

The innovative Tuscan health system. A focus on hospitals' organization

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Abstract: The aim of this paper is to explore the recent legal interventions affecting the hospitals' organization in Tuscany. Within the health system of the Tuscany Region, the hospitals' setting has been developed in the last decade through two main directions: the efficient organization of flows of care and the grounding of the right to health in a relational context.

Keywords: Tuscany Health System, Right to Health, Hospitals' Organization, Flows of Care, Relational Approach to the Right to Health

1. Introduction

Since Laws No. 22 of 2000 until the Laws No. 40/2005 and 60/2008, some general trends characterizing the Tuscan health system are detectable. If on the one hand, attention paid to the rights of users is a primary aspect, on the other, the cost containment is considered a fundamental goal and a way of protecting patients' rights. A variety of innovations such as the establishment of Wide Areas (firstly with the consortia of Wide Areas of the Law No. 22 and then with the Authorities of Wide areas of the Law 40), the definition of integrated care pathway as mode of response to the needs of citizens (Articles 3.2 and 4 of Law 22/2000 as amended) and the reticular integration, between primary health care and hospitals through the provision of a hybrid organization of the Department of Emergency and of specialist outpatient Department, complete the frame.

From the point of view of patients' rights some aspects are of particular importance. It needs hereby to clarify that the Charters of services take into account in particular the rights of patients regarding the "clinical" spaces of hospitals, which are analyzed by numerous papers not only in legal field, but also in architectural and sociological studies (with the notable exception of the Emergency Department on which important studies were conducted on the perceived quality of care in the phases of access and reception and on which there are several regional normative acts). With regard to access to care, as well known, the corresponding legal right is not absolute but guaranteed "within the organization of health services" (article

19.2 of Law 833/1978 – Law instituting the Italian national health system) and "in the context of health care planning" (art. 2 letter. d, law no. 419/1998).

Along with the right to access, the right to choose the doctor and the place of treatment¹, there are subjective situations of varying intensity that characterize the relationship between the users and the structure/ health care professionals. Another important element is that there is not any norm identifying the specific content of the health care obligation, therefore, in practice it is commonly referred to as provided by essential levels regulation and established by what it is legitimate to expect on the basis of social consciousness.

2. Patients' Paths and Organizational Flows

In the decade covered by the above-mentioned legislative regional acts, various types of source have proceeded to decline in different ways the notions of patients' path and the more recent concept of flow of care.

The Tuscan Regional Law No. 22/2000 (article 2.1 letter. M) defines the path of the patient as "the result of an organizational form that ensures to citizens in coordinated, integrated and programmed way, a timely access and an informed and appropriate use of health services and hospital services in the network, in relation to the assessed needs of health education, preventive services, social care,

¹ See artt. 25, 19, 48 of the Italian Law No. 833/1978.

diagnosis, treatment and rehabilitation"².

The notion of flow (see the Program for optimization of flows provided by Resolution of the Regional Executive Branch No. 117/2012), related to the "multidimensional" value (value for professionals, value for the patients, value for the organization)³, is introduced from the Regional Health Plan of 2008-2010 in the reorganization perspective of the functions and nature of hospitals in Tuscany⁴.

On the one hand, the implementation of the organization for progressive care is ongoing in Tuscany⁵, on the other, the need to provide organizational methods that take into account those that are the most obvious and critical issues affecting the perceived quality of care (waiting lists, over-burocratization of the patient's path).

While the path relates to the individual clinical needs taken into consideration, the notion of flow has to do more with the efficiency of spatial-organizational paths channeled in different care settings through which response is given to the clinical needs.

2.1. The Reorganization of Access to Care at the Regional Level

The profound transformation induced by the adoption of a regional model for hospital progressive care has among its consequences relevant effects on spatial and organizational layers.

The model of hospital progressive care implies that the area of outpatient (outpatient) and the area of the diurnal cycle (day hospital, day surgery, day services) are well differentiated from the areas dedicated to recovery. Following the principles of clinical and organizational appropriateness, a process of transfer of many functions from the regime of the hospital admission to outpatient Department has been going on for several years. It is an irreversible process encouraged by the continuous technological innovations, particularly in diagnostics.

