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National Recovery and Resilience Plan and Health: qualitative analysis on the sustainability of the interventions on healthcare

F. Cascini[1], A. Gentili[1]

Key words: Health systems, sustainability, governance, health economics, Italy
Parole chiave: Sistema sanitario, sostenibilità, governance, economia sanitaria, Italia

Abstract

Background. *Sars-CoV2 epidemic was the cause of death of more than 180,000 Italian citizens. The severity of this disease showed to policymakers how easily Italian health services, and particularly hospitals, could be overwhelmed by requests and needs from patients and the general population. As a consequence of the clogging of health services, the government decided to allocate a consistent investment to the community and proximity assistance with a specific section (Mission 6) of the so called "National Recovery and Resilience Plan".*

Objective. *The aim of this study is to analyse the economic and social impact of the Mission 6 of the National Recovery and Resilience Plan, with particular regard to the most relevant interventions (Community Homes, Community Hospitals, Integrated Home Care), in order to understand its future sustainability.*

Material and methods. *A qualitative research methodology was chosen. Documents containing all the relevant information regarding the sustainability of the plan (called in short "Sustainability Plan") were taken into consideration. In case of missing data regarding the potential costs or expenditure of the aforementioned structures, estimates will be made reviewing literature for similar healthcare services, already implemented and active in Italy. Direct content analysis was chosen as the methodology for data analysis and final reporting of results.*

Results. *The National Recovery and Resilience Plan states that it will create savings of up to €1.18 billion thanks to the re-organization of healthcare facilities, the reduction of hospitalizations, the reduction of inappropriate access to the emergency room, and the containment of pharmaceutical expenditure. This amount will be used to cover the salaries for the healthcare professionals employed in the newly planned healthcare structures. The analysis of this study has taken into account the number of healthcare professionals that will be needed to operationalize the new facilities, as described in the plan and compared them with the reference salaries for each category (doctors, nurses, other healthcare workers). The annual cost for healthcare professionals has been stratified for each structure, with the following results: € 540 million*

[1] *Department of Life Sciences and Public Health, Section of Hygiene, Catholic University of the Sacred Heart, Rome, Italy*

Author's contributions: F.C. and A.G. contributed equally

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for the personnel of the Community Hospitals ("Ospedali di Comunità"); € 1.1 billion for the personnel of Integrated Home Care Assistance ("Assistenza Domiciliare Integrata"); and € 540 million for the personnel of Community Homes ("Case della Comunità").

Discussion. *The expected € 1.18 billion expenditure is implausible to be sufficient to cover the cost for salaries of all the healthcare professionals needed, which is expected to be around € 2 billion. The National Agency for the Regional Healthcare Services ("Agenzia nazionale per i servizi sanitari regionali") calculated that in Emilia-Romagna (the only region in Italy to have already implemented a healthcare structure based on the one described in the National Recovery and Resilience Plan), the activation of Community Hospitals and Community Homes reduced the rate of inappropriate access to emergency rooms by 26% (while in the National Recovery and Resilience Plan expectation is a reduction of at least by 90% for "white codes", the identified code for stable and not urgent patients). Moreover, the hypothesis for the daily cost of stay in the Community Hospital is roughly € 106, while the average current cost in the active Community Hospitals in Italy is € 132 (much higher than the National Recovery and Resilience Plan estimate).*

Conclusion. *The underlying principle of the National Recovery and Resilience Plan is highly valuable since it strives to enhance the quality and the quantity of the healthcare services in the country that are too often left out of national investments and programs. Nevertheless, the National Recovery and Resilience Plan has critical issues due to the superficial prevision of cost. The success of the reform appears to be established by decision makers and by their long-term prospective, oriented to overcome the resistance to change.*

Introduction

The Covid-19 pandemic has severely affected the Italian economy, reducing the Gross Domestic Product (GDP) by 8.9%, a consistent decline, even when compared with the average decline observed in the European Union, EU (6.2%). In addition to the economic loss, Italy has been greatly disturbed by a health crisis that led to more than 180,000 deaths for Covid-19, tragically exceeding the average of EU Countries (1).

