ITALY HEALTH SYSTEM ASSESSMENT

Part A: GENERAL ASSESSMENT OF THE NATIONAL / REGIONAL / LOCAL HEALTH SYSTEMS FROM AN ADMINISTRATIVE STANDPOINT

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"Public Health Policies – Training Romanian staff at Regional level to develop Public Health Policies (PHPRO)"

A GENERAL ASSESSMENT OF THE NATIONAL / REGIONAL / LOCAL HEALTH SYSTEMS FROM AN ADMINISTRATIVE STANDPOINT

In order to grasp the relevant information for elaborating the research report "Mechanisms of building and implementation of Public Health Policies in Germany, Italy and Spain" we consider that several general information is needed.

A1 Administrative organization of the country on three levels: national, regional, local

National level

Italy is located in southern Europe and is bordered by France, Switzerland, Austria and Slovenia. It has a population of 57.5 million (2004) and a surface of 301 316 km^2, with a population density of 193 inhabitants per km^2. The 1948 Constitution established the current parliamentary republic, which has a bicameral parliament – the Chamber of Deputies and the Senate. The head of state is the President, who is elected for seven years by a joint session of the Chamber and Senate, while the government is headed by the Prime Minister, who is usually the leader of the party that has the largest representation in the Chamber of Deputies.

Figure 1. Physical Map of Italy (http://www.italiansolution.com/zRegionsMaps.aspx?mapID=0)

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Regional Level

The country is divided into 20 regions, which are extremely varied, differing in size, population and levels of economic development. The regions of Italy are the first-level administrative divisions of the state.

Originally meant as administrative districts of the central state, the regions acquired a significant level of autonomy following a constitutional reform in 2001. There are twenty regions, of which five are constitutionally given a broader amount of autonomy granted by special statutes.

Every region has a statute that serves as a regional constitution, determining the type of government and the fundamental principles of the organization and the functioning of the region, as prescribed by the Constitution of Italy (Article 123). Fifteen regions have ordinary statutes and five have special statutes.

Regions with ordinary statutes

Since the constitutional reform of 2001 Regions with ordinary statute have had legislative as well as administrative powers. The regions have exclusive legislative power with respect to any matters not expressly reserved to state law (The Constitution of the Italian Republic, Article 117). Yet their financial autonomy is quite modest: they just keep 20% of all levied taxes. (Report RAI - *Le regioni a statuto speciale* retrieved 21st Jan 2009)

Regions with special statutes

Article 116 of the Italian Constitution grants home rule to five regions (namely Sardinia, Sicily, Trentino - Alto Adige, Valle d'Aosta and Friuli-Venezia Giulia), acknowledging their powers in the realm of legislation, administration and finance. The five regions are autonomous regions with special statute. They keep between 60% (Friuli-Venezia Giulia) and 100% (Sicily) of all levied taxes. In return they have to finance the health-care system, the school system and most public infrastructures by themselves. Sicily gets additional resources from the Italian state in order to finance all services

Regional institutions

Each region has an elected parliament, called *Consiglio Regionale* (Regional Council) or *Assemblea Regionale* (Regional Assembly) in Sicily, and a government called *Giunta Regionale* (Regional Junta), headed by the regional President. The latter is directly elected by the citizens of each region, with the exceptions of Aosta Valley and Trentino-Alto Adige/Südtirol, where he is chosen by the Regional Council.

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The map of Italy's regions (http://www.italiansolution.com/zRegions.aspx).

