

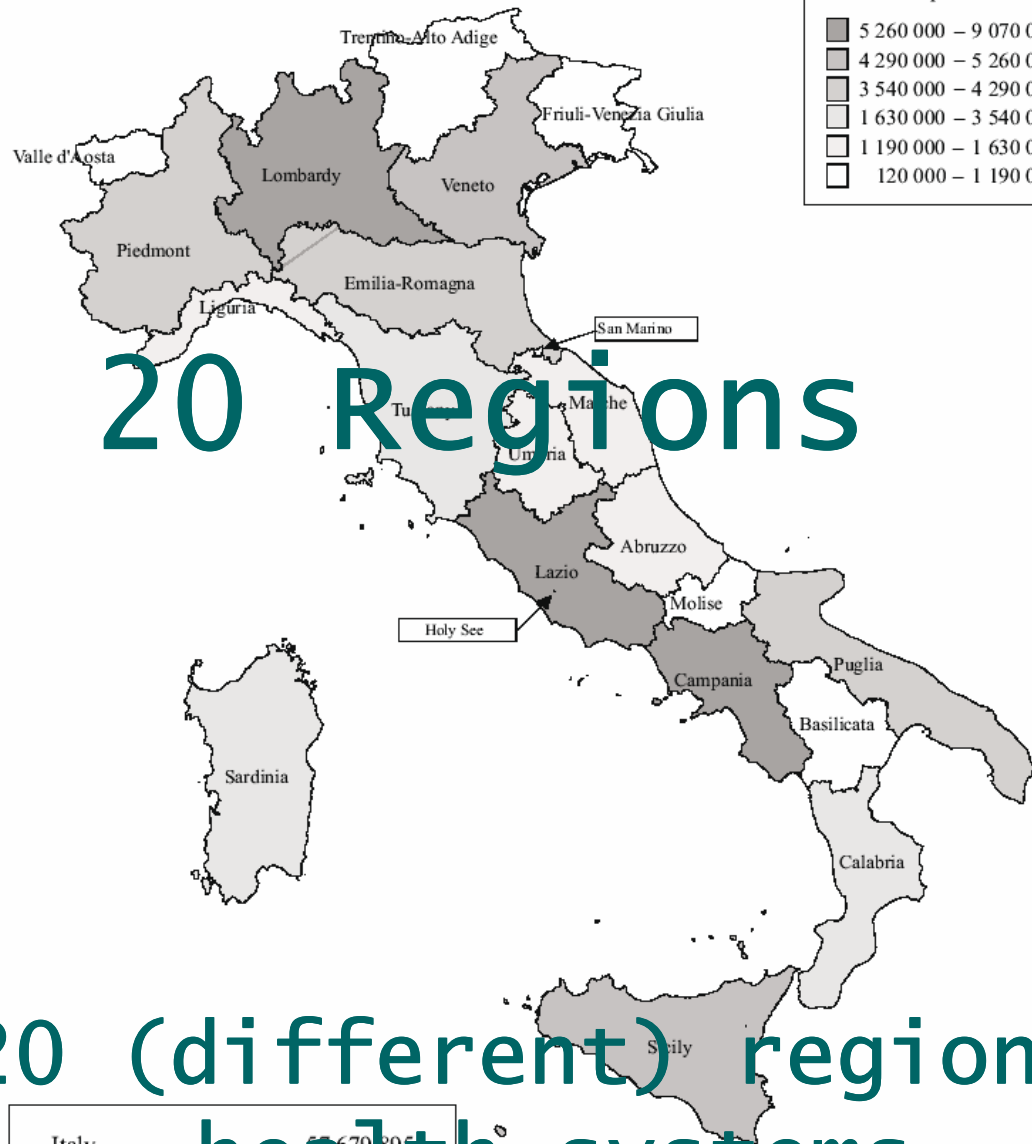
Health care reforms in Italy

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Population	
■	5 260 000 – 9 070 000
■	4 290 000 – 5 260 000
■	3 540 000 – 4 290 000
■	1 630 000 – 3 540 000
■	1 190 000 – 1 630 000
■	120 000 – 1 190 000

Italy	67 679 895
Northern Italy ^a	25 713 406
Central Italy ^a	11 096 946
Southern Italy ^a	20 869 543

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- **Reforms' chronology.**
- **Structure and different levels of health care system: central, regional, local.**
- **Financing & expenditure.**
- **Selected indicators of health and health care resources.**

1. General principles.



Italy's health care system



- **Italy's health care system is a National Health Service** (*Beveridge-like model*):
 - **Universal**: accessible to the entire population;
 - **Comprehensive**: providing the full range of preventive and curative services;
 - (almost) **Free of charge** at the point of delivery;
 - Financed from **general taxation**
 - **Regionally** based

Italy's health care system

- The system is organized at three levels - national, regional and local:
 - The **national level** is responsible for ensuring the general objectives and fundamental principles of the national health service.
 - **The regional governments** are responsible for ensuring the delivery of the health care through
 - a network of population-based health care organizations (**local health units**) and public and private accredited hospitals.

2. The reforms' chronology



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- The NHS was established by Law 833/1978.

Health care reforms has been one of the worldwide epidemics of the 1990s.

Rudolf Klein, 1995

With monotonous regularity, politicians react to often ill-defined problems in their health care systems and “redisorganize” them.

Alan Maynard, 1995

1992-93 - The first reform of the NHS

- The government approved the first reform of the NHS (Legislative Decrees 502/1992 and 517/1993). The reform assigned
 - more power and more financial accountability to the regions* and
 - more managerial autonomy to local health units and hospital trusts.

In order to promote:

- more efficiency and
- more competition within the system.

**The regions incurring budget deficits had to raise the extra-resources either through higher co-payment or higher regional taxes.*

The first National Health Plan

- The National Health Plan for 1994–1996. The plan defined national health targets and established that uniform levels of assistance should be guaranteed to all citizens.

1999. A new reform package

- The Legislative Decree 229/1999 launched a new reform package:
 - re-orientation of the internal market reforms towards strengthening cooperation, integration and regulation,
 - a new structure of primary care services and
 - introduction of clinical guidelines to guarantee quality in health care.


2000 -The fiscal federalism

- The Legislative Decree 56/2000 prescribes the abolition of the National Health Fund to be replaced by various regional taxes. Regions unable to raise sufficient resources will receive additional funding from the National Solidarity Fund.

