

The healthcare service in Italy: regional variability

A. CICHETTI¹, A. GASBARRINI²

¹Faculty of Economics, Catholic University of the Sacred Heart and Graduate School of Health Economics and Management (ALTEMS), Rome, Italy.

²Department of Internal Medicine, Agostino Gemelli Foundation, Catholic University of the Sacred Heart, Rome, Italy.

Abstract. – The Italian health system is highly decentralized, with most administrative and organizational powers governed by Regions and rather limited powers at national level. The state has full control over the definition of the core benefit package (LEA) but there is evidence that the actual provision of these services varies greatly across Regions.

Key Words

Italian National Healthcare Service, Regions, Healthcare access.

One of the pillars of the Italian National Healthcare Service (NHS) is the universal coverage for all citizens. The law n.833/1978 annulled the mutualistic healthcare service, based on individual work taxation coverage, and introduced the universalistic NHS, based on a general taxation. The NHS is approximately 95% funded through direct and indirect taxation, while residual is derived from the incomes of the regional health institutions and from tickets to be paid directly by patients. The inner intent of this law was providing uniform and equal access to NHS all over Italy, in accordance with the article 32 of our Constitution. The aim of the NHS was to create an efficient and uniform health system covering the entire population, irrespective of income or contributions, age, gender, employment or pre-existing health conditions. The NHS provides nowadays health care service to all residents and their families and emergency care to visitors irrespective of their nationality.

During the '90s, the Regions received more relevance from an institutional and an economic point of view. Institutionally, they actually establish the governance of the regional healthcare service; economically, they must manage resources for providers funding and eventual

payback mechanisms¹. The “regionalization” of the NHS, enforced by the law n. 229/1999, became actual “federalism” with the reform of the title V of the Constitution (D.Lgs.vo 56/2000) and its modification in 2009¹. Regions are allocated a proportion of the healthcare budget. This proportion varies annually based on a complex agreement among regional health authorities, Minister of Health and Minister of Economics and Finance.

Currently, the NHS is organized at central, regional and local level. At national level, the MoH, supported by several specialized agencies, sets the fundamental principles and goals of the health system, determines the core benefit package of health services guaranteed across the country (Livelli Essenziali di Assistenza, LEA), and allocates national funds to the Regions. Regions are responsible for organizing and delivering health care. At local level, geographically based local health authorities (Aziende Sanitarie Locali, ASL) deliver public health, community health services and primary care directly, and secondary and specialist care directly or through public hospitals or accredited private providers.

The decentralization is based on the idea that local decision makers are ‘nearest to citizens’ needs and, therefore, can provide better, more efficient services. On the other side, decentralization also means geographical and population differentiation (age, gender, territorial topographies, morbidity, level of attractiveness from other regions and incomes). Disparities can derive from diverse fiscal regional capacity (Southern *pro-capite* gross domestic product is lower than Northern Regions), producing diverse funding capacity and from diverse choices and preferences of the regional governments. Comparing Valle D’Aosta Region and Campania Region in terms of per person public healthcare expenditure

is emblematic: respectively, 3,169€ versus 2,061€, with 48.3% difference also when adjusting for demographic factors².

This pattern is also substantially echoed in the geographical distribution of satisfaction levels with the health-care system and its performance. Generally, however, over the last few years there has been a general decrease in satisfaction levels and problems such as long waiting times for outpatient and diagnostic services exist across the country¹.

Since 2001, agreements between the national level and the regions have become the main instrument for planning and organization of public health care in Italy. In fact, different Regions have made different choices on how to use their increasing autonomy. For instance, Tuscany decided to keep the system heavily centralized, with most hospitals remaining under ASL control and only a handful becoming hospital enterprises. At the other extreme, Lombardy opted in 1998 for a fully-fledged experiment in which all hospital and specialist services are delivered by hospital enterprises or private providers. Diverse key words can be, as a matter of fact, identified in the regional health care plans: “freedom/innovation” for Lombardia, “integration/social” citizenship for Emilia Romagna, “health/innovation/sustainability” for Umbria, “health/integration” for Puglia. Furthermore, when studying indicators of regional programs, like economic equilibrium (expenditure containment and copayment) or innovation/prevention, you can find Lombardia Region deciding for low containment and moderate copayment and, on the opposite, Sicilia Region with high level for both indicators; respectively, moderate and lower relevance for innovation/prevention¹.

