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A healthy lesson, Italian-style?

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Introduction

According to the conclusions of the World Health Organisation's 2000 report Italy had the second best health system in the world [1] with Italians having one of the highest rates of life expectancy... However, since 2001 the 19 Italian Regions and 2 Autonomous Provinces have exercised their autonomy very differently, with Northern regions being more successful in establishing effective structures of health care delivery, management and monitoring, as compared to regions in the South. This regional variation in health care reflects (and exacerbates) differences of contextual, political, economic and cultural, factors as well as differences between regional health systems. A recent survey [2] showed that in 14 of the 21 Regions and Autonomous Provinces, the system is performing fairly well and is well perceived by citizens. 6 Regions, however, are on the verge of financial and service breakdown. This article outlines the structure of Italy health system, analyses its performance and discusses the challenges it faces, not least in trying to contain costs and offer equitable care to all citizens.

Overview of Italian Health System

Italy's health care system is a regionally based National Health Service (Servizio Sanitario Nazionale) that provides universal coverage free of charge at the point of service. 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 care system. Regional governments, through the regional health departments, are responsible for ensuring the delivery of a benefit package through a network of population-based health management organizations (Local Health Trusts) and public and private accredited hospitals [3].

The Italian National Health Service is largely funded through national and regional taxation, supplemented by co-payments. Following a longer process of decentralisation, regions have obtained substantial legislative, administrative and regulatory powers [4].

The process of regional devolution, which started during the 1950s for special regions, was first extended to ordinary regions in the late 1970s. Within health care, regional autonomy was limited to restricted administrative powers over hospital planning and management until the early 1990s, when this autonomy was widened considerably through the 1992 reform legislation.

Starting in the mid-1990s, broader policy proposals to transform Italy into a federal state were debated and adopted.

In particular, a reform passed in 1997 known as Law Bassanini significantly extended the powers transferred to regions through the principle of subsidiarity.

The evolving system of 'fiscal federalism' has been substantially strengthened by the 2001 constitutional reform and now the organisation of health care falls into the remit of the regions and autonomous provinces.

Central government provides the legislative framework for health care and defines the basic principles and objectives within which the National Health Service operates, retains responsibility for such functions as approving the National Health Plan, allocating funding and defining clinical and accreditation guidelines. Central government also has a constitutional obligation to guarantee access to health care in each of the regions, to reduce health inequalities and to ensure that the health system operates efficiently and transparently [3].

The gradual devolution of political power is now running parallel to the fiscal reform which will grant regions significant autonomy over revenue in the regional budget and complete autonomy over the allocation of funds.

The health system (Table 1) is characterised by a relatively ease access to care as general

practitioners (independent contractors paid by capitation) are the main but not the exclusive way to gather secondary care. The number of graduating doctors is fixed nationally by controlling admissions to medical schools and even if at the moment there is no shortage of physicians (as the numerus clausus policy was introduced only in the 80's) a possible shortage is expected in approximately ten years time. An important and positive aspect of the Italian National Health Service is that care is granted to every Italian as a constitutional right and European Union citizen, according to Maastricht Treaty, but since 1998 health care is provided also to illegal migrants being Italy the first country to offer an extensive range of care to every human being independently of his or her civil status [5].

In Table 2 a comparison of selected health indicators in Italy, France, United Kingdom and Germany is presented [6].

The health of Italians or the health of the Regions?

In 1994 Robert Putnam studied the performance of the Italian regional governments since 1970 and found that regional government performed best, holding other factors constant, where there were strong traditions of civic engagement. He came to the interesting conclusion that "economics does not predict civics, but civics does predict economics, better than economics itself." As such, the case of Italy represents an "unparalleled opportunity" to make "a comparative study of the dynamics and ecology of institutional development." [7]

In Table 3 it is possible to see some of these differences in a selected number of indicators as reported in the Rapporto Osservasalute an annual report carried out every year to evaluate the impact of different Regional health systems on the health of the citizens. So it is possible to appreciate that in Italy national health indicators have a relative meaning as the differences between the regions can be striking [2, 8].

