Table of Contents

PART III - Facts and policies of the Italian National Health Service (INHS)

11. From decentralisation to federalism

The Italian National Health Service (INHS), made up of people, means and facilities all committed to the prevention, diagnosis and treatment of diseases and to the promotion of the health recovery of the population in general, was established by law N. 833 of 23 December 1978. The objective, according to article 32 of the Italian Constitution concerning the safeguard of every citizen's health is an individual asset and community interest.

All the health structures operating at that time in Italy moved into an overall national organization consisting of three main institutional levels: *the State level* (or national or central) responsible for overall planning and control; *the regional level* responsible for territorial planning, organization and control; and *the local level* to provide health care.

The "central level" is the national Government and the Ministry of Health; the "regional level" is the Governments of 19 Regions and 2 autonomous Provinces; and the "local level" is the Local Health Units and the Municipalities.

Since it was established 24 years, ago and particularly in more recent years, the INHS has undergone many significant adjustments and changes, progressively increasing the role and responsibility of regional and local levels instead of the central level of planning and management.

11.1. From 1992 to 1996

In the early nineties, the Legislative Decree N. 502 of 1992 and 517 of 1993 increased the responsibility and autonomy of regional authorities considerably in terms of planning, organisation and control of local health services and hospitals, using regional quotas of the "national health fund" derived mainly from the taxation funds allocated by Parliament each year with the national budget and transferred to the Regions and autonomous Provinces by the Ministry of Health.

Local health units and main hospitals were transformed into Agencies to be managed by independent managers with the same principles and rules as private enterprises. Private and public health structures were expected to freely compete for the delivering of health care according to tariffs established with the diagnosis related group (DRG) international system by the Regions within maximum values adopted by the Ministry of Health.

When implementing these regulations, the Regions established, within their vastly differing territories, local health and hospital Agencies, in terms of their size, managerial autonomy and organisational procedures. However, the free competition system between private and public health structures was not fully achieved in Italy at that time. In actual fact, in many Regions, private health structures completed services provided by the public health structures, mainly by integrating activities that the public structures could not offer.

11.2. From 1997 to 2000

From 1997 to 1998, the transfer of responsibility from the Central Government to the Regions spread to many other sectors of the public administration, including education and social services, (see delegation act N. 59 dated 15 March 1997, and Legislative Decree N. 112 of 31 March 1998). Decentralisation was founded on the "*principle of subsidiarity"*. The main administrative functions were attributed to the authority closest to the citizens from a geographic point of view, (i.e., the municipalities, mountain communities, Provinces), whereas functions that require a unitary approach over regional and national territories, became the responsibility of the Regions and the Central Government. Through this process, the Regions became more and more "planning and control bodies" with growing autonomy and responsibility in achieving the fundamental objectives of prevention, treatment and rehabilitation as defined by the national Parliament and Government.

In 1997, current public health expenditure was covered by resources made available by the citizens by means of general taxation. The contribution of the national Government came from the taxation funds assigned by Parliament each year with the national budget, or by the Region. Additional funds came from "direct" taxes, (i.e. co-payment by users of certain service costs, such as medicines, outpatient treatments, and diagnostic tests). The overall yearly amount needed for health financing was established on the basis of "capitation" or *per capita quotas* (known as "quota capitaria di finanziamento"), which represents the national sum per person needed to cover health care guaranteed by the Italian National Health Service. As in 1997 this value was equal to 826,72 euro, the overall health national budget that year corresponded to about 51411 million euro. However, as the actual total health expenditure in 1997 was 56218 million euro, a deficit of 4807 million euro was produced without counting the 350 million euro, which the national Government used to cover the costs of specific health institutions. This deficit had to be levelled off by equivalent additional resources deriving from:

- ✓ the national Government, if the deficit did not depend on regional decisions (e.g. greater expenditure caused by national regulations or higher than expected inflation rate);
- ✓ the regions, if the deficit was caused by regional decisions. To this aim, the Regions were authorized to increase each individual's participation in meeting costs or increase health contributions and regional taxes.

From 1999 to 2000, the decentralisation process was further strengthened with the modification of the INHS structure and organization, according to the Legislative Decree N. 229 of 1999 and with what is known as "fiscal federalism" introduced by the Legislative Decree N. 56 of 2000.

The Legislative Decree N. 299 of 19 June 1999 gave further power to the Regions in regard to health planning, organization and management procedures. The "private" rules and regulations that are applied in the management of local health and hospital Agencies were strengthened and the legal status and responsibilities of their managers became identical to

those of managers of private enterprises. Moreover, local institutions such as municipalities, Provinces and mountain communities were recognized a more important role in participating in regional and local health agencies, health and social planning and control, as well as in district programmes.

With the Legislative Decree N. 230 of 22 June 1999, the reorganization of prison medical services started with the aim of entrusting to the Regions and the Local Health Agencies the control over the functioning of the health assistance services for detained or interned persons.

Relations between Universities and the National Health Services have been redefined by the Legislative Decree N. 517 of 21 December 1999, to strengthen the process of collaboration and to ensure consistency between health care activities and training and research needs.

The Legislative Decree N. 56 of 18 February 2000, concerning fiscal federalism measures according to paragraph 10 of law N. 133 of 13 May 1999, substantially changed the health care financing system in Italy. The traditional system of transferring health financing resources, allocated by the Parliament, to the Regions was replaced by taxation yield directly attributed to the Regions (regional VAT revenue sharing, increase of the personal income tax, regional petrol tax sharing). The change was expected to come about gradually bearing in mind historical health spending during the first three-year period. For Regions in a more difficult situation, the legislative decree sets out, prior to 2013, a national equalisation fund, financed by VAT revenue sharing, aimed at guaranteeing across the entire country the accomplishment of essential levels of health care.

During the first triennium 2001 – 2003, each Region was committed to financing health related activities with resources not inferior to those determined according to the *per capita* assistance budget established by the INHS (according to paragraph 83 of law N. 388 of 23 December 2000, this is not a legal obligation, but a commitment on the part of the Regions).

11.3. From 2001 onwards

Since 2001, a decisive transition is taking place, from decentralisation to true federalism, according to the principle of subsidiarity. As of 2001, the national health fund has been abolished and substituted by taxation yield directly attributed to Regions and autonomous Provinces.

The establishment of a system that monitors and assesses the delivery of health care according to appropriate qualitative and quantitative indicators by means of systematic data collection was also decided and considered extremely important.

Therefore, the Regions contribute directly to and acquired a direct responsibility for the achievement of public finance objectives, including the reduction of health care expenditure fixed on a yearly basis by the finance bill (internal stability pact in accordance with the stability and growth pact signed by our country in the European Union).

The forcefulness of the on-going changes is particularly evident in the reform of the Italian Constitution that has introduced different decision-making responsibilities between central Regions and local Governments. The constitutional law N° 3 of 18 October 2001, concerning "Amendment of chapter V of the second part of the Constitution", has attributed to Regions the general legislative and administrative authority in basic sectors of society, one of them being health.

The national Parliament and central Government maintain the authority of adopting fundamental health principles by means of framework laws and guidelines, whereas the Regions define the detailed regulations (by means of laws or acts).

Furthermore, the "determination of the essential levels of services in regards to civil and social rights to be guaranteed in the whole country" (art. 117 of the Constitution) continues to pertain to the national Parliament and central Government.

All citizens are entitled to receive health care services included in the essential levels at no cost at the point of access or upon payment of a small share for services that are not fully covered by the INHS. Essential health care levels mean services and standards that are necessary (because they satisfy the basic needs of promoting, maintaining and restoring health in the population) and appropriate (both regarding the individual's specific health requirements and the ways in which services are provided). As such, they are expected to be delivered uniformly throughout the nation and be guaranteed to everybody under the supervision of the national Government and in full recognition of the differences that characterize the distribution patterns of health care needs and health risks.

The urgent need to identify essential levels (or services), which must be ensured in the delivery of health care, was stressed in the Agreement between the Central and Regional Governments of 8 August 2001. Resources for financing essential levels of health care for the 2002-2004 period were established and further responsibilities were given to the Regions with regard to the organization of health services and to control health expenditures. This agreement has been implemented by the Legislative Decree N. 347 of 18 September 2001, later converted into law N. 405 of 16 November 2001 that deals with "Urgent action for health care expenditure". Among other things, this law acknowledged the power of the Regions to authorise health units to carry out experimental administration projects (for example, by accepting private participation in the management of health units). It enlarged the power of Regions to create hospital Agencies and has placed a stronger responsibility on the Regions with regard to the control of health care expenditure, giving them the capacity, among others, to increase taxation or adopt co-payment charges for pharmaceutical assistance.

Within the responsibilities regarding levels of care there is also the definition of the measures to control effective and correct delivery of activities in order to guarantee universality and equity of access to services. For this reason a system of indicators has been determined to assess the guaranteed levels of assistance in accordance with those that have been established, the delivery of said assistance according to the principles of appropriateness and timeliness.

Moreover, the information flow between State and Regions has been adjusted which is an indispensable premise for assessment.

It is furthermore necessary to establish the *updating of levels of assistance* according to the development of scientific knowledge and to health needs themselves.

At present, the main responsibility of the central Government is the definition of the general orientations to ensure compatibility and coherence of the overall health system in Italy. This includes the determination of essential levels of care and the identification of fundamental health principles, as well as general guidelines to ensure quality, appropriateness and efficacy of action. The national and regional Governments have to agree upon health objectives to pursue during a set period of time (National Health Plan). It is then up to the Regions to establish the measures needed in order to reach the objectives that have been set by the National Health Plan. Controlling the actual achievement of overall objectives is a task that remains entrusted to the central power.

12. Essential levels of health care

12.1. Health Services delivered by the National Health System

The decree of President of the Council of Ministers of 29 November 2001 (see BOX III-1.) has set out the Essential Levels of Health Care (ELHC) i.e., services that the National Health System is expected to deliver to all the citizens, free of charge at the point of access or upon payment of a small *pro capita* charge. The ELHC costs are covered by public resources that are collected from the general taxation yield.

The ELHC can be divided in three large groups:

- ✓ *collective health care* in the life and working environments, including all the prevention activities addressed to the population and to individuals, including protection from the effects of pollution and industrial-accident risks, veterinary public health, consumer protection, prophylaxis for communicable diseases, vaccination and early diagnosis programs, forensic medicine;
- ✓ *district health care*, including the health and social care services distributed throughout the country, from primary care to pharmaceutical assistance, from specialised and diagnostic out-patient units to supplying disabled with prostheses, from home care services for the elderly and chronically ill people to local consulting services (e.g. family advisory services, SERT, mental health care services, rehabilitation services for the disabled) to semi-residential and residential structures (homes for the elderly and disabled, day centres, family houses and therapeutic communities);
- ✓ *hospital care*, in emergency wards, ordinary hospitalisation, day hospitals and day surgery, structures for long-term hospitalisation, for rehabilitation and so on.

BOX III-1. CLASSIFICATION OF ESSENTIAL LEVELS OF HEALTH CARE

The services to be guaranteed by the Italian National Health Service organization fall within the following essential health care service categories:

1. Services targeted to the population at large and the working community

A. Preventive medicine services: infectious and parasite-related diseases
B. Services intended to protect communities and individuals against environment-related risks, including pollution
C. Services intended to protect communities and individuals against occupational medical risks and industrial accidents
D. Public veterinary medicine services
E. Food hygiene control; nutrition surveillance and nutrition-related disease prevention
F. Preventive medicine services provided to individuals
- mandatory and recommended vaccination programs
- early disease diagnosis schemes

G. Forensic medicine services

2. District health care services

A. Basic health care services
- basic day-hospital and home-based support services and treatments
- night-time and public holiday services and treatments
- doctor-on-call services for tourists (based on regional schemes in force)

B. Local emergency response
C. Pharmaceutical services provided through licensed local pharmacies
- provision of pharmaceutical specialties and class A galenicals (including class C galenicals to disabled war veterans), as well as patient-co-payment medicines under the provision of Decree-Law no. 347 of 18 September 2001, as amended and enacted in Law no. 405 of 16 November 2001
- provision of innovative medicines licensed abroad but not in Italy, whether undergoing phase II clinical testing or used to treat diseases other than those authorized

D. Supplementary health care support
- provision of dietetic products to particular categories of patients
- provision of health care products to pancreatic diabetics

E. Specialist day-hospital services
- physical therapy and rehabilitation treatments
- instrument-aided and laboratory tests

F. Provision of prostheses
- provision of prostheses and other aids to patients with physical, psychiatric and sensorial disorders

G. Local day-hospital and home-based services
- home-based support schemes (integrated and/or long-term home-based health care services, including various forms of home nursing)
- health care & socio-medical support services targeted to women, couples and families, maternity-related and family planning counselling services, including pregnancy termination support
- health care and socio-medical support services targeted to psychiatric patients and their families
- medical rehabilitation and socio-medical support services targeted to patients with physical, psychiatric and sensorial disorders
- health care and socio-medical support services targeted to substance abusers and alcoholics
- health care and socio-medical support services targeted to terminal patients
- health care and socio-medical support services targeted to HIV-positive persons

H. Local health care services provided in residential and semi-residential support facilities
- health care and socio-medical support services targeted to non self-sufficient elderly persons
- health care and socio-medical support services targeted to substance abusers and alcoholics
- health care and socio-medical support services targeted to psychiatric patients
- health care and socio-medical support services targeted to patients with physical, psychiatric and sensorial disorders
- health care and socio-medical support services targeted to terminal patients
- health care and socio-medical support services targeted to HIV-positive persons

I. Spa water services
- cycles of hydrothermal treatments for patients diagnosed with specified pathologies

3. Hospital services

A. First-aid & emergency response
B. Standard hospital treatment
C. Day hospital services
D. Day surgery services
E. Home-based services provided by hospital staff (based on regional organizational schemes)
F. Rehabilitation treatment
G. Long-term hospital stays
H. Taking of blood samples, processing, analysis and distribution of blood components and transfusion services
I. Removal, conservation and distribution of tissue for grafts and transplants

Source: D.P.R. 29 November 2001.

BOX III-2. Services included in Essentials Health Care Levels but provided according to inappropriate organizational criteria which call for streamlining:

Examples of "inappropriate" organizational criteria are those providing for hospital and/or day hospital-based services in respect of pathologies that might be managed in different settings on more cost-effective terms and with the same benefits for the patients concerned.

The following is a list of diagnosis-related groups, which are currently managed, in standard health care facilities according to highly "inappropriate" criteria. Threshold patient admission rates should be defined based on the results of regional monitoring projects and the responsible regional departments are expected to define both additional DRGs and applicable health support services.

006	carpal tunnel decompression
019	cranial and peripheral nerve disorders
025	convulsions and cephaleas
039	crystalline lens surgery, including vitrectomy
040	extraocular – but not orbit – surgery in patients aged > 17
041	extraocular – but not orbit – surgery in patients aged 0-17
042	intraocular – but not retina, iris and crystalline lens – surgery (except for cornea transplants)
055	various ear, nose, mouth and throat surgery cases
065	equilibrium-related disorders (except for emergency cases)
133	vein ligatures and stripping
131	peripheral vascular diseases without complications (except for emergency cases)
133	atherosclerosis, complications apart (except for emergency cases)
134	hypertension
142	syncopes and collapses
158	anus and stoma surgery
160	hernial surgery – excluding inguinal and crural hernias and cases with complications – in patients aged >17 (except for 0-1 day hospitalization)
162	hernial surgery – except for inguinal and crural hernias - in patients aged > ? 17 and in the absence of complications (except for 0-1 day hospitalization)
163	hernial surgery in patients aged 1-7 (except for 0-1 day hospitalization)
183	aesophagitis, gastroenteritis and various gastroenteric digestive apparatus disorders in patients aged >17, in the absence of complications
184	aesophagitis, gastroenteritis and various gastroenteric digestive system disorders in patients aged 0-17 (except for emergency cases)
187	dental extractions and treatments
208	bile duct disorders (except for emergency cases)
222	knee surgery (intervention code 80.6)
232	arthroendoscopy
243	dorsal pathologies eligible for medical treatment (except for emergency cases)
262	breast biopsy and local removal of tissue in patients not affected with malignant tumors (intervention codes 85.20 and 85.21)
267	perianal and pilonical surgery
270	skin, hypoderma and breast surgery of a different nature, in the absence of complications
281	non-malignant breast disorder surgery
281	skin, hypoderma and breast traumata in patients aged >17, in the absence of complications (except for emergency cases)
282	skin, hypoderma and breast traumata in patients aged 0-17 (except for emergency cases)
283	minor skin diseases with complications
284	minor skin diseases in the absence of complications
294	diabetes in patients aged >35 (except for emergency cases)
301	endocrinous diseases in the absence of complications
324	cystolithiasis in the absence of complications (except for emergency cases)
326	signs and symptoms pointing to renal and urinary duct disorders in patients aged >17, in the absence of complications (except for emergency cases)
364	colpectasia, erasion or conization undertaken due to reasons other than malignant tumors
395	red cell disorders in patients aged >17 (except for emergency cases)
426	depressive neurosis (except for emergency cases)
427	organic disorders and mental retardation
467	other factors that impact health conditions (except for emergency cases)

Source: D.P.R. 29 November 2001.

