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### **Overview of the National Health System in Italy: Reforming the System**

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**The Italian National Health Service (Sistema Sanitario Nazionale, SSN) was established in 1978, almost thirty years later than the system in the UK, replacing the previous system of state and professional insurances introduced after 1945. The aim of the SSN is to provide a uniform health system for the whole population without distinction as to social status, income or contributions, based on the principles of the Italian Constitution Chart (art. 32).**

#### **Introduction**

The introduction of the SSN has been particularly difficult in the adaptation of the Italian health system to the standard of most advanced western countries. Particularly relevant was the transformation from a “curative” into a “preventive” and “rehabilitative” system, which was a major improvement, with respect to the previous insurance system. The SSN provides the majority of healthcare in Italy, from general practitioners to Accident and Emergency Departments and longterm healthcare.

It is based on public funding, although health budgeting and financing have been slightly changed in the last 15 years due to the introduction of still-in-progress reforms.

SSN services are “free at the point of delivery” and patients do not pay for them when they use them. This is similar to what most European National Health Systems (NHS) provide (e.g. UK, Netherlands, Spain, Portugal, Sweden, Austria, Denmark, Finland, etc.), though different from the United States and Japan where a “compensation for expenses” principle is used (patients usually pay first for the services delivered and are later reimbursed).

## **Financing the System**

Financing is almost completely realised through both general taxation and by employers' and employees' contributions (about 50% for each, respectively). The national government (and specifically the Ministry of Health, supported by the National Health Council) is in charge of political planning, regulation and supervision, but the main administrative level is regional: the twenty Italian regions are responsible for implementing central decisions and for providing health services through the operational activity of Health Units distributed at the municipal level, providing health services (primary care, prevention, education, provision of occupational services, etc.) and coordinating between hospitals.

## **Reforming the System**

Since the beginning, the SSN has faced some relevant problems common to other national health systems; difficult expense containment, reduced efficiency and inappropriate use of resources. Mainly, most of the public funds were used for financing public hospitals or public health units, thus creating a sort of short-circuit effect contributing to inefficiency of the whole system.

Between 1992 and 1996, an important reform has been introduced, both administrative and financial. A more pronounced "regionalisation" has been supported for financial aspects and, more importantly, for tax imposition, together with autonomy of regions in terms of health regulation and organisation. According to acts DL 502/92 and DL 517/93, the central government is in charge of the health national planning, determination of uniform care levels, financing models, criteria and quality standards ("chart of services"). Health units and public hospitals are converted into companies and management as well as cost/benefit models are largely introduced. Hospitals are financed on a DRG (Diagnosis Related Group) basis. Moreover, the role of possible private operators is improved through the introduction of the so-called "accreditation", on the basis of minimal law requirements, which opens for patients the possibility of choice among several possible providers of services.

## **Further Reforms**

In 2001, (Law 405, 16 November 2001), following an agreement between central and regional governments, a further evolution of the reform was introduced. It ratifies the autonomy of regions in terms of management of health expense and taxation, according to the so-called "devolution" and "subsidiary" principles. An important counterbalance to this change, potentially in conflict with the recalled principle of territorial equity, was the introduction of the "Essential Levels of Care" (Livelli Essenziali di Assistenza), which has even been inserted in the recent modification of the Constitution Chart (October 2001), e.g. "levels of care to be guaranteed to all citizens" which have to be determined by the State. True private healthcare role is limited and mainly financed through private insurance companies.

## **Radiology in the Health System**

Within the described scenario, radiology is performed on a service basis, mainly in public hospitals or in health units, or in accredited private centres. There are several reference laws, the most important being 187/2000, which enforces the 97/43 Euratom Directive "on health protection of individuals against the dangers of ionizing radiation in relation to medical exposure". Radiology, and diagnostic imaging at large, suffer the same limitations as for the whole SSN, i.e. expense increase, relative shortage of resources, increase of the so-called "waiting lists".

Although appropriateness and justification assessments in radiological practice are up to the radiologist, the lack of common knowledge and sharing of protocols and guidelines in prescription, together with a rigid separation between clinicians and radiologists, contributes to a relative inefficiency of diagnostic imaging. The government and several scientific societies (i.e. the Italian Society of Radiology, SIRM) are presently strongly

committed to publishing guidelines in order to define the range of appropriate use of diagnostic tests, according to the concepts of evidence-based medicine and radiology and costeffectiveness, due to the needs of governance of healthcare today.

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