The Italian Health Care System: Universal Health Coverage

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This system could be considered among the best health care systems in providing universal health coverage. Dividing the country into health regions with a good leverage of autonomy could serve as a good example for others to follow. In each region, there exists a network of health care units and primary health care centers linked to a regional hospital or hospitals. There is a good partnership between the mostly public and partly private sectors. I believe it is the good, efficient and accountable management that counts most.Would Lebanon benefit from this experience?

Introduction

Italy has a total area of 301,230 square kilometers, a population of 61,482,297 (July 2013 est.) and a GDP: $1.813 trillion (2012 est.). Health care spending in Italy accounted for 9.0% of GDP in 2006 (about $2,600 per capita) of which 75% is public, slightly more than the average of 8.9% in the OECD countries. In 2000 Italy's healthcare system was regarded, by World Health Organization's ranking, as the second best in the world after France, and according to CIA World fact book, Italy has the world's tenth highest life expectancy. The life expectancy at birth in Italy was 80.9 years in 2004, which is two years above the OECD average. After World War II Italy (re-)established its social security system including a social health insurance administered by sickness funds. In the 1970s the social health insurance faced several equity problems as coverage differed between the sickness funds and around seven percent of the population remained uninsured. Moreover, sickness funds went practically bankrupt by the mid-1970s. Due to growing public dissatisfaction with the existing healthcare system, Italian policymakers fostered a structural reform. In 1978, the government established the SSN (Servizio Sanitario Nazionale) - the Italian version of a National Health Service - including universal coverage and tax funding.

The SSN covers all citizens and legal foreign residents. Coverage is automatic and universal. Since 1998, illegal immi¬grants have been granted access to basic services. Temporary visitors can receive health services by paying for the costs of treatment. Modeled after the British National Health Service, the SSN replaced a Bismarckian system of health insurance funds in 1978. Complementary and supplementary private health insurance are also available.

Role of Government

The central government controls the distribution of tax revenue for publicly financed health care (Servizio Sanitario Nazionale, or SSN) and defines a national minimum statutory benefits package to be offered to all residents in every region, the "essential levels of care" (livelli essenziali di assistenza, or LEAs). The 19 regions and 2 autonomous provinces have responsibility for the organization and delivery of health services through local health units. Regions enjoy signifi¬cant autonomy to determine the macro structure of their health systems. Local health units are managed by a CEO appointed by the governor of the region and deliver primary care, hospital care, public health, occupational health, and health care related to social care.

Coverage

Services: Positive and negative lists are defined using criteria related to medical necessity, effectiveness, human dignity, appropriateness, and efficiency in delivery. Positive lists exist for pharmaceuticals, inpatient care, and preventive medicine. Negative lists include ineffective services; services that are covered only on a case-by-case basis, such as orthodontics and laser eye surgery; and inpatient services for which hospital admissions are likely to be inappropriate (e.g., cata¬ract surgery). Payment rates for hospital and outpatient care are determined by each region, with national rates (deter¬mined by the Ministry of Health) as a reference, while the National Drugs Agency sets the reference price for drugs. Regions can choose to offer non-LEA services, but must finance them themselves. LEAs do not include a specific list of mental health services. Rather, national legislation creates an organizational framework for mental health services, and local health authorities are obliged to define the diagnostic, curative, and rehabili-tative services available at each level of care. Nor do LEAs explicitly define the preventive, public health, or long-term care services that are covered by SSN. Instead, they outline general community and individual levels of preventive ser-vices to be covered, including hygiene and public health, immunization, and early diagnosis tools. In addition, they broadly state that rehabilitative and long-term inpatient care is to be delivered as part of a standard, inpatient curative care program.

Prescription drugs are divided into three tiers according to clinical effectiveness and, in part, cost-effectiveness. The SSN covers the first tier in all cases, but covers the second tier only in hospitals, and does not cover the third. For some categories of drugs, therapeutic plans are mandated, and prescriptions must follow clinical guidelines. Dental care is generally not covered and is paid for out-of-pocket.

Cost-sharing: Primary and inpatient care are free at the point of use. Procedures and visits can be "prescribed" either by a GP or by a specialist. Since 1993, patients have paid for the total cost per visit up to a ceiling determined by law. The ceiling currently stands at €36.15 (US$46.10) per prescription. Therefore, a patient who receives two separate prescriptions (e.g., a magnetic resonance imaging scan and a laboratory test) after a visit has to pay the first €36.15 on each prescription. To address rising public debt, in July 2011, the government introduced, with other economic initiatives, an additional €10 (US$12.75) copayment for each "prescription." Copayments have also been applied to outpatient drugs at the regional level and, since 2007, a €25 (US$31.88) copayment has been introduced for the "unwarranted" use of emergency services—that is, instances deemed to be noncritical and nonurgent (although some regions have not enforced this copayment). Public providers, and private providers under a contractual agreement with the SSN, are not allowed to charge above the scheduled fees.