12.2. Health services which are not included within the essential levels of health care

The BOX III-3. lists services and activities that are not provided by the INHS because:

- ✓ they are not directly intended to the safeguard of people's health;
- ✓ their efficacy has not been sufficiently proven from a scientific point of view; or
- ✓ the results achieved compared to the costs do not prove to be advantageous.

It should be stressed that the exclusion from the ELHC for most health services listed in the BOX III-3. (e.g. unconventional treatments, cosmetic surgery and facultative vaccinations), is not a novelty and, also before the implementation of the decree 29 November 2001, citizens requesting such services had to cover the expense on their own. In particular, for certain types of ambulatory physiotherapy treatments, it should be noted that they are excluded from ELHC in the form of out-patient treatments intended for temporary and/or minimal disabilities, but remain included in the ELHC if they are part of an individual rehabilitation project for recovery from serious disabilities. The main reason for this exclusion is that these types of services are frequently subject to "hyper-prescription" and/or inappropriate prescription compared to the patient's effective clinical needs and, therefore, the balance between INHS costs and patient's benefits is generally considered unfavourable.

In any case, the possibility exists also for some health care presently excluded from the ELHC to be reinserted in this list upon a decision of the Region providing specific clinical justifications.

BOX III-3. Services not included in the Essential Levels of Health Care (ELHC)

a) Plastic surgery due to reasons other than accidents, diseases or congenital malformation;

b) ritual male circumcision;

c) non-conventional medical treatments (acupuncture – except when incidental to anaesthesia), phytotherapy, anthroposophic and/or ayurvedic medicine treatments, homeopathic, chiropractic and osteopathic treatments, as well as any other non-conventional health care methods albeit not specifically mentioned herein);

d) non-mandatory vaccinations prior to travel abroad;

e) medical certificates (except for those required by school authorities for admitting students to non-competitive sports activities under the provisions of art. 31 of Presidential Decree 270/2000 and art. 18 of Presidential Decree no. 272/2000) not designed to safeguard the health of the general public, even though made mandatory by legal provisions in force (including certificates attesting fitness for certain competitive and non-competitive sports, for employment, community service, foster care or adoption of children, assignment of driving and/or firearms licenses, etc.);

f) the following day-hospital health care and rehabilitation services: assisted water exercise, hydromassage therapy, vascular water gym, short-wave and micro-wave diathermy, acupuncture with moxa treatment, hyperthermy, local reflexogenic massotherapy, pressotherapy or intermittent pressure and depression therapy, antalgic electrotherapy, ultra-sound therapy, skeleton traction, curative ionophoresis, extracorporeal photochemotherapy. Based on regional schemes in force, antalgic laser therapy and electrotherapy, ultra-sound therapy and mesotherapy may be subsumed within the treatments in BOX III-4. .

12.3. Health services partially included within essential levels of health care

A third group of services to be supplied to citizens only on condition that the principle of clinical and organizational appropriateness applies, is listed in the BOX III-4. and BOX III-2. . The requirements that must be fulfilled are as follows:

- ✓ the health conditions of the patient are such that the specific services are deemed to be beneficial (clinical appropriateness);
- ✓ the delivery system for the service (e.g. ordinary hospitalisation, day hospital and day surgery) guarantees the most efficient use of the resources in relation to the characteristics of the treatment and patient's conditions (organizational appropriateness).

BOX III-4. Services in part subsumed within the Essential Levels of Health Care (ELHC) because they are made available subject to particular clinical indications listed below:

a) *dentistry services: only available to users meeting the requirements of SS. 9(5) of Legislative Decree no. 502 of 30 December 1992, as amended and integrated;*
b) *bone densitometry: provided clinical treatment is expected to prove successful;*
c) *day hospital-based physical therapy and rehabilitation services: the services concerned may be provided on certain assumptions (well-defined pathological pictures, defined age-brackets, a reasonable time interval with respect to previous treatment, etc.) and at specified conditions (e.g. minimum duration of treatment, non-association with other specified services, etc.), subject to the provisions of SS. of BOX III-3. ;*
d) *excimer laser refraction surgery, only provided to patients suffering from severe anisometropia or prevented from wearing contact lenses or glasses.*

According to the above-mentioned principles, particular conditions and individual cases shall be subsequently identified by the Ministry of Health and/or the Regions. For these conditions and/or cases, the INHS will continue to ensure certain services (as is the case at present for certain pharmaceuticals that can be delivered at no cost only to patients affected by certain types of diseases). Limitations will especially concern: dental and prosthetic care, osseous densitometric services (MOC), physical and rehabilitation treatment and excimer laser surgery. Restriction regarding laser treatment of the crystalline clearly shows the motivation of this measure: this kind of service can be delivered by the INHS only in the case of patients that suffer from serious visual acuity difference between both eyes and cannot wear contact lenses or prescription glasses; persons requesting this treatment for non-clinical and merely aesthetic reasons will have to pay for the cost of the operation.

Moreover, the decree 29 November 2001 lists 43 types of health care that are considered to be at "high inappropriateness risks", because thy are too often performed by means of ordinary hospitalisation whereas e, according to the best practice, they should be performed in day hospitals or day surgeries (some example are decompression of the carpal tunnel, venous ligature or stripping, tonsillectomy or adenoidectomy). In these cases, the Regions will have to identify a "percentage value/admissibility threshold" and, then, to

adopt appropriate measures to bring the number of hospitalisations back to the established threshold.

12.4. The role of the Ministry of Health and of the Regions and Autonomous Provinces

The Ministry of Health will have to act as guarantor for the citizens to ensure that their health rights are fully and uniformly respected and to make sure that regulations in place are properly implemented. To this end, the Ministry will avail itself mainly of the data provided by the National Information System (regarding the activities carried out, health care distribution, resources, expenditure and the results obtained). The data will be classified according to a complex system of indicators to verify whether the essential levels of health care are effectively guaranteed to all citizens. Furthermore, the Ministry will ensure, together with the Regions, the regular updating of the ELHC by assessing, on the one hand, the development of health conditions of the population and of relative health needs and, on the other hand, the improvement of scientific knowledge and technological development. The Law 15 June 2002, N. 112, has, therefore, instituted a national Committee for the definition and updating of the essential levels of health care and relevant health services, that are to be assessed according to scientific, technological and economic criteria in relation to the available resources. The Committee, nominated and chaired by the Minister of Health, consists of 14 experts 7 of which designated by the Regions and 1 by the Minister of Economy and Finance.

Further to the agreement reached on 8 August 2001, an *ad hoc* working group, reporting both to the Central and Regional Governments, has been established to verify on the basis of specific indicators, the effective delivery of ELHC and to compare actual regional expenditures to the planned ones.

The Regions and autonomous Provinces, being fully responsible for the establishment and organization of health structures and services, are directly committed to ensuring effective delivery of the ELHC according to the specific territorial requirements. The Regions are entrusted with the implementation of the organizational and structural measures needed in order to deliver health care according to most appropriate methods and systems (e.g. hospitalisation, day hospital, day surgery, and out-patient) in order to guarantee the efficient use of resources by local health Agencies and hospital Agencies. The Regions have the power to add other health services to the essential levels by taking on the relevant burden with their own resources.

12.5. Monitoring and delivery of health care

Art. 9 of the legislative decree N. 56 of 18 February 2000, on fiscal federalism establishes that the Ministry of Health, in accordance with the Ministry of Economy and Finance and together with the Permanent Conference for Relations between the State, the Regions and the autonomous Provinces, should define, by means of one or more decrees, a guaranteeing system for the achievement of public health objectives pursued by the INHS.

The system adopted includes:

- ✓ a minimum set of reference indicators and parameters to monitor essential levels of health care delivered over the national territory;

- ✓ rules for the identification, assessment and elaboration of the information and statistical data that are necessary for the implementation of the above-mentioned indicator system;
- ✓ procedures to inform the public on a regular basis regarding the results of the monitoring exercise.

Efficacy and quality of health care indicators have been drawn already in the past (ministerial decrees issued in 1995 and 1996, implementing articles 10 and 14 of legislative decree N. 502/1992 and N. 517/1993). However, it proved to be difficult to implement these indicators over the Italian territory, because they were to broad and no agreement could be reached with the Regions on relevant information for the monitoring. Based on the international experience on monitoring health care and the past experiences mentioned above, a minimum set of indicators has been identified in agreement with the Regions and defined in the Ministerial Decree of December 12, 2001; these are 62 indicators as such and 29 indicators known as "context data".

The indicators have been divided into several groups: 8 indicators have been identified for the levels of collective health care in life and work environments; 27 indicators for district health care levels and 18 for hospital health care. Furthermore, there are 9 indicators for the results. These indicators are completed by "context data", consisting of social demographic, economic and environmental-type information that provide for a more complete and correct interpretation of the indicators.

From a formal point of view, the indicators are divided into single profiles containing: the definition; mathematical formula of elaboration; origin of the data; reference parameters (represented by standards defined by regulations and international standards); and some additional help notes for a more correct measurement (whenever possible).

According to Article 8 of the decree of 12 December 2001, the Ministry of Health publishes every year, a specific report on the results of the monitoring; in the first year, this report will only be released at the regional level.

A subsequent decree will define the methodology and procedures for an integrated and global interpretation of the indicator system, based on the assessment of reference parameters and on the dispersion of the regional values measured.

13. Health planning at the national regional levels

Health is, according to the Italian Constitution, a fundamental right of each individual in the interest of society.

In accordance with this principle, the fundamental objectives of prevention, treatment and rehabilitation and the general outline of the INHS are contained in the main planning act of the national Government represented by the National Health Plan on a 3-years scale.

The National Health Plan of 1998 – 2000, approved with the decree of 28 July 1998, attributed particular importance to the overall citizen's health needs and not only to the delivery of health care. This attitude is in line with the indications of the World Health Organization and in particular with the "Health for All Strategy". For the first time in Italy, the plan adopted a number of quantitative priority health objectives, based on the WHO targets and on the epidemiological data available on the Italian population and measures to be taken in order to meet these needs. As no attempt has taken place so far to check the achievements of the specific health objectives of the 1998-2000 plan and doubts on the usefulness of such an approach are legitimate. Moreover, the plan made a strong plea to create a nationwide true "solidarity health pact". The institutions competent for the safeguard of health and a majority of subjects should be involved in this pact: citizens, health operators, institutions, voluntary workers, profit and non profit producers of health related goods and services, media and the national and international society. Apart from the health objectives, this plan also defined some strategies in order to change health care.

13.1. The National Health Plan

As the institutional system in Italy is in a transitional phase rapidly moving towards federalism, the health plan takes a new importance as it must also define the basic outlines of health policy as unifying elements of the health system in Italy.

The federal policy requirements have not modified the basic principles of the Italian National Health System that still remain fundamental points of reference. These principles are the following:

- ✓ right to health;
- ✓ equity within the system;
- ✓ attributing responsibilities to the subjects involved;
- ✓ dignity and involvement of "all the citizens";
- ✓ quality of services;
- ✓ social-health integration;
- ✓ development of knowledge and research; and
- ✓ safety for the citizens.

Bearing these factors in mind, the Ministry of Health has elaborated the draft of the 2002 – 2004 national health plan that has been preliminarily approved by the National Governments and is presently being evaluated by the Regions (as part of the Permanent Conference for Relations between the State, the Regions and the Self-governed Provinces).

The main issues of the plan are as follows:

- ✓ to specify the scope of the guarantees uniformly ensured by the health system to all the citizens (hence, how to realize essential levels of care and how to verify that they are actually ensured);
- ✓ to define the priority health objectives of the population, in regards to the epidemiological situation registered with the aim to prevent diseases and promote healthy lifestyles as well as to ensure the proper public health awareness;
- ✓ to define further strategic objectives, such as the development of scientific research and the upgrading of personnel, also by means of ECM (Continuing Education in Medicine) and the permanent training programs.

According to ascertained health needs of the population, the national health plan includes, as priority objectives, the setting up of health care networks (i.e., a social health integrated network for chronic, elderly and disabled patients; completing the emergency system across the nation; redesigning the hospital network, also by means of more equally distributed "excellence centres").

The Plan also contains proposals on the main operational measures for carrying out these priority objectives. The central level's role is, in fact, to guarantee equity of the health system, while organizing and providing health services are regional responsibilities.

The objectives indicated by the plan are defined in coherence with EU health policies and those of the other international organizations such as the World Health Organization (WHO) and the Council of Europe.

The draft National Health Plan 2002 – 2004 is now going through the procedures (article 1, paragraph 5 of the legislative decree N. 502 of 30 December 1992, and succeeding amendments) for approval.

The plan is divided into two parts: the first is dedicated to strategic objectives whereas the second addresses the general objectives.

The plan in its first part identifies 10 strategic objectives as follows:

- ✓ "Implementation of the Agreement on Essential and Appropriate Levels of Care", as per the Decree of the Prime Minister's office of 29 November 2001. To achieve this objective, it is necessary to define a monitoring system for the delivery of health care across the Italian territory with appropriate indicators; a system to regularly upgrade the levels on a regular basis (the so-called "Working Group for the maintenance of ELHC", defined by Law n. 112/2002 as an organism with an equal number of representatives of the national and regional Governments) and to reduce and control waiting lists for the delivery of health care.

- ✓ "Establishment of an integrated network for health care and social services for chronic patients, the elderly and the disabled". To pursue this objective, it is necessary to raise additional financial resources to cover non self-sufficiency risks as well as to experiment a model of home treatment and care able to integrate territorial and specialist hospital care as well as social services.
- ✓ "Guaranteeing and monitoring the quality of health care and biomedical technologies", including certification of the quality of the providers of the INHS, public and private sectors and by creating, in every health unit a Quality Service at top managerial levels, and a "National Quality Observatory" with monitoring functions.
- ✓ "Amplifying development factors, or 'capitals', of health care". INHS Personnel upgrading will be carried out (especially by means of the Continuing Education in Medicine); using funds for hospital structures and equipment and dedicating a large amount of investments to excellence Centres; relieving public structures and the personnel from constraints and bureaucratic procedures that limit administrative capacity; investing in social values capable of relating citizens to health institutions and care.
- ✓ "Realisation of high-level permanent training in medicine and health care". Specific objectives will be the achievement of intra-company formation, distance training (with approval and accreditation from the National Commission, e-learning platforms and their contents), the implementation of a system that controls the quality of the events, of the providers and ECM programs (that will be entrusted to Scientific Associations and to their Federation) as well as the use of training credits for career qualifications and to confirm validity of University degrees overtime.
- ✓ "Redesigning the hospital network and new roles for excellence Centres and for other hospitals". Certain excellence Centres will be created and developed (in a joint network) and the relevant experimental models will be assessed and transferred to other excellence centres and metropolitan hospitals. Furthermore, distance counselling services will be set up for general practitioners and specialists (including telematics), as well as the experimental transformation of National Institutes for Scientific Research (IRCCS) into Foundations with less b bureaucratic constraints and the participation of non-profit private partners.
- ✓ "Developing Emergency Services". The intention is to avoid improper use of emergency wards, to ensure that general medical consulting rooms are open 12 hours a day for seven days a week (an objective to be reached also for associated consulting rooms) and to develop an emergency network according to the guideline n.1/1996 of the Ministry of Health).
- ✓ "Promotion of biomedical and biotechnological research and health care research". To promote research and streamline research financing procedures are specific objectives. This ranges from increasing the resources allocated to research to re-qualifying IRCCS as Centres of biomedical research and to identifying new instruments to increase the access to private funds.

