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Paper title: The harmony between ethical and rational behaviour in the Health Care System. A relational model based on the Viable Systems Approach (*VSA*)

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Brief professional biography

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Abstract

Title: The harmony between ethical and rational behaviour in the Health Care System. A relational model based on the Viable Systems Approach (*VSA*)

Article Type: Conceptual paper

Purpose
To find the conditions of harmony between ethical and rational behaviour in the context of the National Health Service (the Italian health care system), considering both the needs of the organizations providing health care services and the customers.

Design/methodology/approach
The paper analyses the health care service complexity in a relational view, using, on the basis of the Viable Systems Approach *(VSA)*, the concepts of value categories and interpretative structures to study respectively ethical and rational behaviour and to represent the emerging characters of the systemic instability.

Findings
The main findings consist in the formulation of a relational matrix to represent the essential levels of care from both the points of view of the organizations of the National Health Service and of the customers. The model is useful to analyze and compare their aims and expectations and define the areas of convergence and divergence.

Practical implications
The application of principles and concepts from the *(VSA)* to articulated structures such as health care enables to highlight "pathological" aspects and new interesting "therapeutic" prospects, so to guarantee the viability of the regional and national health care system.

Originality/value
The paper provides new methodological bases to evaluate the appropriateness of the health care in terms of efficiency, effectiveness and sustainability.

Keywords
Ethical behaviour; Viable Systems Approach; Health Care System; Essential Assistance Levels; Categorical Values; Interpretative Schemes.

The harmony between ethical and rational behaviour in the Health Care System. A relational model based on the Viable Systems Approach (*VSA*)

1. Introduction: looking for the harmony between ethical and rational behaviour

The aims of this paper are both explicit and implicit. On one hand, our aim regards the object of the paper that is to find the conditions of harmony between ethical and rational behaviour within the Health Care System. On the other hand, with regard to the method, we wish to portray the new opportunities that the Viable Systems Approach (Golinelli, 2000, 2002, 2005, 2008, 2009) can supply us with.

Economy and, mainly, management, joint to the evolution and the progress, are responsible for a values drift and a wide diffusion of worst practices, which have had an important role in bringing us to the present global crisis. Therefore, it now seems necessary to recover certain ethics, such as the values of merit and responsibility in entrepreneurship.

Our will, firstly, is to underline the necessity to recover a healthy relationship between ethics and rationality in organizational behaviour, starting from the wider theme of ethics and social economy, but moving our focus towards values and emotions.

In business management, this debate has formed two waves of thought: on one side, we have those who consider ethics necessary in the economy, on the other, those who consider ethical aspects irreconcilable with the economical aims of the firm.

Today the prevailing standing-point converges towards the recognition that a merging of ethics and economical rationality is necessary for the survival of the firm. But what really lays behind ethical and rational behaviour?

Amartya Sen (1987) brings us to the heart of the problem, reminding us of the two origins of economy, one which is based on ethics and one which has a technical stand. This separation has brought to two different schools of thought in the art of government, one which pays more attention to ethics. referring to the studies of Smith, Mill, Marx, Edgeworth and one more towards a technical orientation, considering the studies of Petty, Quensnay, Ricardo, Cournot, Walras.

Both approaches are necessary to make organisations function, one concentrates on aims, while the other on mechanisms. Still in practice we have come to witness a clean separation between what we can call ethic rationality and economic rationality, which has made it difficult to reconcile these two naturally harmonic dimensions.

This concept is of course interdisciplinary and has varied forms regarding methodology of interpretation. Economists look at the question of ethics from an economical viewpoint; philosophers, sociologists and theologians look at the question of economy from a social-ethical viewpoint. Whilst the most significant contributions have been given by researchers who, with rigorous methodology, have been able to integrate various viewpoints. Rendering the ethics behind economical action explicit requires specific tools and skills that are not only economical, but also philosophical (Rusconi, 1997) and probably always psychological (Smith, 1759; Kahneman, Tversky, 1979).

Recent studies from the Viable Systems Approach (Barile, 2000, 2008, 2009) have brought us to take into consideration new models of interpretation, with a new open approach towards various disciplines.

In this work we intend to propose a key of interpretation based on the methodology of the Viable System Approach within the context of the HCS, where the dichotomy between ethics and economy can be observed. From this view, we will be able to see how these two dimensions are recomposed in the model of the viable system, in which the institutional government is responsible for the survival of an organisation, taking its aims, rules and constraints from the context in order to successfully conduct the operative structure, responsible for the efficiency of the system. Profits, productivity, resource

saving and efficiency refer to the functioning of the system through its structure, not to its aims and motivations. In this way the efficient functioning of the operative structure, conceived as a means to fully valorise resources paying attention to unnecessary costs, especially in healthcare (Borgonovi, 2008), creates the best conditions to reach the aim of the system.