Safety net: All individuals with out-of-pocket payments over €129 (US$164.48) in a given year are eligible for a tax credit equal to roughly one-fifth of their spending, but there are no caps on out-of-pocket spending. Exemptions from cost-sharing are applied to people age 65 and over or age 6 and under who live in households with a gross income below a certain threshold (approximately €36,000 [US$45,900]); people with severe disabilities, as well as prisoners, are totally exempt from any cost-sharing. People with chronic or rare diseases, people who are HIV-positive, and pregnant women are exempt from cost-sharing for treatment related to their condition. Most screening services are provided free of charge.

Financing the Health System

Publicly financed health care: Public financing accounted for 80 percent of total health spending in 2010 (OECD 2012). The public system is financed primarily through a corporate tax pooled nationally and allocated back to the regions, typically the source region (there are large interregional gaps in the corporate tax base, leading to financing inequalities), and a fixed proportion of national value-added tax (VAT) revenue collected by the central government and redistributed to regions unable to raise sufficient resources to provide LEAs. Regions are allowed to generate their own additional revenue, leading to further interregional financing differences. Every year the

Standing Conference on 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) sets the criteria used to define the level of funding for the delivery of LEAs (population size and age demographics). The 2008 financial law established that regions would be financed through standard rates (not yet operationally defined) for specific functions (e.g., hospital care, pharmaceuticals, primary care) set on the basis of actual costs in the regions considered to be the most efficient. Local health units are funded mainly through capitated budgets.

Privately funded health care: In 2010, 17.8 percent of total health spending was paid out-of-pocket, mainly for drugs not covered by the public system (over-the-counter drugs) and dental care (OECD 2012). Out-of-pocket payments can be used to access specialist care and, to a lesser extent, inpatient care delivered in private and public facilities to paying patients. Private health insurance plays a limited role in the health system, accounting for roughly 1 percent of total health spending in 2009. Approximately 15 percent of the population has some form of private health insurance, generally to cover services excluded under the SSN, to benefit from a higher standard of comfort and privacy in hospital facilities, and to have wider choice of public and private providers. Some private insurance policies cover copayments, but the main use of private health insurance is to cover private services, shorter waiting times, better amenities, and unrestricted choice of specialist, or to provide compensation while hospitalized, with patients receiving a fixed sum per day. In 1999, increased tax relief was established for contributions paid to the funds providing complementary insurance.

How are Health Services Organized and Financed?

Primary/ambulatory care: General practitioners (GPs) are paid via a combination of capitation and fee-for-service, sometimes related to performance, and are regulated under national and regional contracts. Capitation is adjusted for age. The majority of GPs operate in solo practices, although the central government and regions have offered economic incentives to encourage group practice and greater integration between GPs and social care, home care, health education, and environmental health services (see below). In 2009, there were approximately 46,300 GPs (30.2%) and 107,000 hospital clinicians (69.8%). Patients are required to register with a gatekeeping GP, who has incentives to prescribe and refer only as appropriate. People may choose any physician whose list has not reached the maximum number of patients allowed (1,500 for GPs and 800 for pediatricians).

Outpatient specialist care: Outpatient specialist care is generally provided by local health units or by public and private accredited hospitals under contractual agreement with a local health unit. Once referred, patients are given free choice of any public or private accredited hospital. Ambulatory specialists are generally paid on a per-hour basis, while hospital-based physicians are salaried employees.

After-hours care: Guardia medica is a free telephone health service for emergency cases. It normally operates at night and on weekends, and the doctor on duty usually provides advice in addition to home visits if needed. Following exam-ination and initial treatment, the doctor can prescribe medication, issue employee's medical certificates, and recommend hospital admission. To promote coordination among health care professionals and improve the accessibility of primary care, government and GP associations have agreed to implement a model where GPs, specialists, and nurses coordinate to ensure 24-hour access and avoid unnecessary use of hospital emergency departments. The general structure of the model has been outlined in the national contract with no additional payment attached; regions have been given the responsibility of developing the model. Implementation is uneven across regions.

Hospitals: Depending on the region, public funds are allocated by the local health unit to public and accredited private hospitals. Public hospitals either are managed directly by the local health units or operate as semi-independent public enterprises, similar to the British trust hospitals. A DRG-based prospective payment system operates across the country, although it is generally not applied for hospitals run directly by local health units. There are considerable interregional variables in the prospective payment system, such as how the fees are set, which services are excluded, and the tools employed to influence patterns of care. Regions even use different coding and classification systems. Moreover, in all regions, a portion of funding is administered outside the prospective payment system (e.g., funding of specific functions such as emergency departments and teaching programs). All regions have mechanisms for cutting tariffs once a spend¬ing threshold for the hospital sector is reached, to contain costs and offset incentives to increase admissions. Hospital-based physicians are salaried employees. Before 1999, all physicians could earn additional income by treating patients privately on a fee-for-service basis, but since then public-hospital physicians have been prohibited from treating patients in private hospitals; all public physicians who see private patients in public hospitals must now pay a proportion of their extra income to the hospital.