- ✓ "Promotion of healthy lifestyles, public prevention and communication for health related issues". This objective involves setting up an institutional communication plan on health-conducive lifestyles that includes campaigns on themes of public interest (for example for smoking), as well as establishing a regional support program for monitoring and localizing health care and social services that citizens are most interested in along with the creation of a system for storing and transferring data.
- ✓ "Promotion of the rational use of drugs and drug control". The plan envisages a National Drug Control Program, increasing information on drugs and their use and enhancing systematic support to Regions on the monthly trend of their pharmaceutical expenditures.

The second part of the Plan is dedicated to the analysis of short-term and long-term objectives to:

- ✓ Fight the pathologies, which are leading cause of mortality and morbility in Italy. The focus is on: cancer, palliative treatments, diabetes and metabolic diseases, respiratory and allergic diseases, rheumatic and bone diseases, rare diseases, communicable diseases that can be prevented by vaccination, AIDS and sexually transmissible diseases, accidents and invalidity, cerebral injury, transfusional medicine and organ transplant.
- ✓ Improve the quality of the environment in relation to health protection. Priority sectors of intervention concern: atmospheric pollution, asbestos, benzene, shortage of drinking, water and water pollution, acoustic pollution, occupational medicine, waste disposal, planning and the health response to terrorism and similar events.
- ✓ Ensure food safety and improve veterinary health care. The main objective is the adoption of a nation-wide policy for food safety and prevention of zoonoses, based on scientifically based risk management throughout the entire food production chain (from farm to table).
- ✓ Achieve more equitable conditions in the health system for health care delivery to all the different categories of the population that require such care. Apart from conditions that threaten the health of the "weaker" subjects, other factors must be taken into account, such as cultural, psychological and social aspects that cause discrimination in the access to health care particularly for the poor and marginalized social classes.

Once approved, the Plan will become the reference document for the Regions to develop their plan at regional level and to produce and implement specific health projects to achieve the objectives of the Plan.

14. Principles

The INHS basic principles are:

- ✓ **human dignity**: according to which every individual must be treated with equal dignity and have equal rights irrespective of his/her personal characteristics and role in society;
- ✓ **protection**: according to which the health of the individual must be protected before it is undermined;
- ✓ **need**: according to which those in need have a right to health care and available resources must, as a priority, be allocated to the promotion of activities aimed at meeting the primary health care needs of the population and public health;
- ✓ **solidarity** towards the more vulnerable: who demand resources to be allocated primarily to the support of groups of people, individuals and for certain diseases that are socially, clinically and epidemiologically important;
- ✓ **effectiveness** and **appropriateness of interventions** to which resources must be channelled for services whose effectiveness is scientifically grounded and for individuals that can benefit the most from them;
- ✓ **cost-effectiveness**: which stresses that when choosing among different supply patterns and types of activities, priority should be given to solutions which offer optimal effectiveness as compared to costs;
- ✓ **equity**: which guarantees that no geographical and economic barriers should prevent any individual form accessing the health care system and that information gaps and behavioural differences should be bridged to avoid health discrimination among individuals and groups of people; equal access and availability of health care must be guaranteed in the light of equal needs.

15. Overall organization

The operations of the INHS require a complex organization, which must ensure the proper coordination and smooth running of all the components (human resources, facilities and equipment).

The Italian National Health Service is structured on three main different levels (central, regional and local).

15.1. The central level

The central Government and the Ministry of Health, in particular, determine the INHS targets and the most important measures to be implemented. They determine which services are to be guaranteed to citizens in conditions of uniformity, and allocate to the Regions and autonomous Provinces the financial resources deriving from the taxation funds and allocated by Parliament. Moreover, the Ministry of Health has the task of supporting, monitoring and assessing the achievement of health objectives and serves as a guide for the uniform implementation of prevention and care throughout the national territory in order to ensure accessibility equity. If necessary, the Ministry may also intervene in cases of persistent or serious mismanagement. In addition to 6 Offices of Direct Collaboration to the Minister, 2 Departments (comprising 11 Directorates general), based in the headquarters in Rome (Figure III- 1 and Figure III- 2), the Ministry of Health also comprises territorial health and territorial veterinary offices (Figure III- 3). As far as technical and scientific matters are concerned, the INHS is composed of three highly qualified National Organizations, namely the " Istituto Superiore di Sanità" (National Institute of Health), the " Istituto Superiore per la Prevenzione e la Sicurezza del Lavoro" (National Institute for Prevention and Safety at Work) and the "Agenzia per i Servizi Sanitari Regionali" (National Agency for Regional Health Care Services). Expert technical and scientific opinions are provided also by the Higher Health Council that consists of 50 members, appointed by the Minister of Health, selected among the most qualified representatives of different medical fields. The Council, organized in five sections, is consulted by the Minister on specific problems and can autonomously express its advise on items pertaining to its own field of competence.

A reorganization of the Ministry of Health is going on at present; the foreseen new organization is shown in Figure III- 2.

Figure III- 1. Ministry of Health of Italy: Present Organizational Chart

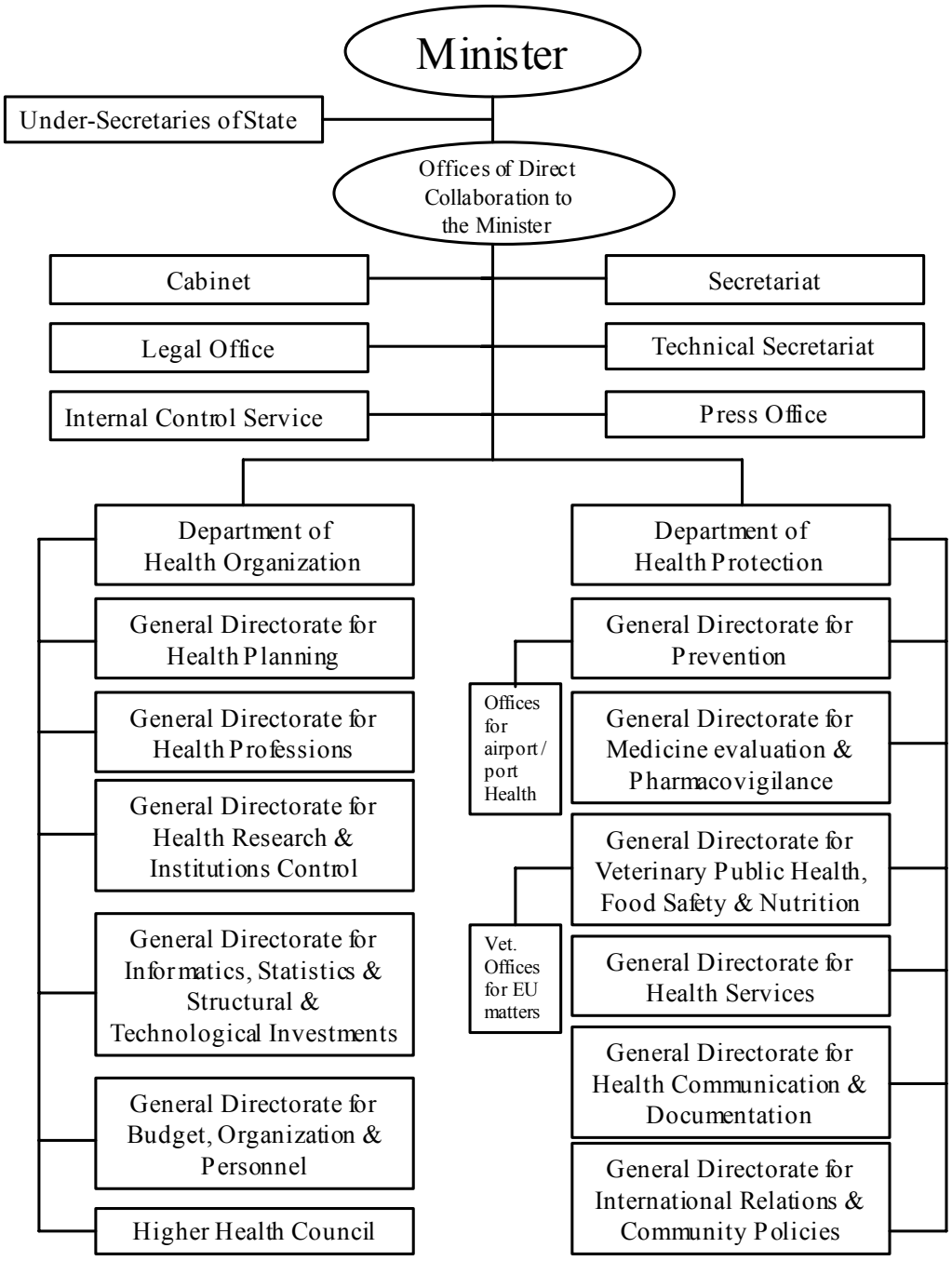


Figure III- 2. Ministry of Health of Italy: Future Organizational Chart

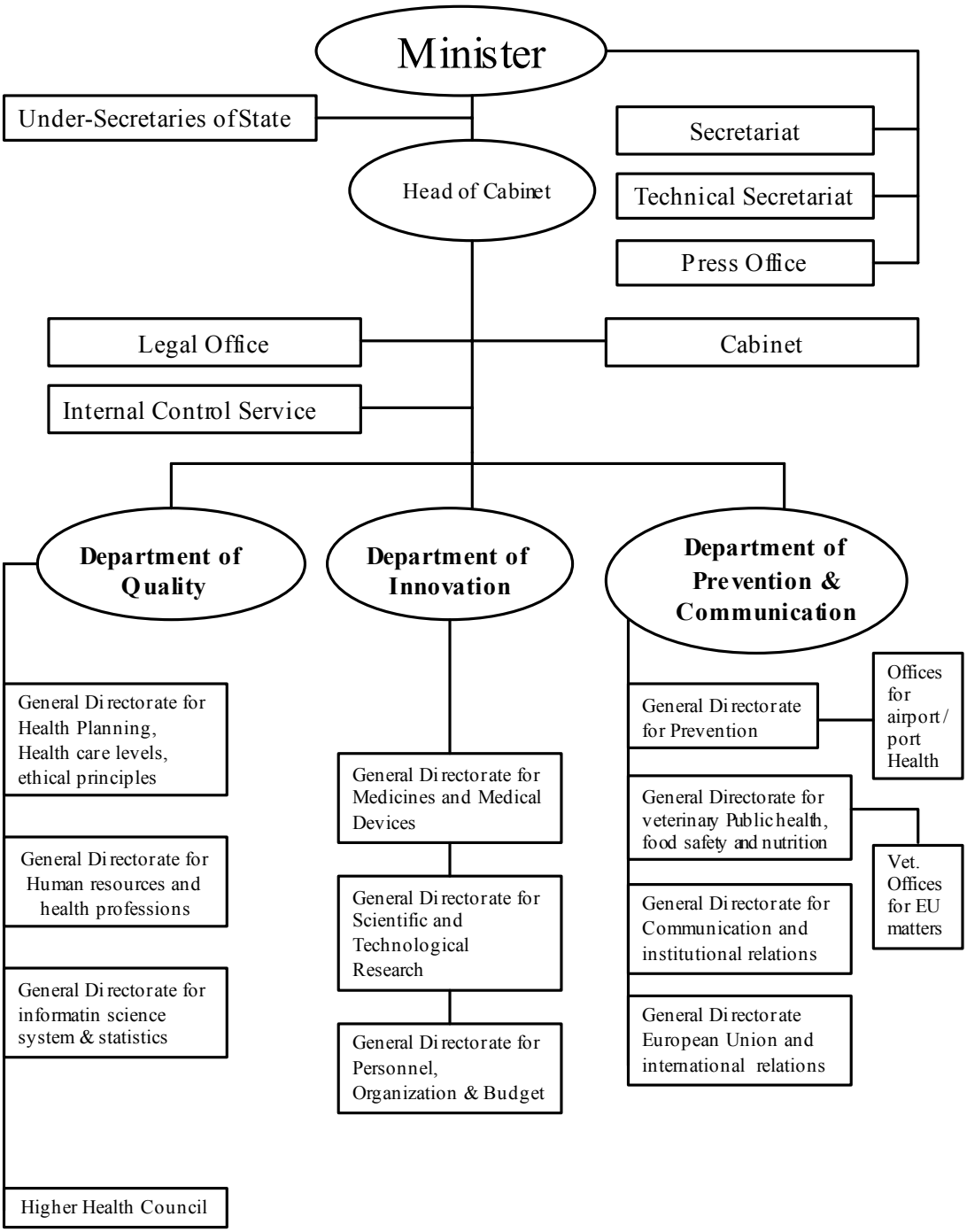


Figure III- 3. Ministry of Health: peripheral health and veterinary offices

Source: Ministry of Health of Italy, 1999.

15.2. The regional level

The 19 Regions and 2 autonomous Provinces plan health care activities and organize services in relation to the needs of the population. They appoint the managers of both Local Health Unit Agencies and Hospital Agencies and coordinate their actions, supervise the attainment of results and intervene in cases of mismanagement.

Each Region and autonomous Province allocates to all the Agencies within the territory of competence a part of the Financial Resources of the NHS. In the structure of each regional and autonomous provincial government there is one sector (called "Assessorato" in Italy) that deals with health issues.

15.3. The local level

The local structure of health care includes community health care at home and at work, district health care and hospital care (Table III-1).

In 2000, there were 197 Local Health Agencies in Italy providing health care services to the population either directly, through their own facilities, or paying for the services provided by independent public structures (hospitals and university-managed hospitals) and private structures (INHS accredited nursing homes and laboratories) which work under their supervision. In 2000 there were also 98 hospitals with the same administrative level as the Local Health Agencies. These hospitals are known as " Hospital Agencies" due to the fact that they have super-regional functions or act also as University centres. Hospitals provide inpatient care for one or several specializations with diagnostic facilities and, possibly, also outpatient care. Hospitals may be public or private and the latter may choose whether or not to become accredited to the National Health Service. Accredited Public and private hospitals are financed mainly according to the services provided ("diagnosis-related groups" system).

Thus, it is up to the individual to choose from which health facility he/she wishes to receive treatment. The Local Health Agencies are also responsible for the daily management of the health services and are in charge of providing primary care, including contracts with general practitioners (GPs), provision of occupational health services, health education, disease prevention, pharmacies, family planning, child health and information services. The " Local Health Agencies", are the mainstay of the INHS. These "Agencies", known as "Aziende Sanitarie Locali", are run by managers appointed by the President of the Government of the Region or autonomous Province to which the Agency belongs. They have full autonomy for organizational, administrative, financial, accounting, managerial and technical issues, and must operate within the limits of the yearly health budget determined by the Regional Government. The managing director is responsible for seeing that the limits of the budget allocated are met. The organizational structure of Local Health Agencies is harmonized at a national level even though significant structural differences exist among different Agencies, as highlighted in Table III-2. This situation depends both on the flexibility of the system, which largely allows for territorial peculiarities and autonomy, and on the fact that the harmonization of Local Health Agency structures according to national guidelines is an on-going process undertaken by Regions according to their own time frames. The number of Local Health Agencies is decided by each Region; and the total number of Local Health Agencies decreased from 227 in 1997 to 197 in 2000 (Table III-3).

In addition to managing hospitals, Local Health Agencies manage the districts that represent the centres where health care is dealt with in a global and unitary way.

The District is an operational structure of the Local Health Agency. Its autonomy is ensured in accordance with the programmes approved by the same Agency, taking into account the area-related service plans established by local governments.

