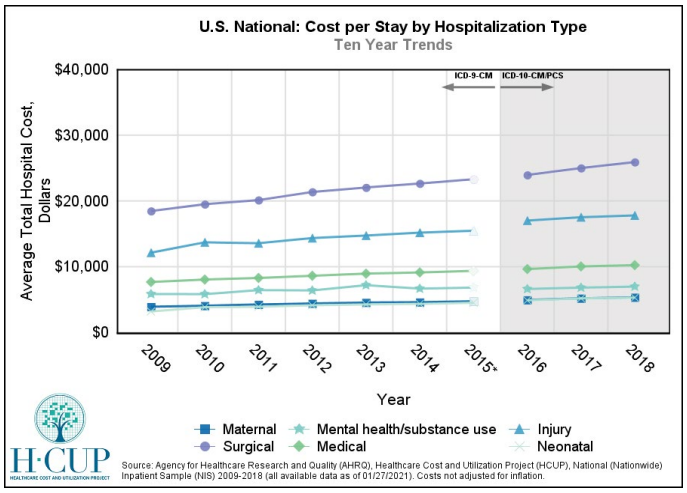

Figure 3. Cost per stay by hospitalization type of US National.

introducing concept like Appropriateness, economicity, EBM, minimum level of assistance LEA and other.

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 Decreto Leg 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 seen 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 introduce: 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: Budget negotiation from general manager of the institution and department directors Management control system, programmation (introduced in health systems) by DLGS 502/92 Official balance sheet (previous year), 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 levels). Also in Italy various Reform Law introduced the management health system named "Aziendalizzazione Della Sanita" (LEGGE 502/ 92 and DL 229/99).

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 derivates
- 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 institution like hospital it is possible to see various positions: Apical Managers 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 Professionality Like: Physicians, Pharmacist, Biologist, Chemists 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 levels: High Professional Appointment Divided in: Elevated Professionality, High professionality or Consulting Study, Research, Verify control (Art 27 Comma 1 Lettera C Ccnl 1998-2001):

C) Positions of a professional nature, including highly specialized, consultancy, study, and research, inspection, verification and control tasks. And according some interna rule of hospitals regolamenti: Incarichi dirigenziali di natura professionale elevata (this is different from basic level).

Di Alta Professional Ita' or of elevated competencies technical specialist that produces high relevant performances for the hospital.

This appointment can be assigned after 5 year of role in position of basis managers.

Basis: <5 year of working experience.

According CCNL 18 October 2008 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 alienate 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 others. 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 is official procedure of selection. Where are evalued the curriculum of the manager and their attitude to cover the specific role?

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 than 5 year in role).

Other role: Manager not in role, free professionals, for limited time, under specialization schools program.

In order to evaluate the result annually of this manager it is used a weighting procedure (what produce an effect or contribute to this and parameters to be evalued. (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 (grad and for specialization programs)

Related the payment of this manager there are 2 voices:

Position: According national contract rules- fixed amount

Variable part: According a local and decent rated agreement -related the amount of Availability of money of the hospital.

All these 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 evalued:

-Autonomy

– Responsibility

– Flexibility

- Behaviours towards innovations, use of ICT, continuous formative programs activity, Proactivity, teaching activity, communication skills and other soft skills.

Methodologies: In example using a multidimensional analysis 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 is also an external control of the results and also by the Politics governor of the region. Also for the health care management 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 evalued the previous one result. After every year monetary prizes goes to pay for single and equip manager's 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 *vs*. 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 Human Resource Director.

Other relevant offices are: 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 professionality.

Worsening factors: Every public administration in the world show various grade of corruption and family influence in Selective procedure for Directorship or professional role in every grade of the organization: this produces lower level of managers a lower level of results of this it must to be taking in consideration.

Materials and Methods

With 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 analysed 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.

Results

From literature

"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 due to the fact that 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" [1].

"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 out-patient 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" [2].

"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" [3].

"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 *vs.* 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" [4].

"Through prepaid compulsory insurance managed by the central government, Italy's National Health Service provides full coverage, free accessibility and no or limited co-payment 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." [5]

"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 analyse 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." [6]

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 behaviour's. 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 first's places also in ranking. The performance measure system applied according Italian rules and law provided great part of the result because it is undeniable that this result was obtained by the health managers that worked in this institution in the period of observation.