Mental health care: Mental health care is provided by SSN in a variety of community-based, publicly funded settings, including community mental health centers, community psychiatric diagnostic centers, general hospital inpatient wards, and residential facilities. At present, promotion and coordination of mental health prevention, care, and rehabilitation are the responsibility of specific mental health departments in local health units. These are based on a multidisciplinary team, including psychiatrists, psychologists, nurses, social workers, educators, occupational therapists, people with training in psychosocial rehabilitation, and secretarial staff. Flat copayments apply to diagnostic procedures, pharmaceuticals, and specialist visits. Physicians or specialists providing mental health services are reimbursed on a capitation basis.

Long-term care: Patients are generally treated in residential or semiresidential facilities, or in community home care. Residential and semiresidential services provide nurse, physician, and specialist care; rehabilitation services; and medical therapies and devices. Patients must be referred in order to receive residential care. Cost-sharing for residential services varies widely according to region, but is generally determined by patient income. Community home care is funded publicly, whereas residential facilities are managed by a mixture of public and private, for-profit and nonprofit organizations. Unlike residential and semiresidential care, community home care is not designed to provide physical or mental care services but rather to enhance a patient's autonomy by providing additional assistance throughout a course of treatment or therapy. In spite of government provision of residential and home care services, long-term care in Italy has traditionally been characterized by a low degree of public financing and provision when compared with other European countries.

Until 1999, palliative care was very limited and was concentrated mainly in northern Italy. Much was left to the efforts of voluntary organizations, which still play a crucial role in the delivery of these services. Although much still needs to be done to ensure the diffusion of homogeneous palliative care services, a national policy on palliative care has been in place since the end of the 1990s and has contributed to an increase in palliative care services such as hospices, day-care centers, and palliative care units within hospitals.

The key entities for health system governance

The Ministry of Health draws on the expertise of various institutions for technical support. Key nongovernmental enti¬ties include the National Health Council (which provides support for national health planning, hygiene and public health, pharmacology and pharmaco-epidemiology, continuing medical education for health care professionals, and information systems) and the National Institute of Health (which provides recommendations and control in the area of public health). The National Committee for Medical Devices (created in 2003) develops cost-benefit analyses and determines reference prices. The Agency for Regional Health Services, the main institution responsible

for conducting comparative effectiveness analysis, is accountable to the regions and the Ministry of Labor. The National Drugs Agency (Agenzia Italiana del Farmaco), founded in 2003, is responsible for all matters related to the pharmaceutical industry, focusing on quality, production, distribution, scientific research, and prescription drug pricing and reimbursement poli¬cies. It is accountable to the Ministry of Health and the Ministry of Economy and Finance.

The national government defines the benefits package with the Standing Conference on Relations between the State, the Regions and the Autonomous Provinces. Decisions are based mainly on clinical effectiveness and appropriateness rather than cost-effectiveness. At the regional level, some governments have established agencies to evaluate and moni¬tor local health care quality and provide technical comparative effectiveness assessments and scientific support to regional health departments (see below). Regional governments underwrite annual "Pacts for Health" that link additional resources to the achievement of health care planning and expenditure goals.

What is being done to Ensure Quality of Care?

The national and regional ministries, which are responsible for upholding quality, ensure that LEA services are provided and waiting times are monitored. Several regions have introduced effective programs for prioritizing the delivery of care on the basis of clinical appropriateness of services prescribed and patient severity (France et al., 2005). All doctors under contract with the SSN must be certified, and all SSN staff participate in a compulsory continuing education program. Private hospitals must be accredited by the region in which they operate in order to contract with the SSN. The National Commission for Accreditation and Quality of Care is responsible for outlining the criteria used to select providers and for evaluating the accreditation models, which are regionally selected and vary considerably across the system.

A national program for producing clinical guidelines, called the National Plan for Clinical Guidelines, has been implemented in recent years. In addition, in 1995, national legislation stated that all public health care providers should issue a "health service chart" that provides the public with information on service performance, highlighting quality indicators, waiting times, and a strategy for quality assurance, while also outlining the process by which patients can make complaints in the system. These charts have been adopted by the private sector for its accreditation process, and must be published annually, although dissemination methods are decided regionally. Most providers issue performance data through leaflets and the Internet, while nurses and other medical staff are offered financial incentives for performance (linked to manager evaluations but not to publicly reported data).

