



HiT summary

Italy

Overview

The Italian health care system has undergone profound changes since the establishment of the NHS model in 1978. The 1990s reforms involved a process of decentralization of the NHS, both by devolving political and financial authority to the regions and by delegating considerable managerial autonomy to lower-level purchaser and provider organizations. Although these reforms have yielded some positive results, citizen satisfaction with the health care system remained under the EU average in the late 1990s which suggests that there are still areas for improvement.

Health expenditure and GDP

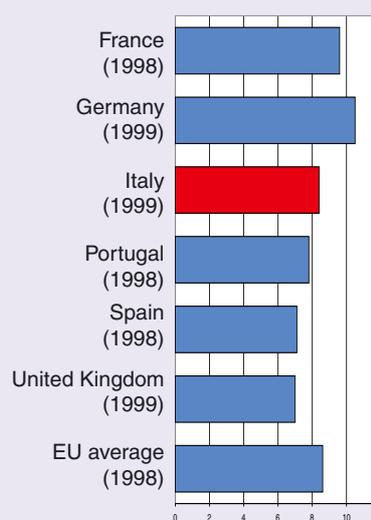
Total expenditure on health accounted for 8.4% of GDP in 1999, while health care expenditure in US \$ PPP per capita that same year was 1839, which places Italy very close to the EU average. Public expenditure accounts for 68% of the total only, one of the lowest percentages in Europe.

Introduction

Government and recent political history

Italy is a parliamentary republic and its political system is based on the 1948 Constitution. Coalition governments have been the rule since then, as a result of an electoral system based on almost pure proportionality. From 1948 to the late 1970s the Prime Minister was consistently from the Christian Democratic Party. During the early 1990s, a profound political crisis led to a thorough reconstruction of democratic institutions such as the electoral system. In 1996, a coalition of left-wing parties entered the central government. In

Fig. 1. Total health care expenditure as % of GDP, comparing Italy, selected countries and EU average



Source: WHO Regional Office for Europe health for all database.

May 2001 the conservative centre-right coalition Pole of Liberties won the general election.

Population

Estimated 57.7 million in 2000. The population growth rate is very low (1.8% annually in 1997). This is a result of having one of the lowest total fertility rates in the world (1.19 in 1998) as well as the highest ratio in the EU of older to younger people (125 people aged 65 years or older for each 100 people 14 years or younger).

European Observatory
on Health Systems and Policies
WHO Regional Office for Europe
Scherfigsvej 8
DK-2100 Copenhagen
Denmark
Telephone: +45 39 17 17 17
Fax: +45 39 17 18 70
E-mail: observatory@who.dk
www.observatory.dk

Average life expectancy

Life expectancy rose substantially during the 1980s and continued to grow during the 1990s to just above the EU average in the late 1990s: 81.2 years for women and 75.8 years for men (1999). Life expectancy figures by region varied by ± 2.0 years in 1997.

Leading causes of death

Cancer and cardiovascular diseases are the most frequent causes of death. Until the age of 35, accidents and other injuries are the main causes of death.

Recent history of the health care system

At the turn of the 20th century, the public sector played a marginal role in health care. During the fascist regime some steps were taken towards compulsory health insurance for workers and their dependants, which was progressively expanded during the post-war period. By the mid 1970s, the system was fragmented into numerous health insurance funds without unified regulation. In 1978, these funds were abolished and the National Health Service (NHS) was established. This new system aimed at granting a homogeneous benefit package to all citizens under centralized financing.

Reform trends

In 1992, faced with widespread problems since the establishment of the NHS, the government launched a pro-competition reform aimed at containing costs and promoting efficiency while retaining universal coverage. However, dissatisfaction with these reforms prompted the government to reorganize the NHS during the late 1990s by introducing fiscal federalism and reinforcing the steering role of the central state over increasingly autonomous regional and local actors.

Organizational structure and management

Italy's health care system is organized at three levels: central, regional and local.

At the central level, the main institution is the Ministry of Health. It is responsible for:

- defining the NHS health targets through the National Health Plan;
- designing framework legislation;
- ensuring uniform resources among regions;
- coordinating the activities of the National Institutes for Scientific Research (IRCCS) and the National Institute of Health (the main scientific and technical body).