In a more recent representation (Barile, 2009), conceiving an organisation as a form of "informative variety", built with categorical values, interpretative schemes and information, enables new perspectives to understand tasks in the management domain and explains how the government can point out values, beliefs and feelings.

2. Theoretical background

In this paper the contributions of literature come from varied fields of study. The relationship between ethics and economy, born thanks to the contributions of great philosophers of the past such as Socrates, Aristotle, Plato, (Croce, 1909), whose works remain as universal reference points, the debate seems to be still alive on a practical scale even though its theory seems to be more accepted.

The scientific community started a strong discussion with Adam Smith, than with economists from liberal schools. Classical studies retain that utilitarianism be the correct strategy to obtain the best result; thinking of one's own interest is good for the economy (Smith, 1776). Later, the utilitarian principle is considered in a different way: an action is considered as valid from an ethical viewpoint only if the total sum of usefulness produced by that act is superior in comparison to the level of usefulness produced by any other act.

The evaluation of the behaviour of homo economicus, firms and organisations can be fully explained only by contemporary economical, social and cultural values (Barnard, 1970). Social institutions have the role of mediating inter-personal and environmental relationships (Rich, 1993).

In the Italian tradition, management studies confirm that ethics have an important role in reconciling economics and social-ethics (Coda, 1989; Miolo Vitali, 1993; Caselli, 1998, 2003; Di Toro, 1993; Sciarelli, 2003; Baccarani, 2008; Borgonovi, Rusconi, 2008). For this reason ethics have become a discipline that is taught not only in American business schools.

Scholars have clear ideas regarding theory but still seem sceptical on the practical side. This theoretical and general convergence towards the necessity to develop a social-ethical dimension in business management, does not correspond to a solid use in a company context. Companies do not leave much space for values, apart from those of the market, such as efficiency and profit, for this reason ethics on the field do not represent a decisive compass (Giaretta, 2008).

The theoretical understanding of such a complex concept needs to be integrated with appropriate models and methods (Taylor, 2001) and must not limit itself to a simple transposition of ethical and moral principles into the firm, but distinguish concrete lines of action for an approach which can be considered ethically responsible in regards to company benefits (Caselli 1998, Barile, 1994). A company is an institution in which legitimacy and social responsibility find a meeting point and ethics are intrinsic to economical rationality (Caselli, 1998).

In relation to healthcare, our analysis extends the focus from the marketing relational view (Fiocca, 1991, Ferrero, 1992, Grandinetti, 1993; Costabile, 2001) to a governmental intra and inter relational view (Lorenzoni, 1992), developed through the viable systems approach, that goes beyond the limits of an analytical-reductionist approach (Gatti, 2000; Golinelli *et al.*, 2002). In this sense, there are interesting interpretative convergences as with the concept of *many to many marketing* (Gummesson, 2004) as with the concept of Service Dominant Logic (Lusch and Vargo, 2006).

To confront our interpretative hypothesis with the orientation developed in the specific sector, we have considered works which treat the concept of public service, with a particular lens towards the healthcare field (Adinolfi, Mele, 1997; Zangrandi, 2000; Genco, 2002; Brenna, 2002).

As already said, the methodological approach refers to the *(VSA)* in systems thinking studies.

3. Methodological approach

Following the systems thinking, the *(VSA)*, starting from the viable system model (Beer, 1985), proposes a new adequate scheme of interpretation towards the instability of the system. It represents a method to observe business phenomena, and more in general social ones, which are adequate in explaining the complexity through general interpretative schemes, enabling us to face in both theoretical and operative terms questions of business management and general social organisation, defining the intra and inter-systems relationships of the organisation.

We consider the following schemes and concepts:

- viable system model;
- consonance and resonance;
- representation of viable systems as "informative variety".

According to the *(VSA)*, an organization, as viable system, is characterized by an universal identity with an area involved into/dedicated to decision-making (*government*) and one into/to decisions-performing (*operative structure*). The government has precise responsibilities regarding the survival of the system in a given context, with the development of conditions of *resonance* and *consonance* with the actors involved in the main dynamics of the system (*suprasystems*).

Recent progress in the *(VSA)* (Barile, 2009) proposes a formal interpretation of emerging processes of interaction in an intra and inter system context. The interaction which results from the relation can be considered as a reciprocal variation of informative variety. The "informative variety" (varied equipment) shows how categorical values (strong beliefs) intertwine with interpretative schemes and information, acting in different ways depending upon the level of difficulty created within the interaction.

