

THE HEALTHCARE SYSTEM – LAWS.

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.

In **1992** the Italian healthcare system changed radically with the adoption of the **law 421**. In this law the reorganisation process of the SSN was based on the provision of services by a large number of public and private providers, making up an integrated system in which citizens were guaranteed full freedom of choice.

In **1998** the Government passed the last reform, called "*reform ter*", or rationalisation of the SSN: a **Delegation Law, n. 419/98**, and the **Decree of enforcement of the law, n. 229/99**, were approved. These measures represent a step backward in the implementation of competition mechanisms between public and private sector within the 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**. Every two years the Ministry also works out a National Plan in order to set strategic objectives and priorities. The **Regions** are competent to issue laws and rules to organise services delivery in their own territory. The **Local healthcare authorities (ASL)** are directly involved in producing or "buying" services in the area under their responsibility (a single town or several associated town councils or co-ordinated suburban areas in a large city).

Health treatments are produced by a plurality of contributing institutions, publics or privates, accredited to work for the National Service.

In the above-mentioned Delegation Law and Decree of enforcement were underlined the need to set "new accreditation patterns in accordance with the programming guidelines both at regional at national level". At present, it is difficult to foresee the final structure of the system as many others measures are still to be taken, both at national and regional level. In spite of this uncertainty, it appears clear that **competition between public and private providers is now only possible in the context of fixed levels of care assistance, according to the recent Decree about the so called LEA (levels of essential assistance). In fact, parameters such as volume, type and availability of services produced, set out by Public Authorities, take precedence over free choice of citizens.**

THE HOSPITAL SYSTEM

The Health Care Service provides services through:

- 75.868 beds in "**public hospitals of national importance**" organised as enterprises:
- 105.489 beds in **public hospitals depending on the ASL**;
- 12.093 beds in **scientific research institutes** (called in Italian "IRCSS");
- 8. 320 beds in **general hospitals of the University** ("POLICLINICI UNIVERSITARI");
- 8.458 beds in **ecclesiastic institutes** legally recognised, called "**classified**";
- 50.896 beds accredited in **private hospitals**.

Scientific research institutes, general hospital of the University and ecclesiastic hospitals classified are private hospitals recognised as equivalent to the public ones.

Hospital care is provided within the National Service also by **private hospitals for profit: private clinics** (called "**CASE DI CURA**") and hospitals organised as public ones and working at the same conditions (called **PRESIDI**), with 1.850 beds.

In Italy there are **631 private institutes**, of which **527 accredited**, i.e. authorised to work for the National Healthcare Service.

The Italian Association of private hospitals (**AIOP**) represents **517 private institutes** with **56.014 beds**; **455** of them (with 47.375 beds) are accredited. They are for profit, but, inside the ones working for NHS, the patient receives free treatment and he only pays low costs for a better comfort (for example single room, television or telephone).

According to the last Decree of 19 June 1999, private hospitals work under conditions, called the "**three A**", **authorisation, accreditation, and agreements**.

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

INSPECTION BY THE AUTHORITIES

The **Decree n.229/1999** has laid down "the criteria aiming at improving efficiency of SSN ". Therefore, it has modified the control methods previously enforced. Under article 8, it is stated that "it is the responsibility of the Regions and the ASL to supervise the enforcement of the new control methods concerning quality of assistance, quantity of services agreed upon by the structures involved and appropriateness of the services produced ".

According to a guideline and co-ordination Act, to be promulgated, the Regions will have to set down the inspection regulations and, if it is still necessary, the possible sanctions. In order to test compliance with the requirements of regulations, arrangements will be made by the Regions:

- to ensure that hospitals meet appropriate standards and that the information provided to the Authorities on the service production matches the production really achieved;
- to check appropriateness of the services performed ;
- to secure that any medical treatment or any listed service are of appropriate quality;
- to check the outcomes of the care delivery with particular attention to patient 's satisfaction.