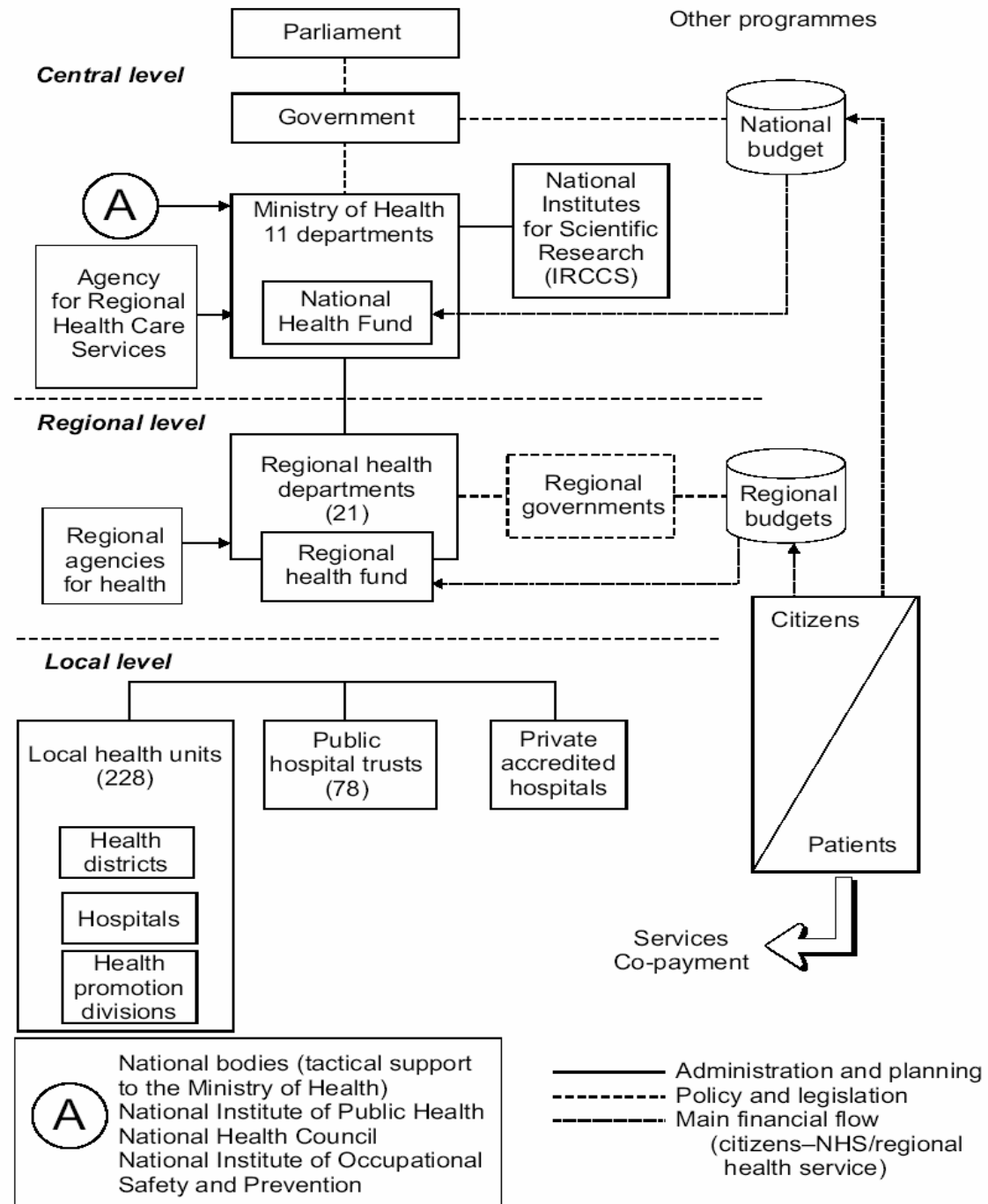
2001. The constitutional reform

- According to the 2001 reform of the Italian constitution, the state and the regions share responsibility for health care.
 - The state has exclusive power to define the basic benefit package (*livelli essenziali di assistenza – LEA*), which must be uniformly provided throughout the country.
 - The 20 regions have responsibility for planning, organizing and administering the health care system.

3. Structure and different levels of health care system: central, regional, local.



Organization of Italy's health care system



NHS - Central level

- Through the national health planning process, the Ministry of Health defines the **basic benefit package** and suggests **how resources should be allocated among different levels of care** (hospital care, district and primary health care and public health services) to address the population needs.

NHS - Central level

- The Ministry of Health is also responsible for technically regulating health care activities in various areas:
- **disease prevention programmes** with a nationwide focus;
- **veterinary health** through the general regulation of a network of ten zooprophyllactic institutes. *Italy is one of the few countries in which the national health service manages veterinary care.*
- authorization of **drug use and research.**

NHS - Central level

- The **AIFA** (*Agenzia Italiana del Farmaco* - The Italian Medicines Agency) provides drugs **expenditure governance** deciding on the specific brands that should be publicly funded and on the co-payment schemes that should apply to them. AIFA continuously monitors **adverse reactions** and risk-benefit profile of medicinal products.

NHS - Regional level

- Regional governments are responsible for pursuing the leading national objectives posed by the National Health Plan at the regional level.
- Regional governments are required to guarantee the benefit package to be delivered to the population through a network of population-based health care organizations (local health units) and public and private accredited hospitals.

NHS - Regional level

- Regional governments are responsible for
 - legislative and administrative functions,
 - planning health care activities,
 - organizing supply in relation to population needs and for
 - monitoring the quality, appropriateness and efficiency of the services provided.

NHS - Regional level

- **The regional legislation should define:**
 - the principles for organizing health care providers and for providing health care services;
 - the criteria for financing all health care organizations (public and private);
 - technical and management guidelines;
 - need assessment for building new hospitals;
 - accreditation schemes and accounting systems.

NHS - Local level

- The 1978 reform gave an **important role to municipalities**, which were in charge of governing the local health units.
- However, the above mentioned reforms **shifted municipal powers to the regional level**.

NHS - Local level

- At the local level the health care organizations can be divided into three different categories:
 - local health units
 - public hospital trusts (*highly specialized hospitals split from local health units*)
 - private accredited providers.

Local health units

Local health units are geographically based organizations responsible for assessing needs and providing comprehensive care to a defined population.

They were created in 1978 and numbered 659 before the 1992 reforms, which reduced the number of local health units, widened their population bases, increased their autonomy and reshaped their organizational structure and management system.

As a result, at present the NHS has **228 local health units**, with an average catchment population of **250 000 inhabitants**.

Local health units

- A **general manager** - appointed by the regional government based on professional qualifications and technical skills - manages each local health unit.
- The **general manager** is responsible for ensuring the sound financial performance of the organization and for fulfilling the objectives laid out by the regional health plan and by the local planning process.
- The **general manager** selects a medical director and a financial manager for support.

Local health units

- **Local health unit** services are financed with a **weighted capitation** mechanism. Additional compensation is given for cross-boundary flows, which vary significantly region by region and inside each region.
- **Hospital trusts** are paid **fee-for-service** based on diagnosis-related groups for inpatient activities and through various mechanisms for outpatient and other specific health care services.

Local health units

- Local health units are responsible for delivering the benefit package
 - by **directly providing services** or
 - by **funding hospital trusts** and private accredited providers.

Local health units

Directly provided services

- **Primary care** (Health district: 50.000 – 100.000 population)
- **Public health services**
- **Secondary care** (Hospital - Specialized ambulatory services)

Primary care

- General practitioners and paediatricians
- Community care (health and social) services for people at home or in residential care homes
- Palliative health care
- Rehabilitation services
- Maternity and child health services
- Mental health services
- Services for minority ethnic people

General practitioners and paediatricians

- General practitioners and paediatricians are self-employed and independent physicians working under a government contract. Their compensation is based on the number of people (adults or children) on their list - a **capitation fee**. Although primary care physicians are given financial incentives to share clinic premises with their colleagues, they usually work in single practices.

General practitioners and paediatricians

- General practitioners and paediatricians initially assess the patient and are expected to provide most primary care.
 - They act as **gatekeepers** for access to secondary services.
 - They write **pharmaceutical prescriptions** and **certifications** and **visit patients at home** if necessary.
 - People may choose any physician they prefer, provided that the physician's list has not reached the maximum number of patients allowed (1500 for general practitioners and 800 for paediatricians).

Public health services

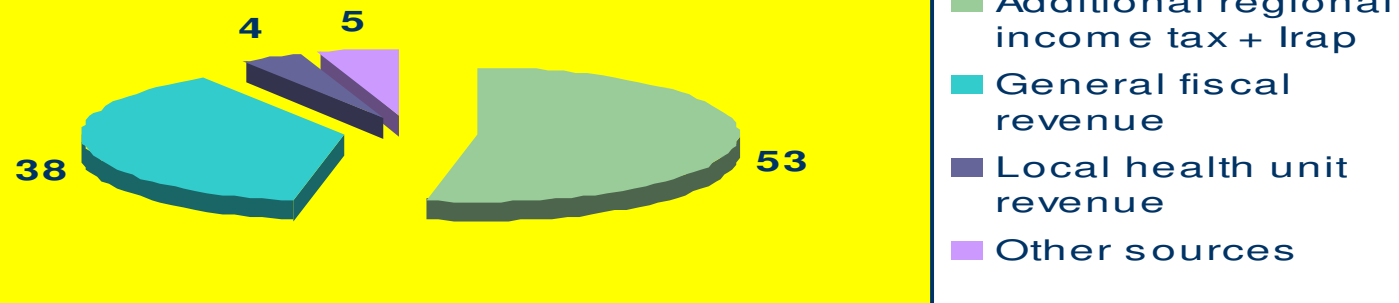
- Each local health unit has a health promotion division with the following activity areas:
 - **hygiene and public health**, including infectious and parasitic disease prophylaxis, health promotion and education and preventing environmental hazards;
 - **food control** (production, processing, preservation, commerce and transport) and **preventing food-related disease** and nutritional surveillance;
 - **preventing occupational diseases and accidents**; and
 - **veterinary medicine** (surveillance of animal stock health, hygiene of food production and animal food safety and control).