In 1992, the ministry stopped regulating prices and criteria for inclusion in the list of publicly financed drugs. This responsibility was assumed by the Interdepartmental Committee on Economic Planning in 1994. The ministry draws on the input of other ministries, namely: the Ministry of Social Affairs (to ensure coordination between health and social services); the Ministry of the Treasury (which participates in setting the health care budget and provides support and control over financing health care services).

Since 1992, the regional level (regional governments and parliaments) is in charge of legislation, management and regional planning of health care services, as well as for monitoring the quality and efficiency of local health units (LHUs), and public and private hospitals. Starting in 1998, they are also responsible for pursuing the leading national objectives posed by the National Health Plan.

At the local level, LHUs are responsible for assessing needs and for providing comprehensive care. Regions define their organizational structure and monitor their operation. Services are territorially structured in four layers:

- public hospital trusts, which provide highly specialized tertiary hospital care, have the

status of quasi-independent public agencies, and fall under the direct responsibility of regional health departments;

- secondary hospitals, organized and managed at the level of LHUs;
- primary care, ambulatory specialist medicine, residential and day care, which are organized at the level of health districts;
- health prevention and promotion programmes, which operate within public health divisions.

National Institutes for Scientific Research and private accredited providers (responsible for ambulatory, hospital and diagnosis services financed by the NHS) complete the network of providers operating at the local level since 1992.

In 1999, approximately 33% of the population was covered by private health insurance. This same year a legislative decree regulated private supplementary insurance, which should provide voluntary coverage for the services not included in the core benefit package of the NHS and for co-payments to the public sector.

Planning, regulation and management

The 1992 reforms strengthened the planning responsibilities of regions. In 1998 the first National Health Plan (NHP) was approved. Objectives, targets and action in the NHP have to be defined taking into account the proposals elaborated each year by the regional health departments. Regions are accountable to the central government for fulfilling regional and national targets. At the local level, the local implementation plan has to be consistent with the regional health plan.

Decentralization of the health care system

During the 1990s, a process of transition towards federal reform of the state ran parallel to the progressive introduction of fiscal federalism.

In addition, since 1992 the NHS underwent a process of delegation so that all LHUs as well as tertiary hospitals were transformed into autonomous bodies. Managerial delegation was part of a broader set of structural changes aimed at introducing managed competition among public and private (accredited) providers.

Health care financing and expenditure

The 1978 reform envisaged universal coverage, a fully tax-based public health system and an increasingly marginal role for private financing. The former aim was almost completely implemented, however, illegal immigrants only have access to a limited range of health care services. The tax-based system has not been fully achieved, since throughout the 1990s social health insurance contributions still represented more than 50% of total public financing. The expected reduction of private financing was not achieved either.

The financial system in place since 1978, although a clear improvement over the previous situation, was still perceived as problematic. In particular, it generated important disparities between wage earners and the self-employed, and provided few incentives and mechanisms to control mounting regional deficits. The 1992–1993 NHS reform and the 1997–2000 fiscal reforms were aimed at counteracting these system flaws, by introducing incentives for cost-containment and launching fiscal federalism respectively. However, the problem of generalized public debt seems to have persisted.

Health care benefits and rationing

The 1978 reform guaranteed access to a broad range of public services, but did not define the benefits for inclusion and exclusion in detail. Even though the 1998–2000 National Health Plan

stressed the need and mechanisms for explicitly defining the content of a homogeneous benefit package, little practical progress has been made in this area yet.

Complementary sources of financing

Italy has two main types of out-of-pocket payments and both receive tax benefits. The first is demand-side cost-sharing for public services: a co-payment for diagnostic procedures, pharmaceuticals and specialist visits. Since 1993, users have paid for the total cost of outpatient care but always up to a ceiling that in 2000 was €36. People with chronic or rare diseases, pregnant women and the disabled enjoy specific types of exemption. There are also criteria for exemption based on income. The second type of out-of-pocket payment refers to direct payment by users for the purchase of private health care services and over-the-counter drugs.