The SARS-CoV2 pandemic, in its severity, highlighted some of the limits of Italy's National Health Service (NHS), including Community Healthcare and its network of services. The growing demand for care and the consequences of the epidemiological trend, caused a blockage of health facilities and services, both public and private, with a consequent share of patients who could not receive the care and services they needed.

The EU's response to the pandemic crisis is represented by the Next Generation EU (NGEU), a massive program of investments and reforms that aims to accelerate the ecological and digital transition to provide more gender, territorial and generational equity, and to improve the education and training of workers (2). Within this program, the National Recovery and Resilience Plan (NRRP) has been established. It is a € 191.5 billion investment package to help boost the Italian economy by enabling green and digital growth after the Covid-19 pandemic (3).

On July 13, 2021, the EU Council of Ministers definitively approved this package, with an Implementing Decision for the NRRP for Italy. The government has accepted the proposal made by the European Commission that defines precise objectives, goals and deadlines for each investment and reform. The allocation of funding is bound to the achievement of specific milestones scheduled on a half-yearly basis (4).

Health has an entire mission dedicated in this plan ("Mission 6") and is structured in 2 components, 8 areas of investment,

and 2 reforms, for a total amount of € 15.63 billion in investments. The strengthening of territorial and community health care has great relevance and importance.

The aim of this study is to analyze the the economic and social impact of the Mission 6 of NRRP, with particular regard to the most relevant interventions (Community Homes, Community Hospitals, Integrated Home Care). This study will allow to frame the possible repercussions and the future sustainability of the reforms.

Methods

A qualitative research methodology was chosen. Data (regarding demographic prevision, entity of investments, management cost prevision for healthcare facilities) contained in the Sustainability Plan (the supporting document annexed to the NRRP) was evaluated and compared, when feasible, with those retrieved from literature in similar structures, already operating in the Italian territory.

The study has been structured to analyze the cost estimates deriving from the implementation and consolidation of the 3 main measures foreseen with Mission 6 of the NPPR:

1. Community Homes
2. Community Hospitals
3. Strengthening of Integrated Home Care

Results

With the aim to fully understand the effective sustainability of the Plan, three main substantial investments have been deconstructed and studied:

1. Home of the community

With an investment of € 2 billion, this piece seeks to create and implement 1,350 "Homes of the Community" by 2026. These are physical places, easy to find and access for the population; a place where citizens and patients can easily have their healthcare needs answered.

The main objective of a "Community Home" is to provide all the necessary and primary healthcare services to the local resident population. To do so, it requires the engagement of a wide variety of healthcare professionals: general practitioners, primary care pediatricians, family nurses, specialists and other healthcare workers (speech therapists, rehabilitation technicians, psychologists, dieticians, physiotherapists).

As described in the Recovery Plan, the Community Home will guarantee the provision of the following services:

- Health and social single point access ("Punto Unico di Accesso – PUA")
- Sampling point
- Diagnostic services for chronic diseases' monitoring (ultrasound, electrocardiograph, retinograph, optical coherence tomography, spirometer, etc.), but also telemedicine services (for example, remote referral and teleconsultation)
- Specialist clinics for high prevalence diseases (cardiologist, pneumologist, diabetologist, etc.)
- Community Health Prevention and Promotion Services, including Family and Community Nurses ("Infermiere di Famiglia e Comunità – IFeC"), nursing clinics for the Integrated Chronic Disease Management
- Community health interventions based on Family Counselling and activities targeted at those under the age of 18 (optional)
- Vaccine prophylaxis, with particular attention for certain age groups or for certain risk conditions and frail patients
- Integrated reservation system
- Integration with social services

For each Community Home there will be 5 administration staff units, 10 general practitioners, and 8 nurses. This results in a

total of 6,750 administration people being staffed and 10,800 nurses who will need to be hired, beginning in 2026 to operationalize all the Community Homes around the country.

