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Healthcare in Italy: The National Health Service (NHS)

Authors:

Karl Kob

Secretary of the Board

Gianfranco Finzi

President

Ugo Luigi Aparo

Scientific Secretary

ANMDO- National Association of Hospitals

Medical Directors

Article 32 of the 1946 Italian Constitution states that health, and healthcare, is a fundamental right of the individual, a primary collective interest, and guarantees free access to medical care to citizens. For the fulfillment of this right and duty enshrined in the Constitution, citizens and stakeholders asked the Italian Parliament to create a uniform health service throughout the country, with equity of access to healthcare for all citizens without exception.

Local Health Units

After more than 30 years of debate at various levels, in 1978 the Italian Parliament finally approved the First Health Reform, entitled "Establishment of the National Health Service." This reform, based on the Beveridge model, created at the municipal level the Local Health Operating Units named USL (Unità Sanitarie Locali).

The USLs cover defined geographical areas within which all health interventions are provided under one management structure, namely the Chairman and Management Committee. They cover prevention, diagnosis, treatment, rehabilitation and forensic medicine, both at a local level and/or at the hospital level. The USL do not have legal enforcement powers. In the implementation of the First Healthcare Reform, the 19 regions and two autonomous provinces of the Italian state established, under their own laws, a network of 673 USL, divided into health districts; each one with approximately 10,000- 15,000 inhabitants.

Reorganisation

Financing of healthcare in Italy occurs through the National Health Fund, which is allocated annually according to a set of parameters (number of inhabitants, number of elderly persons, etc.). In the years following the First Reform, several problems emerged, largely due to the inability of the municipalities to successfully manage healthcare services. People talked about "confusion", and the media filled pages on "a low performing health system."

In 1992/1993 a Second Health Reform was approved, entitled "Reorganisation of the discipline in the health field." This legislation established the transformation of the Local Health Units (USL) into Territorial Healthcare Authorities (ASL- Aziende Sanitarie Locali), with legal enforcement powers. ASLs are operative structures of regions/autonomous provinces and are headed by a General Director, assisted by a Medical Director, and an Administrative Manager.

The main organisational changes due to the Second Healthcare Reform were:

- The transition from 673 Local Health Units to 228 Health Authorities (ASL), articulated in broader Health Districts, accounting for approximately 50,000-60,000 inhabitants and over;
- 940 small and medium-sized hospitals remain ASL presidia;
- 96 large hospitals become autonomous hospital authorities;

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- Each ASL is divided into three organisational units: prevention (budget not less than 5%), community care (budget not less than 48%), and hospital care (budget not more than 47%).

Rationalisation

In 1999, following the ASLs' persistent inability to contain healthcare spending, the Third Healthcare Reform "Rules for the rationalisation of the National Health Service" was approved. This reform confirmed the already existing directional structure: General Director, assisted by the Medical Director and Administrative Manager, and included the following changes:

- Territorial Healthcare and Hospital Health Authorities, in addition to possessing legal powers, have corporate autonomy. Therefore, the responsibility of the General Director includes the establishment of the organisation, and responsibilities, of the different areas and their roles on the basis of a private act approved by the Region /Autonomous Province;
- Territorial Healthcare Authorities and Hospital Authorities must respect budget goals, previously agreed with the Region/Autonomous Province and can not have open deficits;
- A Strategic Direction Committee and a Technical and Advisory board were put in place to support the General Director in planning and organisation.

Since 1999, numerous legislative measures have been adopted with the aim of containing health costs, rather than for the improvement of healthcare itself. A recent one requires that Regions and Autonomous Provinces must either close or convert small acute care hospitals, in order to bring the total number of hospital beds for acute cases to 3 for 1,000 inhabitants for rehabilitation, and to 7 for 10,000 inhabitants for the post acute phase.

The resources retrieved from hospitals, as a result of hospital bed reduction, may be diverted to preventive services, and especially to primary care services. However, many experts have expressed concern about the future sustainability of the current health system and they strongly recommend new reforms.

The National Association of Hospital Medical Directors (ANMDO), an association that represents medical management for both scientific and trade union issues plays an important advisory role with regard to the reform of the Italian healthcare system.

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