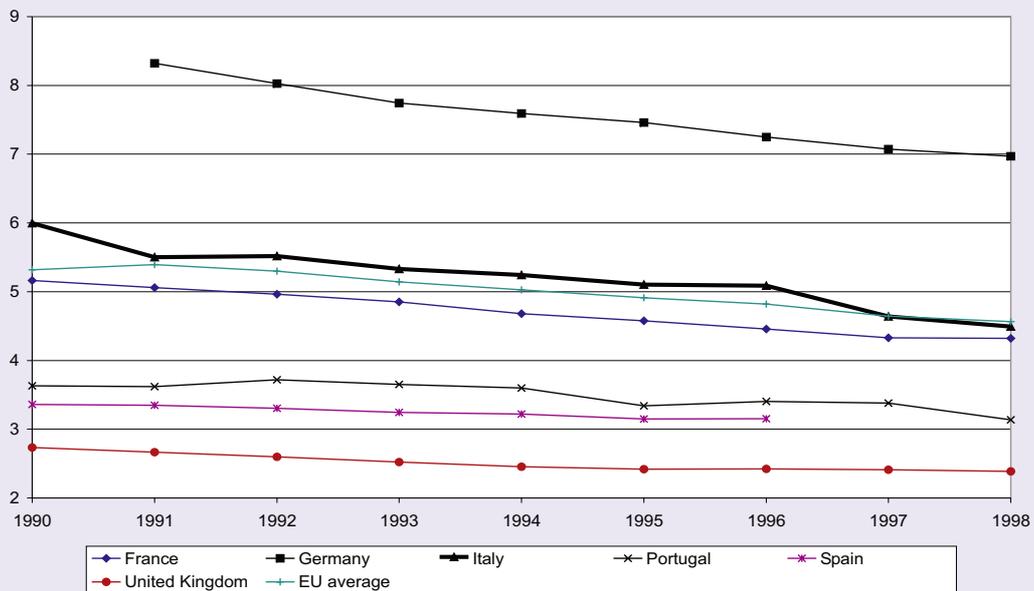
The types of demand for private health insurance include: corporate (where companies cover employees and sometimes their families) and voluntary (individuals buying insurance for themselves or for their family). That demand is covered by for profit (60%) and non-profit organizations (40%). The private insurance sector is poorly integrated in the public sector so that companies mainly provide services that substitute rather than complement those supplied by the NHS.

The 1999 reform of private health insurance companies aimed at expanding the market for supplementary policies to cover co-payments and complementary services not included in the basic benefits package provided by the public sector.

Health care expenditure

From 1980 to 1999, total health care expenditure has increased from €43.7 million to €85.5 million. The introduction of co-payment schemes for outpatient care and pharmaceuticals has raised the percentage of private expenditure, which

Fig. 2. Hospital beds in acute hospitals per 1000 population, Italy, selected countries and EU average, 1990–1998



Source: WHO Regional Office for Europe health for all database.

accounted for 32% of the total in 1999, one of the highest percentages in Europe. Although regional variation in per capita public health care expenditure narrowed during the 1990s, it is still large.

Public health services

LHUs are in charge of protecting and promoting public health mainly through disease prevention (especially immunization), health education and promotion, and food control. They are also responsible for veterinary medicine, which in Italy is integrated into the NHS.