The investment allocated for the Community Homes' personnel is € 94.5 million and that will only cover the cost of 2,363 nurses – or at least 8,000 fewer than required (D.L. 34/2020 art.1 c.5). The NRRP claims to obtain the resources needed to hire the remaining part, more than 15,000 healthcare professionals, thanks to the healthcare reorganization (and so, reduction of inappropriate access to emergency services, reduction of pharmaceutical expenditures, reduction of inappropriate hospitalization).

The technological equipment needed for the full implementation of the medical practices inside the Community Homes (electrocardiograms, spirometers, ultrasound, etc.) will be financed through an investment of € 235 million.

Recruitments are not included in the NRRP and they will weigh on the public budget starting from 2027 (meaning that Community Homes will not be operative until 2026). The analysis quantified the number of healthcare professionals needed and their costs (based on the current National Collective Labour Agreements), and it is estimated that, beginning in 2026, at least € 634,5 million per year will be needed in order to pay the management of the 1,350 Community Homes spread across the Italian territory (Table 1).

2. Community Hospitals

The investment of €1 billion, is dedicated to the construction of at least 400 Community Hospitals and structures for patients requiring short, low-intensity procedures, both due to the mild nature of the episodes and the recidivism of more chronic illnesses. They can also be used to safely discharge, from acute hospitals, stable patients that still need clinical assistance (5).

The NRRP highlights some characteristics needed in order to be admitted for hospitalization in a Community Hospital:

• Patients with multimorbidity from acute hospital or rehabilitative care

• Fragile and/or chronic patients coming from home due to the presence of an exacerbation of pre-existing clinical condition, in any case not worthy of hospitalization to an acute hospital

• Patients in need of nursing assistance in the ADL (Activity of Daily Living), for administration of drugs, for the management of devices or the monitoring of parameters, which is not feasible to do at home.

Table 1 - Cost estimates for Home of the Community personnel (based on the national collective labour agreements)

Healthcare Personnel	Unit (for each Home)	Unit cost (€)[1]	Total units of personnel required in Italy	Funds (€)	Source of funding
Administratives	5	30,000	6,750	-	No funding expected
General Practitioners/ Primary Care Pediatricians	10	-	13,500	-	
Family Nurses	6	40,000	8,100	-	
	2	40,000	2,700	94,500,000	D.L. 34/2020 art.1 c.5
Total	23	634,500,000	31,050	94,500,000	

[1] Identified through national collective labour agreements (CCNL) by sector and management

Table 2 - Cost estimates for Community Hospital personnel (based on the national collective labour agreements)

Type of Personnel	Unit (for each Community Hospital)	Unit cost (€)[1]	Personnel required at national level	Total cost (€)
Doctors	1 (4.5 h/die x 6 days/week)	70,000	400 (561,600 h/year)	28,000,000
Nurses	9	50,000	3,600	180,000,000
Health workers	6	40,000	2,400	96,000,000
Total	16		6,400	304,000,000

[1] Identified through national collective labour agreements (CCNL) by sector and management

• Patients and/or caregivers needing training/education before complete discharge from acute hospitals.

At least 20 beds (up to a maximum of 40 beds) with mainly nursing management will be provided in each Community Hospital, with a structure for every 100,000 inhabitants (6). Healthcare personnel and costs expected for each hospital are summarized in Table 2.

The expenditure for the personnel of each structure amounts to € 760,000, so the overall cost for all the 400 Community Hospitals amounts to € 304,000,000. This figure is not part of the NRRP, and it will place additional demands on public budget starting 2027 (7). This does not include the maintenance cost, the cost for technologies or the cost for physical environments, which should also be considered.

3. Strengthening of Integrated Home Care Services

With a total amount of €4 billion in investment, "Home as the first place of care: Home care assistance" has 3 primary objectives: improving the number of patients assisted in their homes to over a million and a half by 2026 (10% of >65 years old population); implementing a new organizational model by creating local operational hubs, for the purpose of ensuring the continuity, accessibility and integration of healthcare; and promoting and financing the development of new telemedicine projects for remote assistance by regional healthcare systems.