The new criteria governing control procedures are expected to take into account quality and appropriateness of the services. Nevertheless the basic problem of three functions in one hand remains unsolved. In fact, the public authority has responsibility for determining regulations, operating institutions and inspecting all hospitals including the ones it manages directly.

INTERNAL MANAGEMENT AND ORGANISATION

Public hospitals of national importance and highly specialised hospitals (hospital enterprises) are obliged by law to establish the same bodies as the ASL: the chief manager, the council of auditors, the administrative manager, the health care manager and the council of the service providers. The **chief manager** has managerial and representation powers. He must appoint an administrative manager and a health care manager. The **health care manager** must be a doctor, with at least 5 years experience in technical health care management in a public or private medium-or large-scale structure. He is in charge of the organisational and hygiene aspects of the Health Care Service. The **administrative manager** has studied either law or economics and has five years experience in technical or administrative management, in the same type of establishment as the health care manager. Both managers report to the chief manager for matters within their competence. These three top-managers work full-time on the basis of a private law contract lasting for five years, which is renewable.

Hospitals, that are "**dependencies of the ASL** ", have at the top of their internal organisation a medical manager responsible for hygiene and organisation, as well as an administrative manager who co-ordinates administration activities. These two managers strive to achieve the objectives determined by the chief manager of the **local health care unit**.

University polyclinics are organised and administered in line with a model determined by the statutes of the University. **The scientific institutes** must also follow the rules of the above institutions, but in their organisation the scientific manager is particularly important, since he is responsible for research activities and their financing.

An health care manager and an administrative manager also administer the private health care institutions like classified religious hospitals, "dependencies " (PRESIDI) and private clinics (CASE DI CURA). The management of the operational unit is the responsibility of the personnel, whose qualifications must comply with the laws in force.

FINANCING

The Italian National Health Service was financed by the **National health fund**, but in accordance with the new **Law by decree 56/2000**, this Fund was cancelled beginning from the 1st January 2001. It is replaced by different sources of financing: a sharing of the Regions to the VAT, equivalent to the 25,7% of the general tax yield; an increased per cent of the taxation on earnings of individual persons (IRPEF); a greater share on the taxes on petrol. It will remain in force the regional taxation on productive activity (IRAP). In 2001 the State integrated the regional healthcare finances on the basis of the previous health expenditure, decreasing progressively this contribution till to 2013, when the Regions will be entirely responsible for the funding.

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

CLOSING REMARKS

A process of devolution, extending the responsibilities of the Regions, is in progress. Freedom of choice of citizens, as a driving force of competition, is still limited by Public Authorities. The problem of the functions of the ASL need to be solved, as they have actually responsibility for purchasing and providing healthcare, controlling at the same time publics and privates providers.

The competition and the impartial management of the public – private mix must be based on a system of equitable rules fixing equality of rights and duties among all the providers of health care services, public and private, lucrative or not, in regard to accreditation terms, remuneration criteria, quality control. In a health care system where the State establishes the rules of a fair competition, based on the correlation among costs – quality - benefits, the private sector can assure a function of general interest.

The European private hospital sector, represented by the **UEHP (European Union of private hospitals)** shares some fundamental trend, in keeping with the common principles on which the building of Health Europe is founded. In this perspective the UEHP policy is settled on a level higher than the variety of national health care systems.

In brief, the **UEHP is in favour 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 without discrimination regarding conditions of accreditation and criteria of remuneration;**
- **the abolition of public monopolistic or quasi monopolistic regimes in the health field and competition among hospital structures whether public or private;**
- **a better use of the richness of structural, technological, professional equipment both public and private;**
- **a rational and effective allocation of the resources;**
- **a more adequate and rapid answer to the needs of demand,**
- **a constant research toward a better quality.**

These positions are according with the general logic of the Communication from the Commission to the Council and the European Parliament, concerning "*The future of health care and care for the elderly: guaranteeing accessibility, quality and financial viability*", presented at the European Council of Barcelona. The document adopts these three criteria – access, quality, financing - to approach the analysis of the healthcare system performances. On this base a report will be presented at the European Council of spring 2003.