Below there is a table with basic data on the administrative organization of the country at regional level (regions, surface, population):

No	Region	Capital	Area(km²)	Population
1	Abruzzo	L'Áquila	10,794	1,324,000
2	*Valle d'Aosta*	Aosta/Aoste	3,263	126,000
3	Apulia	Bari	19,362	4,076,000
4	Basilicata	Potenza	9,992	591,000
5	Calabria	Catanzaro	15,080	2,007,000
6	Campania	Napoli	13,595	5,811,000
7	Emilia-Romagna	Bologna	22,124	4,276,000
8	*Friuli-Venezia-Giulia*	Trieste	7,855	1,222,000
9	Lazio	Roma	7,207	5,561,000
10	Liguria	Genoa	5,421	1,610,000
11	Lombardia	Milano	23,861	9,642,000

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No	Region	Capital	Area(km²)	Population
12	Marche	Ancona	9,694	1,553,000
13	Molise	Campobasso	4,438	320,000
14	Piemonte	Torino	25,399	4,401,000
15	*Sardinia*	Cagliari	24,090	1,666,000
16	*Sicilia*	Palermo	25,708	5,030,000
17	*Trentino – Alto- Adige*	Trento	13,607	1,007,000
18	Toscana	Firenze	22,997	3,677,000
19	Umbria	Perugia	8,456	884,000
20	Veneto	Venezia	18,391	4,832,000

Local level: provinces and muncicipalities

Provinces

In Italy, a province (in Italian: *provincia*) is an administrative division of intermediate level between municipality (*comune*) and region (*regione*).

A province is composed of many municipalities, and usually several provinces form a region. The region of Aosta Valley is the only one that, strictly speaking, has no provinces: the administrative functions of its province are provided by the corresponding regional government; however, loosely speaking, it is seen as a single province.

The three main functions devolved to provinces are:

- Local planning and zoning
- Provision of local police and fire services.
- Transportation regulation (Car registration, maintenance of local roads)

There are 109 provinces in Italy. Aosta Valley is the only region without a province. Lombardy has the most provinces, with 12.

Each province is headed by a President assisted by a representative body, the Provincial Council, and an executive body, the Provincial Executive. President and members of Council are elected together by resident citizens: the coalition of the elected President (who needs an absolute majority in the first or second round of voting) gains the three fifths of the Council's seats. The Executive is chaired by President who appoints others members, called *assessor*i.

In each province there is also a Prefect (*prefetto*), a representative of central government who heads an agency called *Prefettura-ufficio territoriale del governo*.

The table below shows provinces of each region:

No	Region	Capital	Provinces
1	Abruzzo	LÁquila	Cheti, LÁquila, Pescara, Teramo
2	*Aosta Valley*	Aosta/Aoste	
3	Apulia	Bari	Bari, Barletta-Andria-Trani, Brindisi, Foggia, Lecce, Taranto
4	Basilicata	Potenza	Matera, Potenza
5	Calabria	Catanzaro	Cantanzaro, Cosenza, Crotone,

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No	Region	Capital	Provinces
			Reggio Calabria, Vibo Valentia
6	Campania	Napoli	Avellino, Benevento, Caserta, Napoli, Salerno
7	Emilia-Romagna	Bologna	Bologna, Ferrara, Forli-Cesena, Modena, Parma, Piacenza, Ravenna, Reggio Emilia, Rimini
8	*Friuli-Venezia-Giulia*	Trieste	Gorizia, Pordenone, Trieste, Udine
9	Lazio	Roma	Frosinone, Latina, Rieti, Roma, Viterbo
10	Liguria	Genoa	Genoa, Imperia, La Spezia, Savona
11	Lombardia	Milano	Bergamo, Brescia, Como, Cremona, Lecco, Lodi, Mantua, Milano, Monza and Brianza, Pavia, Sondrio, Varese
12	Marche	Ancona	Ancona, Ascoli Piceno, Fermo, Macerata, Pesaro and Urbino
13	Molise	Campobasso	Campobasso, Isernia
14	Piemonte	Torino	Alessandria, Asti, Biella, Cuneo, Novara, Torino, Verbano-Cusio-Ossola, Vercelli
15	*Sardinia*	Cagliari	Cagliari, Carbonia-Iglesias, medio Campidano, Nuoro, Ogliastra, Olbia-Tempio, Sassari
16	*Sicilia*	Palermo	Agrigento, Caltanissetta, Catania, Enna, Messina, Palermo, Regusa, Siracusa, Trapani
17	*Trentino –Alto-Adige*	Trento	Bolzano-Bozen, Trento
18	Toscana	Firenze	Arezzo, Firenze, Grosseto, Livorno, Lucca, Massa - Carrara, Pisa, Pistoia, Prato, Siena
19	Umbria	Perugia	Perugia, Terni
20	Veneto	Venezia	Belluno, Padua, Rovigo, Treviso, Venice, Verona, Vicenza