4. Financing & Expenditure



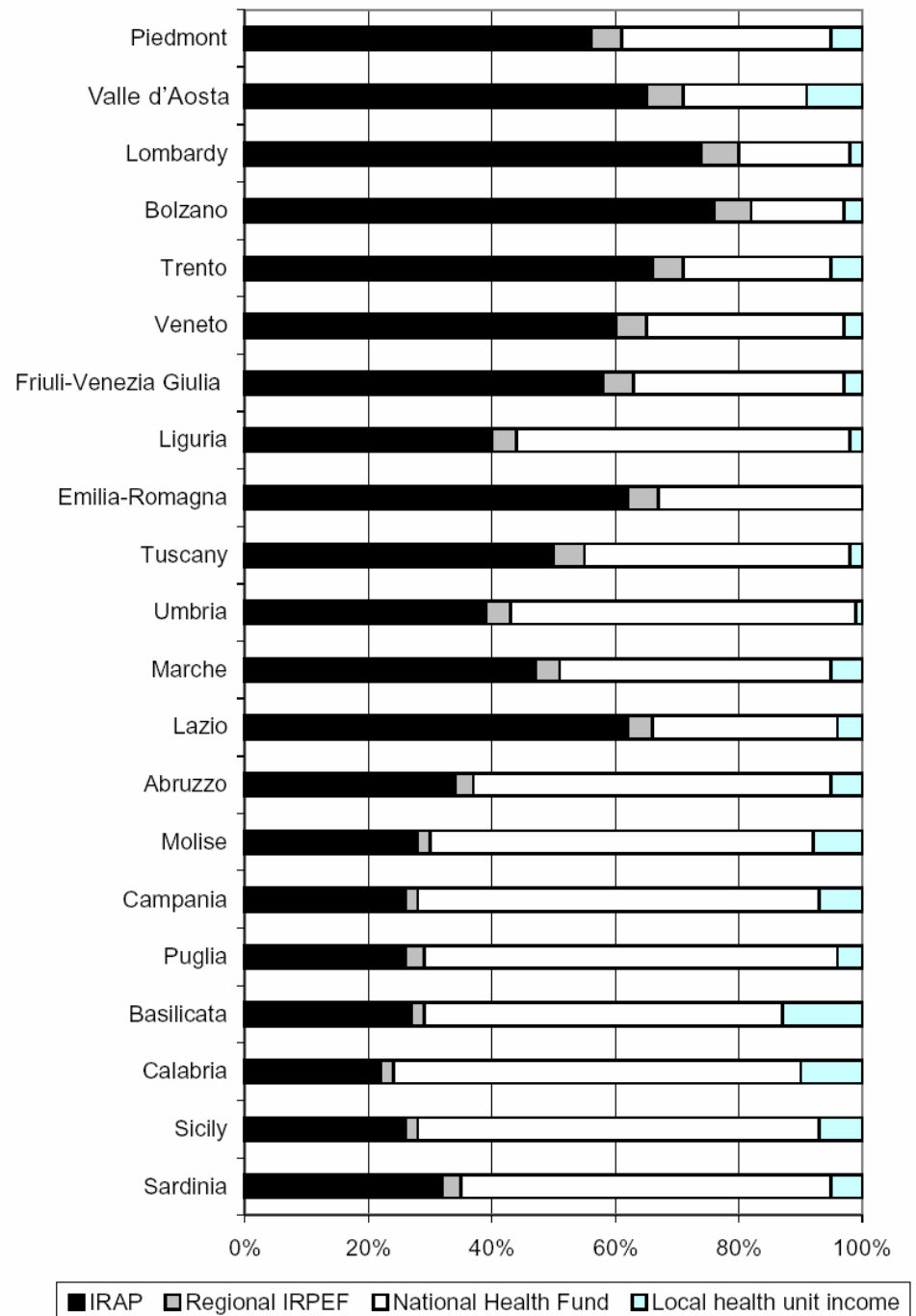
Financing

Sources of revenue of NHS



The central government is responsible for filling the gap between the financial needs of each region and actual regional funding - the additional regional income tax (IRPEF) + IRAP.

Sources of health care financing according to region, 2000



Italy

**PRIVATE
EXPENDITURE**
24,7% of the total
health expenditure

OUT-OF-POCKET
91%

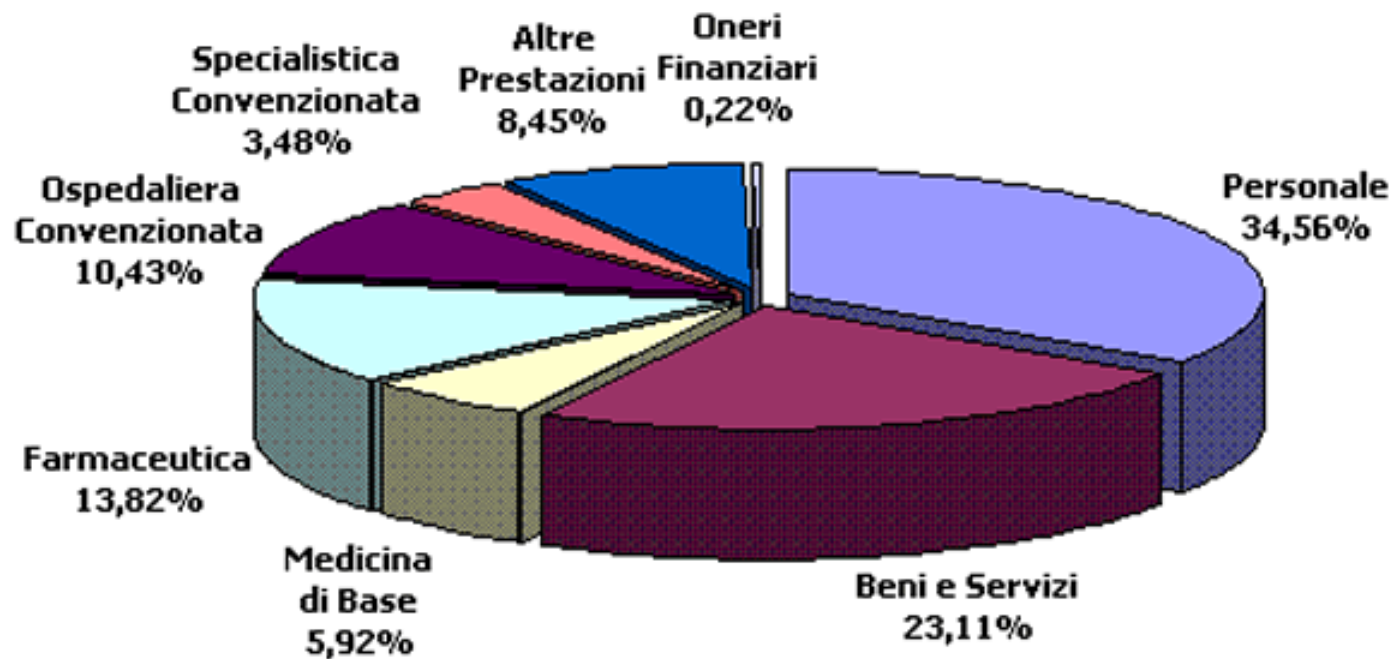
Voluntary health insurance
9%

Out-of-pocket payments

- Italy has two main types of out-of-pocket payments.
 - The first is demand-side **cost-sharing**: a co-payment for diagnostic procedures, pharmaceuticals and specialist visits. Co-payments to the public sector were estimated to be about 3% of total expenditure.
 - The second is **direct payment** by users for the purchase of private health care services and over-the-counter drugs.
- People with chronic or rare diseases, disabled people and pregnant women enjoy specific types of exemption.