Take in Table (No. 1)

Table (No. 1) - The characterisation of the "informative variety" in viable systems depending on decision-making contexts

Informative variety / Problematical area	Categorical values	Interpretative schemes	Information units
Certainty			
Complication			
Complexity			
Caos			

Source: Barile, S. (2009), p.32.

Categorical values and interpretative schemes act in reducing and simplifying the immense variety of the context, which would otherwise be perceived as a chaotic flux of informative units, making the viable system more consonant with the context.

The categorical values, which represent the strong beliefs of a viable system, are responsible for the refusal or acceptance regarding rationally justified elaborations. They are strongly linked to the emotional level of the decision maker and qualify states of unconsciousness which tell us if something is "good" or "bad". They establish the ethics of context and general moral (Barile, 1994) enabling us to express judgement on facts and happenings. Categorical values are rooted inside individual and organisational value systems and demonstrate a certain reluctance to change.

Categorical values tend to be shared by people who belong to the same social group (Capra, 1996; Barile, 2009). The effects of the dynamics of interaction depend on the concepts of what we call *resonance* and *consonance*. The consonance represents the major or minor potential that the relative informative varieties have to be able to align themselves on the same level. The resonance intervenes to modify the level of consonance and make a choice possible. The modalities with which an informative variety transforms itself in a context represent the level of sensibility that it shows towards the suprasystems. It is important to understand that, determining the level of consonance, the action of the categorical values is more significant in comparison to rational interpretative schemes.

The proposed methodology offers a conceptual framework for the analysis and development of consonance in the processes of inter-systems interaction for the survival of the system.

The analysis of the relationship between ethical and rational behaviour in healthcare uses the relational key of the VSA as a general conceptual framework of interpretation and applies the model of informative variety to explain the dynamics of evolution in this sector and the implications for the consonance with the client/users suprasystem.

4. A relational model for the Health Care System from a Viable Systems Approach *(VSA)*

In healthcare rational decision-making inspired by business management has become an established standing-point, since the managerial culture has been introduced in the health sector (Zangrandi, 2000; Michelini, 2000). We have witnessed the tendency of this system go towards a progressive company set up with a managerial configuration, making the government approach not only political, but also more technical.

The following Italian norms show us the fundamental objectives: (Law 833/1978; Legislative Decree 502/1992; Legislative Decree 229/1999; Law 405/2001):

- safeguard human dignity;
- health care;
- equal assistance;
- service's quality and appropriateness;
- efficiency.

From a paternalistic healthcare scheme, in which the patient would passively undergo medical treatment, we have progressed towards a contractual assistance scheme, in which the patient has become a client. In this sense, there has been a process of evolution in structure, services and needs, efficiently synthesized, in a relational view, with the passage from the original *doctor-patient* relationship to the current *provider-client* relationship, centred on the principle of the patient's autonomy and based on a wider service.

Take in Figure (No. 1)

The Italian health care system, with the institution of the Essential Assistance Levels, provides payment of essential and uniform aid services in order to safeguard the values of human dignity, personal health, equal assistance and good health practices (Bernardi and Pegoraro, 2003; Borgonovi, 2004).

With the progressive tendency towards a business logic and the introduction of competitiveness, managers are asked to reconcile efficiency with effectiveness (Kongstvedt, 2001). For this reason, decision-making processes use models, techniques and instruments originally conceived for business organisation and the approach towards healthcare is characterized by a progressive growth in technicality. Thus the management has been formalised with the use of codes and procedures.

What can we observe from a (VSA)?

From the *(VSA)* view and according to the relevance model, it is clear that the government considers the political-institutional suprasystem as its main reference point, relevant to satisfy and guarantee the necessary resources for its viable functioning. The political-institutional suprasystem, given its aims, has projected upon healthcare the expectation to recover efficiency, creating behavioural bonds and rules and premium/sanction mechanisms.

Considering also the politically based nomination of managers, the healthcare system has progressively become more consonant to the expectations of the political-institutional suprasystem, interested in efficiency of the system, thus ending up neglecting the client/users suprasystem, who are primarily interested in the effectiveness of the service

Take in Figure (No. 2)

In a context with chronic scarcity of resources and continuous growth of health care needs, the Italian Health Care System (HCS) – in Italy called National Health Service – government, when evaluating the expectations of the political-institutional suprasystem, given the mechanisms of the financing system, interprets the concept of efficiency on a resource-disposability basis. This has brought to a limited view which has inspired business expense-strategies based on rigid definitions of operative protocols.