Another fundamental feature of spatial-organizational

model is the reinforced function of filter and supervision carried out by the system of Emergency and Outpatient Departments in the newly conceived hospital. The ambulatory system plays an important function of filter in the case of planned surgery. The Emergency Units clinically stratify the patient and guide him/her to the more appropriate setting. The filter of Emergency Units must be able to act in all directions: admission in the level and in the appropriate area; taking care of patient in outpatient and day services - both on an immediate and fast path (fast track) as well as continuity provided within a short-stay period.

In the resolution of the Regional Council No. 27/2011 "Regional Integrated Health and Social Plan 2012-2015. Preliminary Information" we can read: In the perception of people, protection of health is achieved when the system is felt close to the need. But this result is not achieved, as it could be expected, through the presence of more services closer to home, that does not represent absolutely a guarantee for a real ability to identify the problem and pick it up as soon as possible and with the best results. From the evidence gathered during the hearing and in daily encounters with professionals, it appears that the system is not only close when provides easily reachable services, but especially when it facilitates to start a simple path, clear in his steps, aimed at eliminating burdensome activities for citizens. All this can be achieved only if within the services there are operators able to listen to people, guiding them and involving them actively in their stories of health and illness. Synthetically through an active search of the proximity with an adequate understanding of the need, even if expressed in different ways, cultures, contexts and orientation in the path best suited to specific circumstances".

The Regulation No. 61/2010 of the President of the Region, as modified by the Regulation No. 10/2012, provides some organizational and structural requirements for accreditation pursuant to Regional Law No. 51/2009.

The Management Board shall, for each hospital, provide information available to users, specifying: procedures relating to access and timetables; operators responsible for the performance, price and/or tariffs; commitments and standards of quality of service (waiting time for access and delivery reports, delivery time of medical records, time response to complaints); communication mode of information to patients; mode of delivery of reports, including aspects concerning the protection of personal data; procedures for forwarding complaints and / or reports.

In reference to Outpatient Departments, Regulation No. 61/2010 establishes the separation between spaces with different functions such as waiting, acceptance, administrative tasks. If in the same building more health activities carried out on an outpatient basis coexist, the spaces for waiting, acceptance and administrative and sanitary facilities for the users may be common if appropriately dimensioned. Where the outpatient activities are carried out within hospitals providing also admission services (acute and post-acute), access routes should preferably be diffe-

²The Regional Health Plan of 2002-2004 represents the patient's path as "the guided routes of the citizen through the health care system; it is intended to put in the correct link all the components of a multidisciplinary team, who, for that particular health problem, follow specific shared guidelines".

³In this sense, if the balance between values / interests / rights fails, it occurs what shown by the research of Joshua J. Fenton, Anthony F. Jerant, Klea D. Bertakis, Peter Franks, The Cost of Satisfaction. National Study of Patient Satisfaction, Health Care Utilization, Expenditures, and Mortality, Arch Intern Med 2012; 172 (5) :405-411.

⁴In the Regional Health Plan of 2008-2010 we can read: "the hospital has always been in itself a value and a reference point for the community who spontaneously, or through its institutions, has constantly monitored its efficiency. Simplifying, the use of hospitals has always been due to the following reasons: a) response to an acute event that requires emergency services, b) execution of complex procedures that require technology c) the need for specialist supervision d) performance status of patient considered unsustainable by family or social network, also considered the characteristics of his home."

⁵The Regional Health Plan of 2008-2010 identifies as a new paradigm of the concept of care, the Hospital for progressive care that promotes an approach that focuses on the needs of the individual, providing support and personalized care, multi-professional and multi-disciplinary path and appropriate use of resources. With Resolution n. 697 of 08.03.2009, the Regional Executive Branch established a "Permanent observatory on the hospital for progressive care", pursuant to art. 43, paragraph 3 of the Regional Law No. 40/2005 and subsequent amendments and additions.

rentiated between outpatients and inpatients; also the waiting areas should be differentiated or a procedure, that regulates the wait differentiating it between outpatients and inpatients, is established.

In relation to the admission, the Regulation No. 61/2010 states that the hospitals that ordinarily deliver highly specialized activities or other activities performed in both medical and surgical areas should ensure the healthcare acceptance, appropriately separate from the administrative acceptance, organized according to the type and complexity of the activities.

In relation to the flow of emergency, the triage function must be guaranteed (compulsory over 25,000 accesses), as the first moment of acceptance and evaluation of patients according to defined criteria that enable to determine the priorities for action.

