THE HEALTHCARE SYSTEM IN ITALY

In Italy health treatments are delivered by a **National Healthcare Service (SSN),** founded in 1978, taking the English system as a model. In the following years many measures tried to improve the functioning of the whole system. Actually, the health service is organised on three levels. The **Ministry of Health** is responsible for the national planning and for the co–ordination of Regional activity, in order to guarantee the same **essential level of assistance** in all the areas of the State**,** while a **process of devolution,** attributing health competencies to the Regions, is in progress. The **Regions** are competent to issue laws and rules to organise services delivery within their own territory. The **Local healthcare authorities (ASL)** are directly involved in producing or "buying" services in the area under their responsibility. **Health treatments are produced by a plurality of contributing institutions, publics or privates, accredited to work for the National Service.**

In 1998 the Delegation Law 419 was approved, followed be the Decree of enforcement of the law 229/99, underlining the need to set new accreditation patterns. According to this Decree, private hospitals work under conditions, called the "three A":

- **Authorisation:** the Regions supervise that the authorised healthcare institutes, besides the required conditions, meet the population needs, considering the location of existing facilities.
- **Accreditation** is granted to health care institutions, in principle whether public or private, according to the type of structure, on the basis of the appropriateness of services produced and on their outputs, in compliance with regional objectives.
- **Agreements** with private hospitals are negotiated by the Regions through a comparative survey of costs and quality, in line with predetermined estimates of activity, defining the volume and types of services, in the context of fixed levels of health expenditure.

New criteria, governing the payment of hospital care, are based on **Diagnosis related Groups (DRGs)** and in principle they are calculated homogeneously for each Region, whether the provider is public or private. As a matter of fact, public hospitals are still paid by the ASL according to the final balance and they are not submitted, as the private ones, to the rule of predetermined rates.

In accordance with the Decree 229/1999, "**it falls under the competence of the Regions and the ASL to supervise the enforcement of the new control methods concerning quality of assistance, quantity of services agreed and appropriateness of services produced"**. Within this system, the Public Authority is responsible for determining regulations, operating institutions and inspecting all hospitals including the ones it manages directly.

The **hospital system** within the SSN provides services through: **97 "public hospitals of national importance"** organised as enterprises, **455 public hospitals depending on the ASL, 55 scientific research institutes, 11 general hospitals of the University, 32 ecclesiastic institutes**, called "classified", legally recognised as equivalent to the public ones. Hospital care is provided within the National Service also by healthcare institutions for profit: **549 private clinics** (called "CASE DI CURA") and **16 private hospitals organised as public ones** and working at the same conditions (called "PRESIDI"). The **Italian Association of private hospitals (AIOP)** represents **519 private clinics with 56.799 beds;** at present **about 87% of them are accredited** to work for the SSN. Inside private clinics associated to the AIOP and working for the NHS, patients only pay low costs for a better comfort (for example a single room with TV). Non accredited clinics are usually high quality standard institutions working for patients paying out of pocket or privately insured. Concerning **quality improvement,** the increase in the complexity of the services provided on the basis of the pathologies treated is evidenced both in public and accredited private sector. Within the latter this complexity amply regains positions, and indicators show that in many cases it in fact exceeds the public institutions. Patients are aware of this phenomenon and they give a positive judgement, with a trend which is on the increase of their satisfaction concerning hospital services.

❖ Final remarks

Freedom of choice of citizens, as a driving force of quality, is still limited by Public Authorities. In fact, parameters such as volume, type and availability of services, take precedence over free choice of hospital and doctor. **Competition between public and private providers** is only possible in the

context of fixed levels of care assistance. The key problem of the **ASL functions** need to be solved, as they are responsible for purchasing and providing care, controlling public and private hospitals.
Each year the Italian Association promotes the drawing up of the **Annual Report "Health & Hospitals"** worked out by the independent research institute**, ERMENEIA**. This survey shows an evident inequality of treatment with regard to the accredited private sector concerning the so-called tariff regressions, the accreditation system, which still does not cover all the facilities, the information spread to ensure that citizens can really enforce their freedom of choice, the actual "outsourcing" mechanisms used by the National Health System. An efficient management of the health sector, inspired by a correct implementation of the "outsourcing", would allow to use all medical institutions available in a given area by applying the logics of a competitive cooperation.
In short, the integrated public/private system finds problems in being coherently accepted and applied by the National Health System. On the contrary, an **impartial management of the public–private mix** should be based on a system of equitable rules in regard to:

- unbiased and accurate **accreditation procedures** for all the providers, public and not only private
- **a well balanced funding system on the basis of homogenous remuneration criteria**
- **an effective quality control granted by independent institutions**
- **a rational planning** allowing to use all medical institutions available, public or private.