This logic, introduced by managerial leadership, has matched with the healthcare logic, producing two types of effects (Thompson, 1967): on the one side, an antagonistic interaction, when the health care logic does not accept the economical logic; a synergic interaction, when a progressive acceptance is witnessed.

The present service-offering of the Italian HCS is based on Essential Assistance Levels articulated in (DPCM, 23th april 2008):

- collective prevention and public healthcare;
- district assistance;
- hospital assistance.

In order to guarantee the correct functioning of the system, the assistance given has to be done by respecting the criteria of *appropriateness*, in other words, its adequateness for the needs of a given user. Indeed, this evaluation of adequateness, in line with the prevailing limiting scheme, has been defined mainly by comparing costs and results and thus fixing a cost-benefit profile, rather than a risk-benefit one (Brook, 1994; Schweiger, 1994). But the interpretative schemes of management rather than imposing a limiting precept, intervene to assure an efficient use of limited disposable resources, inspired mainly by their full enhancement (Cifalinò, 2000). In reality, the HCS does not seem to be very interested in sanctioning the widely diffused waste of resource practice.

Moreover, in many cases, rational behaviour has gone beyond the economical logic and management has performed distorted practices, on the limit of legality, offending twice the person, as citizen and, what is worst, as patient.

How does the (VSA) explain this practice?

In relation to the role and the responsibilities of the HCS government, a new *(VSA)* study (Barile, 2009) offers a key able to interpret the process of evolution which has conditioned the decision-making and operative practices of management in time, bringing to a behavioural model upon which reflection and constructive criticism has been made by the scientific community (Birkinshaw and Piramal, 2005) and by the actors of the economic society. Barile considers the historical evolution of the managerial approach as one which has progressively lowered its values and for this reason today management has lost its original virtuous dimension, originally legitimating the company-institution as a beneficial instrument to the well-being of society. We have arrived to such a managerial practice thanks to the establishment of best practices, to models, techniques and instruments which have made it possible to re-use winning models in a general model of progress.

According to Barile's interpretation, the myopia of certain managers has established itself in facing choices fundamental for the survival of the system, which show high level of complexity and cannot be included in common interpretative schemes, as *problem solving* issues (operative structure's level), with a technical approach of management, instead of *decision making* ones (government's level). These choices are that ones which often call fundamental values of society into action.

The ways in which Health Care government has acquainted itself with the principles and criteria of business practice have shown, also in this context, the development of a problem-solving orientation (Churchill, 1999). We can thus understand the meaning of what has already been said in the World Health Report 2008, entitled *Primary Health Care – Now More Than Ever*: "rather than improving their response capacity and anticipating new challenges, health systems seem to be drifting from one short-term priority to another, increasingly fragmented and without a clear sense of direction" (WHR, 2008 p. Xiii).

With the time certain practices become habits (Maslow, 1970). Thus, the progressive diffusion of such practices in the managerial context has formed a decision-making style and behaviour based upon rational schemes and by certain categorical values which are not consonant to the needs of the client/user. If the execution of certain supplying of services can be optimised by the use of codes and protocols (Casati, 1999), the same cannot be said for the *relation* which conducts the given service performance in which the value of complex and emotional expectations intertwine (Olesen and Bone, 1998).

The logic of protocols, with codes and schemes, seem to have prevailed upon values and emotions.

What implications are there in the relationship between healthcare organizations and users?

Firstly, let us take into consideration the client/user point of view.

In this scenario, it must be said, users are continuously becoming less passive spectators and it seems clear that the HCS seems to continuously underestimate their potential influence capability.

If to health care organizations economical aspects have often become more important than values, users seem to have gone in the opposite direction. Originally, the patient was more interested in the functional medical performance, rather than in the value relationships. It seemed natural for the patient to accept the illness with resignation. Today, in our society of well-being and scientific progress, health is considered as a primal value, constitutionally protected, and the patient, as client in a more complex relationship and still in a condition of asymmetrical information, does not have the adequate interpretative schemes to rationally evaluate service performances and tends to make his decision from a relational point of view, guided mainly by trusted categorical values.

In order to understand these relational implications more deeply, let us consider the nature and the dynamics of the needs of assistance in detail. To the typical health care needs, that are the wellness (psycho-social aspect), the recovery from an illness (biological aspect) and the functional recovery (functional aspect), the HCS respectively responds with prevention, cures and rehabilitation. Considering the patient viewpoint, it is possible to represent the dynamics of needs of assistance with a curve which shows the variation of intensity in a typical succession of assistance phases.