Municipalities (commune)

In Italy, the *comune* (plural *comuni*) is the basic administrative division of both provinces and regions. The comune provides many of the basic civil functions: registry of births and deaths, registry of deeds, contracting for local roads and public works, etc.

It is headed by a mayor (*sindaco*) assisted by a legislative body, the *Consiglio Comunale*, and an executive body, the *Giunta Comunale*. Mayor and members of *Consiglio Comunale* are elected together by resident citizens: the coalition of the elected Mayor (who needs an absolute majority in the first or second round of voting) gains the three fifths of the Council's seats. The *Giunta Comunale* is chaired by mayor who appoints others members, called *assessori*. The offices of the *comune* are housed in a building

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usually called the *Municipio*, or *Palazzo Comunale*. Since the start of 2009 there have been 8,100 *comuni* in Italy; they vary considerably in area and population.
A commune usually comprises:

- a principal town or village, that almost always gives its name to the *comune*; such a town is referred to as the *capoluogo* ("head place", or "capital";) of the *comune*; the word *comune* is also used in casual speech to refer to the town hall.
- other outlying areas called *frazioni*, each usually centred on a small town or village. These f*razioni* have usually never had any independent historical existence, but occasionally are former smaller *comuni* consolidated into a larger.

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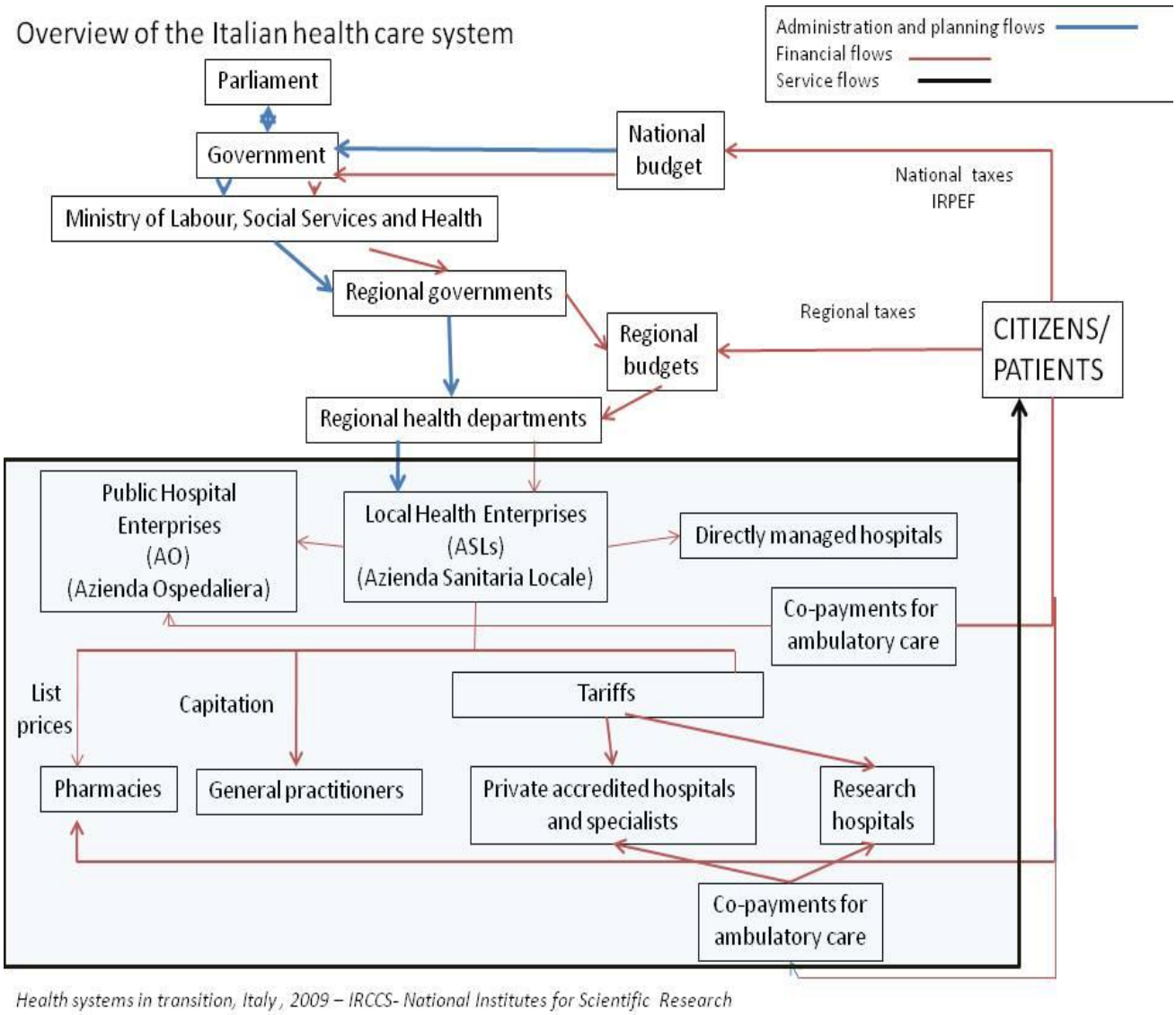
A2 Organization and Functioning of the Health System