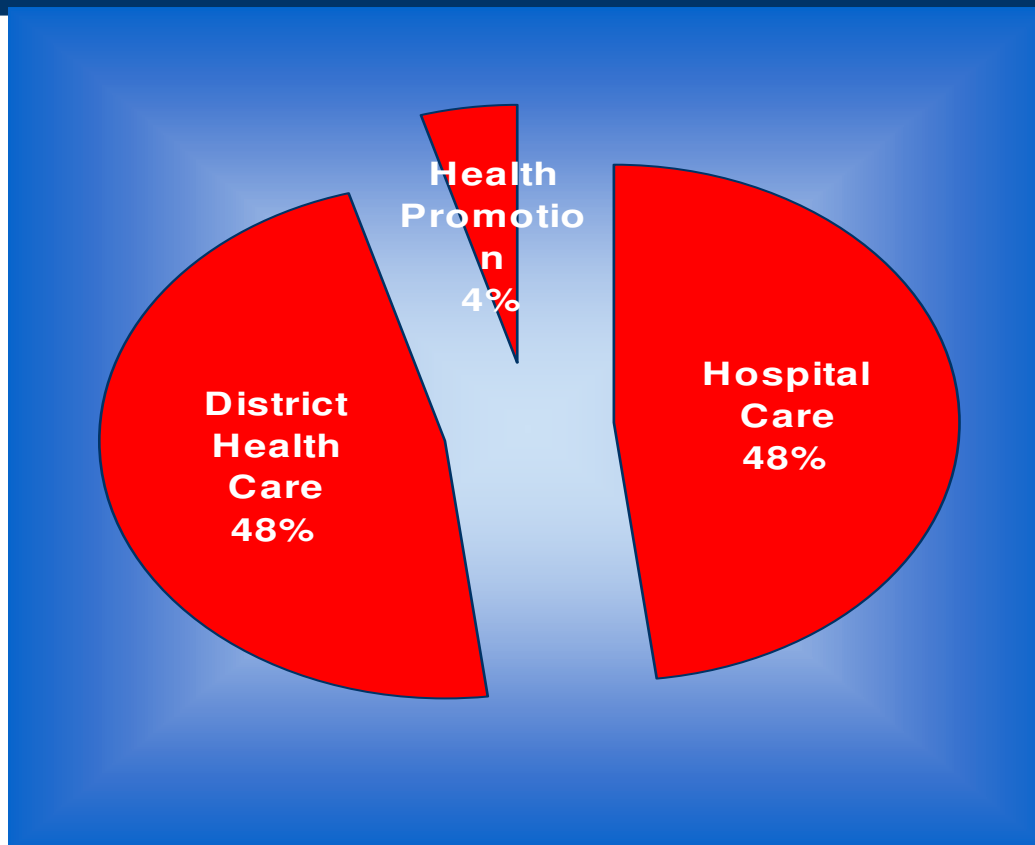
Allocation of public expenditure by functions, % - 2003. Source: Ministry of Health

Ripartizioni % funzioni di spesa sulla spesa Totale - Anno 2003



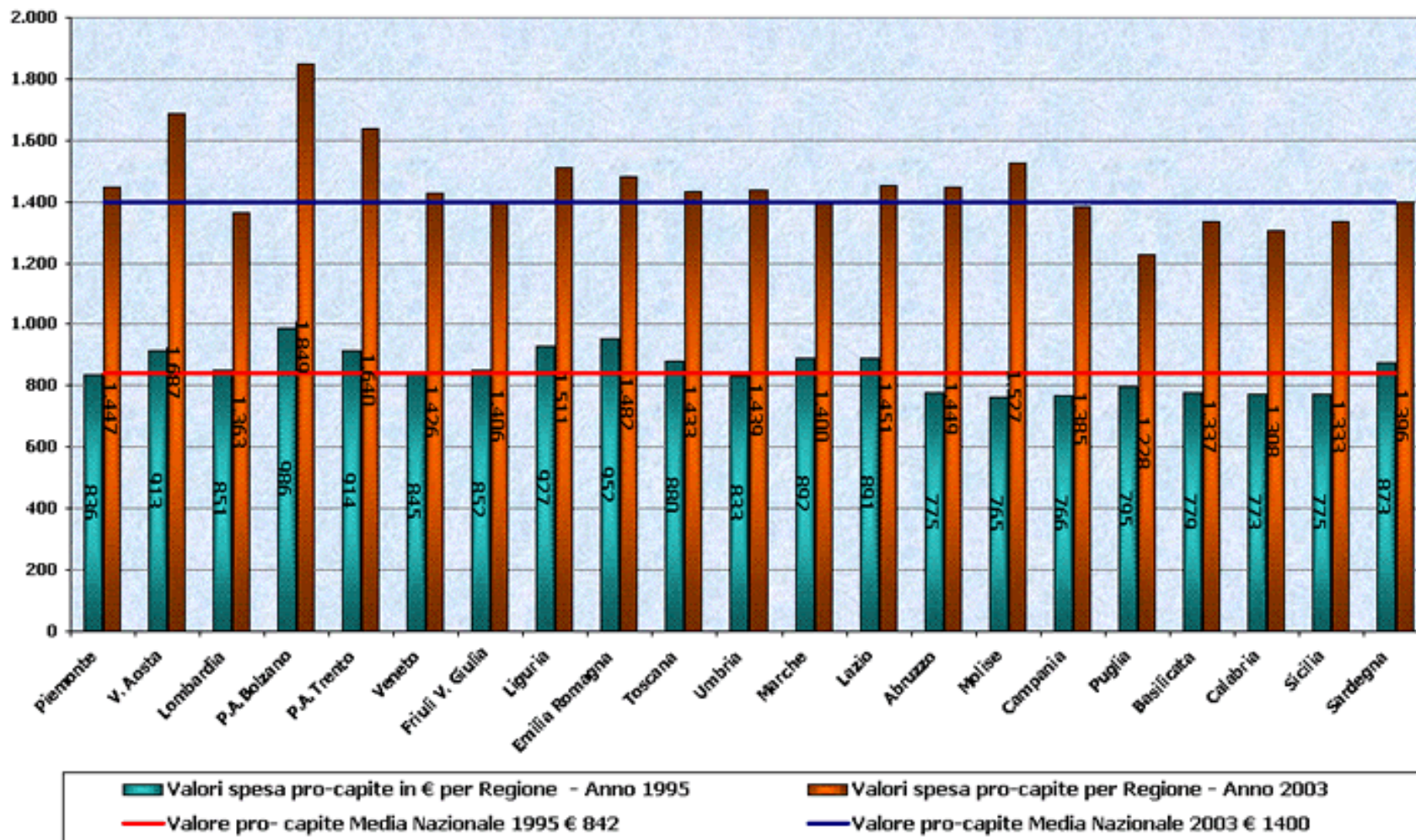
- | | | |
|---------------------|-----------------------------|--------------------------------|
| ■ Personale | ■ Beni e Servizi | ■ Assistenza Sanitaria di Base |
| ■ Farmaceutica | ■ Ospedaliera Convenzionata | ■ Specialistica Convenzionata |
| ■ Altre Prestazioni | ■ Oneri Finanziari | |

Allocation of public expenditure by level of care, % - 2001. Source: Ministry of Health