The size of the District is set according to the guidelines provided for by Art. 2 of Legislative Decree No. 502/1992 and its successive amendments. The characteristics of the

area, population distribution and its productive activities are also taken into account. The organizational structures will depend on the number of health care services provided and the nature of these services. Even when resources and production are equal, the Districts' organizational profiles may differ from one District to another, depending on local strategies. Districts are responsible for ensuring that people have access to basic health services with clear methods and defined timing through a network of on-line systems that link all health service providers. Finding health services, both outpatient and hospital based, shall be guaranteed by Districts to all area residents. Within each District, General Practitioners and Paediatricians chosen by a resident are the direct reference points for people and families. They are in charge of promoting and fostering health and for evaluating the real needs of the people so as to orient and ensure access to the National Health Service.

Districts benefit from resources allocated by Local Health Agencies, which depend on the volume of activity planned in each District. In order to optimize District services, regional governments must specify in their plans the home care, intermediate and residential care services to be delivered and the different financing sources.

Professional, economic and other types of resources in a District are managed by the executive responsible for that District. General Practitioners, together with other health and social sector operators, play a very relevant role and are integrated into the District's organization.

Table III-1. HEALTH CARE STRUCTURES

1. Community Health Care at home and at work
• Prevention of communicable diseases • Protection from environmental pollution-related risks • Protection from risks at home and at work • Veterinary Public Health • Food Safety
2. District Health Care
• Primary Health Care • Pharmaceutical Care • Outpatient specialist care • Community-based and semi-residential care • Residential health care
3. Hospital Care
• Acute care (emergency, routine and day-hospital care) • Post-acute health care (hospital-based and long-term rehabilitation)

Source: Ministry of Health of Italy, 1999.

Table III-2. STRUCTURE AND SOME SPECIAL SERVICES OF LOCAL HEALTH AGENCIES IN ITALY IN 2000

Region	Active districts*	United reservation center*	Mental Health Department*	Prevention department*	Service haemo dialysis center*	Maternal and child health department*	Integrated home care service*	Local health Agencies	
								Monitored	Existing
PIEDMONT	68	22	22	21	16	21	22	22	22
VALLE D'AOSTA	4	1	1	1	1	1	1	1	1
LOMBARDIA	110	6	4	15	4	6	15	15	15
PROV. OF BOLZANO	18	2	1	1		1	4	4	4
PROV. OF TRENTO	11	1	1	1	1	1	1	1	1
VENETO	84	20	20	21	13	11	20	21	21
FRIULI V.G.	20	4	6	6	2	5	6	6	6
LIGURIA	9	4	4	3	2	1	4	5	5
EMILIA ROMAGNA	31	10	10	10	4	7	11	13	13
TUSCANY	133	12	12	12	9	7	11	12	12
UMBRIA	12	4	3	3	1	3	3	4	4
MARCHE	36	11	13	12	9	13	13	13	13
LAZIO	47	9	11	11	3	9	11	12	12
ABRUZZI	37	5	4	4	1	4	3	6	6
MOLISE	12	4	2	3		3	4	4	4
CAMPANIA	105	7	12	12	2	9	10	13	13
PUGLIA	71	9	12	12	2	4	11	12	12
BASILICATA	21	5	5	4		4	5	5	5
CALABRIA	25	2	9	11	2	6	8	11	11
SICILY	50	4	9	2	3	3	8	9	9
SARDINIA	19	1	5	5		3	6	8	8
ITALY	**923**	**143**	**166**	**170**	**75**	**122**	**177**	**197**	**197**

Source: Ministry of Health of Italy - *(*)* No. of Local Health Agencies with active services.

Table III-3. LOCAL HEALTH AND HOSPITAL AGENCIES IN ITALY IN 2000 BY REGION

Region	Local health agencies	Hospital agencies
PIEDMONT	22	7
VALLE D'AOSTA	1	
LOMBARDIA	15	27
PROV. OF BOLZANO	4	
PROV. OF TRENTO	1	
VENETO	21	2
FRIULI VENEZIA GIULIA	6	3
LIGURIA	5	3
EMILIA ROMAGNA	13	5
TUSCANY	12	4
UMBRIA	4	2
MARCHE	13	4
LAZIO	12	3
ABRUZZI	6	
MOLISE	4	
CAMPANIA	13	8
PUGLIA	12	6
BASILICATA	5	2
CALABRIA	11	4
SICILY	9	17
SARDINIA	8	1
ITALY	**197**	**98**

Source: Ministry of Health of Italy.

16. Health financing

In countries that belong to the European Union, total health care expenditure for the year 2000 ranged from 7.0% in the United Kingdom to 10.9% in Germany. In 2000, Italy spent 7.5% of the GDP on health care.

In 2000, public health care, was 5.9% of the GDP; in France it was 7.2%; in the United Kingdom 5.8%; in Spain 5.8% and in Ireland 5.1%.

In the year 2000, National Health System (NHS) expenditure reached approximately 70 million Euro, and in 2001, almost 76 million Euro (Table III-4 and Table III-6). *Pro capita* expenditure was 1 310 Euro. The NHS has delivered levels of care as determined by the current National Health Plan according to regional organizational procedures that have gradually developed during the years as a result of 90 – 92 and 99 health reforms.

Table III-4. YEARLY EXPENDITURE OF THE ITALIAN NATIONAL HEALTH SERVICE

Year	Expenditure (million euro)
1995	48.136
1996	52.180
1997	56.562
1998	59.640
1999	63.145
2000	69.696
2001	75.682

Source: Ministry of Health of Italy.

Presently, more than half of INHS expenditure is for hospital care. These costs derive from direct hospital management in the Local Health Agencies and from admission production costs for hospital trusts or from the acquisition of health care that is delivered by public hospitals and private providers accredited by the INHS.

Costs related to pharmaceutical care and to specialized care together make up one fourth of INHS expenditure.

Presently, the hospital network is going through a reorganization and rationalization process in several Regions. Consequently, part of the health care that is presently delivered by hospitals in residential and semi-residential structures will be provided at home. In fact, more beds for post-acute treatment will be increased and agreements are being reached with general practitioners and health care operators in regards to nursing care in order to ensure home treatment.

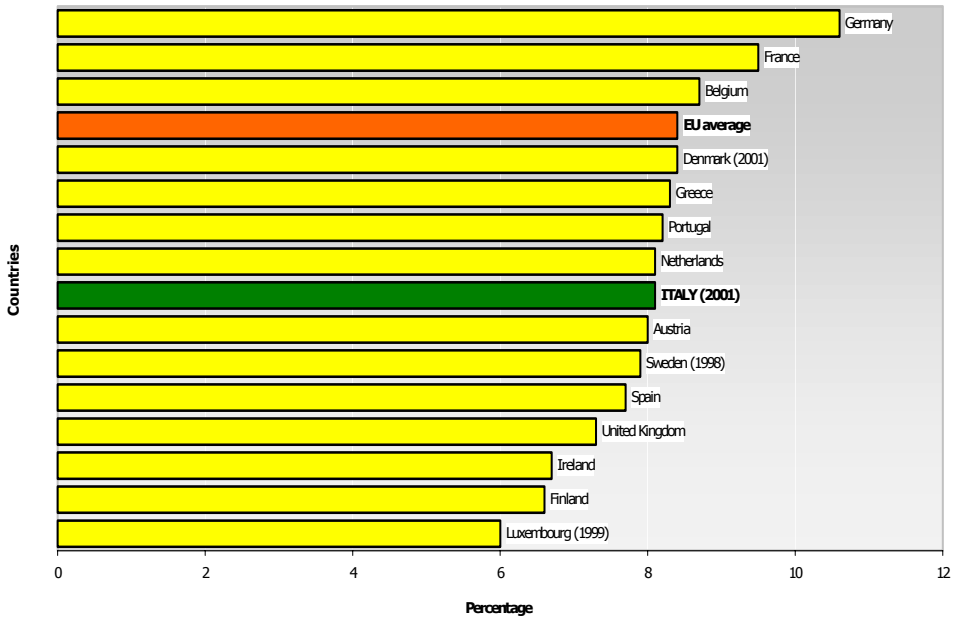
In August 2001, the State and Regions signed a health care agreement fixing the all-inclusive health care requirements for the years 2002 – 2004 and increasing the requirements for the year 2001. The 2002 requirements are 74.56 million Euros, for 2003 77.53 million Euro and for 2004 80.50 million Euro.

For the year 2001, the all-inclusive requirements were increased to 71.27 million Euros. At the same time, the Regions committed themselves to cover, as of 2001, any future management deficits.

The 2001 management deficit was approximately 4.13 million Euros. The Regions are covering this deficit by means of additional resources of their own or resources that come from the introduction of regional prescription charges on health care, saving on the acquisition of goods and services, limits to expenditure imposed on health care providers, reclassifying drugs that are charged to the INHS, imposing mark-ups of the regional tax rates or by selling properties.

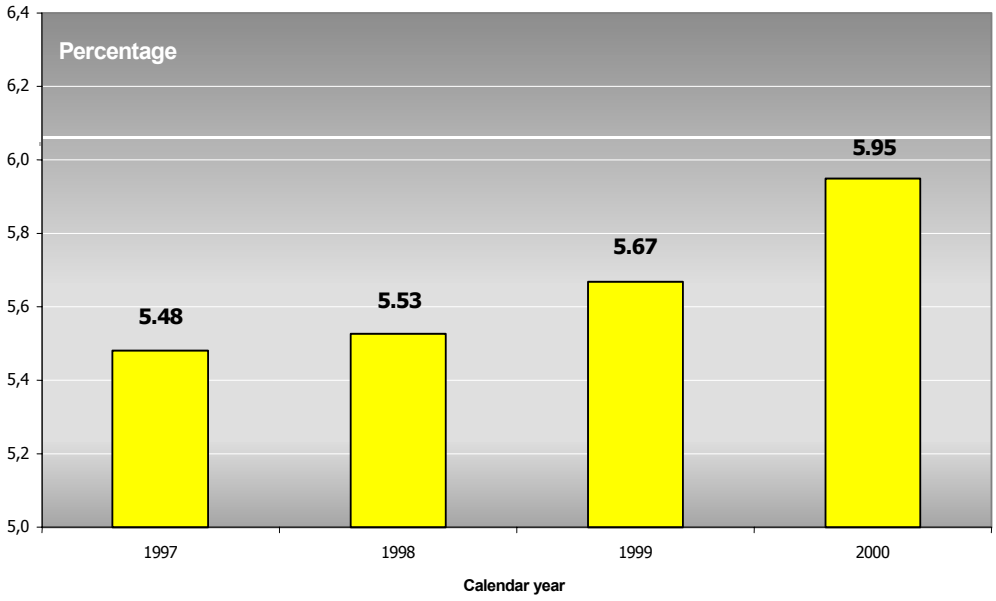
In 2002, a decree was passed on Essential Levels of Care that defined kinds of care to be guaranteed free of charge by the INHS or by co-sharing costs with recipients. Within of regional autonomy in health care organization, the State ensures that the levels of care delivered by each Region are monitored. Furthermore, Regions autonomously and by their own additional resources can provide their citizens with health care services additional to those guaranteed as essential levels of care by the INHS.

Figure III- 4. Total expenditure as a percentage of the GDP in EU Countries – Year 2000



Source: OECD 2001.

Figure III- 5. Public expenditure on health as a percentage of the GDP in Italy Years 1997 - 2000



Sources: Ministry of Health of Italy (for both Figure III- 5 above and Figure III- 6 below).

Figure III- 6. Health care expenditure per inhabitants in Italy, by Regions – Year 2000

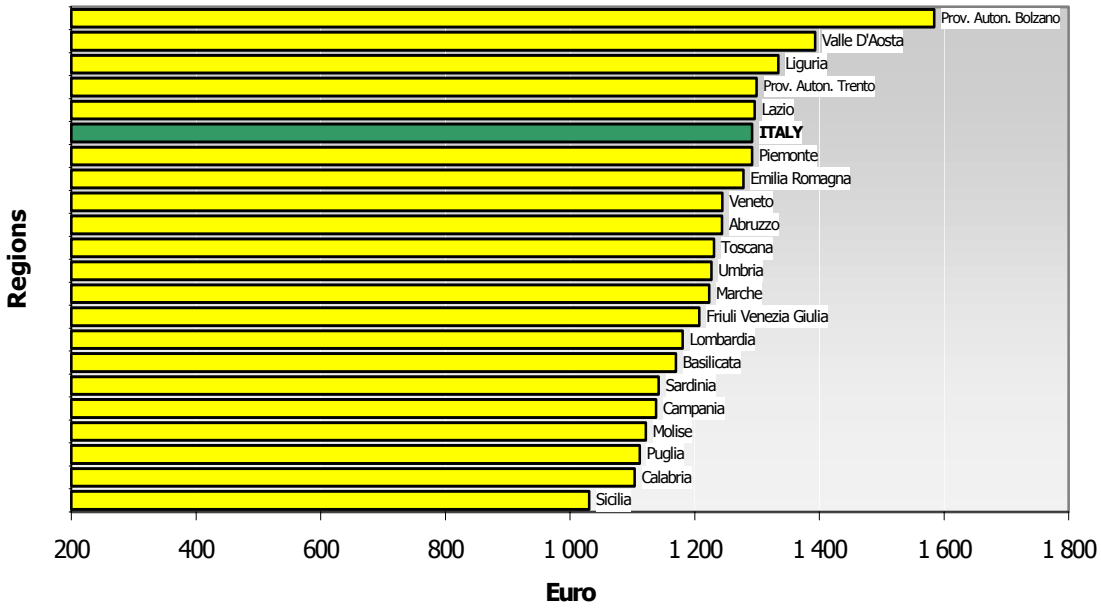


Table III-5. TOTAL AND AVERAGE CURRENT HEALTH EXPENDITURE IN ITALY. YEAR 2000.

Region	Population	Total Expenditure (in EURO)	Average expenditure per inhabitant in EUROs	Total expenditure in EUROs	Average expenditure per habitant in EUROs	Present difference from national Average
PIEDMONT	4 287 465	10 730 982	2 502 873	5 542 089 688	1 293	8
VALLE D'AOSTA	120 343	324 954	2 700 232	167 824 735	1 395	16
LOMBARDIA	9 065 440	20 786 247	2 292 911	10 735 200 669	1 184	-1
PROV OF BOLZANO	462 542	1 423 287	3 077 098	735 066 391	1 589	32
PROV OF TRENTO	473 714	1 196 940	2 526 714	618 167 921	1 305	9
VENETO	4 511 714	10 903 968	2 416 813	5 631 429 501	1 248	4
FRIULI V G	1 185 172	2 775 105	2 341 521	1 433 222 123	1 209	1
LIGURIA	1 625 870	4 193 954	2 579 514	2 165 996 478	1 332	11
EMILIA ROMAGNA	3 981 146	9 888 242	2 483 768	5 106 850 801	1 283	7
TUSCANY	3 536 392	8 441 420	2 387 015	4 359 629 597	1 233	3
UMBRIA	835 488	1 990 899	2 382 918	1 028 213 524	1 231	2
MARCHE	1 460 989	3 470 473	2 375 427	1 792 349 724	1 227	2
LAZIO	5 264 077	13 259 954	2 518 951	6 848 194 725	1 301	8
ABRUZZI	1 279 016	3 082 802	2 410 292	1 592 134 361	1 245	4
MOLISE	327 987	711 348	2 168 830	367 380 582	1 120	-7
CAMPANIA	5 780 958	12 739 150	2 203 640	6 579 221 906	1 138	-5
PUGLIA	4 085 239	8 796 581	2 153 260	4 543 054 946	1 112	-7
BASILICATA	606 183	1 371 582	2 262 653	708 362 987	1 169	-3
CALABRIA	2 050 478	4 374 525	2 133 417	2 259 253 616	1 102	-8
SICILY	5 087 794	10 142 873	1 993 570	5 238 356 737	1 030	-14
SARDINIA	1 651 888	3 649 479	2 209 278	1 884 798 608	1 141	-5
ITALY	**57 679 895**	**69 336 799 620**	**2 327 583**	**69 336 799 620**	**1 202**	**98**

Source: Ministry of Health of Italy.