Going deeper we are interested on how the health system is organized within this administrative framework (national/regional/local):

The Italian Health Care System is regionally based and organized at three levels: national, regional and local. Under the Italian Constitution, responsibility for health care is shared by the state and the 20 regions. The state has exclusive power to set the 'essential levels of care' (*livelli essenziali di assistenza* (LEAs)), or basic package, which must be available to all residents throughout the country, and is responsible for ensuring the general objectives and fundamental principles of the national health care system. Regions have virtually exclusive responsibility for the organization and administration of publicly financed health care.

Overview of the Italian health care system



Health systems in transition, Italy, 2009 – IRCCS- National Institutes for Scientific Research

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Central level

The main central institution is the Ministry of Health. In 2008, the Ministry of Health has been replaced by a joint ***Ministry of Labour, Social Services and Health***. Through its departments and services, it is responsible for five different functions:

- health care planning
- health care financing
- framework regulation
- monitoring
- general governance of the National Institutes for Scientific Research ((*Istituto di Ricovero e Cura a Carattere Scientifico* (IRCCS)).

The Ministry is currently structured into four departments:

- Department of Quality: responsible for defining the SSN's health targets through the National Health Plan, responsible for allocate resources to regions.
- Department of Innovation
- Department of Prevention and Communication
- Department of Veterinary Care and Food Safety

The Ministry of Labour, Social Services and Health draws on the input of a number of other ministries and institutions:

- the Ministry of Social Affairs, to coordinate social services provided within the infrastructure owned by the SSN (*Servizio Sanitario Nazionale* -National Health Service);
- the Ministry of the Economy and Finance, a critical agent in the process of setting the health care budget and providing technical support and institutional control over financing health care services;
- the Standing Conference on the Relations between the State, the Regions and the Autonomous Provinces, set up in 1988 with the presidents of the regions and representatives from the central government as its members, constituting the main consultative body for all the legislative activities with a regional dimension (it can promote collaboration schemes across regions and the central government and propose its own legislation);
- the National Health Council -provides important technical and consultative support to the SSN;
  the National Institute of Health (*Istituto Superiore di Sanità (ISS*)- The ISS is the main institution for scientific and technical research, control and advice in public health;
- the National Institute for Occupational Safety and Prevention (*Istituto Superiore Prevenzione e Sicurezza sul Lavoro (ISPESL)*- responsible for providing information and research on health promotion and healthy conditions in the workplace;
- the Agency for Regional Health Care Services (*Agenzia per i Servizi Sanitari Regionali* (ASSR)) (since 2007, AGENAS (National Agency for Regional Healthcare)); The Agency is accountable to the regions and to the Ministry of Labour, Social Services and Health
- the Italian Medicines Agency (*Agenzia Italiana del Farmaco AIFA*).