AIOP is a member the **UEHP (European Union of private hospitals),** where national Associations - representing private hospital sector within the Member States - share many fundamental trends, in keeping with the principles of a **European model of healthcare service, based on a public-private mix, fairly managed and able to guarantee the free choice of citizens among a plurality of providers**. In a health care system, where the State establishes a fair competition, based on the balance among costs – quality - benefits, verifying the standards through independent institution, the private sector can assure a **service of general interest,** according to the European Commission perspective.

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Table 1 - Comparison between public institutions and private hospitals (accredited institutions) members of AIOP according to the "case mix index" of services supplied. Years 2001, 2002, 2003 and 2004

2001		2002		2003		2004	
Public institutions	AIOP private hospitals (accredited institutions)	Public institutions	AIOP private hospitals (accredited institutions)	Public institutions	AIOP private hospitals (accredited institutions)	Public institutions	AIOP private hospitals (accredited institutions)
1.00	**0.96**	**1.01**	**0.97**	**1.01**	**0.98**	**1.01**	**1.08**

Table 2 – Quality of public and private services as measured according to the incidence of highly-specialised DRGs

DRG		Public institutions (incidence on 1,000 discharges)				AIOP private hospitals (accredited institutions) (incidence on 1,000 discharges)			
		2002	2003	2004	2005	2002	2003	2004	2005
104	Cardiac valve procedures w cardiac cath	0.706	0.815	1.157	1.302	2.196	3.083	3.264	3.394
105	Cardiac valve procedures w/o cardiac cath	1.336	1.511	1.679	1.996	1.380	1.964	1.918	1.839
106	Coronary bypass with cardiac catheterisation	0.825	0.845	0.878	0.875	2.624	3.560	3.293	2.621
107	Coronary bypass w/o cardiac cath	1.636	1.647	1.539	1.423	3.519	4.143	3.682	3.037
108	Other vascular procedures	0.447	0.506	0.524	0.581	0.585	0.733	0.712	0.702
110	Major procedures to circulatory system, with CC	1.098	1.149	1.304	1.361	0.961	1.236	1.179	1.188
Average incidence		**12.581**	**13.510**	**14.701**	**15.156**	**12.241**	**16.460**	**16.165**	**15.089**

Table 3– Public and private hospitals (accredited and non-accredited medical institutions) certified with the ISO 9000

Italy	Certified private hospitals (accredited. & non-accredited Institute.)		Public hospitals	
	Entire institute	Individual wards or services	Entire institute	Indivudual wards or services
2006	**187**	**63**	**20**	**207**
2005	**147**	**51**	**20**	**197**
% Variations in 2006/2005	***+27.2%***	***+23.5%***	***0.0%***	***+5.1%***

Table 4 – Current health expenditure. years 2001-2006 *(in billion euros)*

	2001	2002	2003	2004	2005	2006
Public hospitals and hospital enterprises	32,828	34,199	35,843	39,012	43,786	44,947
Medical Institutions operating within the NHS	7,997	8,151	8,364	9,133	8,147	8,337
among which: private hospitals (accredited)	3,277	3,291	3,429	3,732	3,973	4,065
Total public expenditure for hospitals	40,825	42,350	44,207	48,145	51,933	53,284
Other expenses	36,861	37,199	38,083	42,383	44,852	45,883
Total public health expenditure	77,686	79,549	82,290	90,528	96,785	99,167

Table 5 - Incidence of current expenditure for accredited private hospitals over the total current public expenditure for hospitals

Year	%
1999	8.9%
2000	8.4%
2001	8.0%
2002	7.8%
2003	7.8%
2004	7.8%
2005	7.7%
2006	7.6 %

Source: ERMENEIA - Hospitals& Health