In 2003 the National Technical Committee on Clinical Risk was established, and a year later the Working Group for the Assessment of Methodological Approaches for the Evaluation of Clinical Risk was formed. In February 2006, the two groups merged into the Working Group on Patient Safety, and in 2007 the Ministry of Health initiated the National System for Patient Safety as a two-year pilot project, which also functions as the National Observatory for Patient Safety in collaboration with the Working Group on Patient Safety.

What is being done to Improve Care Coordination?

In the past few years general practice has witnessed a transformation, with the solo practice model being progressively modified by new organizational forms (networks, groups, etc.), particularly in the northern part of the country. Specifically, recent legislation encourages multidisciplinary teams to work in three ways: base group practice, where GPs from different offices share clinical experiences, develop guidelines, and participate in workshops that assess perfor-mance; network group practice, which functions like base group practice but allows GPs to access the same patient elec¬tronic health record system; and advanced group practice, where GPs share the same office and patient health record system, and are able to provide care to patients beyond individual catchment areas.

Also in recent years, significant inroads have been made into better integration of health and social care services, with the vision of shifting long-term care from institutional services to community care with an emphasis on the home. The community home care scheme was founded as part of the National Health Plan for 1998–2000, and establishes a home care network that integrates the competencies of nurse, GP, and specialist physician with the needs and involvement of the family. GPs oversee the home care network, liaise with social workers and other sectors of care, and take responsibil¬ity for patient outcomes.

What is being done to Reduce Health Disparities?

Interregional inequity is a long-standing concern. The less-affluent southern regions trail the northern regions in the number of beds and availability of advanced medical equipment, have more private facilities, and have less-developed community care services. Data show a rise in interregional mobility in the 1990s, particularly from southern to central and northern regions (France, 1997). Income-related disparities in self-reported health status are significant, though relatively low and similar to those observed in the Netherlands, Germany, and other European countries (Van Doorslaer and Koolman, 2004).
The National Health Plan for 2006–2008 cites overcoming large regional discrepancies in care quality as a key objective for future reform. The Ministry of Health and Ministry of Economics and Finance signed an agreement in April 2007 to direct EU resources toward health services in eight regions in the south as a first step in reducing this persistent varia¬tion. To avoid inequalities among regions and to provide equal access to LEAs, regions receive a quota from an equaliza¬tion fund (the National Solidarity Fund), which aims to reduce inequalities between northern and southern regions. Aggregate funding for the regions is set by the Ministry of the Economy and Finance, and the resource allocation mechanism is based on capitation adjusted for demographic characteristics and use of health services by age and sex.

What is the Status of Electronic Health Records?

In 2001, the New Health Information System (NSIS) was developed to establish a universal system of electronic health records that connects every level of care and provides information on the services delivered, resources used, and associated costs. The NSIS has been implemented incrementally since 2002, but is not yet universal. A core part of NSIS is represented by a nationwide clinical coding program, the "bricks" program, aimed at defining a common language to classify and codify concepts in a uniform manner; to share methodologies for measuring quality, efficiency, and appropriateness of care; and to allow an efficient exchange of information between the national level and regional authorities. The bricks program has been the focus of considerable effort and is one of the most mature elements of Italy's developing electronic health program. Some regions have developed computerized networks connecting physicians, pediatricians, hospitals, and territorial services to facilitate communication among health care professionals and to improve continuity of care. These networks allow automatic transfer of patient registers, services supplied to patients, prescriptions for specialist visits and diagnostics, and laboratory and radiology test outcomes.

What Major Innovations and Reforms have been Introduced?

Because of the regionalization of the health system, most innovations in the delivery of care take place at the regional rather than the national level, with some regions viewed as leaders in innovation. Significant innovations can be found in:

- primary care: regions are developing and supporting group practices and collaboration between professionals, as well as attempting to establish medical homes;
- psychiatric care;
- home care, with several projects involving multiprofessional teams;
- pharmaceutical care: both the National Drugs Agency and the regions are particularly active in coordinating guidelines and rules to promote appropriate and cost-effective prescribing; and
- hospital care: various innovations have been introduced concerning the overall organization, management of operations (e.g., planning of surgical theaters and delivery of drugs), and health information technology (e.g., electronic medical records, automation of administrative and clinical activities).

Regions have used the accreditation system and introduced caps on spending to create barriers to entry and to maintain control over expenditure. With regard to cost containment, in August 2012 the national parliament passed a law aimed at curbing and rationalizing public expenditure (so called "spending review"). The law further promoted the prescription of generic drugs, cut the hospital beds standard from four per 1,000 people to 3.7, and reduced the public financing of the SSN by €900 million (US$1.15 billion) in 2012, €1.8 billion (US$2.3 billion) in 2013, €2 billion (US$2.6 billion) in 2014, and €2.1 billion (US$2.7 billion) in 2015.

In Lebanon, the formation of somehow self-sufficient health regions is of great importance especially when involving multiple stakeholders including municipalities and related non-government organizations.