The requirements set out in Regulation 61 concerning access to and reception within structures must be put in evidence: the development of a system to reduce differences in access to services for fragile citizens (fragile citizenships are defined, on the basis of the "Guidelines to manage and report adverse events in health care" of the Ministry of Health of June 2011, those of advanced age, pediatric patients, patients with disabilities or specific problematics); the organization must provide a way to share information directly with the patient during the entire continuum of care including discharge; the contact of the citizen with the hospital must be ensured (especially through an opening time of the Front Office that allows it); recreation activities must be provided and the environmental comfort developed in order to improve the quality of permanence. In the flow of emergency patients have the right to receive adequate information about their health, about their treatment and health care professionals, aiming to promote their active participation (requirement ER2 - M25 of the regulation 61/2010); appropriate language and understandable by the patient and his family should be used (requirement ER2 - M28); there must be a process of information to patients on clinical risk, also aimed to activate participation consistent with the specific path of treatment (ER2 - M41).

2.1.1. Emergency Flow

On the basis of the Resolution of the Regional Executive Branch No. 601/2009 "Approval of the program to improve the welcome and information in Emergency Departments of Tuscany", concrete indications addressed to the hospitals were those of "taking care" of the relational dimensions related to listening, attention, openness to the needs expressed by users. In this sense, the practical instructions to hospitals have focused on the spatial and functional separation of the welcome from Triage. The welcome spaces in this sense become the first point of contact with users. The reception staff has no healthcare assignments but carries out actions to support and facilitate the communication with relatives or friends, informing them on waiting times and location - service period and resignation - in compliance with right to privacy of the patients. The activity of the reception staff, to facili-

tate contacts and relationships, cannot fail to fulfill its obligations of confidentiality under the law in force.

The reorganization of the emergency flow at the regional level begins with a number of fundamental regional interventions. First, the emphasis on the quality perceived by the patient: the profound change in the perception of the need for health, subjectively considered urgent, and the type of supplied service considered the most effective for his satisfaction over the years have represented an organizational challenge, for the Tuscany health system. The Region has decided to ensure a response to those accesses to the Emergency Department (ED) than in previous years were considered inappropriate (white, blue and green codes of Triage procedure) and a consequence of opportunistic behavior on the part of users (see Decision of the Regional Executive Branch No. 140 of 02.25.2008 "Interventions and initiatives for the improvement of the Tuscan Emergency Departments. Approval").

On the one hand, the results of several innovative primary care patterns (Points or First Aid Centres established by Resolution No. 293 of 29.03.2004) experienced in recent years were not entirely satisfactory with regard to the ability to intercept and decrease the inflow of urgent needs with less severity to the system of Emergency Department. On the other, there is, probably, a profound change in the health needs perceived as urgent by citizens and consequent behavior adopted for the satisfaction of this need: the Hospital and the Emergency Department have taken the reassuring dimension of complexity and effectiveness of the diagnostic and therapeutic treatment.

The response to this increased demand for emergency has been declined in several directions: the Tuscany Region, also with reference to international experience, has introduced organizational innovations to address the increasing frequency of access in the emergency department of the codes less serious and, in addition, outpatient department specifically devoted to the codes white and blue made it possible to respond to this type of need with reasonable time sufficient to recover, at least in part, a relationship and a climate of trust; in order to further improve this relationship and the climate of trust system of Tuscan emergency became more responsive to all the needs of the citizen, taking care of relational and psychological dimension of "emergency", according to which citizens often assess the quality of received services (Resolution No. 140).

The Tuscan model of the emergency, with a special focus on organizational and structural aspects, has been strengthened in his "original mandate" directed to take charge of the urgent needs of greater severity. Some critical issues have been addressed through the introduction, in some situations, of dedicated Radiology Services that allow rapid pathways, adjustment of the structural and organizational conditions for the most important moments of the patients' stay in the emergency department (health care and administrative reception, triage area, waiting rooms, temporary observation spaces equipped with beds for the performance of diagnostic and therapeutic treat-

ment, procedures of monitoring and procedure for expressing the waiver and departure from the emergency rooms).

These orientations of the Resolution No. 140 were translated into specific projects that have approached both structurally and organizationally aspects that determine the quality of patients' experience, during the waiting and permanence, in the emergency department.