Consequently, it is possible to have Regions with completely different experiences both concerning health outcomes and health services performance indicators. Within Italian borders, one can find some Regions being able to offer their citizens ease access to standard care and to innovative products, good access to emergency care and appropriate and safe care in hospitals. In other instances, mainly in the South, there are first class clinical units in areas that struggle to offer even the minimum level of care granted by the Italian constitution as a right to every citizen (Figure 1).

An example of the first set of Regions are Lombardy and Tuscany which following different if not opposite ideological and organisational

Table 1. Italian health system.

- Total health expenditure: 8.9 % of gross domestic product in 2005
- Financing in 2006:
  Public funds (national social insurance + health allocated taxes): 77,1%
  Private: 22 %
  Complementary voluntary health insurance: 0,9 %
- Regional planning:
  195 Local Health Trust (ASL)
  650 Hospital
  Single data collection system (SDO) used to report medical activity in public and private healthcare organisations
- Healthcare provision in 2005:
  3.8 doctors/1000 inhabitants (25.1 % general practitioners, 74.8% specialists)
  7 nurses/1000 inhabitants
  0,7 pharmacists/1000 inhabitants (2006)
  17.524 pharmacies (2007)
  3.3 acute care hospital beds/1000 inhabitants (2005)
  76,92 % public hospitals beds
  21,03 % private, not for profit hospitals beds
  2,05 % private, for profit hospitals beds

approach have shown to be extremely successful.

In 1997 the Region of Lombardy, Italy's largest and most prosperous (with 9 million inhabitants) chose a managed competition approach based on

Table 2. Comparison of selected indicators in Italy, France, United Kingdom and Germany.

	Italy	France	United Kingdom	Germany
Population (millions)	58.1	60.9	60.2	82.5
Share population aged 65 and over (%)	19.3	16.4	16.0	19.2
Fertility rate	1.3	1.9	1.8	1.3
Life expectancy at birth (years)	80.4	80.3	79.0	79.0
Mortality from heart disease (males) SR per 100,000	97.7	64.2	153.6	142.9
Mortality from heart disease (females) SR per 100,000	46.9	26.3	73.1	75.7
Mortality from cancer (males) SR per 100,000	231	244	214	210
Mortality from cancer (females) SR per 100,000	122	115	149	128
Medical graduates per 1,000 physicians	28.9	17.5	35.8	not available
Nursing graduates per 1,000 nurses	22.3	44.6	38.5	not available
Practising physicians per 1,000 population	3.8	3.4	2.4	3.4
Practising nurses per 1,000 population	7.0	7.7	9.1	9.7
Average income of hospital doctors (2003-2004) £ *	42,000	48,000	82,000	50,000
Average income of primary care doctors (2003-2004) £ *	31,000	43,000	83,000	61,000

Source: Health at a Glance 2007: OECD Indicators

*Day M, So how much do doctors really earn?, 2007;334;236-237 BMJ

Table 3. Italy's selected health indicators.

Indicator	Italian mean	Indicator	Italian mean
Life expectancy at birth males	78.3 years	Health expenditures as a % on national/regional GDP	6.4
Life expectancy at birth females	83.9 years	Women aged 50-69 invited in a publicly funded breast cancer screening programme (%)	76.4
Obesity %	9.9	Cesarean births %	39.69
Infant mortality rate	3.7	Drugs expenditures per capita	7 Euros
Malignancies stand.rate per 100,000 males	357.0	Malignancies stand.rate per 100,000 females	267.7