Table III-6. CURRENT HEALTH EXPENDITURE IN ITALY BY ITEMS. YEAR 2001.

Region	Personnel	Goods and Services	General Practitioners	Medicines	Hospitals	Specialized treatments	Other health care services	Financial items and burdens (**)	Total current expenditures
PIEDMONT	2 171 910	1 373 678	303 411	804 191	496 565	99 891	513 076	16 932	5 779 655
VALLE D'AOSTA	84 174	48 685	9 042	21 146	0	5 907	10 139	3	179 096
LOMBARDIA	3 775 390	2 443 411	617 518	1 713 262	1 822 808	328 756	1 078 890	23 355	11 803 392
PROV OF BOLZANO	338 147	226 183	33 242	68 927	44 132	4 757	56 029	4 740	776 157
PROV OF TRENTO	270 848	155 973	38 991	71 293	38 405	6 685	95 197	44	677 436
VENETO	2 202 615	1 571 696	337 826	785 927	343 299	167 182	523 640	19 580	5 951 765
FRIULI V G	593 317	399 593	89 082	210 389	93 128	19 404	125 110	513	1 530 536
LIGURIA	840 755	528 398	110 126	384 442	293 319	37 368	165 123	2 780	2 362 311
EMILIA ROMAGNA	2 124 433	1 467 934	301 734	739 741	375 965	85 686	463 416	18 420	5 577 329
TUSCANY	1 984 103	1 270 571	291 664	673 807	213 578	78 935	242 629	6 770	4 762 056
UMBRIA	470 913	301 133	64 302	165 714	33 325	11 413	68 007	1 245	1 116 052
MARCHE	776 634	503 741	119 395	294 580	67 887	35 980	103 405	3 001	1 904 623
LAZIO	2 096 696	1 120 977	405 593	1 244 979	1 513 525	313 067	530 681	51 181	7 276 698
ABRUZZI	603 101	331 316	110 960	284 214	115 646	27 206	122 020	1 166	1 595 629
MOLISE	173 322	94 559	28 654	67 032	24 634	11 427	27 894	352	427 874
CAMPANIA	2 410 876	1 063 233	528 617	1 258 386	889 192	472 955	618 605	9 657	7 251 521
PUGLIA	1 614 673	909 106	293 058	851 736	566 890	185 350	307 561	7 667	4 736 041
BASILICATA	277 059	166 486	51 802	119 404	5 862	15 964	57 440	460	694 477
CALABRIA	1 006 269	394 798	179 140	466 805	195 976	110 129	143 788	2 968	2 499 873
SICILY	2 131 378	922 377	426 359	1 189 542	758 040	361 011	388 957	62 170	6 239 834
SARDINIA	834 959	433 814	127 874	317 541	121 438	66 015	115 661	6 041	2 023 343
Other Institutions									515 940
ITALY	**26 781 572**	**15 727 662**	**4 468 391**	**11 733 057**	**8 013 613**	**2 445 088**	**5 757 268**	**239 046**	75 681 638

Costs refer to health care assistance provided by regions to citizens independently on their residence. Costs on Sicily are underestimated.

(**) Relatively to the autonomous provinces of Bolzano and Sicily, the plan objectives and the passive interests are included in this stable.

17. Services

The services provided by the INHS include:

- ✓ community health and hygiene;
- ✓ primary health care;
- ✓ specialist treatment;
- ✓ hospital care;
- ✓ care and rehabilitation of non self-sufficient persons.

17.1. Community health and hygiene

Activities related to community health and hygiene include:

- ✓ vaccinations: e.g. compulsory vaccinations(polio, tetanus, diphtheria, hepatitis B) and optional - though strongly recommended vaccinations (rubella, measles, parotitis and whooping cough);
- ✓ control of living and working premises and of environment-related health risks: e.g. inspection and sanitary control of schools and occupational health and safety;
- ✓ livestock control: e.g. inspection and control of farms and of animal trades for the prevention of zoonoses and supervision of animal health protection;
- ✓ control of food and beverages: inspection and sanitary control of foodstuff processing operations from production to sale, as well as the handling of food and beverages, including dietary products and baby food.

These activities are carried out by the 139 Departments of Prevention (health and hygiene), which are currently part of the Local Health Agencies in Italy. Environmental sampling and laboratory activities are carried out mainly by the Regional Agencies for the Environment, which are in the process of being set up based on a restructuring of the former 105 Presidi Multizonali di Prevenzione (Multi-areas Hygiene and Prevention Laboratories and by the 10 Istituti Zooprofilattici Sperimentali and their numerous territorial stations (Experimental Zooprophylac-tic Institutes) (Figure III- 7). It should also be mentioned the Anti-sophistication and Health Groups of the Carabinieri that is a specialized military body in charge of enforcing health and safety regulations and is answerable to the Minister of Health (Figure III- 8)

Figure III- 7. Geographical distribution of Experimental Zooprophilactic Institutes in Italy

Source: Ministry of Health of Italy, 1999.

Figure III- 8. Geographical distribution of Anti-sofistication and Health Groups (NAS) in Italy

Source: Ministry of Health of Italy, 1999.

17.2. Primary health care

In Italy, primary health care includes diagnosis, treatment and first level rehabilitation together with prevention, health promotion and education activities, and, in particular family doctors and paediatricians, on-call services, pharmacies and home carers.

In Italy, primary health care is mainly provided by general practitioners (GPs) included in an *ad hoc* list (Figure III- 9). The main activities of GPs include providing medical care, prescribing drugs, ordering diagnostic tests and hospitalizing patients. Patients are registered with a GP who acts as a gatekeeper to specialist services. The relationship between patient and GP can be terminated by either party at any time if it is not considered satisfactory. The services of GPs are free at the point of use. GPs have contracts with the INHS managed by the competent Region, and are paid on a capitation basis, depending on the number of patients enrolled in their lists up to a maximum of 1 500 per GP. GPs usually work alone, although they may share their office with one or more colleagues (so-called "group practice"). Patients are registered with the doctor and not the practice. GPs are responsible for organizing the practice and hiring the necessary staff (e.g. nurses and secretaries) who are not under contract to the INHS. In comparison with other countries, the GP/population ratio is close to the average reported for the EU but lower than the ratio observed in some northern European countries, such as Ireland, Sweden or the UK. Children under 12 years are looked after by paediatricians. They have the same contracts as GPs but are limited to a maximum list size of 1 000 (Figure III- 10). There are important geographical variations in the size of GP lists and the availability of their services, especially where paediatricians are concerned, and some Regions have smaller physician/population ratios.

A Physician-on-call service, comprising some 15 000 doctors, provides out-of-hours medical care and services (Table III-7). Doctors working in the Guardia Medica are not allowed to take extra contracts, either full or part-time.

In case of need or emergency, patients can go directly to the hospital emergency departments. Patients who turn to hospital emergency departments may have to pay a small contribution (known in Italy as a "ticket"). Public health nurses have the specific function of safeguarding the health of individuals and the community through preventive and health education activities. They establish direct relationships with people in their daily life and work, families and the community, using such methods such as interviews, home visits and epidemiological surveys. Public health nurses organize and participate in health promotion programmes, as well as organize and coordinate preventive facilities and services, e.g. family/paediatric consultation and immunization centres, the prevention of infectious diseases, school health, preventive medicine and occupational health services. They carry out projects and studies on organizational models for providing services which are tailored to individual needs.

17.2.1. Pharmacies

Pharmacies have the monopoly of drug sales but are subject to numerous clauses. A pharmacy can be privately owned (and have a convention with the relevant Local Health Agency) or belong to a municipality or a hospital, in which case the pharmacists are paid a

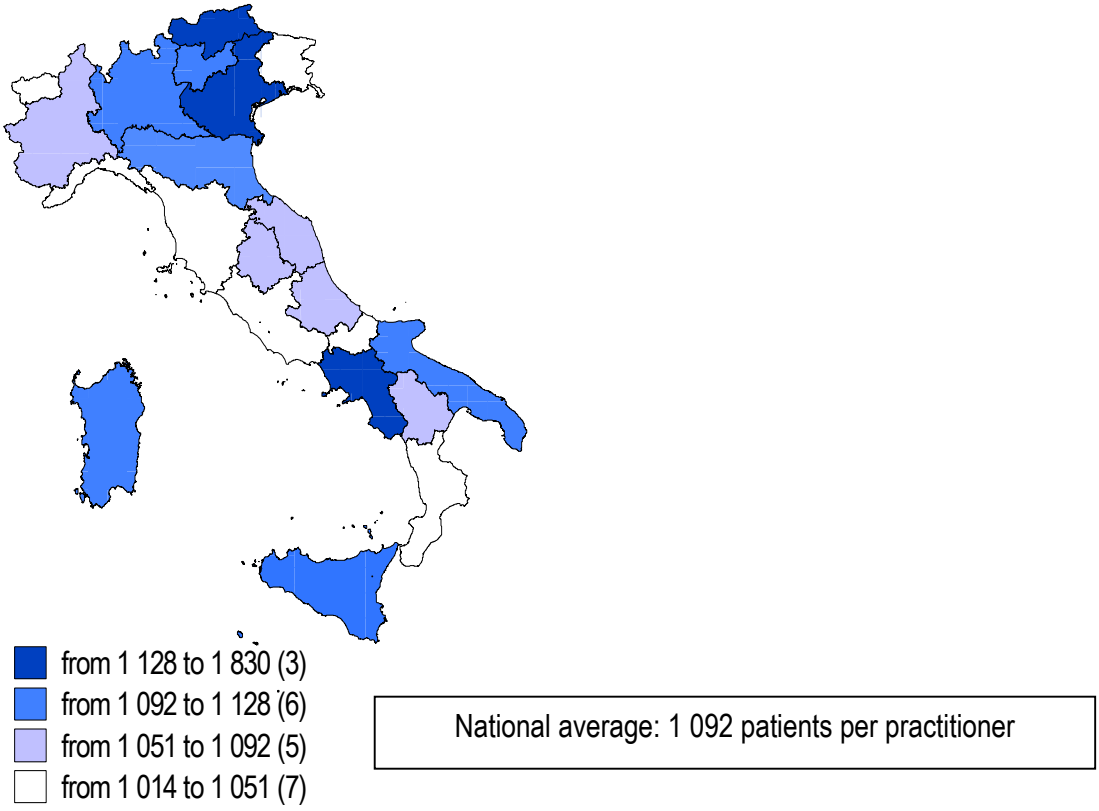
salary. In general, hospital pharmacies are not accessible to the public. In Italy, there are 16250 private pharmacies and 1129 owned by municipalities.

Given the limited number of public resources available for the pharmaceutical policy, evidence based medicine and benefits/costs are the main criteria for providing drug treatments within the NHS in Italy.

Prescribed essential medicines and medicines for chronic diseases are free of charge at the pharmacy (List A) if below or equal to the extent of reference price fixed for medicines belonging to each class therapy, specific dosages and therapeutic indication. Medicines belonging to a given class therapy more expensive than the reference price are not covered by the NHS. Most drugs prescribed under the INHS can have a regional prescription charge (ticket) according to the financial policy of each Italian Regions. However, exemptions are made on the basis of income, particular medical conditions or special status (e.g. disable persons)

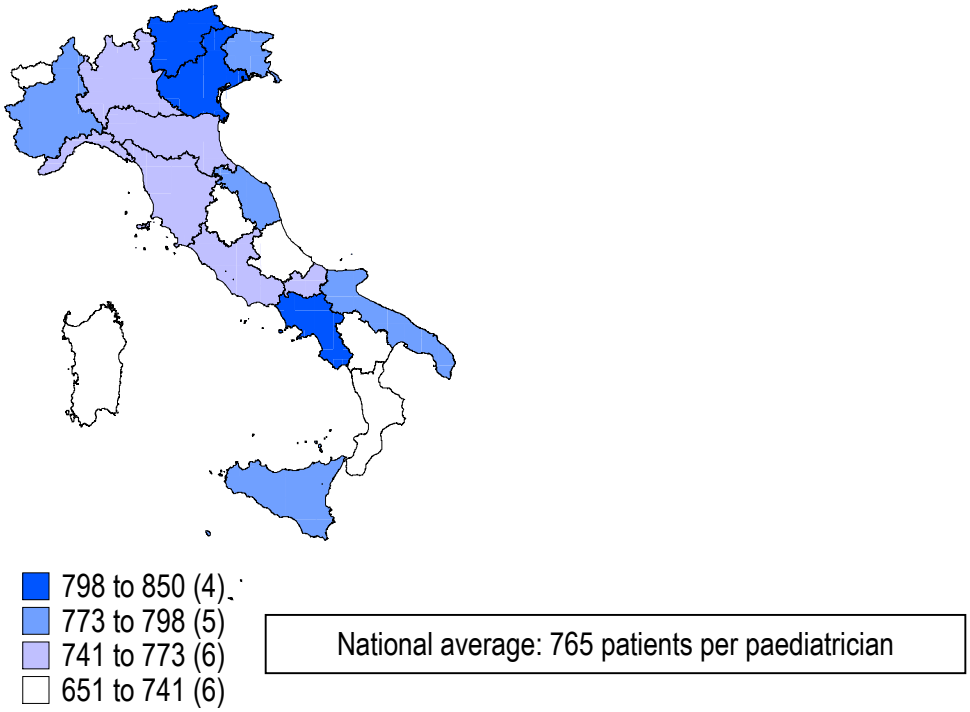
The remaining medicines, also known as "comfort medicines" belong to List C and are fully charged to patients (Table III-8).

Figure III- 9. Number of registered patients per pratictioner in Italy- Year 2000



Source: Ministry of Health of Italy.

Figure III- 10. Number of registered patients per paeditrician in Italy – Year 2000



Source: Ministry of Health of Italy.

Table III-7. ON-CALL SERVICE IN ITALY IN 2000

Region	Number of on call stations	Number of on duty doctors		Total numbers of hours
		Numbers	Per 1000 inhabitants	
PIEDMONT	142	643	0.1	962 658
VALLE D'AOSTA	8	25	0.2	51 228
LOMBARDIA	231	1 208	0.1	1 769 578
PROV. OF BOLZANO	7	21	0.0	38 450
PROV. OF TRENTO	33	272	0.6	203 800
VENETO	114	742	0.2	1 035 194
FRIULI VENEZIA GIULIA	45	164	0.1	286 906
LIGURIA	53	219	0.1	300 151
EMILIA ROMAGNA	150	667	0.2	1 049 413
TUSCANY	176	881	0.2	1 283 366
UMBRIA	49	234	0.3	351 700
MARCHE	93	410	0.3	571 846
LAZIO	120	620	0.1	957 960
ABRUZZI	95	384	0.3	556 475
MOLISE	71	294	0.9	263 304
CAMPANIA	251	1 860	0.3	2 614 359
PUGLIA	229	896	0.2	1 825 351
BASILICATA	140	459	0.8	687 248
CALABRIA	380	1 387	0.7	2 044 362
SICILY	514	2 305	0.5	3 069 698
SARDINIA	165	810	0.5	952 145
ITALY	**3 066**	**14 501**	**0.3**	**20 875 192**

Source: Ministry of Health of Italy.