According European and national rules and las to become a manager in ROLE in public health care systems: Is needed to have a degree (medicine, pharmacy, biology, chemists and other biomedical scientific field.) > Then 4-5-6 year a specialization about more then 4-5 year in university course.

State professional examination-Abilitazione Professionale (An examination after degree to verify minimum level of professionally to play their heathcare 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 evalued title, publication, year of practical experience and other of CV. To be assigned for complex unit management is required by

law a 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 rues (central and regional) and the managerial role of many health care's professional contributed in great part to this result. Central agency politics of drugs and medical devises management, regional buying area vasta systems.

New diagnostic procedure or surgery contributed with many other factors. ICT was a strategic tool as like as the Global Human Resource Management (Figure 4).

Historical series of national per capita public health expenditure from 1990 to 2016, in current currency and projection-trend (and 95% confidence interval) based on data up to 2010 (Figure 5) [6].

After this economic analysis as final conclusion the authors think that this approach: the manager's evaluation systems in use in Italy can be an useful instrument to be translated also in other countries to get the same results. (In advanced or not advanced countries).

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 (Figure 6).

Figure 4 shows the national per capita public health expenditure from 1990 to 2016, in current currency. The trend of the data shows a decline in per capita expenditure from 1993 to 1995, attributable to legal events which in that period involved various sectors of the state, including health care. Furthermore, there is a significant stabilization of per capita public spending after 2010, probably as a consequence of the effects that the international financial crisis has had on the public accounts of the state. In terms of per capita health expenditure, the average annual reduction after 2010 was -13.2%, corresponding to a per capita value of 1,846 euros in 2016, instead of 2,232.6 euros of public expenditure. Overall, the historical series of public health expenditure per capita- yearly (in current currency) grows linearly (R-squared 0.93; p <0.001), with an average

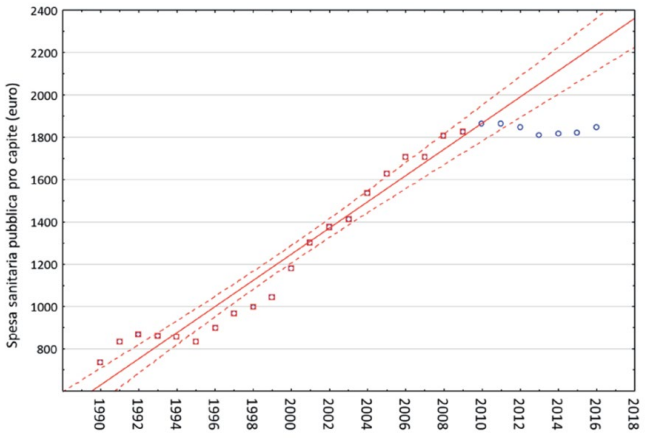

Figure 4. Historical series of national per capita public health expenditure from 1990 to 2016.

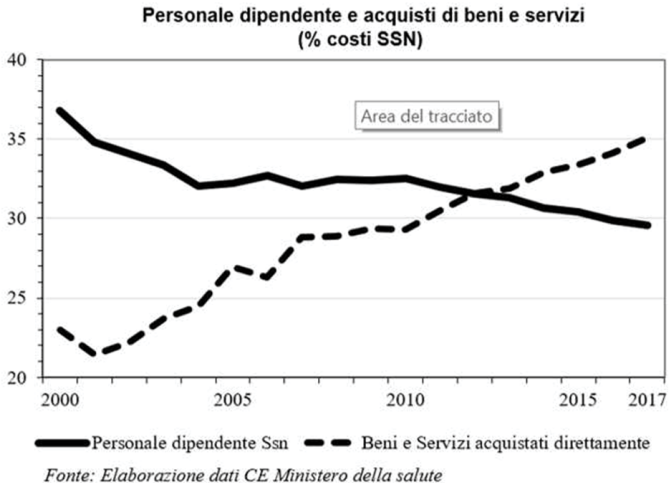

Figure 5. Direct healthcare professional cost in role in public healthcare systems and costs for services and health care goods.