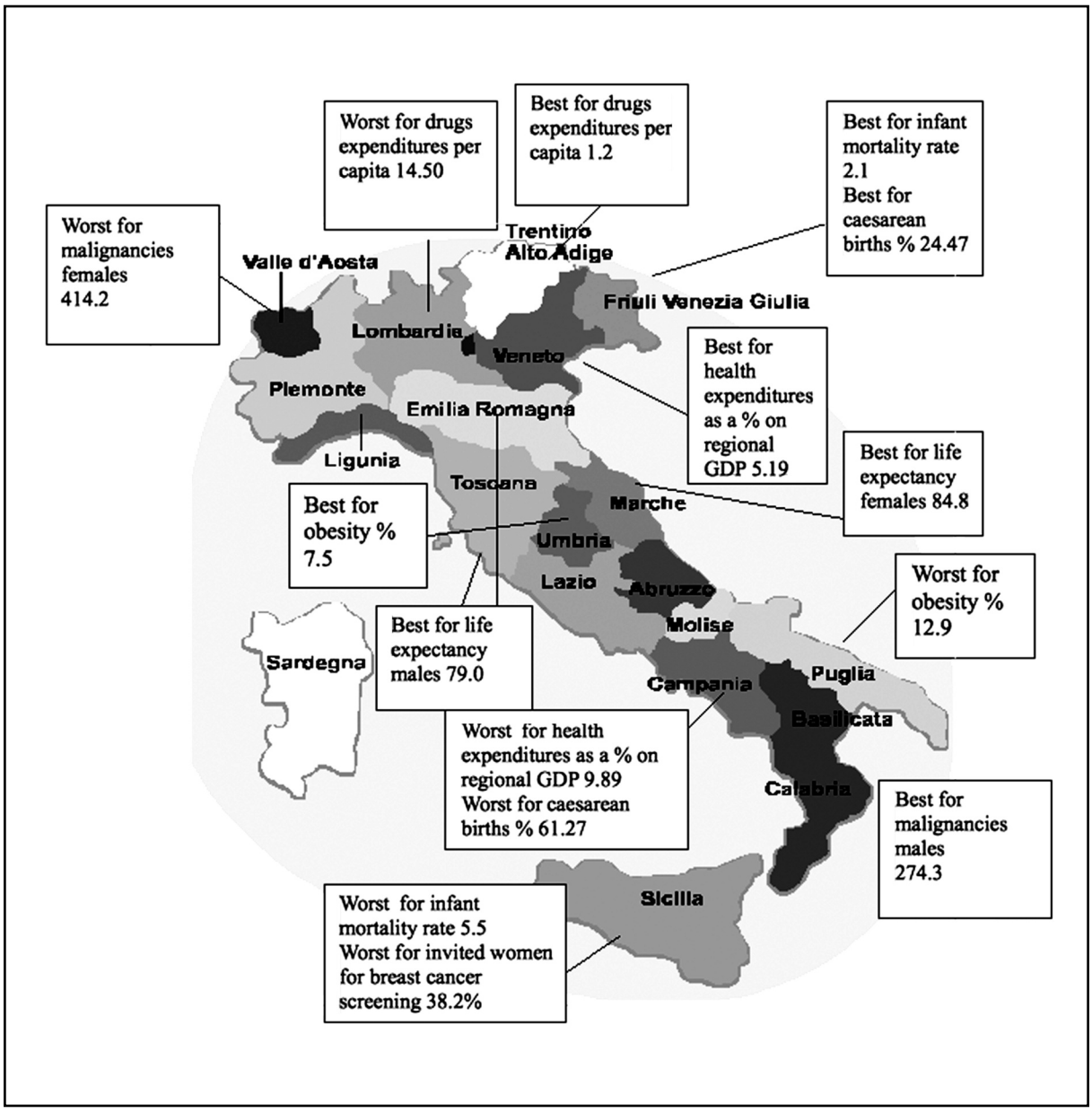
three criteria:

- free access to the market to private providers with the same rights and duties of public providers;
- a regional system of accreditation and control;
- free choice for the citizens to access any provider accredited by the Region.

The "quasi market" competition has produced in the last ten years a substantial increase in the private provision of services, now more than 30% of the total and a blossoming of "centres of excellence" for both care and biomedical research. Since then the Regional Health Service of Lombardy has become one of the best in Italy and possibly in the world according not only to health and financial indicators but also to citizens' satisfaction and to the increasing choice from citizens coming from virtually all the other Italian regions, as well as from abroad (Switzerland and United Kingdom included) to seeking care in this Region [9].