By January 1, 2019, the population over 65 years old was 13.8 million people (representing 22.8% of the total population), and it is estimated that by the end of 2026 there will be an additional 807,907 elderly people, for a total amount of 14.6 million Italians over 65 years old (8).

The NRRP, in order to obtain an estimate of the cost necessary to satisfy these numbers of patients with home care services, referred to the case studies from the integrated home care experiences of the following regions: Toscana, Veneto and Emilia-Romagna. In those regions, the integrated home care assistance has 4 different levels of care intensity (each level is defined according to the number of accesses needed by the patient per month, with a different cost needed per patient in each level) (Table 3) (9).

The cost of the taking care of patients varies based on the level of care intensity (from a minimum of 1 access/month for the 1st level to a maximum of 15 accesses/month for patients in palliative care). However, on average, the annual expenditure for each patient assisted at home is €1,980. To sustain this expense, the government scheduled, for each year of the plan, a sequential increment of the budget addressed to Integrated Home Care (Table 4).

According to the Government's documentation sent to the EU in support to the NRRP, funding for the healthcare personnel dedicated to the reorganization of healthcare services will be covered until 2027. From that year, NRRP specifies that the necessary amount (€1.1 billion

Table 3 - Estimated costs for enhanced Integrated Home Care, stratified by intensity

Integrated Home Care – Assistance level stratified by intensity	% of total patients	Additional amount of elderly people assisted	Additional cost for home access (€)
Base	60%	483,782	104,712,925
First level	20%	161,594	204,343,403
Second level	10%	80,797	353,655,358
Third level	4%	32,319	325,504,494
Home palliative care	6%	48,478	611,763,186
Total	100%	807,907	1,599,979,366

missing) will result from savings due to the reorganization of the health system, the reduction of pharmaceutical expenditures, and the reduction of inappropriate accesses to emergency services.

Discussion

Italy completed all the milestones and targets present in the NRRP timetable scheduled for the 2021 (51/51), signal of the serious engagement of all Ministers involved in implementation of the Plan, including the Ministry of Health. Nevertheless, after analyzing the Mission 6 of NRRP in-depth, it is possible to notice some criticalities that need to be explored, with particular regards to the Community Hospitals.

NRRP claims to save €1.18 billion thanks to the reorganization of healthcare structures, and the reduction of hospitalizations, of inappropriate access to emergency rooms and of pharmaceutical expenditure (Table 5).

According to the Government's documentation sent to the EU to support

Table 4 - Planning of NRRP investments allocated to Integrated Home Care Services

	2022	2023	2024	2025	2026	2027
Cost						
Cost for Integrated Home Care Personnel (€)	578,231,762	760,889,632	997,151,408	1,283,890, 954	1,599,979,366	1,599,979,366
Funding						
Health fund (comma 4, art. 1 del D.L. 34/2020) (€)	265,028,624	265,028,624	265,028,624	265,028,624	265,028,624	265,028,624
Health fund (comma 5, art. 1 del D.L. 34/2020) (€)	235,000,000	235,000,000	235,000,000	235,000,000	235,000,000	235,000,000
NRRP (€)	78,203,138	260,861,007	497,122,784	783,862,329	1,099,950,742	–
Costs avoided via reorganization (€)						1,099,950,742
Patients						
Additional number of elderly treated at home	292,000	384,240	503,549	648,349	807,970	807,970

Table 5 - Assumptions of annual savings following the healthcare reorganization, as provided by the NRRP

1	Reduction of hospitalizations for chronic diseases at high risk of inappropriateness	€134,379,918
2	Reduction of inappropriate access to emergency rooms for white and green codes	€719,294,197
3	Reduction of pharmaceutical expenditure for 3 high intake and high risk of inappropriateness categories of drugs (diabetes, COPD, and arterial hypertension)	€329,000,000
	Total	€1,182,674,115

the NRRP submission, funds allocated to sustain the labor of healthcare personnel engaged in the strengthening of home care services and in the implementation of the new facilities in the territory (Community Homes, Community Hospitals) will be available until 2027, when the possibility to use NRRP funds will end.