Because of these regional differences in policies and financing, a large vertical fragmentation exists in the extent and the quality of such strategies between Regions or ASLs of excellence, which are mainly found in the northern part of the country, and areas where self-directed initiatives are limited. In addition, horizontal fragmentation undermines the continuity of care for chronic diseases, as integration between actors of social care (municipalities) and health care (ASLs) varies across the country and is mostly incomplete.

In Italy, as in most Organization for Economic Co-operation and Development countries, health expenditure has steadily increased over time, making its containment a major issue for governments. To address this financial failure,

the government introduced a special regime for overspending regions that requires the adoption and implementation of formal regional ‘financial recovery plans’ (Piani di Rientro). Since 2007, ten out of the twenty-one regional health systems have adopted these plans, which include actions to address the structural determinants of costs. Financial recovery plans have further affected the level of decentralization of policies.

A further element of differentiation is LEA provision: out of 16 regions monitored by the MoH and Ministry of Economics and Finance, 8 (Basilicata, Emilia Romagna, Liguria, Lombardia, Marche, Toscana, Umbria e Veneto) are providing LEA. Remaining 8, although improving the level of care, are still defaulting some commitments, like reorganizations of birth point of care, palliative care, prevention, reorganization of laboratories networks³.

Another item of differences is patients’ co-payments for out-patient care. Tickets for out-patient care were firstly regulated by the Law No. 553/1993, which introduced national co-pays for specialist services up to a limit of €36.15 for each referral. Regions, however, were acknowledged a level of autonomy in setting different maximum caps (only 5 Regions introduced different caps) and in introducing possible additional forms of cost-sharing (like Lazio for MR and X-ray CT €15)⁴. The Decree Law No. 98/2001 introduced an optional and additional co-pay of €10 per referral. Regions were again left free to substitute this co-pay on referral with different measures able to grant the same increase in revenues on local budgets. The ticket per referral is calculated by considering household income or considering the value of the service prescribed in the referral. Also criteria for exemption largely vary in the country. The extremely diverging regulation implemented in regional healthcare systems reveals how different criteria are used and different economic incentives may arise for patients when they access out-patient care. On the other hand, Agenas itself underlines how the consumption of out-patient services has extremely diminished in all SSN during the last years. Main reasons are both the increase of co-payments, which led many patients to shift to seek services to private providers, and the reduced supply of public providers, due to the increasing budget constraints existing on regional systems⁴.

Last but not least aspect of variability is drug access. The national drug access system is in fact characterized by diverse models of drug distribu-

tion among Regions/ASL, which are influenced by complex authorization procedures linked to diverse system of drug formularies. This latter are not homogeneously present all over Italy and can, in some cases, actually limit the drug access for patients⁵. Besides, the assessment process appears fragmented and may take a long time (around 100 days in order to be included in regional/local formularies): drugs inclusion into hospital formularies requires two steps in most regions (regional and local assessment). Prioritization in the assessment is mostly driven by disease severity, clinical evidence, and the absence of therapeutic alternatives; only thirteen out of the seventeen regional committees have a public application form for drugs inclusion into regional formulary. Regional and local committees (i) often re-assess the clinical evidence already evaluated at the central level and (ii) mostly rely on comparative drug unit prices per DDD and drug budget impact⁶.

The rich supply of indicators on the performance of regional health-care systems clearly shows that the SSN is actually fragmented into twenty-one different systems.

Conflicts of interest

The Authors declare that they have no conflict of interests.

References

- 1) TANESE A. sistemi sanitari regionali verso il federalismo. Appunti per una riflessione sull'evoluzione del SSN. La formazione manageriale. 2011; pp. 21-79.
- 2) SPANDONARO F. Investimenti, Innovazione e selettiva: scelte obbligate per il futuro del SSN. 10° Rapporto Sanità. CREA Sanità, Università di Tor Vergata, 2014.
- 3) MINISTERO DELLA SALUTE. Direzione Generale Della Programmazione Sanitaria Ufficio X ex DGPROG – SiVeAS. Verifica adempimenti lea anno 2013.
- 4) AGENAS. La compartecipazione alla spesa nelle regioni sintesi della normativa vigente al 1 maggio 2015.
- 5) CENTRO STUDI E RICERCHE SULLE BIOTECNOLOGIE SANITARIE E SETTORE BIOTECH. Primo Rapporto di ricerca 2013: i farmaci biotecnologici e le politiche nazionali e regionali per il loro governo. 2013; pp. 1-233.
- 6) JOMMY C, COSTA E, MICHELON A, PISACANE M, SCROCCARO G. Multi-tier drugs assessment in a decentralised health care system. The Italian case-study. Health Policy 2013; 112: 241-247.