Per capita public health spending (€), by regions, 1995 - 2003 –

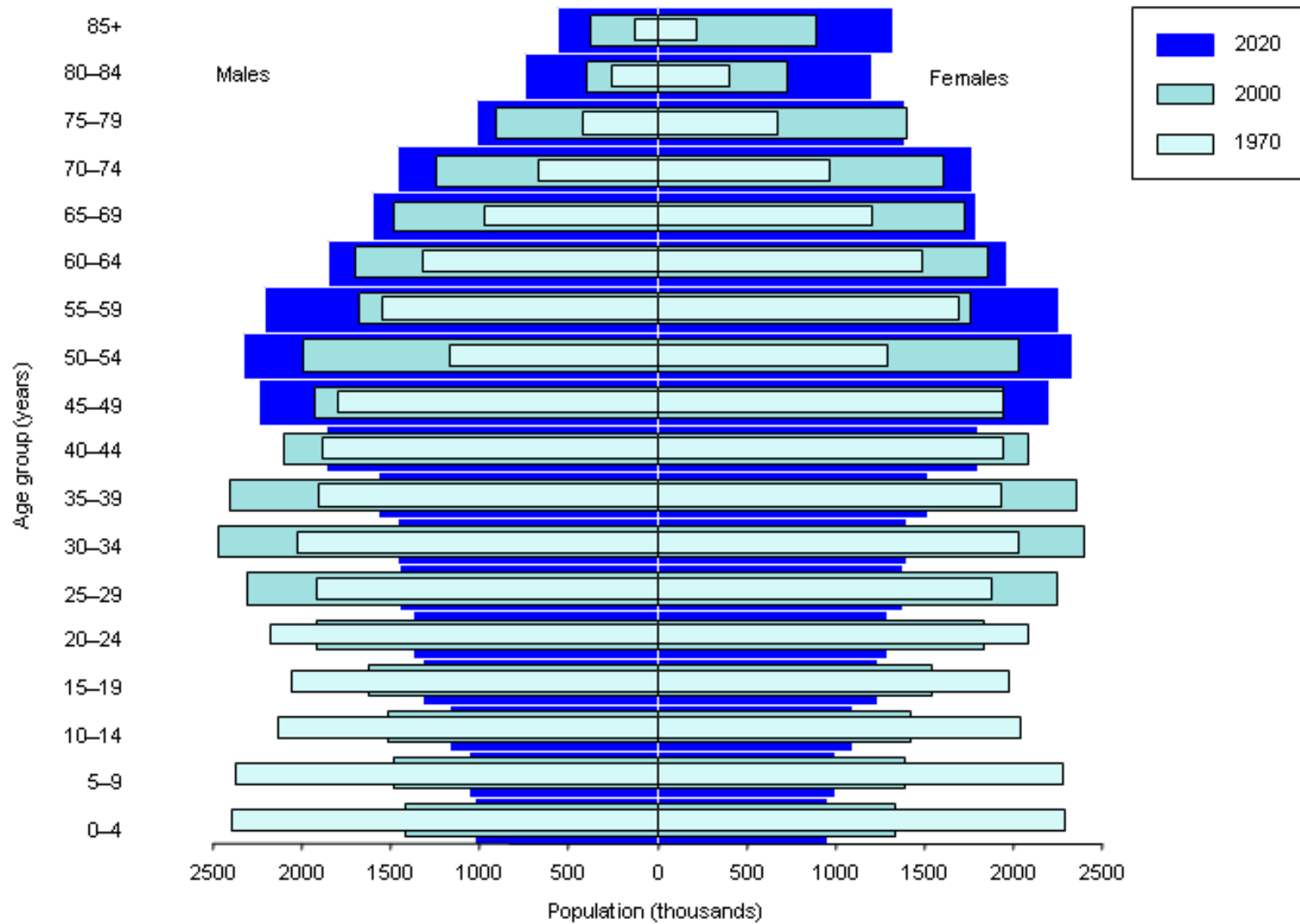
Source: Ministry of Health





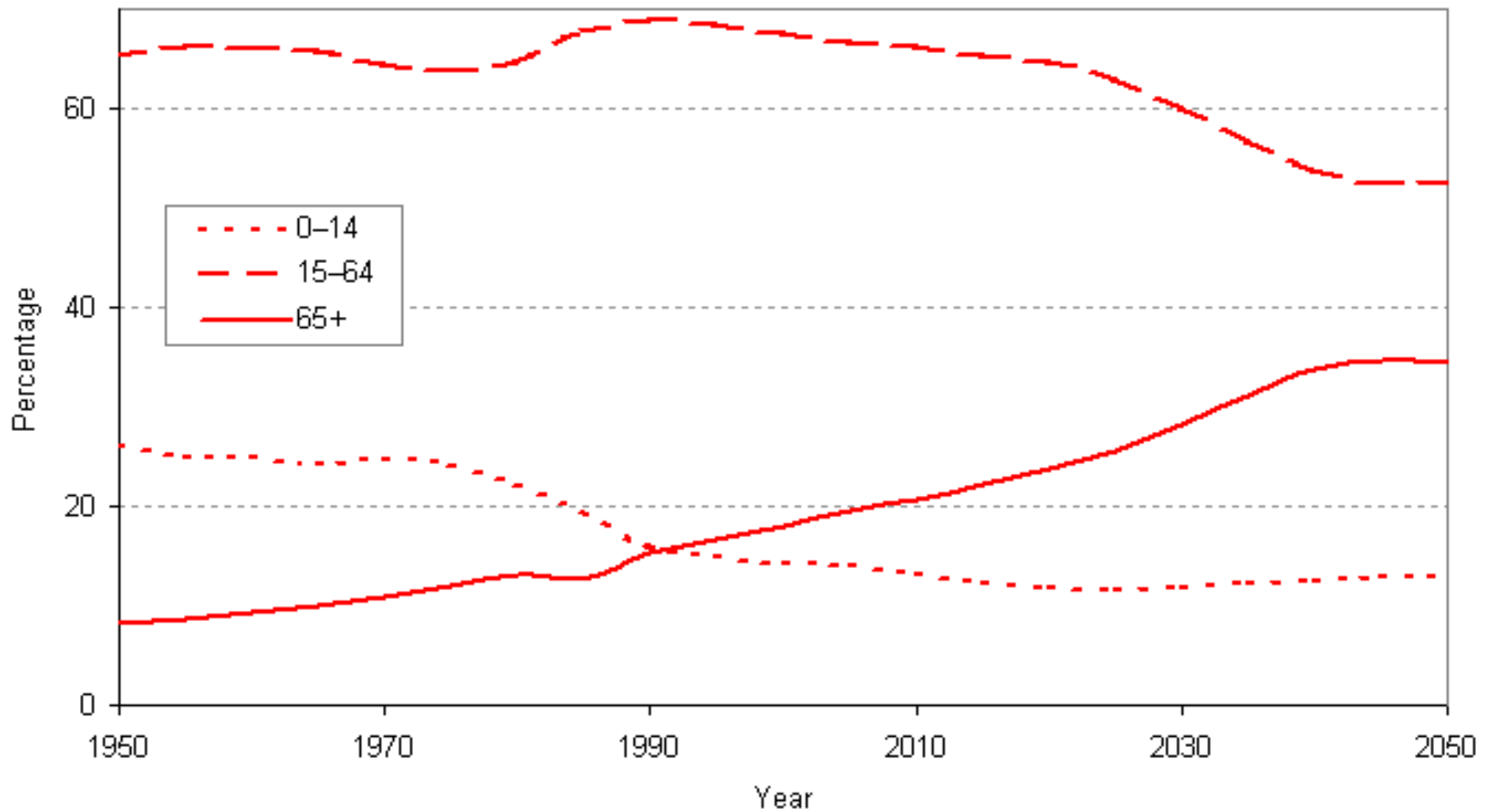
5. Selected indicators of health and health care resources.