Table III-8. PHARMACEUTICAL ASSISTANCE INDICATORS WITH THE ITALIAN NATIONAL HEALTH SYSTEM YEAR 2000

Region	Prescriptions		Average cost per prescription	Cost of prescriptions for integrative care
	Number	EUROS	EUROS	(EURO)
PIEDMONT	24 922 336	708 132 663	28.41	51 659 973
VALLE D'AOSTA	621 923	16 451 576	26.45	442 538
LOMBARDIA	46 048 080	1 379 001 160	29.95	74 854 218
PROV. OF BOLZANO	1 904 056	54 193 118	28.46	4 912 360
PROV. OF TRENTO	2 079 997	54 733 163	26.31	0
VENETO	23 410 609	607 584 651	25.95	17 557 383
FRIULI VENEZIA GIULIA	6 467 019	163 888 785	25.34	10 045 251
LIGURIA	10 862 927	287 573 700	26.47	4 214 154
EMILIA ROMAGNA	24 133 366	550 239 264	22.80	18 215 214
TUSCANY	22 910 843	518 930 782	22.65	20 972 416
UMBRIA	5 834 888	147 334 896	25.25	14 372 698
MARCHE	9 339 120	231 702 535	24.81	1 773 798
LAZIO	34 631 670	1 015 507 219	29.32	75 667 040
ABRUZZI	8 366 622	230 360 491	27.53	885 058
MOLISE	1 912 269	54 849 866	28.68	9 074 702
CAMPANIA	38 247 839	1 036 310 443	27.10	37 625 346
PUGLIA	24 089 561	632 680 247	26.26	15 117 179
BASILICATA	3 729 867	91 580 568	24.55	6 332 377
CALABRIA	14 081 513	359 475 097	25.53	19 130 668
SICILY	35 182 383	942 758 710	26.80	9 501 073
SARDINIA	9 431 798	255 051 260	27.04	7 524 172
ITALY	**348 208 686**	**9 338 340 194**	**26.82**	**399 877 618**

Source: Ministry of Health of Italy.

17.2.2. Home care of patients and non self-sufficient people

The elderly population is constantly increasing along with many correlated diseases and disabilities. It is evermore necessary to truly integrate health care with social assistance. The elderly and the disabled request to receive home treatment in order to avoid unnecessary hospital admission or in residential health care structures as soon as it is possible. There is a lack of post-acute rehabilitation centers, in patients care and day hospitals, and most of all there is no adequate systems that globally take charge of the patients by solving his health needs and guiding him through a network of health care services in which he often feels lost.

It is also necessary to develop what is called "home hospitalization", i.e., transferring certain services that are at present only available in hospitals to the patient's home, including palliative treatment, dialysis, etc.

The extent of home care provided in Italy in 2000 is shown in Table III-9

Home care implies a radical change in traditional health care approaches: the focus shifts on patients relying on health care providing facilities, as well as hospitals, to services that are tailored to meet the needs of patients in their home environment.

Table III-9. INTEGRATED HOME CARE IN ITALY - 2000

Region	Assisted patients		Hours of care by assisted patient			
	Total	Elderly (%)	Physiotherapists	Nurses	Others	Total
PIEDMONT	14 717	54.6	4	20	8	32
VALLE D'AOSTA	12 092	81.0	0	3		3
LOMBARDIA	45 704	62.1	5	17	3	24
PROV. OF BOLZANO	97	85.6				
PROV. OF TRENTO	7 289	100.0		14		14
VENETO	21 482	86.3	2	17	3	21
FRIULI VENEZIA GIULIA	24 145	85.8	2	8	1	11
LIGURIA	8 985	95.6	9	23		32
EMILIA ROMAGNA	8 929	73.7	9	15	1	25
TUSCANY	13 945	87.0	2	14	9	25
UMBRIA	15 903	88.4	0	8	2	11
MARCHE	14 147	89.6	5	18	3	26
LAZIO	19 854	89.1	7	16	4	27
ABRUZZI	2 789	59.7	3	8	2	13
MOLISE	3 285	76.9	8	8		16
CAMPANIA	6 363	91.8	10	33	10	53
PUGLIA	8 629	85.0	22	32	12	66
BASILICATA	2 666	86.5	27	29	2	58
CALABRIA	2 935	84.6	7	18	1	25
SICILY	4 777	89.2	11	18	1	30
SARDINIA	1 372	38.4	44	49	0	94
ITALY	**240 105**	**79.8**	**5**	**16**	**3**	**24**

Percentage Sample: 95.8% Over The Total Of Local Health Agencies Declaring To Have Integrated Home Care Fully Operational

Source: Ministry of Health of Italy.

There are several ways in which districts can provide patients with home care services. Home care, and in particular integrated home care, represents a unique opportunity to ensure health care flexibility and effectiveness. Home care becomes integrated (IHC) when different health and social professionals cooperate in order to implement projects tailored to a patient's various needs.

Planning IHC implies integration among the different health care modules, as well as the enhancement of nursing skills and the collaboration of patients' families, bearing in mind that close cooperation between hospitals and districts can also enable non-self-sufficient people to be treated in their homes. Integrated home care must rely on the systematic planning of each district's health service providers entailing a multidimensional assessment; the holistic aspect of the treatment plan and its intensiveness; the therapeutic continuity of the services; collaboration between health and social professionals; the cost-assessment of the actions to be undertaken; the collaboration of the patients' families and the evaluation of the outcomes.

17.3. Specialist treatment

Specialist treatment includes:

- ✓ clinics and laboratories: public and private clinic and laboratories under contract with the INHS providing specialist examinations, clinical analyses and other diagnostic examinations (e.g. X-rays, echograms and CAT scans);
- ✓ family planning clinics: family planning clinics dealing with such issues as infancy-related problems, women's health, sex information and education, contraceptives, pregnancy protection and menopause problems; these also provide counseling services for couples and assist women requesting abortion;
- ✓ drug services for addiction, prevention and rehabilitation: public service for drug addiction prevention and rehabilitation (SerT) which provides users with psychological and social support, monitors the state of health of drug addicts and the diseases associated with drug- addiction, administers pharmacological and other detoxicating therapies; implements therapeutical and rehabilitation programmes, and gives support to other organizations providing similar services;
- ✓ departments for mental health: centres for mental health that guarantee specialist care to people suffering from psychological disorders. These centres actively promote discharging patients from mental hospitals and integrating them socially either at home or within residential or semi-residential settings; and
- ✓ rehabilitation centres: rehabilitation centres which guarantee outpatient and semi-residential care to the disabled and the elderly, leading to their functional rehabilitation and social reintegration; they also provide prostheses and technical aids for the disabled.

In Italy, a number of the above structures, both public and private, provide specialist treatments (Table III-10). On average, there are more private than public outpatient clinics, although this depends largely on the area of Italy considered. The public clinics are mainly located in hospitals and other health structures. As far as the rehabilitation centres are concerned, the situation in 2000 is described in Table III-11.

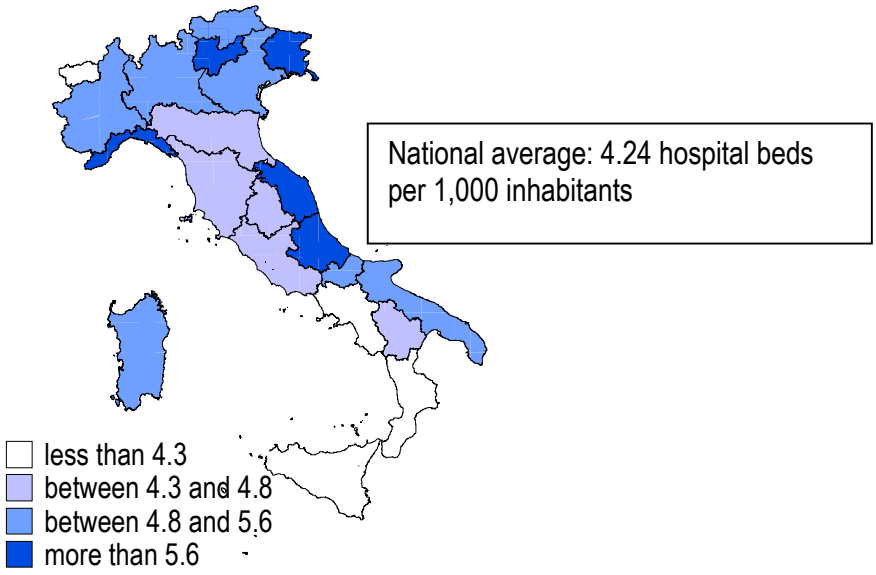
17.4. Hospital care

The INHS guarantees hospital admission for conditions that cannot be treated on a home or outpatient basis, as well as for interventions in day hospital structures.

Most general hospitals include at least four basic services: general medicine, surgery, paediatrics, gynaecology and obstetrics. Depending on referral by a GP care is provided free of charge in public hospitals or in private facilities under contract with the National Health Service. Patient choice is respected and as a result there are important cross-border flows between Regions and self-governed Provinces, even though all have at least one general hospital. Hospital services are mainly free of charge at the point of use. The yearly figures for hospital care services are described in Table III-12, Table III-13, Table III-14, Table III-15, Table III-16 and Table III-17.

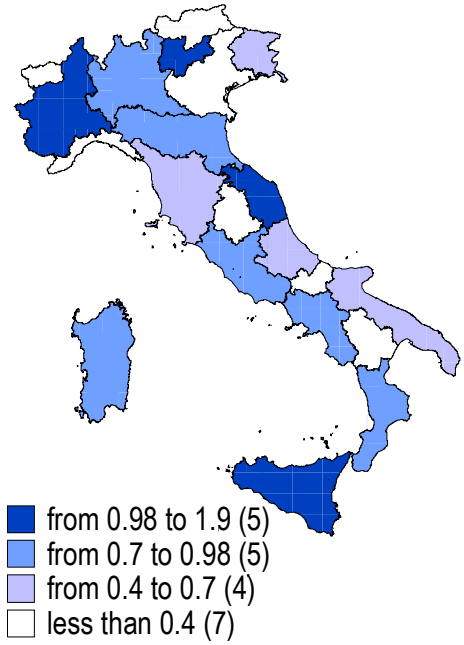
The number of beds available in different Regions of Italy is shown in Figure III- 11 and Figure III- 12. As far as the comparison with other EU countries is concerned, Italy ranks in the middle both for the number of hospitals and beds available to the population (Figure III- 13). From Figure III- 13 and from the comparison of data for Italy in 1993 and 1997 (i.e. 6.6 beds/1 000 people versus 5.8 beds/1 000 people), it can be seen that the total number of hospital bed has fallen significantly in recent years. The reasons containment policies, changes in technology or for these changes are not well documented, methods of treatment probably reflect a combination of cost- roles of PHC and social care. Furthermore, in most countries, there has been an increase in admission rates together with a reduction in average length of stay. The latter trend has accompanied changes in the management of patients, improvements in clinical techniques such as minimally invasive surgery, and incentives to reduce length of stay and ensure that patients who no longer need acute care are discharged to other facilities. In more recent years, the progressive ageing of the population and decreasing birth rate has led to a reduction in the number of beds in medical-surgical and maternity-children's wards, as well as an increase in the number of beds in such wards as rehabilitation and long-term care. On the other hand, a significant increase has been observed in the number of public health care centres with transplant departments (particularly kidneys, heart, liver and lungs). According to very recent regulatory decisions in Italy, the maximum number of beds for acute care should not exceed 4 per 1 000 inhabitants and that for post-acute care 1 per 1 000 inhabitants

Figure III- 11. Number of hospital beds in public health care facilities per 1000 inhabitants in Italy – Year 2000



Source: Ministry of Health of Italy.

Figure III- 12. Number of accredited beds in private health care facilities per 1000 inhabitants in Italy – Year 2000



Source: Ministry of Health of Italy.

Table III-10. PUBLIC AND PRIVATE HEALTH CARE FACILITIES IN ITALY BY TYPE – YEAR 2000

Region	Public Facilities				Accredited private facilities			
	Outpatient clinic and laboratories	Other outpatient services	Semi-residential facilities	Residential facilities	Outpatient clinics and laboratories	Other outpatient services	Semi-residential facilities	Residential facilities
PIEDMONT	605	356	74	135	153	8	64	265
VALLE D'AOSTA	20	23			5	1		
LOMBARDIA	755	890	261	226	603	16	192	557
PROV. OF BOLZANO	200	62	1	7	41	1		16
PROV. OF TRENTO	87	41	5	9	16		5	61
VENETO	442	457	176	141	337	118	180	374
FRIULI V. G.	160	68	46	79	50	4	12	72
LIGURIA	343	183	26	39	152	3	2	65
EMILIA ROMAGNA	384	308	222	230	256	21	96	181
TUSCANY	663	462	183	250	339	41	51	314
UMBRIA	111	150	33	41	24	2	7	21
MARCHE	299	61	30	55	101	5	6	21
LAZIO	641	347	63	56	776	16	1	48
ABRUZZI	129	138	5	9	131	4		2
MOLISE	44	7			23			3
CAMPANIA	513	256	44	66	1 412	11	6	18
PUGLIA	429	275	12	14	417	1	6	37
BASILICATA	144	32	1	13	42	4		7
CALABRIA	340	86	7	24	299	3	3	22
SICILY	548	374	16	46	1 352	11	3	26
SARDINIA	282	135	12	24	222	4	4	16
ITALY	**7 139**	**4 711**	**1 217**	**1 464**	**6 751**	**274**	**638**	**2 126**

OUTPATIENT CLINICS AND LABORATORIES: *Special Treatment Facilities (Outpatient Clinics, Laboratories And Diagnostic Facilities)*
OTHER SERVICES AT LOCAL LEVEL*: Dialysis centres, hydrothermal establishments, mental health centres, maternal and child consulting rooms, district centres and other facilities operating at local level. -* ***SEMI-RESIDENTIAL STRUCTURES****: Daily psychiatric centres and semi-residential facilities in general.*
RESIDENTIAL STRUCTURES*: Residential health care facilities, and residential facilities in general.*
Source: Ministry of Health of Italy.

Table III-11. REHABILITATION INSTITUTES OR CENTRES IN ITALY – YEAR 2000

Region	Public facilities			Private facilities		
		Beds			Beds	
	Monitored	Residential facilities	Semi-residential facilities	Monitored	Residential facilities	Semi-residential facilities
PIEDMONT				9	446	76
VALLE D'AOSTA	28	2 761	217	53	2 833	1 354
LOMBARDIA				3	130	
PROV. OF BOLZANO	2	15		4	62	11
PROV. OF TRENTO	3		30	14	557	390
VENETO	1	8	5	9	155	228
FRIULI VENEZIA GIULIA	1			12	327	208
LIGURIA				3	329	5
EMILIA ROMAGNA	79	150	35	38	808	862
TUSCANY				2	20	31
UMBRIA	3			23	615	125
MARCHE	9	232	138	51	1 241	1 278
LAZIO				32	571	620
ABRUZZI				7	273	
MOLISE	7	27		118	836	1 928
CAMPANIA	35	165	81	30	751	361
PUGLIA	1			5	582	30
BASILICATA	3	40	35	11	740	146
CALABRIA	12	30	120	70	842	1 164
ITALY	**196**	**3 428**	**661**	**559**	**12 712**	**9 028**

Source: Ministry of Health of Italy.

Table III-12. BEDS AVAILABLE IN PUBLIC HEALTH CARE FACILITIES AND ACCREDITED BEDS IN ITALY BY TYPE – YEAR 2000

Region	Public beds available								Accredited beds
	Hospital agencies	Directly-managed hospital	University hospitals	IRCCs (*)	Other hospitals	LHA (*) Inpatient institutes	Research bodies	Total	
PIEDMONT	5 386	9 020		659	1 043	566		16 674	3 395
VALLE D'AOSTA		447						447	
LOMBARDIA	25 891	3 033		5 049	1 330	217		35 520	8 483
PROV. OF BOLZANO		2 115				29		2 144	184
PROV. OF TRENTO		1 899			215			2 114	235
VENETO	3 509	14 506			1 252	742		20 009	1 229
FRIULI V. G.	2 788	1 933	288	354				5 363	538
LIGURIA	2 904	3 476		591	742			7 713	117
EMILIA ROMAGNA	5 138	9 237		359		45		14 779	4 012
TUSCANY	4 188	9 180		99			87	13 554	2 081
UMBRIA	1 432	1 563						2 995	233
MARCHE	1 339	4 257		335				5 931	973
LAZIO	3 354	8 095	3 493	1 811	2 009	251		19 013	9 562
ABRUZZI		4 899						4 899	460
MOLISE		1 274		107				1 381	93
CAMPANIA	4 358	6 752	1 674	590	662			14 036	5 949
PUGLIA	4 781	8 187		1 642	924			15 534	1 704
BASILICATA	852	1 549						2 401	60
CALABRIA	2 028	3 545		181				5 754	3 249
SICILY	7 431	5 261	1 912	278	281			15 163	3 470
SARDINIA	489	5 261	953	38				6 741	1 469
ITALY	**75 868**	**105 489**	**8 320**	**12 093**	**8 458**	**1 850**	**87**	**212 165**	**47 496**

(*) INCLUDES MAIN AND SECONDARY LOCATIONS - (**) Local Health Agencies - Public Facilities Included In The Survey: 99% - Accredited Private Facilities Included In The Survey: 92,5%.