Take in Figure (No. 3)

According to this representation, we can assume that the intensity of the needs varies in relation to the different types of health care service, so we can consider it:

- high for cure;
- medium for rehabilitation;
- low for prevention.

This brings us to say that users have different standing-points in regards to the HCS, according to the different situations regarding the perceived problematic level. According to the model of Barile, we can theorize that *while the need of assistance rises, the influence of categorical values and emotional components rise also, in comparison to interpretative scheme*.

Now let us take into consideration the healthcare organizations point of view.

If healthcare organisations follow the protocols and have to face the pressure of the focalisation on saving resources, we can say that decision-making and behavioural logic be conditioned particularly by the *cost of the health care service* and by what we can call the *risk of inappropriateness*, which, given the present structure of health care costs (Pessina and Cantù, 2008) can be considered:

- high for hospital assistance;
- medium for district assistance;
- low for collective prevention and public health, in public and work places.

If we represent the organisational healthcare needs with those of the user in a relational matrix, we can see the areas of convergence/divergence in which conditions of consonance/dissonance emerge.

Take in Figure (No. 4).

The two dimensions of the matrix define a continuum in which the health care service is articulated in every Essential Assistance Level.

The representation shows how HCS and users seem to converge regarding the health care appropriateness at the hospital assistance level for cure, at district assistance level for rehabilitation and at collective and public healthcare for prevention. From a real viewpoint, however, the evolutional dynamics described tend to make the parts of the relationship diverge: economical rationality pushes HCS go towards (when possible) a lower assistance level. On the other hand, users tend to ask for a higher assistance level. This determines a reduction of consonance with users suprasystem.

The matrix also clearly shows a worrying convergence: how less relevance is given to prevention, upon which a modern society should invest significantly.

The representation explains the different mentalities of users and healthcare organizations. Thus, we are able to notice that the evaluation seems to converge in *grade* terms, while the *criteria* adopted diverge*: users are guided by values and emotions (categorical values), while the healthcare organizations are guided by protocols and codes (rational schemes).*

Take in Table (No.2)

Table 2 - Healthcare Organizations and Users: two different ways of thinking

Users viewpoint: The importance of categorical values			Healthcare organisations viewpoint: The importance of rational schemes
High	Hospital assistance	**High**	
Medium	District assistance	**Medium**	
Low	Collective prevention and Public healthcare	**Low**	

Essential Assistance Levels

It means that there is a growing risk of *relational dissonance* with users. This seems to be particularly risky because the divergence is clear not only between categorical values or between interpretative schemes, but between the complex architecture of the informative variety regarding the different sides in the relational context.

So, if the HCS tends to get closer to the political-institutional suprasystem logic, it seems to be going further and further away from users suprasystem. Whilst becoming more resonant with the first, it seems to be jeopardizing the conditions of consonance with the second, generating thus a *new risk of inappropriateness*, that addresses to taking into consideration not only the criteria of efficiency and effectiveness, but also psychological, emotional, relational and social dimensions.

The users suprasystem, even though it still shows an informative asymmetry, is expression of the wider consumers system, which is proving the potential capability of pressure and configures itself as a particular system able to rapidly evolve from an embryonic condition to one which is complete. This is made possible by the relevance perceived and by the sharing of the aims which determine its emersion. Furthermore, the suprasystem influence is not only activated directly, but also indirectly thanks to the political-institutional representations. Considered as the inter-systems connections which are activated on various levels of the articulated relational context in the healthcare domain, this interaction seems also to be developed on a *many to many* type of relation (Gummesson, 2004).

A deep rethinking of the HCS is required to "prevent" the risks of system's instability, connected to the drifting away of consonance with the users suprasystem, correctly evaluating its influence and intervening appropriately to obtain an ideal level of resonance.

On the other hand, it is clear that HCS and users result in being in poor *reciprocal* harmony. Indeed, even users, in a general context of a higher need of assistance, show poor predisposition to rational responsible behaviour. Too many times users contribute in wasting resources.

The recovery of relational consonance, in which a new concrete harmony is found between ethical and rational behaviour, asks for a convergence between categorical values and interpretative schemes. This demands from both sides an effort to bring their cognitive-behavioural varieties closer together, to a path of awareness of values and emotions from the HCS and more rational behaviour by users. Users must be able to understand, share and contribute to the needs which an efficient and effective HCS demands. This must be done through a fully sharing and valorising scarce resources.