Any project aimed to improve the activities of ED made reference to a specific action to reorganize processes and care pathways between ED and the whole hospital - and out of the ED -, so as to ensure a flow, not intermittent, but continuous of patients. In order to ensure a continuity of the flows, Resolution No. 1010 of 12.01.2008 "Actions and initiatives to improve the effectiveness and efficiency in the emergency department of Tuscany" establishes the Discharge Room, in order to eliminate bottlenecks in outflow, and the Agencies for the continuity between hospital and primary care -, in order to govern the flow of patients from the Emergency Department to the inpatient unit and to the primary care unit⁶.

As regards the improvement of aspects of the reception and taking charge of the need of the citizen the objective is articulated, and creates, through the design and structuring of new and specific activities such as activities related to the phases of acceptance - registration - information - monitoring of routes within the ED, the activities related to triage, through which the citizen is informed of the meaning of the allocated color code, the activities of management of waiting.

2.1.2. *Outpatient Flow*

The Tuscany Region (with the Regional Executive Branch Resolution No. 578 of 06.07.2009 "Guidelines for the management and development of specialist outpatient care and adoption of implementing programs in order to promote the right of access of citizens and ensure defined waiting times") intended to frame the issue of reorganization of specialist outpatient care, focusing on elements such as the rationalization of the supply and management of the access system with the objective of simplification of institutional levels and better definition of the respective roles of the effective integration of responsible actors for the primary care management and the provision of services, aimed at health objectives for the local community; enlargement of the potential satisfaction of needs through the involvement of new actors; the greater rooting and consent of the interventions in local communities.

With the Decision of the Regional Executive Branch of Tuscany No. 887 of 8 September 2003 was approved the project "Specialist and diagnostic outpatient: a plan for a sustainable quality", which provides access to specialist and diagnostic services according to priority. By activating as defined by mentioned project, for which there is a

phase of experimentation initially only on some hospitals during the year 2004, it was necessary to redefine a classification system that, maintaining the identification of access within 72 hours, provides for the systematic and structural survey of the priority classes defined during the experimentation.

The maximum times to wait established at the regional level that commit local health units are established by Resolution No. 245/2000 in 30 days and for the following phase, the seven specialist visits identified by Resolution No. 143 of February 2006, in fifteen days; with the latter resolution, there has also been established that, in the event of failure to comply with this deadline, the citizen has the right to be indemnified by the Health Authority of residence⁷.

The request for provision of simplified means of access, within path, or in waiting times, both by individual citizens or the various associations of users has led to the development of tools that would respond to the complex needs of the citizens.

The Resolution of the Regional Executive Branch No. 356 of 22.03.2010 which relates to the "Testing of a different mode of access to provide specialized outpatient cardiological examination. Approval of the project 'cardiology consult' presented by Health local Unit n. 10 in Florence and resources destination" recognizes that the development of scientific knowledge, the availability of technology, and health expertise, make it possible and appropriate, in certain medical specialties, a rearrangement in a single act of some diagnostic analysis, initially proposed as distinct specialist services, with the objective clinical assessment, specifically recorded as "specialistic visit", taking shape as a new and overall performance that, because of the competences required is defined as "expert advice". The goal of a range of specialist skills so redesigned is to promote the accessibility and equity of the concerned pathways, increasing the efficiency and the related continuity of care, as well as the quality and effectiveness of the public health response to the complexity of need that the supply system can accept and resolve, through a single encounter.

2.1.3. *Admission Flow*

The guarantee of access to the services of planned admission is based on organizational policies, and prioritizing criteria, basically uniform on the whole regional territory. Regional policy has focused on the definition of an overall framework, providing for concurrent actions of the hospitals and wide areas (Area Vasta), in coordination with the Regional Department of the right to health and

⁶ See also Resolution No. 360 of 04.05.2009 "Approval of initiatives and interventions to improve the effectiveness and efficiency of actions in the emergency department according to the models of Discharge room and Agencies for the continuity between hospitals and primary care units - resources assignment".

⁷ On waiting times, see the Resolution No. 493 of 13-06-2011, "Understanding between the Government, the Regions and the Autonomous Provinces of Trento and Bolzano on the National Plan for the management of the waiting lists for the years 2010/2012, pursuant to art. 1, paragraph 280 of the Law of 23/12/2005 No. 266, signed on October 28, 2010: approval of the Regional Plan for the Government of waiting lists".