The Tuscany Region has, on the other hand, based it's approach on a "centrally planned" system with the Region in charge of every planning activity. There is an emphasis on the "public mood" of the Regional Health Service and the private provision of service (only after formal authorisation) by the Region, while at the same time, maintaining a focus on an ancillary and complementary function to public services. The

Figure 1. Best and worst regional performers for selected indicators.



result is a successful system close to the need of every citizen, though less successful in terms of centres of excellence, as in Lombardy.

Regions with systems in between the two previously mentioned such as Veneto, Friuli Venezia Giulia, Emilia Romagna, Umbria and the two Autonomous Provinces of Trento and Bolzano are also successful cases [10].

Less successful results come from other Regions, mainly but not only in the South, where centres with high standards of care, often spontaneously started and developed, are exceptions in a regional environment where poor vision, mismanagement and in some cases corruption have seriously affected the capacity of these Regions to offer a complete and appropriate set of care to their citizens.

The unhappiness of Italian doctors and the search for nurses

The number of health care professionals increased in Italy from 1970 to 1995. Specifically, the number of active physicians grew during the 1990s and so did the number of dentists. The number of physicians and pharmacists per 1000 population entering the workforce in Italy was among the highest in Western Europe. Today, Italy is third (after Greece and Belgium) with 3.8 doctors per 1000 inhabitants. Alternatively, the numbers of nurses were among the lowest of these countries, Italy ranks third lowest in the WHO European Region in active nurses per 1000 population. This rate (7.0 nurses per 1000 population) has remained almost unchanged since the mid-1970s. Of the 47 countries of the European WHO Region only Greece and Italy have fewer nurses than physicians [6].

In recent years, the main aim of legislation for the nursing profession over the last decade has been to provide nurses with a more autonomous and active role and to give them new responsibilities so that this important profession is no longer seen as auxiliary.

According to many national and international indicators (health care performances, scientific publications, research activities, etc) Italian doctors are considered objectively competent and professional but increasingly unhappy. Even though the medical profession is still one of the most trusted institutions in Italy there are signs of crisis in the structural relationship with it's patients. The number of doctors sued by patients is dramatically increasing fuelled also by a legal system (to our knowledge unique in Europe) where medical errors lie under the penal jurisdiction rather than being considered in the framework of civil laws. The result being often that unhappy citizens who feel to have been compromised by some form of malpractice tends quite immediately to file suit. Under Italian law it is compulsory that a penal file is immediately opened in tribunal, which is already filled with thousands of presumed malpractice cases. With the addition of the media it is easy to understand why in the most recent Eurobarometer survey 96% Italians are scared to seek medical care because of fear of malpractice (1st country among 27 in the European Union) [11]. However, in the same survey citizens that are asked whether themselves or immediate family have personally experienced some form of medical error, Italy takes a more reasonable 16th place in ranking, confirmed by the fact that less than 3% of the previously mentioned sues are confirmed by judges to deserve penal attention.

Another determinant of unhappiness among Italian doctors is that in the last 15 years they have been involved in management primarially on a superficial basis, consequently carrying the responsibility of overspending, but without the authority to manage their part of the system effectively.

Furthermore Italian doctors appear to be the less paid in Western Europe and this is also due to the lack of the incentives in place to enthuse and encourage doctors to take on leadership and management roles and to the up to now inadequate system to training doctors on management.

A possible advance in this field is the recent birth of the Italian Society of Medical Managers (Società Italiana Medici Manager) twinned with the British Association of Medical Managers (BAMM) and determined to establish clinical leadership and management as a highly respected career for doctors, a rigorous discipline underpinning medical leadership and management, a career structure and a framework for recognising and rewarding medical leadership.

This also to put a limit to the intrusiveness of politicians who tend to play not only a strategic and control role but also to interfere with the day by day management and the appointments of single administrative and medical officers.