Source: Ministry of Health of Italy.

Table III-13. PUBLIC HEALTH CARE FACILITIES IN ITALY BY TYPE – YEAR 2000

Region	Hospital agencies	Directly managed hospitals	University hospitals	Scientific bodies		Other hospitals	Remaining psychiatric hospitals	LHA inpatient institutes	Research bodies	Total
				Main location	Secondary location					
PIEDMONT	7	25			2	6		4		44
VALLE D'AOSTA		1								1
LOMBARDIA	27	19		13	5	6		2		72
PROV. OF BOLZANO		7						1		8
PROV. OF TRENTO		11				2	1			14
VENETO	2	64				8		4		78
FRIULI VENEZIA GIULIA	3	13	1	2						19
LIGURIA	3	19		2	1	2				27
EMILIA ROMAGNA	5	37		1				1		44
TUSCANY	4	35		1	1				1	42
UMBRIA	2	9								11
MARCHE	4	31		1	2					38
LAZIO	3	50	2	4	4	8	1	2		74
ABRUZZI		22								22
MOLISE		6		1						7
CAMPANIA	8	51	2	1	1	3				66
PUGLIA	6	55		3	1	2				67
BASILICATA	2	9								11
CALABRIA	4	32			1					37
SICILY	17	48	3	1		1				70
SARDINIA	1	29	2		1					33
ITALY	**98**	**573**	**10**	**30**	**9**	**38**	**2**	**14**	**1**	**785**

Source: Ministry of Health of Italy.

Table III-14. ADMISSIONS IN PUBLIC ACUTE CARE* HOSPITALS IN ITALY – YEAR 2000

Region	Actually used beds	Admissions	Admissions rate	Average length of stay (days)	Occupancy rate	Monitored facilities
PIEDMONT	14 908	516 557	120.5	4 156 985	8.0	77.4
VALLE D'AOSTA	447	16 090	133.7	146 878	9.1	89.4
LOMBARDIA	32 640	1 209 617	133.4	8 957 098	7.4	75.9
PROV. OF BOLZANO	2 084	85 168	184.1	557 881	6.6	73.8
PROV. OF TRENTO	1 841	68 125	143.8	485 478	7.1	72.3
VENETO	17 615	631 879	140.1	5 106 159	8.1	79.8
FRIULI VENEZIA GIULIA	5 140	160 883	135.7	1 257 415	7.8	67.4
LIGURIA	7 496	280 211	172.3	2 228 301	8.0	82.3
EMILIA ROMAGNA	13 197	551 564	138.5	3 838 769	7.0	80.2
TUSCANY	13 341	501 246	141.7	3 773 788	7.5	79.5
UMBRIA	2 911	132 163	158.2	837 910	6.3	79.8
MARCHE	5 690	221 036	151.3	1 578 514	7.1	76.2
LAZIO	17 912	692 245	131.5	5 376 198	7.8	83.7
ABRUZZI	4 729	217 362	169.9	1 500 248	6.9	86.8
MOLISE	1 287	59 048	180.0	409 384	6.9	87.1
CAMPANIA	13 708	678 226	117.3	4 036 228	6.0	81.1
PUGLIA	15 042	721 020	176.5	4 231 227	5.9	77.2
BASILICATA	2 328	89 276	147.3	566 285	6.3	66.7
CALABRIA	5 692	245 023	119.5	1 518 951	6.2	73.9
SICILY	14 553	614 898	120.9	3 567 254	5.8	68.1
SARDINIA	6 709	211 770	128.2	1 493 169	7.1	61.0
ITALY	**199 270**	**7 903 407**	**137.0**	**55 624 120**	**7.0**	**77.2**

(*) Not including: 22 - Remaining mental hospitals; 28 - Spinal units; 56 - Recovery and functional rehabilitation; 60 - Long-term hospitalisation; 75 - Neuro-rehabilitazion

FACILITIES INCLUDED IN THE SURVEY (DECLARING THEY HAVE PUBLIC ACUTE CARE FACILITIES): 99.1%

Source: Ministry of Health of Italy.

Table III-15. ADMISSIONS IN PUBLIC NON ACUTE CARE* HOSPITALS IN ITALY – YEAR 2000

Region	Actually used beds	Admissions	Bed days	Average length of stay	Occupancy rate (%)
PIEDMONT	1 766	17 542	547 889	31.2	87.0
VALLE D'AOSTA	2 880	39 084	852 496	21.8	83.0
LOMBARDIA	60	408	8 338	20.4	38.0
PROV. OF BOLZANO	273	4 335	81 997	18.9	82.1
PROV. OF TRENTO	2 394	29 352	657 526	22.4	81.0
VENETO	223	2 102	66 086	31.4	87.9
FRIULI VENEZIA GIULIA	217	2 056	65 481	31.8	90.5
LIGURIA	1 582	19 665	668 088	34.0	117.6
EMILIA ROMAGNA	213	2 627	61 239	23.3	83.0
TUSCANY	84	896	22 324	24.9	84.7
UMBRIA	241	1 961	52 079	26.6	65.1
MARCHE	1 101	6 887	331 408	48.1	85.6
LAZIO	170	2 487	38 140	15.3	64.4
ABRUZZI	94	795	27 823	35.0	96.6
MOLISE	328	4 826	100 020	20.7	85.6
CAMPANIA	492	7 223	145 430	20.1	88.5
PUGLIA	73	590	15 519	26.3	59.8
BASILICATA	62	769	15 113	19.7	66.6
CALABRIA	610	3 211	113 500	35.3	52.7
SICILY	32	134	8 244	61.5	82.7
ITALIA	**12 895**	**146 950**	**3 878 740**	**26.4**	**85.9**

(*) Including: 22 - Remaining mental hospitals; 28 - Spinal units; 56 - Recovery and functional rehabilitation; 60 - Long-term hospitalisation; 75 - Neuro-rehabilitazion

FACILITIES INCLUDED IN THE SURVEY (DECLARING THEY HAVE PUBLIC ACUTE CARE FACILITIES): 95.2%

Source: Ministry of Health of Italy.

Table III-16. ADMISSIONS IN PRIVATE ACCREDITED ACUTE HEALTH CARE* FACILITIES IN ITALY – YEAR 2000

Region	Accredited beds	Admissions	Admissions rate (per 1000 inhabitants)	Actual beds days	Average length of stay (days)	Occupancy rate (%)
PIEDMONT	1 668	30 475	7.1	387 166	12.7	86.0
VALLE D'AOSTA	6 596	267 072	29.5	1 418 842	5.3	60.7
LOMBARDIA	50	981	2.1	15 633	15.9	85.4
PROV. OF BOLZANO						
PROV. OF TRENTO	963	33 046	7.3	301 815	9.1	86.5
VENETO	448	13 655	11.5	83 035	6.1	55.5
FRIULI VENEZIA GIULIA	52	1 506	0.9	9 953	6.6	68.8
LIGURIA	2 862	66 246	16.6	516 909	7.8	52.2
EMILIA ROMAGNA	1 474	32 358	9.2	221 007	6.8	42.5
TUSCANY	218	8 591	10.3	38 964	4.5	55.0
UMBRIA	741	21 456	14.7	144 792	6.7	56.6
MARCHE	4 417	125 049	23.8	1 190 067	9.5	76.1
LAZIO	357	18 265	14.3	119 405	6.5	96.3
ABRUZZI	93	2 932	8.9	21 418	7.3	72.6
MOLISE	4 555	189 000	32.7	1 080 832	5.7	69.8
CAMPANIA	1 582	53 337	13.1	361 605	6.8	64.5
PUGLIA	60	2 173	3.6	11 802	5.4	53.7
BASILICATA	2 451	81 566	39.8	543 557	6.7	61.1
CALABRIA	3 389	135 842	26.7	801 644	5.9	65.3
SICILY	1 330	40 603	24.6	279 680	6.9	59.3
ITALY	**33 306**	**1 124 153**	**19.5**	**7 548 126**	**6.7**	**65.1**

(*) Including: 22 - Remaining mental hospitals; 28 - Spinal units; 56 - Recovery and functional rehabilitation; 60 - Long-term hospitalisation; 75 - Neuro-rehabilitazion

FACILITIES INCLUDED IN THE SURVEY (DECLARING THEY HAVE PUBLIC ACUTE CARE FACILITIES): 96.4%

Source: Ministry of Health of Italy.

Table III-17. ADMISSIONS IN PRIVATE ACCREDITED NON ACUTE HEALTH CARE* FACILITIES IN ITALY YEAR 2000

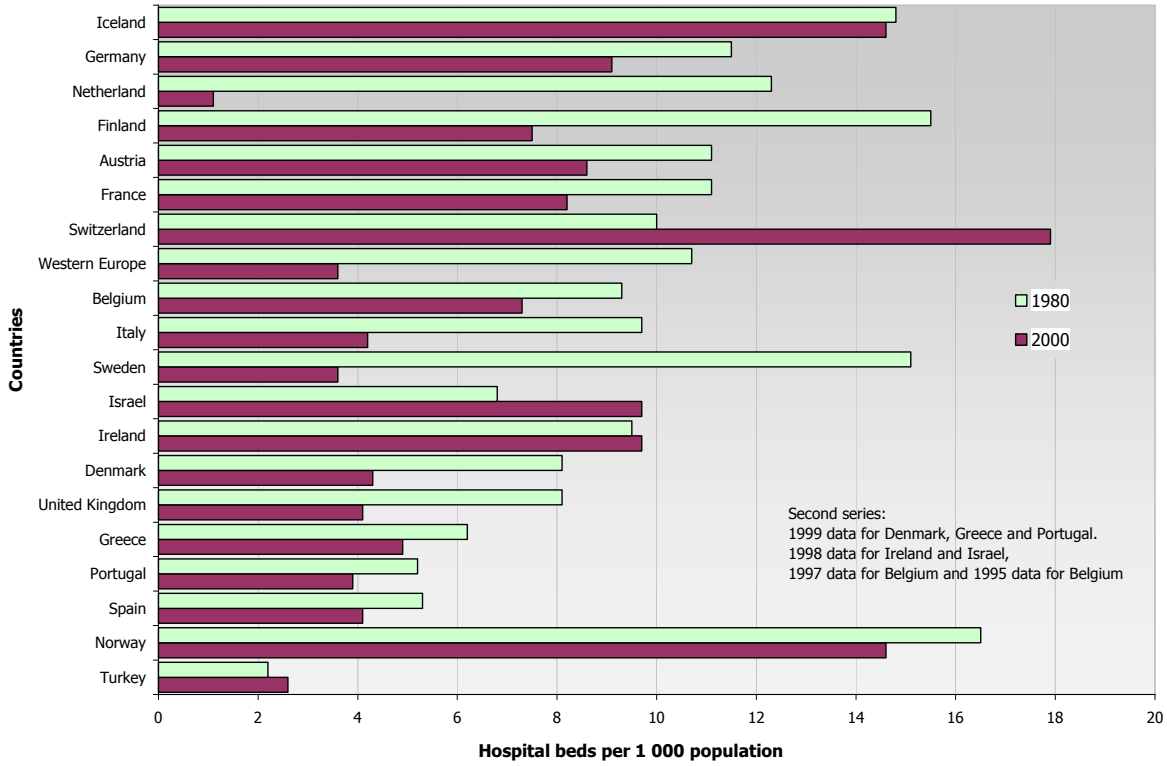
Region	Accredited beds	Admission	Bed days	Average length of stay (days)	Occupancy rate
PIEDMONT	1 727	11 277	361 020	32.0	78.2
VALLE D'AOSTA	1 887	32 530	646 871	19.9	93.7
LOMBARDIA	134	1 617	45 790	28.3	93.4
PROV. OF BOLZANO	235	5 017	111 661	22.3	129.8
PROV. OF TRENTO	266	4 143	87 769	21.2	90.4
VENETO	90	1 307	33 175	25.4	100.7
FRIULI V.G.	65	1 177	18 286	15.5	76.9
LIGURIA	1 150	14 758	333 116	22.6	87.0
EMILIA ROMAGNA	607	6 678	198 498	29.7	89.3
TUSCANY	15	456	4 011	8.8	73.1
UMBRIA	232	1 841	83 006	45.1	97.8
MARCHE	5 145	24 048	1 697 727	70.6	91.8
LAZIO	103	1 467	38 099	26.0	107.0
ABRUZZI	1 394	11 795	455 223	38.6	89.9
MOLISE	122	1 381	41 325	29.9	93.8
CAMPANIA	798	6 218	262 370	42.2	90.2
PUGLIA	81	2 233	35 320	15.8	119.1
BASILICATA	139	665	52 235	78.5	102.7
ITALY	**14 190**	**128 608**	**4 505 502**	**35.0**	**91.1**

(*) Including: 22 - Remaining mental hospitals; 28 - Spinal units; 56 - Recovery and functional rehabilitation; 60 - Long-term hospitalisation; 75 - Neuro-rehabilitazion

PRIVATE ACCREDITED ACUTE HEALTH CARE FACILITIES CONSIDERED IN THE SURVEY (DECLARING THEY HAVE PUBLIC NON ACUTE CARE FACILITIES): 94.2%*

Source: Ministry of Health of Italy.

Figure III- 13. Hospital beds in the WHO European Region from 1980 to the last available year



Source: WHO 1997; OCDE 2000.

17.5. Care and rehabilitation of non self-sufficient persons

This service provides admission to specially designed sheltered facilities for the rehabilitation of persons who are not self-sufficient with a view to their social reintegration:

- ✓ **Persons with mental disorders:** the INHS takes care of patients suffering from long-term psychiatric disorders by providing accommodation in sheltered residential settings (e.g. half way homes, community-type housing).
- ✓ **The disabled:** the INHS provides the disabled (either from birth or as a consequence of disease or trauma) with specialist residential care in rehabilitation centres. The activities of these centres aim to re-gain the use of disabled limb(s) and subsequently re-integrate patients into their family and work environment. These centres are staffed with specialist physicians (psychiatrists, orthopaedists, neurologists, etc.), rehabilitation therapists (physiotherapists, speech therapists, occupational therapists), psychologists and nurses.
- ✓ **Drug users:** the INHS provides drug users with care facilities in specially designed communities, which allow their rehabilitation and social integration. In this context, they are given psychological assistance to solve their problems and are encouraged

to acquire a new life-style. While living in the community, they work or attend vocational training courses;

- ✓ **The elderly:** among the objectives of the National Health Plan, it has been identified the "establishment of an integrated network for health care and social services for chronic patients, the elderly and the disabled".

  The elderly population is constantly increasing along with many related diseases and disabilities. It is evermore necessary to truly integrate health care with social assistance. The elderly and the disabled ask to be able to receive home treatment in order to avoid unnecessary hospital admission. There is a lack of post-acute centres, relief rehabilitation treatment, in-patient care and Day Hospitals, and most of all there is no system that globally takes charge of the patients by solving their health needs and guiding them through a health care network. Other countries have already taken measures to set up appropriate insurance funds against the risks of non self-sufficiency or to somehow find resources that can guarantee a dignified life to the elderly persons who are no longer self-sufficient and to their families.

  It is necessary to develop what is called "home hospitalization", i.e., transferring certain services that are at present only available in hospitals to the patient's home, including palliative and drip treatment, dialysis, etc. The National Health Plan envisages a model of home treatment and care that integrates territorial and specialist hospital care as well as social services.