Furthermore, see the Resolution No. 45 of 01.26.2004 "Monitoring waiting times: amendments and integrations to the Resolution No. 418/2001 and Resolution No. 1351/2001; Decision No. 245 of 01.03.2000 "Restatement of the maximum times for the delivery of specialistic services and management of waiting list".

solidarity policies, evaluated, as well, the complexity of the variables involved in the management of waiting lists that only at local level finds appropriate solutions (Resolution No. 649 of 06.30.2003 "Guidelines for the definition of the system of access to services for planned hospitalization").

In each Health Service in Tuscany is usually formalized the institutional path of the surgical patient since the formulation of the question, and the access path to the surgical activity guarantying the free choice of the assisted, defined by Executive Branch Resolution No. 351 of 04-05-2009, can be easily integrated with the institutional path, which is also regulated for the specific line of ambulatory surgery with Executive Branch Resolution No. 408 of 18.05.2009, organizing functionally a single access to the surgical treatment, both for outpatients and inpatient, because of the opportunity to ensure the surgeon, for properly organizing the need for surgery, the availability of all the surgical supply lines: hospitalization, week surgery, day Surgery, ambulatory surgery. The Tuscany Region has established in order to ensure an equitable access, the unique registry of reservation (Resolution No. 638 of 7.20.2009 "Directive for the unique management of the lists of surgical operations and maximum waiting times, under both ordinary and intra-moenia context. Protection of the right of access of the patient")⁸.

This register, called the "registry of reservation for planned surgical operations", must be distinguished for ordinary admissions and those in day surgery and be available (in computer network) at the individual Clinical Unit according to requested specialty and at the Management of the Hospital. The procedures for accessing and maintaining the register of waiting lists, (article 3, paragraph 8 of the Law No 724/94) for outpatient surgery, laid down in Executive Branch Resolution No. 408 of 18-05-2009, are regulated in accordance with procedures adopted by the Reservation Centre.

3. A Relational-based Approach

The relational nature of the right to health is a well-analyzed perspective in literature⁹. From a legal point of view, the relational character of the right to health ensues from the relational character of the Constitutional dimensions constituting the right to health (see artt. 2, 3, 32 of the Italian Constitution). Indeed, autonomy, dignity, equity and solidarity are all dimensions characterized by a relational nature. Moreover, it is not possible to define the concrete meaning of the aforementioned principles without delimiting a specific context of guarantee. To this aim, the Constitutional provisions refer to legislation and case

law in order to specify the scope of the main constituencies of the right to health.

The case law on the liability of healthcare professionals and healthcare facilities highlights a key figure for our purposes: the social contact. The attempt of the case-law is to extend the protection of the citizen-user by shifting the traditional tort liability to contract liability with all the consequent changes in test point (the difference between the criteria for allocating the burden of proof and the nature of the evidence disclaimer required by art. 2043 and art. 1218 of the Civil Code)¹⁰. In the transition from tort liability to contract liability the poles of protection change from medical-professionals of health care to the patient. the most favorable rules of evidence and of prescription under the rules of the Civil Code relating to contractual liability in favor of patient-creditor must be considered.

It is relevant that the growing in extension "contractualization" concerns not only the health professional-patient relationships (contract of health care)¹¹, but also between the patient and health care facility (contract of hospitalization)¹², overcoming the dualism between the two different types of liability through a way that involves moving the center of gravity of protection to the patient within relationships that occur in the structures and with the same structure.

The "contractualization" has been carried out, among other things, but for what interests us here regarding access, through the use of that notion of social contact (to which also the resolution of the Tuscan Regional Executive Branch No. 1351 of 2001, Annex, and Resolution No. 45, 2004, Annex, referred).

Responsibility from contact is taken up by German civil law, and used later for the accountability of public administration¹³, and then in the health sector¹⁴.

Social contact is a hypothesis of qualified relationship between citizens and health administration and professionals, which in turn is the source of an obligation that does not coincide wholly and exclusively with the mere health service. From social contact, structure and health professionals are entrusted with a position of guarantee regarding the interests and needs of the individual with respect to his/her care needs, so the concept is part of the movement that leads to overcome the dualism existing in

¹⁰ See G. Iadecola M. Bona, *La responsabilità dei medici e delle strutture sanitarie* [The responsibility of physicians and health care facilities], Milan, Giuffrè, 2009, p. 240 seq.