The effort of bringing these two parts closer needs to be accompanied by a full understanding of value systems and interpretative schemes. The interaction which is guided by a striving towards makes it able for us to metabolize reciprocal incoming information with shared schemes which enable an interpretative alignment. Of course, this effort of getting closer is conditioned mainly by the grade of convergence of the categorical values. It is mainly on this point that the effort of acquaintance needs to be done.

This demands a paradigmatic exchange in the offering and in the supplying systems which must reciprocally converge in the common context, society, and consider each other partners of a sharing process and co-creators of value. This paradigmatic exchange finds a concrete expression in SDL (Vargo and Lusch, 2008).

5. Practical implications

The Italian HCS has experienced, and is still doing so now, with other viable parts of the social body of our country, a moment of radical change. The regional structures are in a difficult situation, the aging of the population will bring to an increase of healthcare need and will risk causing a socio-economical crisis hardly controllable (Barile, 2007).

The *(vSA)* proposes a new scheme of interpretation which is adequate to the emerging instability of the system. The application of principles and concepts of viable systems to the articulated architecture of the healthcare service, enables us to underline innovative and interesting "pathological" and "therapeutic" aspects, a way to recover a form of harmony between ethics and rational decision-making.

According to the SDL paradigm, the recovery of harmony between ethical and rational behaviour in the Healthcare System implies a unified-system-vision in which the client assumes a central position in a vast scheme of relations and is no longer a simple passive receiver of the performance of a service (Miceli *et al.*, 2007).

This change needs the support of adequate interpretative schemes able to synthetically represent the pluralism which characterizes the endowing of a service. For this the *(vSA)* can be very useful.

From a practical point of view, organisations must recognize their responsibilities towards the various categories of the suprasystems they belong to. The pyramidal representation of organisations (Maslow, 1970; Carroll, 1991; Sciarelli, 2003) reminds us that secondary needs (ethical and philanthropic) do not emerge if primary ones (economical and legal) are not satisfied (Barile, 1994).

As already said, the HCS will has to recover an social-ethical dimension, regaining the original sense and values of its mission and recognising its value (Sancetta, 2007), while the user will have to begin acting more rationally.

A desirable effect of this paradigmatic change could be more the result of greater attention paid to prevention, by both the Healthcare System and the users. The area of prevention, as shown above, seems to be the less critical one, but this is the result of the scarce relevance that the collectiveness gives to it and because of the poor effort shown by Healthcare System in communication and in involving people in activities of prevention. On the other hand, prevention represents an area in which a new economical paradigm can express itself, demanding a determined participation on the citizens, in a value co-creating view.

6. Conclusion

Having taken into consideration our study, the research for harmony between ethical and rational behaviour in the healthcare system, representing the relationship between ethics and economical rationality, conducts us towards an emotions/codes axis, opening the reflection of economical studies to the psychological field.

The concept of appropriateness of the health care service widens itself from a cost/benefit relation to a more complex evaluation of sustainability. This requires also the control of the system's instability that could erode its ability of survival (Piciocchi, 2003).

Therefore, the implicit contribution from a methodological point of view, becomes clear: the *(VSA)* enables us to mould a unified vision regarding complex objects of analysis and underscores the various converging elements amongst the different viewpoints and thus the benefits from the use of varied interpretative schemes, as proposed in the Service Science (Sporher *et al.*, 2007).

The managerial approach offers general and synthetic schemes able to diagnose phenomena and put different alternatives in comparison. The decision to follow one path rather than another has deep ethic implications which depend upon subjective categorical values. Business management gives us a wide group of interpretative schemes which enable the government in a HC context to resolve, in a systematic and conscious manner, typical problems of decision–making. Still, complex decisions regarding the use of resources need in depth thought relating to patients, families and society on a whole.

The focus must turn on human resource, the key factors upon which HCS must concretely invest in order to obtain a paradigmatic change and adapt new solutions based on the knowledge of cognitive and behavioural dynamics. The role of categorical values, in particular, which aim towards a recovery of an ideal path, enables us to consider the right values and conduct the decision-makers towards a path of moral treasuring (Etzioni, 1988; Barile, 2009). This path can work as a foundation upon which social and human questions could be tackled.