Age pyramid for Italy



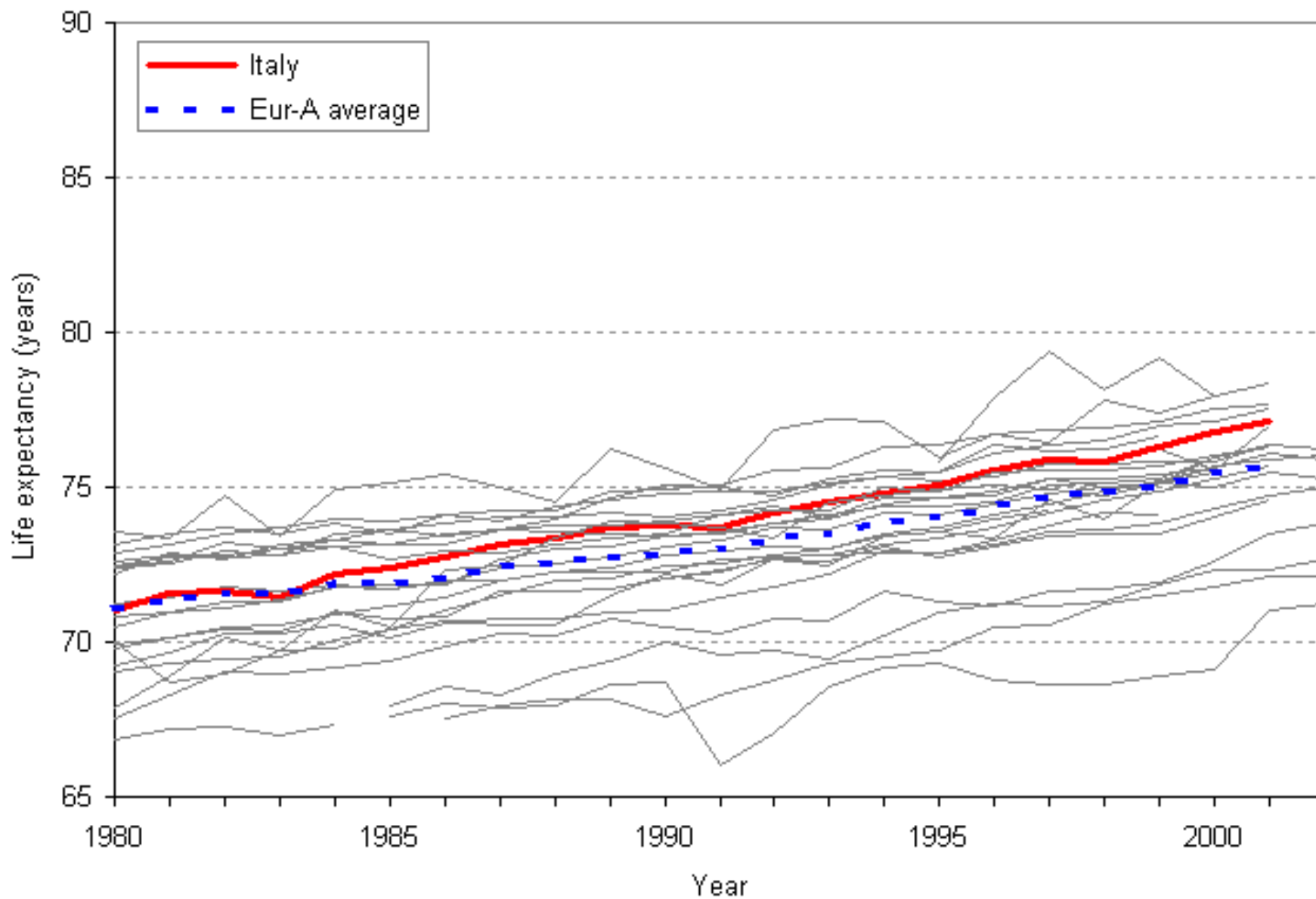
Sources: WHO Regional Office for Europe (2004c) and United Nations (2002).

Percentage of the population aged 0–14, 15–64 and 65+ years, Italy, 1950 to 2050 (projected)

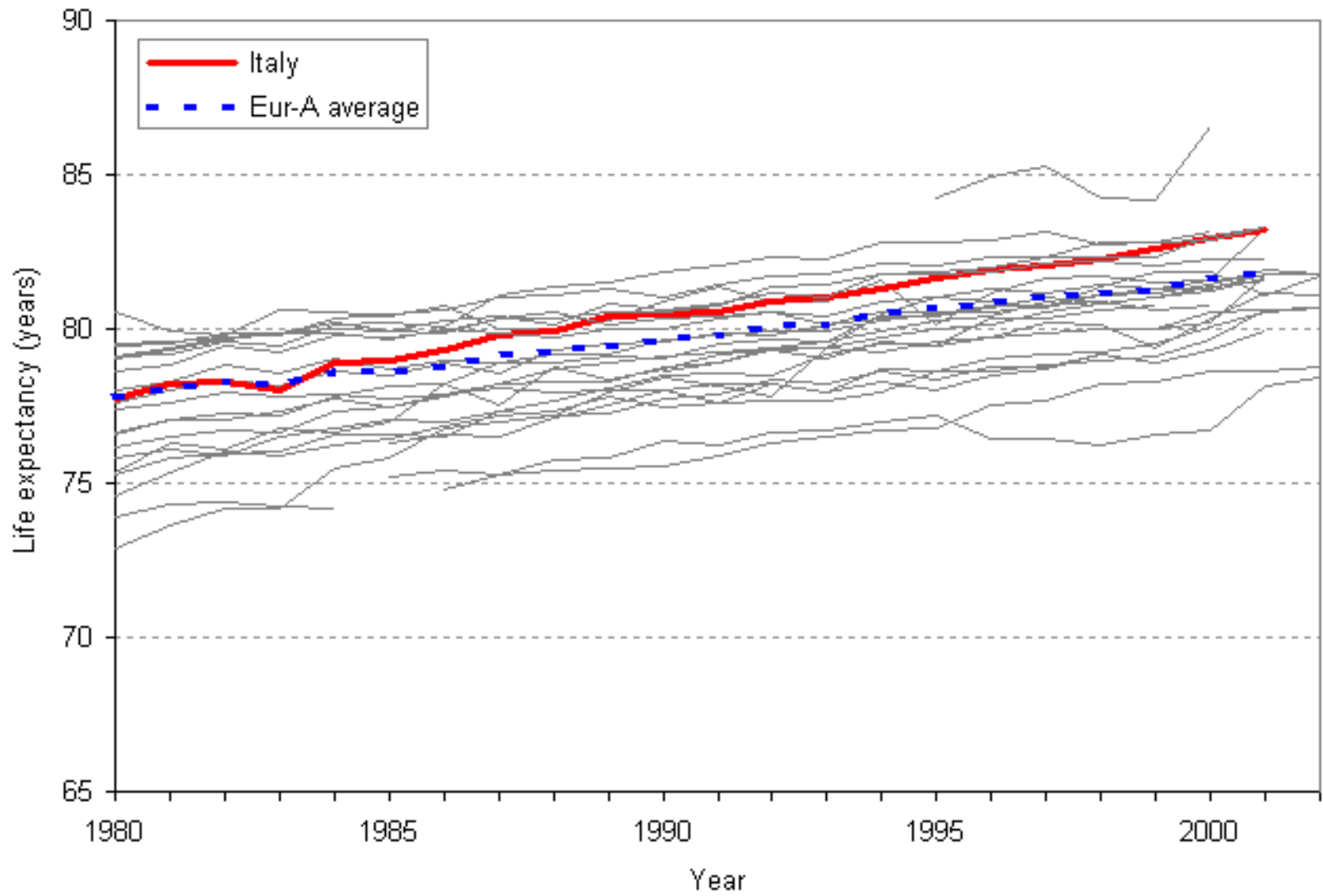


Source: United Nations (2002).