The long march toward enhancing quality and efficiency in the system

Italy's health care system has experienced important transformation during the last thirty years. The transition to the NHS model initiated in 1978 ultimately guaranteed all Italian citizens access to a wide range of services, irrespective of

their social and economic conditions signalled a strong commitment to equity.

Some of the critical aims of the 1978 reforms, however, had not been accomplished by the early 1990s. In particular, the balance in economic efficiency was mixed. Some of these persistent problems have been adequately addressed during the 1990s. The significant efforts at containing costs initiated during the 1980s and further developed during the early 1990s led to positive results with public satisfaction while the NHS more than doubled during the same period. Some of these good results can be attributed to the measures launched by the 1992–1993 reform, which initiated a deep process of political and financial devolution to the regions and aimed at introducing managed competition within the NHS. The reforms further promoted economic efficiency by delegating considerable managerial autonomy to local health care trusts and hospital trusts, changing resource allocation systems to encourage productivity and enforcing innovative monitoring systems aimed at improving the perceived quality of services and implementing patients' rights [3].

The period 1997–2001 witnessed a series of radical and innovative changes in state institutions and health care regulation. First, political devolution of health care powers to the regions was promoted, and the transition towards fiscal federalism started within the context of a profound transformation of Italy towards a federal state.

This creates the need for a new regulatory framework that radically transforms the institutional rules of governance and simultaneously enables state authorities to adequately perform a new control role. The legislation adopted during the late 1990s addressed many crucial issues, such as guaranteeing political accountability over financial management, controlling pharmaceutical expenditure, training health personnel, and accrediting and regulating health care providers. However, some critical areas still have not yet been either addressed or fully regulated, such as reaccreditation of health care professionals, utilization review and clinical management.

In 1994 Robert Putnam and his collaborators wondered why some regional governments succeeded and others failed and in "Making Democracy Work: Civic Traditions in Modern Italy" they offered empirical evidence for the importance of "civic community" in developing successful institutions and revealed patterns of associationism, trust, and cooperation that facilitate good governance and economic prosperity. [7]

Differences in the present-day institutional performance of the various regions of Italy can be traced to differences in patterns of civic engagement that extend back to the early Middle Ages.

In contrast with the existence of this civic culture in Northern Italy, identified as having a millenium-long pedigree due to the North's highly decentralized political history, Putnam uses the concept of "amoral familism" to characterize the civic culture (or lack thereof) in Southern Italy. Amoral familism implies that reciprocity and engagement are limited to family relations and to vertical networks of hierarchical power alone (in contrast to more participatory and egalitarian horizontal networks in the North), and that all other social relations, as a consequence, are characterized by material self-interest.

Northern and Central Italian regions are today active in setting guidelines and standards for the delivery of health services and setting up specific programmes for population groups (women, children, elderly, migrants, etc) and some of them have agreed on procedures for regulating cross-border flows of patients, organised their own schemes for centralised purchasing of services and equipment and have experimented with complex accounting systems.

While some regions are funding medical and health services research others are struggling with serious deficits (three such regions accounted for the 75% of the total national deficit in 2006 (Lazio, the region of the country's capital. Rome, Campania, including Naples, and Sicily). [12]

If there is a lesson to be learned from the recent experiences is that without new institutional mechanisms able to guarantee the basic benefit package and a similar quality of health care to all citizens Italy will experience wider inequalities among and within the regions and a bigger divide between North and South.

Contributors and sources: WR is professor of Hygiene and Public Health and Director of the National Observatory for Health in the Italian Regions, CF is a senior civil servant and President of the Italian Society of Health Technology Assessment and RB is professor of Surgery and Secretary General of the Italian Society of Surgery. The authors views are derived from the Report "Osservasalute" a survey carried out annually by almost 300 researchers and practitioners working in all the Italian Regions, from the Report on

Health Care Systems in Transition about Italy produced by the European Observatory on Health Systems and Policy and from their own personal experience in the Italian health system.

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