NRRP specifies that for 2027, the necessary amount needed to finance the healthcare professionals' labor will be obtained through savings derived from healthcare reorganization, and from the reduction of pharmaceutical expenditures and inappropriate access to urgent care.

Analysis took into account the number of healthcare professionals that will be needed to operationalize new services and facilities, evaluating also reference salaries for each category. Estimates of the annual cost, regarding only the salaries for healthcare professionals, are: € 540 million to Community Home, € 304 million to Community Hospitals and € 1.1 billion to Integrated Home Care Assistance. The total amount (about € 2 billion) would clearly exceed the estimated savings due to the implementation of the plan (about €1.2 billion) (10).

In addition, according to the estimation of NRRP, the average cost for 1 day of stay in the Community Hospitals would be € 106 euro/day (a figure that includes only the cost for the personnel and not regular costs due to the sanitary equipment, management, and maintenance of the structure). It is important to underline how this amount, already underestimated, is lower than the average cost per day of the already active Community Hospitals in Italy (11, 12). If it will be not possible to guarantee the management cost for Community Hospitals as indicated in the NRRP, it will be necessary to tap into additional funds (around 25% more than what expected from the Plan, or € 76 million per year, if the management cost will be in line with the maintenance cost of current, existing Community Hospitals).

Moreover, the € 1.18 billion, that the Government plans to save from the reduction of drug expenditure and inappropriate access to hospitals, seems to be overestimated and difficult to reach, when compared with the current evidence.

In fact, when evaluating the data from the Emergency 2019 flow, it is possible to calculate the number of white and green code access that did not lead to hospitalization, and that would so be called "inappropriate". In 2019, there were 2,735,519 and 11,234,872 white and green codes respectively, that did not lead to hospitalization. NRRP argues that 60% of green codes (in this case, more than 6.7 million accesses) and 90% of white codes (in this case, more than 2.4 million of accesses) will be avoided.

To verify if this reduction in emergency access is feasible, it has been compared with the results coming from an AGENAS report that analyses the repercussions of the activation of Community Home and Community Hospitals in the Emilian territory. Emilia-Romagna, in fact, has developed a healthcare model oriented to the enhancement of the territory and in line with the principles and structure of the NRRP since 2009. The results, although encouraging, are far from target: the average reduction for inappropriate access in acute

hospitals (thanks to the implementation of Community Home and Community Hospitals) achieved a maximum of 26%, meaning a -34% and -64% for green and white codes respectively of what was planned in the NRRP (12).

Conclusions

The principle that guides the NRRP is honourable, since it strives to improve the quality and to enhance the quantity of territorial and community healthcare services, usually underestimated and consequently underfunded, through the ideal of a care proximity network.

Nevertheless, the NRRP shows criticalities mainly due to the underestimation of cost and maintenance, in the medium- and long-term, and at the national and regional levels.

The need to develop a massive program such as NRRP in a very short time led to the lack of a deep analysis and constructive dialogue with regional realities. The direct consequence is a framework set on a demographic basis that does not take into account the real needs and the demands of care of citizens and patients. It does not take into account the diverse context in which the future healthcare services will be implemented nor are the economic and human resources needed to realize such structures fully incorporated.

The success of the territorial healthcare's reforms now seems to be based on the will of the decision-makers and on their medium- to long-term perspective. They are willing that people will not resist the change and will actively engage in a synergic way - multiple actors across various healthcare fields are committed to facilitate this new paradigm for health.

Riassunto

Piano Nazionale per la Ripresa e la Resilienza e Salute: analisi qualitativa sulla sostenibilità degli interventi dedicati alla Sanità

Introduzione. La pandemia da SARS-CoV2, nella sua drammaticità, ha determinato un intasamento delle strutture sanitarie sia pubbliche che private, con una conseguente quota di pazienti che non ha potuto ricevere le cure e i servizi di cui avrebbe avuto bisogno. Si è deciso quindi di valutare il possibile impatto sociale della Missione 6 ("Salute") del Piano Nazionale di Ripresa e Resilienza, con particolare riferimento agli interventi dedicati al potenziamento del territorio, come gli "Ospedali di Comunità" e le "Case della Comunità", allo scopo di inquadrare tempestivamente la futura sostenibilità nel tempo della riforma.