Life expectancy at birth for males, Italy and Eur-A,
1980 to latest available year



Life expectancy at birth for females, Italy and Eur-A,
1980 to latest available year



Total mortality by sex and age group in Italy
in comparison with Eur-A (Eur-A = 100), 2001

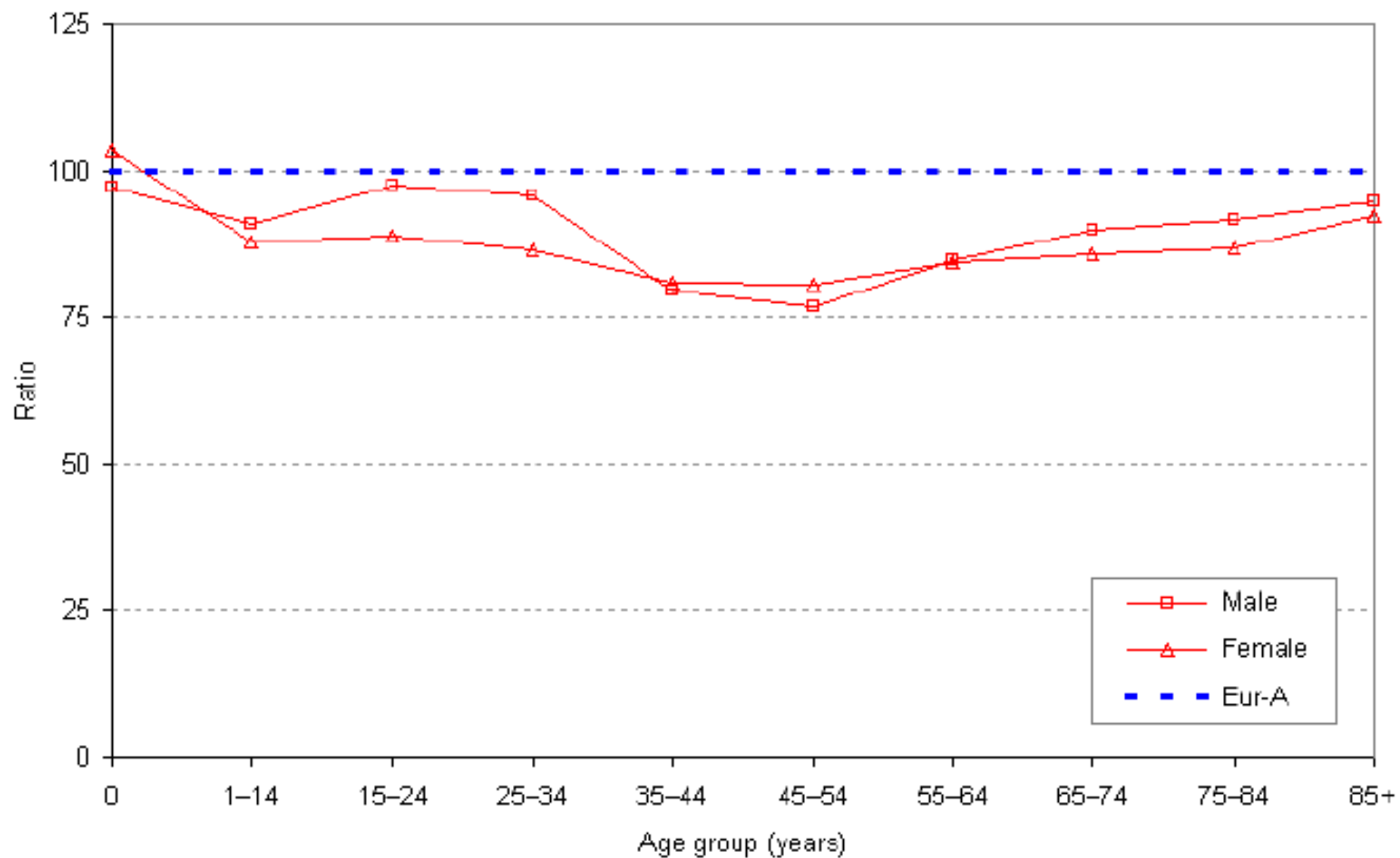


Fig. 22. Satisfaction (“very good” or “good” versus “poor” or “very poor”) of people surveyed in Italy who had used various NHS services in the past year (%), 1997