Regional level

The regional level has legislative functions, executive functions and technical support, as well as evaluation functions.

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Legislative functions: Regional legislation should define the principles for organizing health care providers and for providing health care services and the criteria for financing all health care organizations

Executive functions: Regional governments, mainly through their departments of health, outline a three-year regional health plan. Based on this plan, on the National Health Plan and on assessed regional health care needs there are established strategic objectives and initiatives, together with financial and organizational criteria for managing health care organizations.
Regional health departments allocate resources to ASLs (*Azienda sanitaria locale* = local health enterprise), a public institution and AO, coordinate technically health care activities through a Standing Conference for Regional Health and Social Care Planning, appoint the general managers of ASLs (*Azienda sanitaria locale* =local health enterprise) and AOs (*Azienda ospedaliera* -hospital enterprises'), public hospital,, define a regulatory framework governing how the general directors of hospitals and ASLs exercise autonomy in the strategic planning process.

Technical support and evaluation functions: provide technical support directly or to a regional agency for health to the ASLs and to public and private hospitals. Ten regions have created a regional agency for health:
Emilia-Romagna (1994), Friuli-Venezia-Giulia (1995), Campania (1996), Marche (1996), Piedmont (1998), Lazio (1999), Abruzzo (active since 2006), Tuscany (2000), Veneto (2001) and Puglia (2001).

Decentralization
Several legislative measures approved during the period 1997–2000 have further promoted the devolution of political power to the region and continue the process of transferring the funding of the SSN from the central to the regional level, thus strengthening the fiscal autonomy of the regional health departments.
The chief problems have been the shortage of own-source resources for the regions to match their new responsibilities, large interregional differentials in fiscal capacity and conflictive intergovernmental relations, especially over the adequacy of central government funding for the SSN.

Local level
Health services are delivered through a network of population-based ASLs (*Azienda sanitaria locale* =local health enterprise) and public and private accredited hospitals.

A3 Financing of the health system

In 2000 started a slow and at times a difficult approach to fiscal federalism; this process was accompanied by a shift in central health care financing from general revenue to indirect taxes that the state transfers to the regions. Further changes in SSN funding mechanisms are planned within the broader context of significant devolution of revenue raising powers to the regions. Currently, however, taxation is the main pillar of SSN financing.
Regional governors are requested annually to balance the books in health care expenditure; failure to do so might refer the administration of the region to an external commissioner nominated by the regional government.
These measures have created an incentive for regions to perform better, with positive results overall.

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A main feature of Italy's health care system is the presence of deep regional inequality in health care expenditure and in the supply and utilization of health care services.
Available research on public health care expenditure shows that differences in regional expenditure are mainly explained by socioeconomic factors, such as differences in GDP, and in the supply of health care.

Main sources of health financing
Currently, the main source of finance for the Italian SSN is a mix of hypothecated taxes applied both at the regional and national levels:
The IRAP *(Imposta Regionale sulle Attività Produttive* (regional business tax*)* is a regional corporation tax imposed on the value added of companies (corporations, partnerships and self-employed workers) and on the salaries paid to public sector employees. The value added is defined as the difference between income and production costs; labour costs and financial costs are not counted in the production costs.
A regional tax is imposed on top of the national personal income tax (*Imposta sui Redditi delle Persone Fisiche (IRPE*F));
Since 2001, regional financing has come from:

- IRAP, with regions obtaining 90% of IRAP revenue;
- the regional share of IRPEF, now set at 0.9%, with regions allowed to modify the total regional IRPEF rate from 0.9% to 1.4%;
- a set amount (€0.13 per litre) of the petrol excise tax; regions have the right to increase the petrol excise by a further €0.026 per litre; and in addition, regions also have revenues from motor vehicle tax and
- other taxes.