Materiale e metodi. Si sono presi in considerazione i dati contenuti nel Piano di Sostenibilità (documento allegato a sostegno del Piano Nazionale di Ripresa e Resilienza). I dati qui presenti (relativi alle previsioni demografiche, all'entità dei finanziamenti, ai costi di gestione delle strutture previste) sono stati confrontati, quando possibile, con quelli provenienti da strutture simili già operative nel territorio italiano.

Risultati. Il PNRR sostiene di poter risparmiare €1,18 miliardi dalla riorganizzazione delle strutture sanitarie e dalla riduzione delle ospedalizzazioni, degli accessi inappropriati nei Pronto Soccorso e della spesa farmaceutica. Il finanziamento del personale sanitario, non inserito nel Piano Nazionale di Ripresa e Resilienza, sarà coperto interamente da tale risparmio. Le analisi hanno tenuto conto del numero di personale sanitario necessario per l'implementazione delle strutture e dei servizi (per Ospedali di Comunità, Case di Comunità, Assistenza Domiciliare Integrata) e degli stipendi di riferimento. Il solo costo annuo del personale sanitario è stato quantificato come segue: € 540 milioni per le Case della Comunità, € 304 milioni per gli Ospedali di Comunità, € 1,1 miliardi per l'Assistenza Domiciliare Integrata. Tale cifra non sarà sufficiente a coprire la spesa necessaria per gli stipendi del personale impiegato, che sarà molto più elevata (circa € 2 miliardi).

Discussione. La sostenibilità del Piano, così come elaborato, appare molto difficile. Gli € 1,18 miliardi di risparmio, dovuti alla riorganizzazione sanitaria, non solo risulterebbero insufficienti al mantenimento dell'operatività delle strutture sanitarie, ma risultano anche difficilmente ottenibili. Uno studio dell'Agenzia Nazionale per i Servizi Sanitari Regionali, ambientato in Emilia-Romagna (unica regione ad aver un modello sanitario territoriale simile a quello proposto nel Piano Nazionale di Ripresa e Resilienza) ha evidenziato come Ospedali di Comunità e Case della Comunità siano utili

sì a ridurre gli accessi inappropriati in Pronto Soccorso, ma come tale percentuale non superi il 26%, vale a dire un -34% di quanto previsto per i codici verdi e un -64% di quanto previsto per i codici bianchi dal Piano Nazionale di Ripresa e Resilienza. Inoltre, sempre riportando le stime proposte nel Piano Nazionale di Ripresa e Resilienza, si può notare che l'ipotesi di spesa per una giornata di degenza negli Ospedali di Comunità andrebbe ad essere mediamente di soli 106 euro al giorno. Occorre ricordare che attualmente la tariffa media degli Ospedali di Comunità già operativi in Italia è di 132 euro al giorno.

Conclusioni. Il principio alla base del Piani Nazionale di Ripresa e Resilienza è di notevole importanza, poiché ambisce a migliorare la qualità e ad aumentare la quantità dei servizi sanitari territoriali, sempre poco calcolati e di conseguenza finanziati, tramite un principio di rete di prossimità di cura. Ciononostante, il Piano Nazionale di Ripresa e Resilienza mostra criticità legate principalmente alle previsioni di spesa e di mantenimento, sul medio e lungo termine, a livello nazionale e di singole regioni. Il successo della riforma della sanità del territorio appare ora sostanzialmente in mano al decisore politico ed alla sua prospettiva di medio-lungo termine, orientata a vincere la resistenza al cambiamento.

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Corresponding author: Andrea Gentili MD, Dipartimento di Scienze della Vita e di Sanità Pubblica, Sezione di Igiene, Università Cattolica del Sacro Cuore, L.go F Vito 1, 00168 Roma, Italy
e-mail: andrea.gentili1989@gmail.com