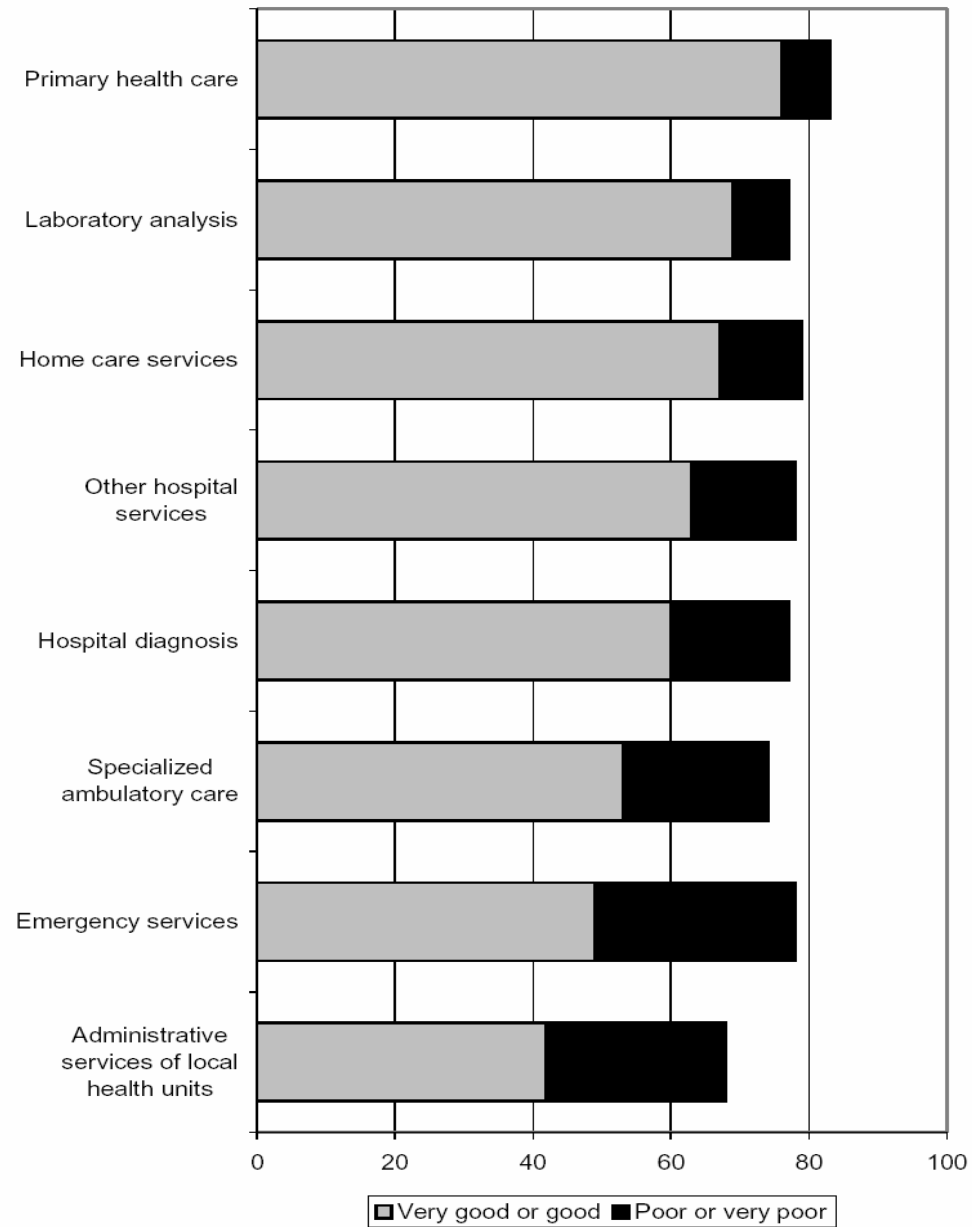
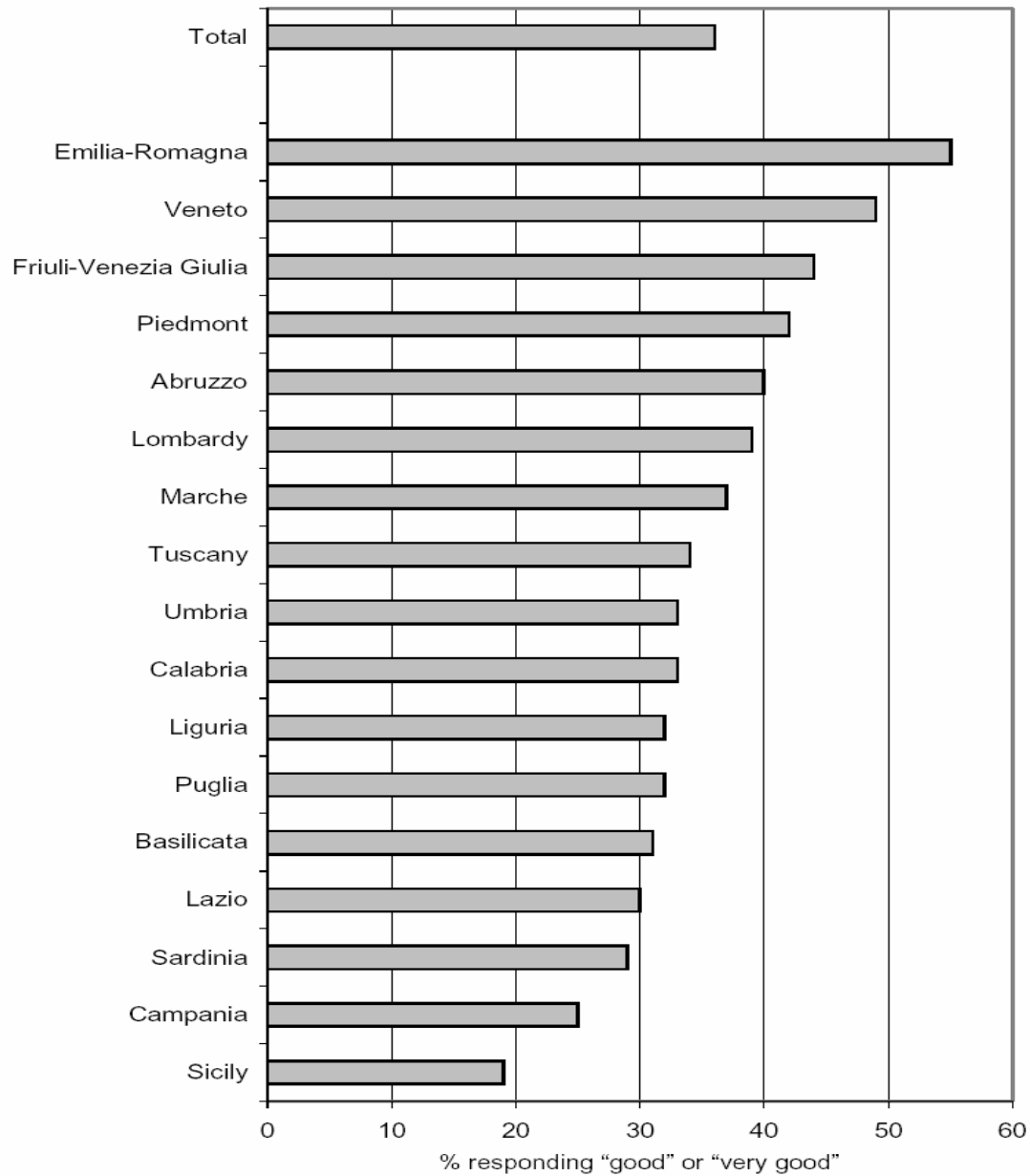
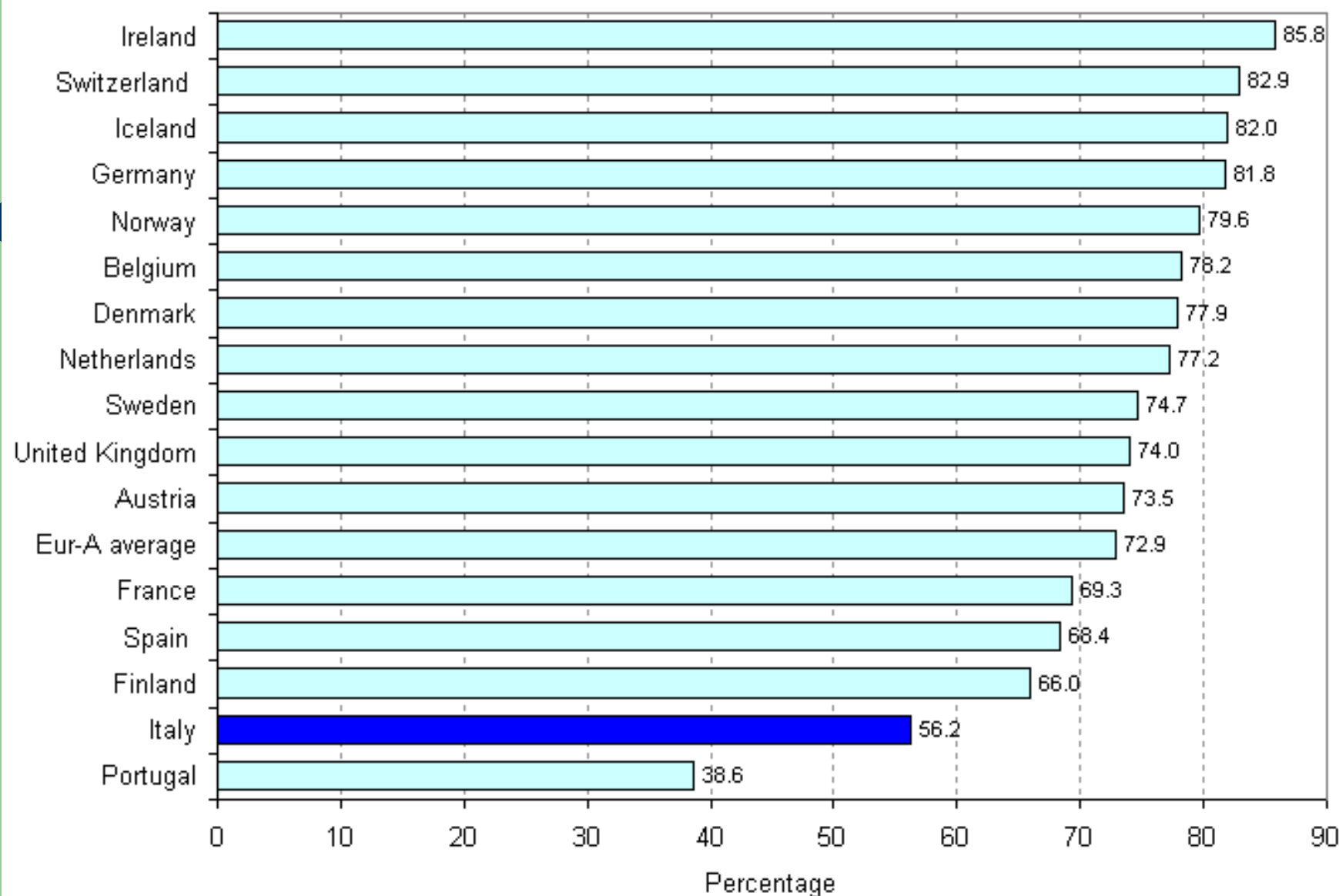


Fig. 23. Percentage of people surveyed in 17 regions of Italy who said that they were satisfied (“very good” or “good” versus “poor” or “very poor”) with the NHS according to region, 1997



People who perceive their health as good or very good,
selected countries in Eur-A, 1997–2000



Sources: European Commission (2003) and Kasmel et al. (2004) for data on Finland.