Public funding accounts for about 70% of total health care expenditure and private insurance companies account for about 11%. Out-of-pocket payments and co-payments account for the remaining part of expenditures

Out-of-pocket payments. Italy currently 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. The second is direct payment by users to purchase private health care services and over-the-counter (OTC) drugs. The amount of co-payment differs from one region to another and also the list of services with co-payment.

Voluntary health insurance. As a result of the near universal coverage, voluntary health insurance (VHI) does not play a significant role in funding health care in Italy. Spending on voluntary health insurance, both as a percentage of total expenditure and of private expenditure is well under 5%. Voluntary health insurance is provided both by mutual associations (distinguished by their non-profit status) and by commercial companies (with a for-profit status), with very few of them (0.8%) specializing in health care insurance only

Pooling of funds.
The allocation of resources for the SSN has always been a source of friction both between the central government and the regions and between the regions, contributing to delays in assigning each region's annual share of health care resources. It has proven difficult to design an equitable allocation formula in the face of such large geographical differences in levels of economic development size and age composition of the population, and availability and utilization of health services.

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The guidelines used by the central government to allocate financing to the regions have changed frequently over the past two decades, mainly because they have not always been very clear. Finally, in 1997, a weighted capitation rate was introduced that took into account demand for health care services and reflected the age structure and health condition of the population as represented by the mortality rate.
It is also the responsibility of the Ministry of Health to propose the allocation of resources to each region: the proposal is then discussed by the Standing Conference on the Relations between the State, the Regions and the Autonomous Provinces, which must approve or reject it.
Under Ministry of Health specifications, health care funding should be allocated to three different health care categories as prescribed below:

- public health services in working and living environments (5%)
- community health care (50%)
- hospital health care (45%).

Regions can then choose how to allocate resources within different programmes. Thus, the percentages fixed by the Ministry of Health can be modulated at the regional level in accordance with regional planning targets. In addition, regions may decide how to allocate resources to the ASLs. Nevertheless, most regions transfer funds to the ASLs based on capitation. Each region sets aside some central funds for special projects and then transfers the remainder to the ASLs. In case a patient receives medical services in another region than his residence region, the latter pays the provider of services (money follows the patient).

A4 Health care providers

Starting in 1992, a network of public and private health care structures and providers began operating at the local level, and these can be divided into four different categories:

- local health enterprises (ASLs)
- public hospital enterprises (AOs)
- National Institutes for Scientific Research (IRCCS)
- private accredited providers.

ASLs are geographically based organizations responsible for assessing needs and providing comprehensive care to a defined population. Regions are responsible for determining the size and organization of ASLs and monitoring their operation. ASLs provide care directly through their own facilities or through services supplied by AOs, research hospitals and accredited private providers (acute and long-term hospitals, diagnostic laboratories, nursing homes, outpatient specialists and GPs). Each ASL is managed by a general manager appointed by the regional department of health, based on professional qualifications and technical skills; general managers are appointed for 5 years, and their results are assessed every 18 months.

AOs were established in 1992 when public hospital enterprises, especially university hospitals and highly specialized and national relevant hospitals become quasi-independent public agencies In 2005, the SSN had 102 AOs. AOs provide highly specialized tertiary hospital care (inpatient and outpatient). The general managers of AOs have more autonomy, for example they have the power to define a hospital's mission and objectives through a three-year strategic plan, consistent with the recommendations of the regional health plan.