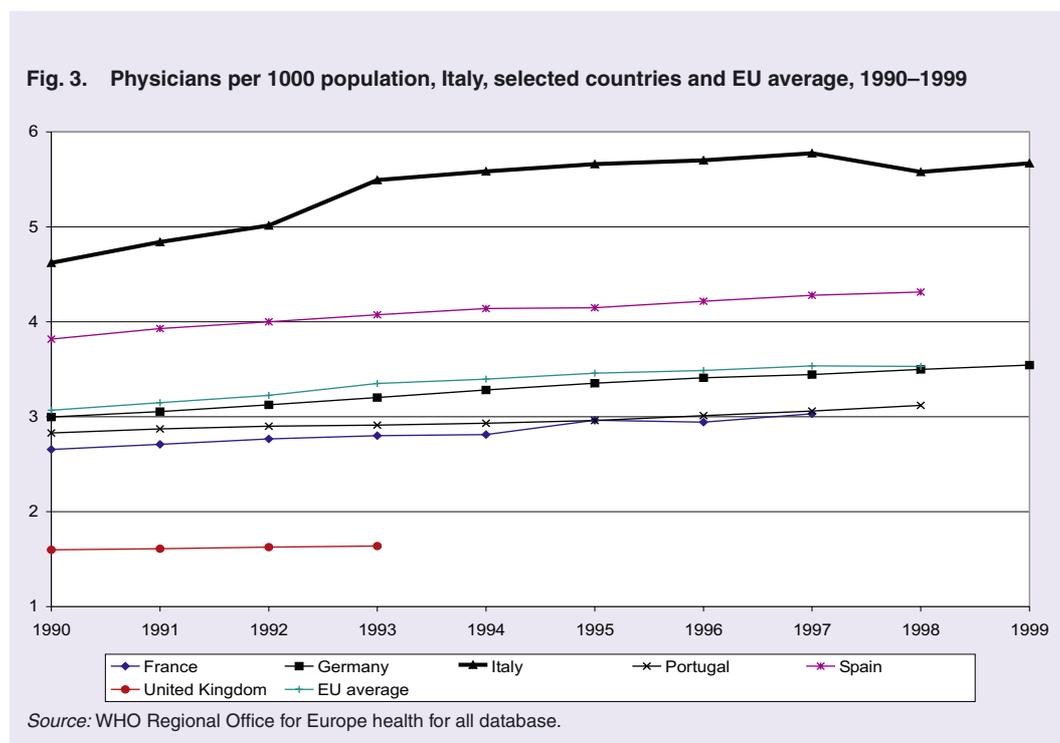
Health care delivery system

Primary health care

Primary health care (PHC) is provided by general practitioners and paediatricians who are independent contractors of the NHS. They act as gatekeepers for access to secondary services. People may choose any physician they prefer provided that the physician's list has not reached the maximum number of patients. The 1999 reform aimed at reinforcing group practice, and promoting tighter linkage between PHC and other district services such as social care.

Secondary and tertiary care

Specialized services are provided either directly by LHUs, or through contracted-out public and private facilities accredited by LHUs. Once the GP authorizes secondary care, people are free to choose their provider among those accredited by the NHS. Since 1993 users have paid for the total cost of outpatient care up to a ceiling which in 2000 was €36. High co-payments, together with long waiting lists and low quality of services lead many people to seek care outside the NHS, especially in central and southern regions.



Starting in 1994, LHUs and major hospitals (which were given the status of independent trusts) were given financial and technical autonomy. In addition, the principle of free choice (applied since 1978) was extended to private, contracted-out hospitals within their LHU or from another LHU (even in another region), which increased cross-boundary flows. As the 1992–1993 reform introduced a prospective payment system for hospitals and increased regional financial responsibility, it encouraged regions to try to bring in more patients (i.e., incentives for more inward than outward mobility). This may further increase the number of patients from the South seeking care in the Northern regions.

Hospital care is delivered mainly by public structures (61% of the total) which provide both outpatient and inpatient services. The remaining 39% consists of contracted out services mainly provided by non-profit institutions. The number of beds per 1000 population decreased slightly during the 1990s, from 7.2 in 1990 to 5.9 in 1997. During 1990–1997, admission rates increased from 15.5 to 18.3 per 100 population, and the average length of stay decreased by 3.6 days. These upward trends in hospital utilization and productivity may reflect the effects of the prospective payment system introduced in the early 1990s.

Social and community care

The presence of two different providers (municipalities responsible for the delivery of social care and for community care) has hampered unified social and health care services. Guidelines developed in the late 1990s aimed at improving the coordination and integration of health and social care.

Human resources and training

Between 1970 and 1995, the number of health care professionals increased in Italy. In 1992, the number of physicians and pharmacists per 1000 population entering the workforce was among the highest in western Europe. On the other hand, the number of new dentists and nurses was among

the lowest of the EU. The National Health Plan for 1998–2000 has provided a broad framework regulating professional training.