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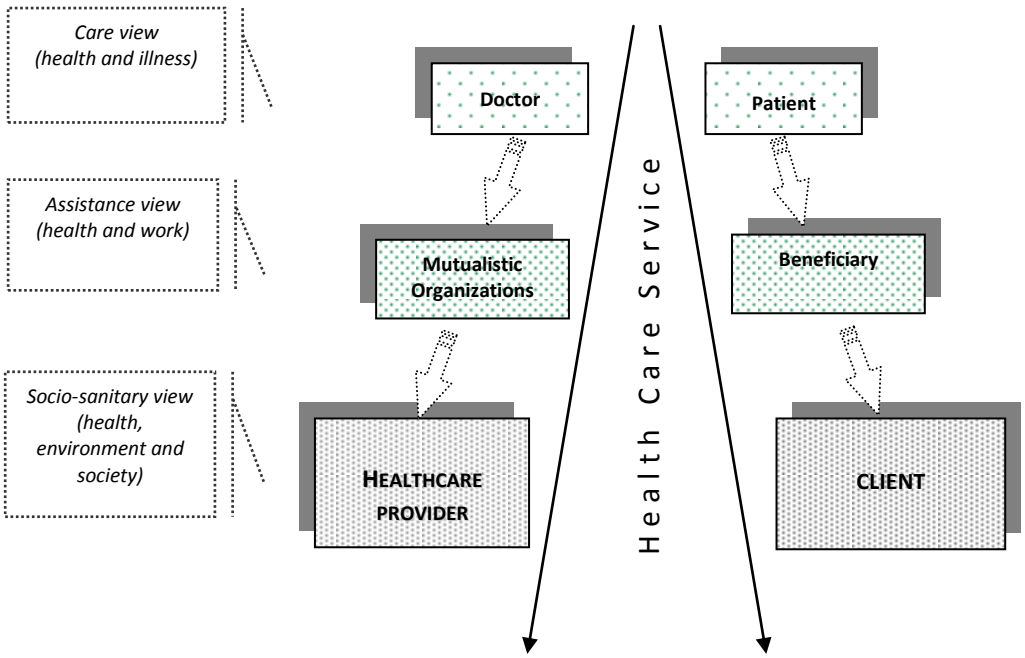
Figure (No. 1) - The passage from a *doctor-patient* to a *provider-client* relationship



Source: Saviano, M. (2007), p. 57.