17.6. Prevention of the Severe Acute Respiratory Syndrome (SARS) in Italy

After the alarm set off by the World Health Organization on March 12, 2003 concerning the possible international spread of SARS, the Ministry of Health established a series of initiatives aimed at stopping the importation of the infection and ensuring surveillance and control of this disease within the country. The efficacy of the interventions adopted until now, almost two months after the global alarm set off by the WHO, is confirmed by the prompt identification of all suspect cases coming exclusively from affected areas as well as by the absence of secondary spreading of the disease among health operators or among the general population. For all the cases identified and addressed to the specialised Centres in Milan and Rome, an epidemiological investigation has been carried out to monitor the health conditions and trace back all the contacts held.

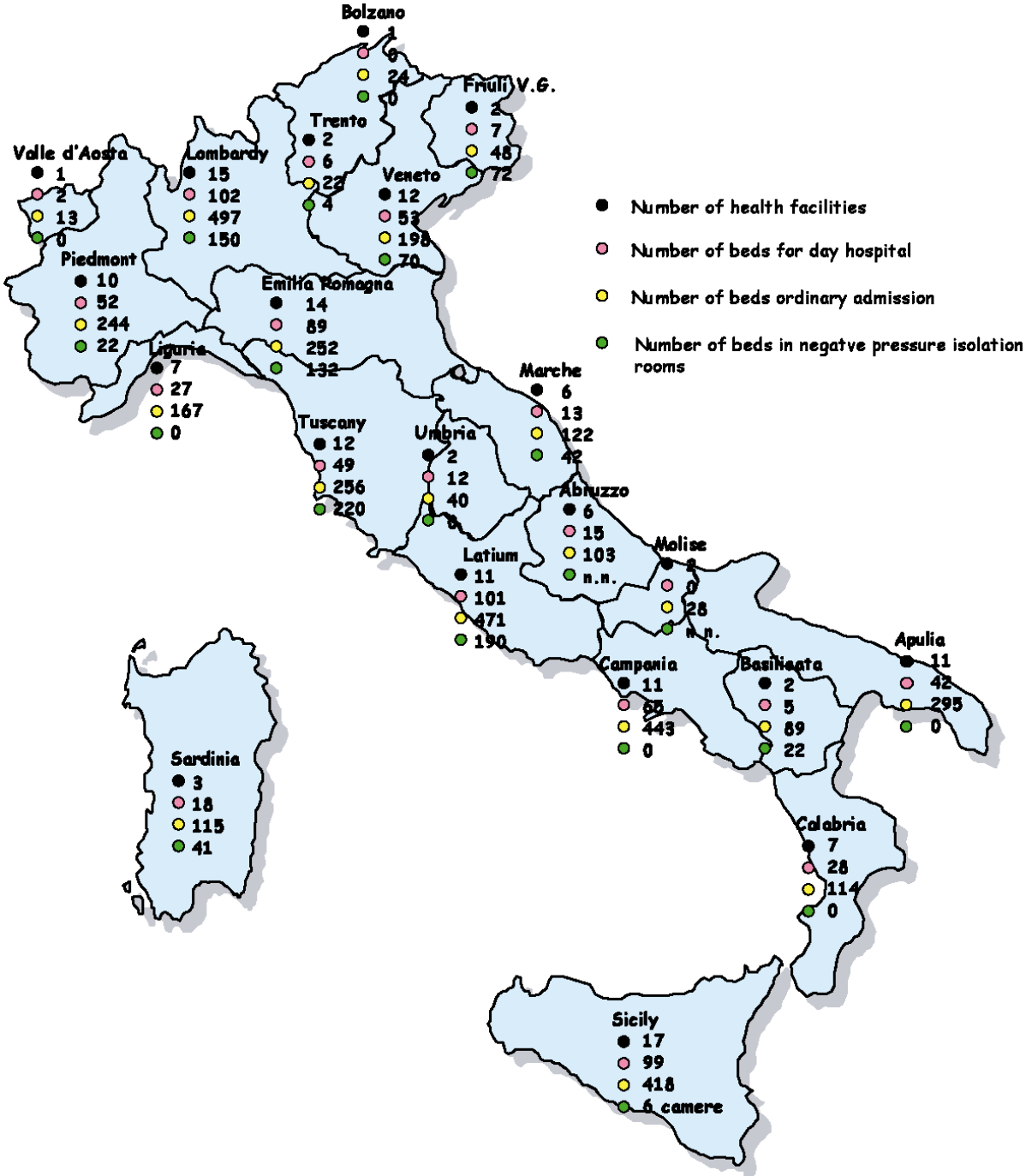
Measures adopted in Italy at different times between 12 March 2003 and 22 May 2003 to prevent and to control the SARS have included:

- request of collaboration to the captain of each airplane arriving in Italy from SARS risk areas to notify to the Italian authorities the incoming passengers (including those in transit to other European destinations) showing specific symptoms and other passengers in contact with them;
- distribution of SARS information leaflets in different languages to all passengers arriving at international airports in Italy from SARS risk areas;

- administration, since 10 April 2003 to all passengers arriving at international airports in Italy from SARS risk areas, of a data recording form to declare their places of origin and addresses while in Italy;
- careful inspections of the baggage of all passengers from SARS risk areas (measure discontinued on 22 May 2003);
- medical anamnesis and distance measurement of body temperature for each passenger arriving in Italy with flights from SARS risk areas (activity started on 4th May 2003 at the airports of Rome and Milan and extended later on to other Italian international airports and also to passengers arriving from risk areas on transit from other European countries);
- strengthening of health surveillance at the seaports with emphasis on ships and cargoes from SARS risk areas;
- activation of a free-tall telephone number to provide personalized information to citizens;
- reinforcement of medical staff, particularly at the international airports of Rome and Milan and at the Istituto Lazzaro Spallanzani in Rome and Ospedale Sacco in Milan (national Reference Centres); and
- reinforcement of health measures and surveillance in the illegal immigrants first reception camps in Italy.

All the information concerning the various aspects of SARS are published and updated on a regular basis on a web site www.ministerosalute.it. See Figure IV-32 and IV-33 for distribution in Italy of hospital facilities with infectious diseases wards and number of beds and negative pressure isolation rooms.

Figure III- 14. Hospital facilities with wards for communicable diseases. Year 2001



Source: Mister of Health General Diractorate "Prevenzione - Ufficio III Malattie Infettive e Profilassi Internazionale" and National Epidemiological Observatory.

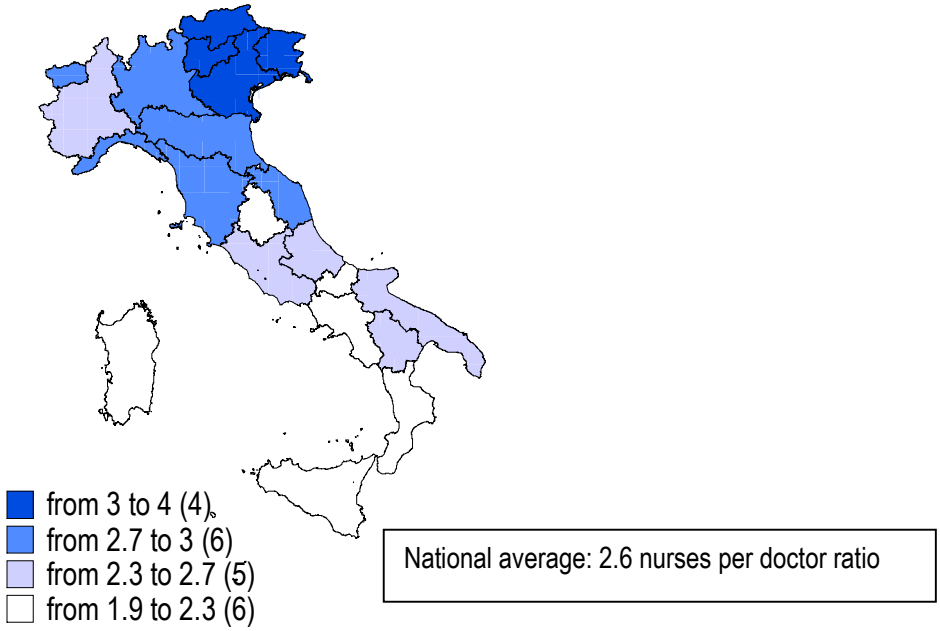
Figure III- 15. Geographical distribution of wards for communicable diseases and number of hospital beds with negative pressure isolation room. Year 2001

Source: Mister of Health General Diractorate "Prevenzione - Ufficio III Malattie Infettive e Profilassi Internazionale" and National Epidemiological Observatory.

18. Human resources

In 2000, about 420 000 people were employed in Local Health Agencies in Italy (Table III-18), of which approximately 15% were physicians, including dentists and 38% nurses. An additional number of about 302 000 people were employed in hospitals and similar institutions managed by Local Health Agencies, with an average physician/nurse ratio of 2.63 (Figure III- 16).

Figure III- 16. Nurses –pysicians ratio in Italian hospitals and Local Health Unit Agencies – Year 2000



Source: Ministry of Health of Italy.

Table III-18. EMPLOYEES OF LOCAL HEALTH AGENCIES IN ITALY. YEAR 2000

Region	Total	of which	
		Physicians and dentists	Nurses
PIEDMONT	37 015	5 396	14 220
VALLE D'AOSTA	1 810	229	630
LOMBARDIA	22 744	2 438	6 583
PROV. OF BOLZANO	7 049	692	2 768
PROV. OF TRENTO	6 691	802	2 698
VENETO	44 985	6 160	20 341
FRIULI V. G.	9 188	1 081	4 078
LIGURIA	13 807	1 888	5 574
EMILIA ROMAGNA	36 704	5 340	14 681
TUSCANY	35 895	4 969	14 800
UMBRIA	6 357	1 066	2 412
MARCHE	13 303	1 925	5 224
LAZIO	36 475	5 860	13 611
ABRUZZI	15 104	2 485	6 079
MOLISE	3 759	648	1 376
CAMPANIA	38 626	6 388	14 281
PUGLIA	26 879	3 807	9 379
BASILICATA	4 262	633	1 543
CALABRIA	16 752	2 520	5 277
SICILY	26 759	4 639	8 682
SARDINIA	19 078	3 260	6 774
ITALY	**423 242**	**62 226**	**161 011**

Source: Ministry of Health of Italy.

19. Quality

Major ongoing quality assurance programmes in Italy include:

- ✓ accreditation of health care facilities;
- ✓ clinical practice guidelines, in order to provide a sound evidence base for assuring and improving the quality of clinical practice;
- ✓ clinical performance measures, to assess the extent to which providers deliver appropriate medical services;
- ✓ population-based, health related measures to assess the goals of the Health Improvement Programmes included in the National Health Plan.

The World Health Organization has carried out in the year 2000 the first worldwide analysis of the performance of National Health Systems of 191 Member States (WHO- the World Report Health Systems: Improving Performance- June 2000) It was concluded that the performance of the Italian Health System, as assessed in terms of "life expectancy corrected by disability", is the third highest among 191 different countries, whereas, in terms of global performance, Italy is only second to France.

However, public opinion is to some extent dissatisfied in Italy with faulty services and accidents in health-related issues that are caused by lack of a global system that guarantees quality standards: medical errors, long waiting lists, duplication of tasks and services, lack of trained staff and training programmes, the absence of set procedures and manifest wastefulness. A survey was carried out by EURISKO by interviewing a representative sample of 10.000 people, from 14 years of age onwards, in 1997. The results of the EURISKO study shows that 41% of the population sample considered the service offered "barely satisfactory", while 23% think it is "not at all satisfactory". On the other hand, 34% think it offers a fairly satisfactory service, and only 2% of the sample considered it to be very satisfactory.

After heaving been successfully applied to the industrial sector and to other services, ISO 9000 norms were also designed for the health care sector, establishing a series of rules that include business management, responsibilities, meticulous process analysis, staff training and external auditing systems.

The instrument of certification is therefore different from the accreditation one set out in Legislative Decree N.502 of December 1992. Accreditation, in fact, should be carried out by regional authorities authorizing providers, i.e., authorized and certified structures, to deliver services financed by the Regional Health Fund, after having duly assessed the typology and volume of services as well as relevant prices. The accreditation process establishes further prerequisites for those who deliver certified services but should not replace the process of authorization and certification.

Official auditing of service providers can help strengthen public control instead of bureaucratic control carried out by the State until now. The role of a third party

Observatory that assesses the outcome of delivered and certified services must complete this new form of public control over health care services.

The following objectives will be pursued during the next three years:

- ✓ promoting quality services in each Health Agency according to certification benchmarks established by ISO 9000 regulations;
- ✓ giving strategic value to quality services by placing the administrators at top levels of management and using division referees as intermediaries between the Service and the operational divisions;
- ✓ assisting the quality services in writing up of a quality manual;
- ✓ reviewing present accreditation norms;
- ✓ promoting the establishment of a Quality Observatory that will plan and set up a complete monitoring and reporting system.

20. Participation of the Italian Ministry of Health to the work of the European institutions

A peculiarity of the Italian Ministry of Health is its administrative and normative competence which is, in general, wider compared to the Ministries of Health of the majority of the EU Member States.

In fact, besides the competences related to the health sector, the Ministry of Health has important administrative and normative responsibilities also with reference to some key sectors in the field of production, both industrial (*i.e.* biotechnologies) and agricultural (*i.e.* food safety and veterinary public health) as well as environmental (*i.e.* air and water quality).

This explains the active participation of the Ministry of Health to several working groups of the EU Council, among which the most important are the following:

- ✓ "Agricultural Problems" (H.7)
- ✓ "Animal products" (H.8)
- ✓ General Directors/Heads of Veterinary Services" (H.31)
- ✓ "Veterinary experts" (H.32)
- ✓ "Codex Alimentarius" (H.37)
- ✓ "Pharmaceutical products and medical devices" (K.10)
- ✓ "Alimentary products" (K.13)
- ✓ "Health Group" (S.1)

Moreover, experts of the Ministry of Health have provided and yet provide an important contribution to Scientific Committees of the European Commission, to European Agencies competent in health matters (in particular EMEA and Commission's Scientific Committees) and to a great number of working groups established by the European Commission in order to carry out the preparatory work for new directives' proposals and community regulations. Therefore, the Ministry of Health has played and continues to play a very important role for the development of European Union policies in the field of medicines, nutrition and food safety, air and water quality, fight against tobacco smoke, communicable diseases control, drug-addiction, blood safety, organ and tissue transplantation not to quote the role of promoting the participation of Italian health institutions and Universities to the community research programmes which have health implications and to programmes for which the European Commission provides incentives, in the field of health promotion, cancer, HIV/AIDS, rare diseases, injuries and pollution related diseases.

21. Italian Presidency of the Council of the European Union in the Health Sector in the year 2003

The Italian Presidency of the European Union in the health sector is devoted to far reaching political issues reflecting Italy's commitment to promote health of the European citizens in the framework of the on-going historical developments of the E.U., i.e. the "European Convention" and the "Enlargement of the Union".

The main focus of the Italian Presidency is on initiatives targeted at making readily and clearly available to the European citizens and consumers the information needed to protect their health by avoiding or minimizing the challenges of unhealthy lifestyles.

The Italian Presidency intends also to promote patients' accessibility to valuable innovative medicines; orphan drugs and new health technologies such as those related to cellular treatments and tissue/organ transplants. These fast-developing sectors offer many potential benefits to patients, but they also require careful consideration in relation to both sound industrial policies and safety and ethical issues.

Another priority of the Italian Presidency is the exchange of experience among competent Authorities in order to promote quality in health care; this applies particularly to continuing education in medicine, to telemedicine and to methodologies for benchmarking the outcomes of specific health care interventions and to measure excellence. An exchange of experience and information will also be encouraged on proposals concerning social and health services for non self-sufficient elderly people as well as on optimal means to make available the resources needed.

In order to pursue the above-mentioned objectives, the Ministry of Health of Italy intends to ensure continuity to the issues deriving from previous Presidencies and to initiate new issues by offering to the Ministers of Health opportunities for informal and formal reflections and discussions which may help to pave the way for the future of health in the European Union.

To this end, an informal Conference of the Ministers of Health and two formal Councils will be held during the Italian Presidency, together with six conferences and eight regular meetings and committees, described in the Annex 1.