Pharmaceuticals and health care technology assessment

The 1990s witnessed radical change in the field of pharmaceutical policy, prompted by a series of scandals as well as mounting cost-containment pressures. In 1994, the previous positive list was abolished and drugs were classified into four groups, which were subject to different co-payment rates and exemption schemes. A number of products, considered to be of limited therapeutic value only, was excluded from public financing. In the same year, the government introduced a ceiling on annual public pharmaceutical expenditure, and in 1998 it made private companies, wholesalers and pharmacists partly responsible for public deficits over the agreed pharmaceutical bill. In addition, reference prices were introduced in 1996. From 1997 onwards, pharmacies' margins were scaled so that they decreased with price, in order to provide an incentive to sell the cheapest of all equivalent brands. In spite of these reforms, there are areas for improvement such as the market for generics, which is still negligible; and GPs' prescription profiles, which have never been monitored.

Finally, Italy still lacks a national agency responsible for promoting and financing health technology assessment activities. The creation of some regional health agencies appears to be a promising start.

Financial resource allocation

Between 1978 and 1992 regional resource allocation was mainly based on simple capitation formulas. In 1997, a weighted capitation rate was introduced that took into account the age structure and health status of the regional population. Based on capitation formula, regions also transferred funds to the LHUs.

The 1997–2000 fiscal federalism reforms entailed a profound transformation of the regional financing system. Regional value-added taxes (VAT) on companies and on the salaries paid to public-sector employees (IRAP) were introduced. In addition, a piggy-back regional tax was imposed on the national income tax (IRPEF). Regions now receive almost all the revenue from these taxes. Since the National Health Fund was abolished in 2001, the central government is responsible for a new fiscal equalization mechanism (the National Solidarity Fund) financed by indirect value-added taxes (VAT). This mechanism transfers funds to the regions unable to raise sufficient resources.

Payment of hospitals

After the 1992 reform, tertiary hospitals were given the status of trusts, so that they enjoy expanded financial freedoms. Public hospitals without trust status were also granted some economic and financial autonomy, although remained under the control of LHUs. In addition, the 1992 reform substituted retrospective reimbursement mechanisms with a prospective payment system for both inpatient and outpatient procedures (for rehabilitation and long-term care a bed-day rate still applies). Hospitals are reimbursed according to nationally predetermined rates. Regions can redefine the latter using the national rate as the maximum level.

Finally, the 1999 reform strengthened the principle of a prospective payment system by linking financing to diagnosis-related groups for inpatient and outpatient care, as well as to average production costs for transplants, emergency care, prevention, long-term care and social services.

Payment of physicians

General practitioners and paediatricians are independent contractors mainly paid on a capitation basis. The 1992 and 1999 reforms complemented the basic capitation fee with two additional financial supplements in order to reinforce incentives for efficiency: fees for specific treatments (e.g. minor surgery); and financial

rewards for effective cost containment (calculated as a proportion of the positive difference between expected and actual expenditure).

Hospital physicians earn a monthly salary. The salary structure depends on the responsibilities performed.

Health care reforms

During the last quarter of the 20th century, Italy has experienced three main waves of reforms. The first, in 1978, instituted a National Health Service aimed at providing all Italian citizens with free access to extended public health care services and financed by taxation. However, following the profound economic crisis that Italy experienced in the late 1970s, cost containment policies were increasingly perceived as a priority, and only universal coverage was fully implemented. The shift towards a fully tax-based system was not implemented, partly because widespread tax fraud was acknowledged, especially among the group of high income self-employed. In addition, fiscal centralization provided regions with incentives to overspend and thus increase the debt that the central government had to pay. Another unintended consequence of the 1978 reform was that management at the local level was inefficient and excessively politicized.

During 1992–1993, within the context of a profound national political and financial crisis, the government launched the second health care reform. The latter aimed at establishing an internal market similar to the British model, and a parallel process of political and financial devolution to regions. The internal market reforms envisaged delegating significant managerial autonomy to hospitals and LHUs, and introducing a partial split between purchasing and providing functions. Market competition was promoted by introducing fee-for-service financing for inpatient and ambulatory care. In addition, civil law replaced public law in regulating the basic organizational

framework of tertiary hospitals and LHUs. Finally, health service charts were created to safeguard citizens' rights in public services and a package of performance indicators and other quality promoting measures was established. However, there were several deviations from this internal market model, namely the perverse incentives that fostered hospital activity and expenditure; the rebound of the regional debt; the sluggish implementation of the internal market reforms in the less developed regions; and an incomplete separation between providers and purchasers, as exemplified by the dual role of LHUs.