¹¹ See Supreme Court (Court of Cassation) No. 589/1999; Supreme Court No. 10297/2004; Cass. 9085/2006; Cass. 8826/2007; Cass. 3520/2008; Cass. 577/2008.

¹² The judicial construction of the social contact dates back to the late seventies, but here it is sufficient to refer to Cass. 6707/1988; Cass. 5939/1993; Cass. 4152/1995; Cass. 7336/1998; Cass. 8826/2007; Cass. 10297/2004; Cass. Joint sections 577/2008.

¹³ On which V. Antonelli, *Contatto e rapporto nell'agire amministrativo* [Contact and relation in the administrative act], Padua, Cedam, 2007; F. Cimballi, *La responsabilità da contatto* [The responsibility from contact], Milan, Giuffrè, 2010, p. 135 seq.

¹⁴ G. Corso E. Balboni (eds.), *Le responsabilità in ambito sanitario: atti del Convegno svoltosi il 13 luglio 2009 in Roma presso l'Accademia Nazionale dei Lincei* [The responsibilities in health: proceedings of the conference held in July 13, 2009 in Rome at the Accademia Nazionale dei Lincei], Turin, Giappichelli, 2011.

⁸ See also the Resolution of 30.11.2009 No.1107 "Further measures to support purpose stated in Resolution No. 638 of 20.07.2009: "Managing the lists of surgical operations and maximum waiting times, in both ordinary and intra-moenia context. Protection of the right of access of the patient." On access to the planned admission see Resolution No. 649 dated 30-06-2003 "Guidelines for the definition of the system of access to services of hospitalization."

⁹ See M. C. Beach, T. Inui, *Relationship-centered Care. A Constructive Reframing*, *J Gen Intern Med*, v.21(S1); Jan 2006.

the field of liability and which arises from a different case law approach, with respect to the relationships between the patient and professionals/structure.

The contact is social because the principle (social consciousness) at the basis of its regulation is social and because its goal is to build that relationship which is the real source of legal situations and legal obligations.

The health service is thus not the primary obligation of the relationship that arises with social contact but is one of the parts of this relationship, which includes a plurality of entitlements and interests that go beyond this relationship and involve both the organization itself and the interests of the other users-citizens. It is therefore not a purely bilateral relationship but a relationship that takes into account multiple interests.

3.1. The Tuscany Region Capital Model

The specific Tuscany Region relational model, beyond the notion of social contact, is mainly developed through the application of the notion of "taking charge" used in some regional legal acts and through some tools of participation of patients and representative organization of patients.

3.1.1. The Legal Notion of Taking Charge

The widespread use of the lemma "taking charge" shows the transition from a care based on expertise model, centered on the competence and professionalism of the doctor, on a vision of the whole patient as a sick part, to a system in which the patient with all of its needs is central.

While there is a corresponding expression in French to Italian (*la prise en charge*), in English the general expression "taking charge" is characterized by a strong paternalistic nuance.

The Italian notion of taking charge is used primarily in the social services and later as part of the health and social services (see Regional Law No. 72 of 1997 "Organization and promotion of a system of rights of citizenship and equal Opportunities: reorganization of integrated social and health services", art. 28; Tuscan Regional Law No. 22/2000 art. 56; art. 14 of National Law No. 328 of 8 November 2000 where the commitment to define and guarantee the process of global care based on the individual project is provided).

Its use in health occurs mostly through the programming tools (under Law No 833 of 1978, art. 53 and Regional Law No. 49, 1999) such as national and regional health plans (see the National Health Plan 2003-2005, p. 19 et seq.; Regional Health Plan 2002-2004, p. 6; Regional Health Plan 2008-2010, p. 31 et seq.).

There is no a general notion but a case-by-case notion defined on the basis of the functions performed by the person who "takes charge" and the space in which it takes place.

On the basis of the functional criterion, the meaning of taking in charge varies when performed by a nurse or a doctor. In the first case, there is a global care of the person and their needs, ranging from cognitive, social to the health needs. In the second case, the assumption is mainly

concerned with health issues related to the clinical needs identified and assessed in the doctor-patient relationship.