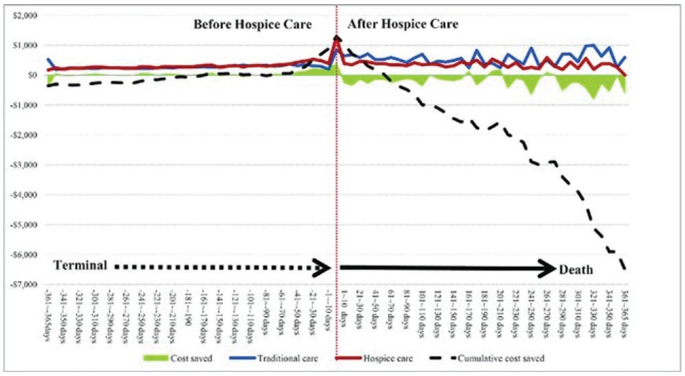

Figure 6. Trends in medical- costs before and after hospice care in the year before death.

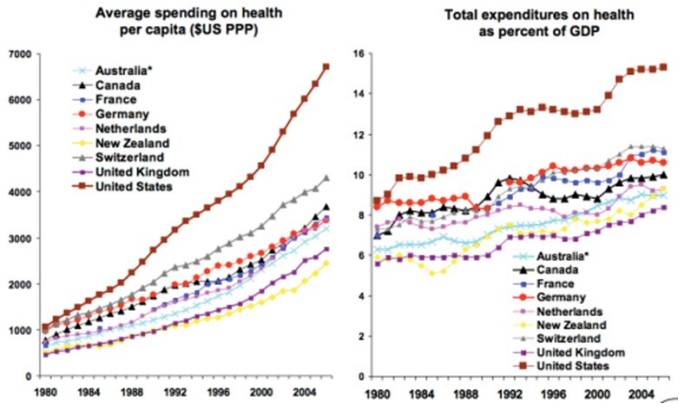

Figure 7. How economic crisis can act on the management of the systems in order to contain costs in efficiency way.

growth of 51.5 euros per capita per year (95% CI: 45.6-57.4). In table 1 (see Original article), the annual data and the cumulative variation of the national per capita public health expenditure, before and after the discounting of the expenditure to the 2017 currency are reported. The cumulative variation in 25 years of the per capita public health expenditure was +1,112.4 euros (+471.8 euros at the 2017 currency), corresponding to an increase of 152% compared to 1990 (+ 33.8% based on the 2017 currency series from 19 March 2019 GIHTAD (2019) The value of healthcare expenditure in Italy from 1990 to 2016 [1].

Figure 7 shows how economic crisis can act on the management of the systems in order to contain costs in efficiency way.

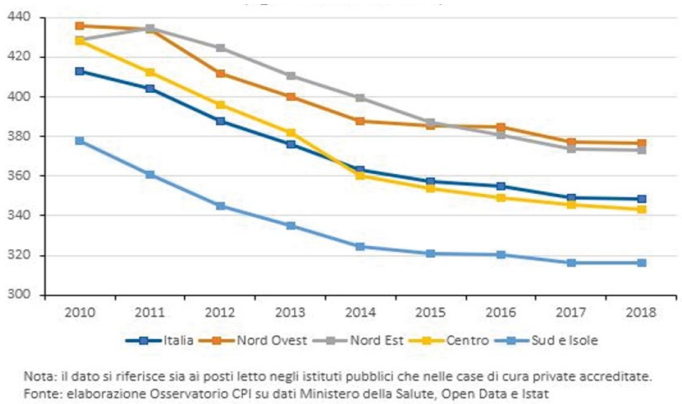

Figure 8. Changed in the last decade for health care in Italy.

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 efficiency regulated (In central or local way).

The global sustainability is the final endpoint for an equal opportunity, accessibility, universalistic and Cost effectiveness management.

From Healthcare in Italy: what has changed in the last decade by Beatrice Bonini and Francesco Tucci 11 May 2020 (Figure 8).

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 Pandemic 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 a health care systems depends on the organization model choose in heavy way.

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