The third wave of reforms actually consisted of two kinds of reforms: the first was aimed at establishing fiscal federalism (launched in 1997 and further elaborated in 2000) and the second contained the National Health Plan for 1998–2000 and the subsequent 1999 NHS reform. The fiscal federalism reform aimed at clarifying accountability by transferring to regions full responsibility for providing a basic benefit package under a balanced budget. During the transition period, total regional autonomy in allocating funds among different functions is contingent upon implementation of the monitoring system defined by the central government.

The introduction of fiscal federalism has been surrounded by considerable debate. Its advocates expect that it will promote political transparency and financial responsibility. Its critics point to the following potential dangers. As the tax base is unevenly distributed across the country, large equalization transfers will be needed, which might reduce the effective political autonomy of the less affluent regions. In addition, to obtain equivalent cash increases, low-income regions will have to raise tax rates more than high-income regions, which may hinder private investment. Finally, higher reliance on indirect taxes would make overall health financing more regressive.

The push towards federalism also led to increasing awareness of the potential negative effects of devolution on interregional differences.

To address this, the National Health Plan (NHP) for 1998–2000 and the 1999 reforms launched four sets of regulatory measures aimed at developing mechanisms to guarantee equity of access and treatment across Italy.

Low levels of citizen satisfaction have remained as one of the most enduring problems of the NHS throughout the different waves of reform. Despite significant progress, Italy was still markedly below the EU average in overall satisfaction in the mid- to late 1990s. The main areas of concern in the late 1990s were the administrative services of LHUs, emergency care and specialist outpatient care. In addition, problems of access and high co-payments also account for the low average satisfaction levels, which, in addition, differ markedly across the north-south divide.

Conclusions

The inception of the Italian NHS in 1978 represented an ambitious, laudable effort to rationalize and expand public health care services. However, due to mounting financial pressure and incomplete implementation, the initial reform aims were only partially achieved. The market-oriented 1992–1993 reforms, represented an important attempt to address some of the most enduring problems of the sector.

The period 1997–2000 witnessed a series of radical and innovative changes, including the introduction of fiscal federalism in 1997, and the 1999 NHS reforms, which represent one of the most ambitious attempts in Europe to produce a detailed regulatory framework to guarantee adequate levels of health care quality, efficiency and equity. Some critical areas have not been addressed nor fully regulated yet; it remains to be seen to what extent the available institutional mechanisms will be able to guarantee the free provision of the basic benefit package as well as similar health care quality across the regions.

Table 1. Inpatient utilization and performance in acute hospitals in the WHO European Region, 1999 or latest available year

Country	Hospital beds per 1000 population	Admissions per 100 population	Average length of stay in days	Occupancy rate (%)
France	4.3 ^a	20.3 ^d	5.6 ^a	75.7 ^a
Germany	7.0 ^a	19.6 ^b	11.0 ^a	76.6 ^b
Italy	4.5 ^a	17.2 ^a	7.1 ^a	74.1 ^a
Portugal	3.1 ^a	11.9 ^a	7.3 ^a	75.5 ^a
Spain	3.2 ^c	11.2 ^c	8.0 ^c	77.3 ^c
United Kingdom	2.4 ^a	21.4 ^c	5.0 ^c	80.8 ^a

Source: WHO Regional Office for Europe health for all database.

Notes: ^a 1998, ^b 1997, ^c 1996.

The HiT on Italy was written by Andrea Donatini (Agency for Regional Health Care Services, ASSR), Ana Rico (European Observatory on Health Systems and Policies), Maria Giuseppina D'Ambrosio (ASSR), Alessandra Lo Scalzo (ASSR), Letizia Orzella (ASSR), Americo Cicchetti (ASSR) and Silvia Profili (ASSR). The HiT was edited by Ana Rico and Teresa Cetani (European Observatory on Health Systems and Policies).

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The Health Care Systems in Transition (HiT) profiles are country-based reports that provide an analytical description of each health care system and of reform initiatives in progress or under development. The HiTs are a key element that underpins the work of the European Observatory on Health Systems and Policies.

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