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Primary care

Primary care is provided by GPs, paediatricians and self-employed and independent physicians working alone under a government contract who are paid a capitation fee based on the number of people (adults or children) belonging to their own list.
In particular, the law allows GPs to work in a team in several ways:

- Medicina in associazione (base group practice): from 3 to 10 GPs who keep on working in their own offices but share clinical experiences, adopt guidelines and organize workshops aimed to assess quality and prescribing appropriateness.
- Medicina in rete (network group practice): same characteristics as the base group practice but in addition GPs share the patient electronic health record system.
- Medicina di gruppo (advanced group practice): 3 to 8 GPs share the same office and the patient electronic health record system. They also provide primary care to patients who do not belong to their catchment area.

Ambulatory care

Specialist ambulatory services, including visits and diagnostic and curative activities are provided either by ASLs or by accredited public and private facilities with which ASLs have agreements and contracts. Services are listed in specific formularies that vary among regions.
People are allowed to access specialist care in two ways.

- Indirect access (referral): after approval by their GP, who is responsible for the referral.
- Direct access: patients can obtain an appointment themselves through what is known as the central booking point (*centro unico di prenotazione* (CUP))

Secondary/ inpatient care

Starting in 1994, ASLs and major hospitals (highly specialized hospitals with national relevance) were given financial and technical autonomy. The major hospitals were given the status of independent AOs. The rest of the public hospitals were kept under the direct management of ASLs. In addition, patients were given the choice of opting for private, contracted-out hospitals that were required to be accredited by the government.
Currently, hospital care is delivered mainly by 669 public structures, which provide both outpatient and inpatient services; nevertheless, ASLs also contract out services to 553 private hospitals, especially not-for-profit institutions. Hospitals are paid by DRG.

A5 Indicators

A list with the following indicators for the three levels (country, region, municipality) would be useful:

The structure of the population changed significantly between 1970 and 2006 owing to marked declines in fertility rates (from 2.42 to 1.35) and increases in life expectancy. Italy has one of the lowest total fertility rates in the world: in 2006, it was 1.35, far below the replacement level. The population growth rate is, therefore, very low (0.52), and immigration is the source of most of the growth.

Population, demographic indicators, 1970-2006

Indicators	**1970**	**1980**	**1990**	**2000**	**2003**	**2004**	**2006**
Fertility rate, total	2.42	1.64	1.33	1.23	1.26	1.33	1.35

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(births per woman aged 15 to 49 years)							
Birth rate, crude (per 1000 people)	17.0	11.7	10.2	9.5	9.4	9.7	9.6
Death rate, crude (per 1000 people)	9.8	9.9	9.6	9.8	10.1	-	9.5

Source: OECD, 2009b.

Mortality and health indicators

Indicators	**1980**	**1990**	**2000**	**2003**	**2005**
Life expectancy at birth (years) Total	74.0	76.9	79.6	79.7	80.4
Life expectancy at birth (years) Female	77.4	80.1	82.5	82.9	83.2
Life expectancy at birth (years) Male	70.6	73.6	76.6	76.8	77.6
Mortality rate Female adults (per 10 000 female adults)	67.6	53.7	44.1	41.4	45.0
Mortality rate Male adults (per 10 000 male adults)	115.6	93.0	75.4	71.2	76.1
Mortality rate Infant (per 1000 live births)	14.6	8.2	4.5	4.2	4.7

Sources: aWHO Regional Offi ce for Europe, 2002, 2007; OECD, 2009b.

With regard to perceived health, 59.6% of a sample of Italy's population self-assessed their health status as being good in 2002. In particular, more men claimed to be in good health than women (ISTAT, 2005b).
Cancer is the most frequent cause of death for people under 64, followed by cardiovascular diseases. However, when all ages are considered, cardiovascular diseases cause more deaths than cancer.
The disability-adjusted life expectancy (DALE) index summarizes the expected number of years to be lived in what might be termed the equivalent of "full health". The indices at birth in Italy are equal to 71.0 for the total population (69.2 for males and 72.9 for females).

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