ICU MANAGEMENT & PRACTICE

ICU Volume 8 - Issue 4 - Winter 2008/2009 - Country Focus:Italy

An Overview of Healthcare in Italy (M. Capuzzo, D. Resi)

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Organisation of the Healthcare System

The Italian National Health Service (INHS), named “Servizio Sanitario Nazionale”, was instituted in 1978 by law N. 833. The founding principles were universality, equality and equity. Accordingly, the aims were to promote, maintain and recover the physical and mental health of the whole population, and to guarantee that all residents and citizens receive healthcare and treatment without any discrimination based on gender, age, residence, income or job.

In the early nineties, the INHS was reformed (laws by decree N. 502 of 1992 – N. 517 of 1993 – N. 512 of 1994) and a new managerial style was introduced, in accordance with the cultural changes and the economic constraints, which had intervened since its’ inception. The principle of universality became “to assure health services necessary and appropriate for those needing them”. The new criteria included clinical appropriateness (i.e. provision of the most effective services to those requiring them) and economic appropriateness (i.e. provision of the most efficacious and least expensive services). At the same time, the concept of equality evolved from “people with the same health needs have to be treated in the same way” to the following socalled ‘vertical equity’: “people with poorer health, or higher health needs have to be treated in a more favourable way”.

At the end of nineties, the third reform of INHS (laws by decree N. 229 of 1999) was based on the dignity of the human being, the need of health and well being, equity of health services, appropriateness and suitability of health services, and budget concerns. At the same time, legislative and administrative functions were given to the 20 regions and autonomous provinces of the country, which enjoyed considerable autonomy in organising healthcare delivery and became responsible for their health strategies. The process was gradual and concluded with the changes of the Italian Constitution 2001 (article 117, comma 2, letter m and Titolo V of part II) toward federalism.

Moreover, to guarantee that all citizens of the different regions and autonomous provinces receive the same basic level of health services, a decree of the Italian Prime Minister defines the “essential levels of care” (Livelli Essenziali di Assistenza sanitaria or LEA), that are the minimum standards of healthcare which must be given free of charge to all citizens in all regions and autonomous provinces. Those LEA include the following: i) prevention activities such as controls of food, vaccinations, screening tests for early diagnosis of cancer; ii) health services such as access to General Practitioners (GPs), diagnostic tests and imaging techniques, and drugs; iii) hospital services such as access to emergency departments, general hospital admissions, surgery and rehabilitation. On the other hand, each region has to assure the LEA but can give additional services to residents using its own funds

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Financing of the Healthcare System

The INHS is financed in each region by the taxes (direct, such as income tax, and indirect, like part of Value Added Tax) paid by residents, even if there are equalizing funds to help less rich regions. Moreover, as a general rule, patients pay a small charge given as contribution for the services received. Hospital admission and services are free of charge for the following categories of citizens: Those aged less than 6 years or

more than 65 years, those with income lower than a determined value, and those having one of 51 chronic illnesses, such as cancer, chronic obstructive pulmonary disease, heart failure, etc.

Hospitals are reimbursed by the administration of the regions or autonomous provinces where they are. The reimbursement is given according to the Diagnosis Related Group (DRG) system of the country, with a higher reimbursement for cases concerning patients of regions or autonomous provinces different from that where the hospital is located. The aim is to press the hospital to be attractive for patients of other parts of the country.

The reimbursement for patients admitted to the intensive care units is included in the DRG given to each hospital admission. Moreover, the reimbursement for each hospital admission is assigned to the ward dis charging the patient from the hospital, and it is subsequently divided among wards where the patient was treated according to the days spent in each of them.

Each of the regions and autonomous provinces has a plan to create an integrated system of social and healthcare services that can provide unitary and global responses to the needs of the society. Accordingly, there are health districts where GPs work is integrated with territorial healthcare services, including social support for non-auto nom ous people.

Responsibility for healthcare delivery is on Local Health Trusts; public enterprises funded by the regions through a per capita budget for a wide range of hospital and community services. Most public hospitals are directly managed by the Local Health Trusts, except those providing tertiary care (IRCCS), and/or with a teaching status (University Hospital Trusts). Private hospitals are mostly for profit and account nationally for 14% of total hospitalisations, with a wide regional variation. Private hospitals respecting the quality requirements defined by the regions and autonomous provinces can be accredited and can take care of citizens being reimbursed according to the DRG system.

All patients in Italy are registered with a GP or a paediatrician who is responsible for providing most primary care, referrals to specialists, and prescribing diagnostic interventions and drugs. To be treated, citizens are free to choose their GP as well as the hospitals and doctors in public and private accredited structures. The 118 Emergency System (118 is the phone number) is active through - out Italy. The system is composed of operation centres, a network of stations for ambulances, equipped cars with physicians and nurses, and some helicopter ambulances. The operational centres are active 24 hours a day, and nurses triage patients on the basis of information collected during phone calls, sending the rescue vehicle suitable for each case. Once the location of the intervention is reached, the rescue team decides the best referral hospital on the basis of the care needed, facilitated by radio communication systems. Voluntary associations such as the Italian Red Cross manage the network of vehicles and each region and autonomous province may define the lead time allowed for the rescue. For instance, in the region Emilia Romagna, according to the agreed standard, the 118 system has to guarantee that rescue vehicles arrive within 8 minutes in urban areas and within 20 minutes in rural areas. In the same region, major traumas are managed by a hub and spoke network.

As far as ICUs are concerned, the only census available was made by the As sociazione Anestesisti Rianimatori Ospedalieri Italiani (AAROI) in 2005. According to that, there were 3774 ICU beds in the country with wide variability among regions, due to the number of inhabitants.

Total expenditures for Region and Auto nom ous Provinces Health Services in 2006 was 98,682,688 billion euros, with an increase of 9.55% in comparison with 2004 expenditures.

Moreover, there are contracts and agreement protocols with universities for research, education and training.

Residents of the Specialisation School in Anaesthesia and Intensive Care (in Italy both disciplines are in the same Specialisation School) regularly attend the Intensive Care Units of the hospitals of the regions and autonomous provinces.

Published on : Thu, 15 Aug 2013