This first criterion does not escape criticism - has long been well focused - related to the difficulty of clearly distinguish "social facts" from "clinical facts" which in many cases are inevitably destined to intersect. The notion of taking charge in this case works as part of the internal division of hospital work, which provides that the "care" of the relationship in some cases be entrusted solely to the non-medical hospital staff.

The second spatial criterion requires that the needs of a social nature are tackled mainly in the public spaces of the hospital and gradually penetrating into clinical spaces the taking charge especially regards health needs.

The case-by-case definition of the taking charge, through the analysis of regulatory documents in which it is used, but not defined, poses some scientific problems. Using a general notion, without the necessary specific adjectives that this concept would require, at least becomes problematic when the individual aspects of it are not clearly defined.

3.1.2. Participation (Health Democracy)

The Regional Law No. 22/2000 concerning the reordering of the rules for the organization of regional health service, at art. 19, stresses the importance of protecting the user's right to information about the possibility of participation and how the task of the Region is to define the criteria and procedures for public participation in the initiatives for verification of the functionality and quality of services hospitals¹⁵.

At the regional level in order to implement participation a Permanent Forum for the exercise of the right to health have been established – Resolution No. 1075/2001 (Sector Equity and Access) and the Regional Committee on the Charter of services – Resolution No. 808/2002 (Sector Equity and access).

At the health services level for the same purpose the Committee of participation and the Joint Commission for conciliation have been established. The Committee of Participation pursuant to article 17 undecies of Law No. 40 of 2005, has a number of functions related both to the functioning of the local health services and of the Society of Health.

The Committee makes proposals for the preparation of planning documents and general governance; expresses opinion on the proposal of Integrated Plan for Health and on the draft of the annual report of the Society of Health within thirty days of receipt; it expresses opinions on the quality and quantity of the provided services and on cor-

¹⁵Already the Regional Health Plan of 1999/2001 identified, within the framework of policies for a quality system, the communication as an instrument to "qualify the relationship between the citizen and the health service and support decision-making autonomy of users."

The Regional Health Plan 2002/2004 includes among the linchpin of organization the communication, both internal and external, identifying it as "a strategy for fostering a shared development of the" network "of services and the sense of belonging and sharing of citizenship with the regional health care system, and patients' decision-making autonomy". On this point see also National Health Plan 2011-2013, p. 11-12.

responsiveness between these and the needs of users, as well as on the effectiveness of information provided to users and any other issue related to the respect of citizens' rights and their dignity; it draws, issuing specific comments and suggestions, its own annual report on the effective implementation of the Integrated Plan for Health and the state of local services, to be forwarded to the bodies of the Society of Health, trade unions and social partners; it access to statistical data of epidemiological type and activities that constitute the framework of health and social interventions in the area of competence and requires specific and in-depth analysis to the Director of the Society of Health.

The Resolution of Executive Branch No. 462/2004 "Regional guidelines for the exercise of protection of service users of Tuscany", lays down certain rules common to all providers of health services to guarantee to citizens a clear and unambiguous path, in particular, it specifies functions of Office of public relations, of the Joint Commission for conciliation, the regional Ombudsman; it defines the procedures for handling relational, technical and professional complaints; it promotes the use of claims in the process of evaluating and improving the quality of provided services.

In particular, the establishment of the Joint Commission for conciliation, in accordance with the principles of transparency and participation, has the function, provided in paragraph 7 of article 14 of Legislative Decree 30 December 1992, No. 502, to facilitate the presence and activities of voluntary and protection organizations in health care facilities with the specific objective of protecting the user. This Commission, which acts as a review body of the replies of Public relations office to the users' complaints is composed by 7 members and their substitutes, appointed by the General Director (the President, three representatives of the voluntary and protection organizations, three employees of the hospital).

4. Conclusions

The paper illustrated some relevant transformations in the organization of hospitals in Tuscany. The adoption of

a regional model for progressive care has induced a reorganization of flows of care and a particular attention paid to the relational dimensions of care.

Indeed, the focus on flows ensues mostly by the introduction of progressive care in the Tuscan hospitals. Along with the attention paid to efficiency of care improved through the organization of flows, a specific care of relational aspects has been developed into the Tuscan hospitals. In this regards, many tools have been put in force in order to balance the search for efficiency in the respect of the patients' rights.

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