Figure (No. 2) - The relevant suprasystems in the HCS

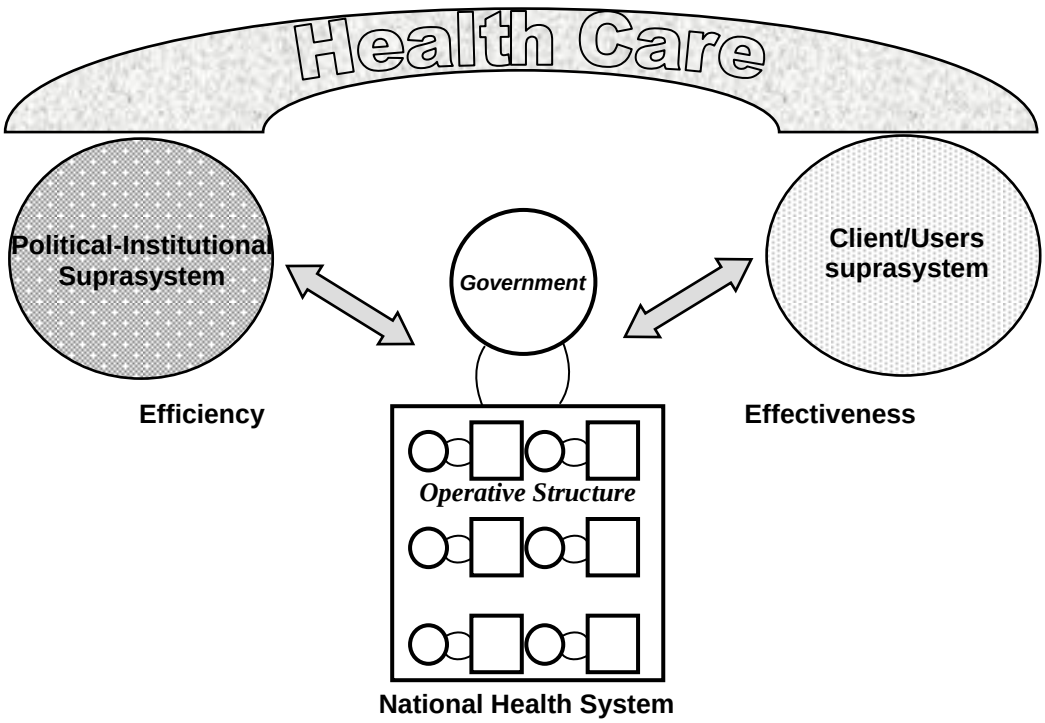
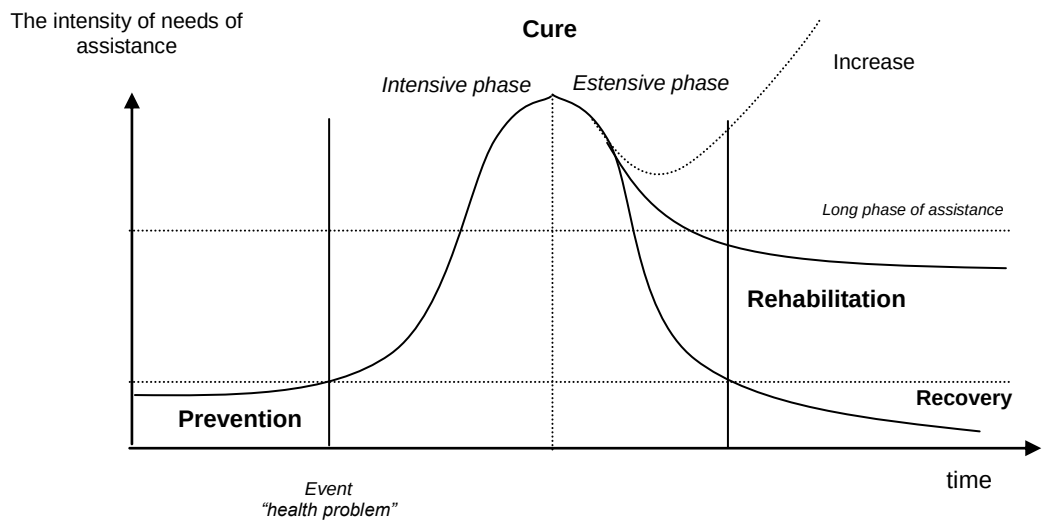
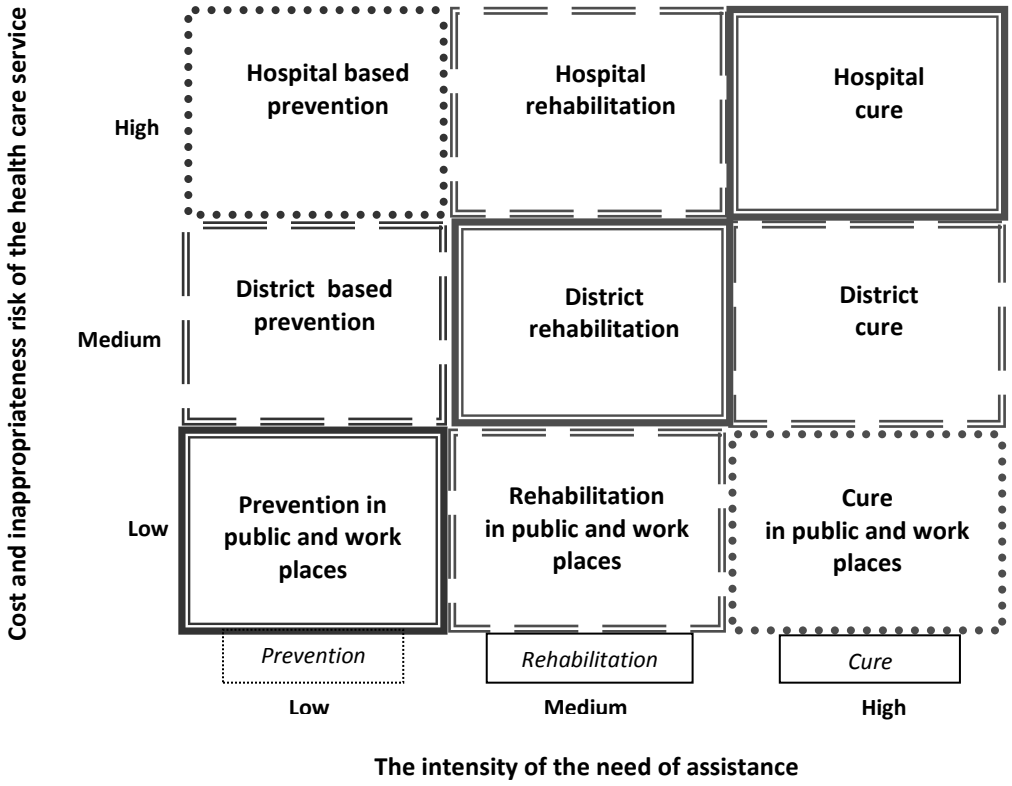


Figure (No. 3) – The Curve of needs of assistance



Source: Saviano, M. (2007), p. 61.

Figure (No. 4) – The Health Care Service Relational Matrix



Source: Re-elaboration of Saviano M. (2007), p. 72.