An overview of the Italian NHS, the Veneto Region and its Health Care System

Palazzo Balbi - Dorsoduro 3901
30123 Venezia
Tel. +39 041 2792863 - 2864
Fax. +39 041 5242524
E-Mail: presidente@regione.veneto.it

The Official Veneto Region Website: www.regione.veneto.it

The Italian National Health Care System
Fiscal federalism and the decentralization of the NHS to the Regions

1. The Evolution taking place in the Italian Health Service – the process of delegation or “aziendalizzazione”.

Italy’s health care system is a regionally based national health service, organized at the national, regional and local levels, providing universal coverage free of charge at the point of service. The national level is responsible for ensuring the general objectives and fundamental principles of the National Health Care System. Regional governments, through regional health departments, are responsible for ensuring the delivery of a benefit package through a network of population-based health management organizations (local health units) and public and private accredited hospitals. The 1978 reform law assigned an important role to municipalities which were in charge of governing the local health units. From the late 1980s a series of reforms progressively shifted municipal powers to the regional level.

Legislation of the early 1990s (with particular reference to legislative decree n.502/92) meant a significant transfer of power from the State to the Regions, which in turn were granted the freedom to decide on how to spend their health care budget allocation, as well as on how to organize the health care system within the framework of the National Health Plan, in line with the essential levels of health care provision. During that decade, the NHS underwent a process of delegation or “aziendalizzazione”. All local health units as well as tertiary hospitals were transformed into autonomous bodies. The delegation process was based on a more general set of structural changes aimed at introducing managed competition among public and private (accredited) providers. A network of public and private health structures and providers began to emerge at the local level, categorised as follows: local health units (ULSS or LHUs) which operate on a more territorial level, acting as both “providers” and “purchasers” of health care services, and responsible for the management of hospitals, districts and the GP network; public hospital trusts (azienda ospedaliera), which are “providers” of health care services only and include university teaching facilities; national institutes for scientific research (IRCCS); and private accredited providers.

Local health units provide care directly through facilities or through services rendered by public hospital trusts, research hospitals and accredited private providers (acute and long-
term hospitals, diagnostic laboratories, nursing homes, outpatient specialists and general practitioners). These are governed by a general manager appointed by regional health departments based on qualifications and technical skills. Under this new governance model, the local health units and the public hospital trusts have been given greater financial and decision-making autonomy, and top management teams have acquired greater responsibility for the effective management of resources and the quality of services delivered. Consequently, a “market” approach has clearly emerged within the Italian health care system as distinctions are made between the “purchaser” and the “provider” of health care, thereby engendering competition between public and private services, as well as among public services.

2. Fiscal federalism, and the decentralization of the NHS to the 20 Italian Regions.

Essentially, decentralization of the NHS to the twenty Italian regions is linked to a process geared towards embracing the concept of fiscal federalism, as well as the rationalization of the health care budget. The result of Reform Laws of the 1990s paved the way for a process of decentralisation and political devolution with a view to investing local authorities (regions, provinces, municipalities, and local health units) with greater autonomy in planning, funding, organizing and delivering services to citizens. Provided there is effective co-operation at every level of authority to integrate health and social services and to work closely with local health units, money can be better spent, and an improved quality of services offered. The Veneto Region, for example, has accelerated a process of integration between its health and social sectors, and continues to foster effective co-operation with provincial, and municipal authorities and LHUs.

In the mid 1990s, a Permanent Conference of the Presidents of the Regions and of the Autonomous Provinces was set up between the State, the regions, and the autonomous provinces with the aim of promoting co-operation among them. In fact, the regions were soon to become models par excellence of a federalist state in the making, invested with greater responsibility for budget allocation as well as autonomy in making key decisions on how the health care system should be organized and structured. This legislative and political body led to newly defined roles of the State and of the regions.
Annually convened meetings began to generate tensions due to the inherently diverse range of perceptions on the part of the State, and on the part of the regions as regards the cost of managing the health care system: according to the State’s perspective, the regions are entitled to their share allocation from the National Health Fund based on needs evaluations and analyses carried out at the central level. From a regional perspective, however, perceptions about the financing of the health care system differ widely: more often than not, the regions consider their budget allocation to be totally insufficient to meet the real costs of running their regional health care systems.

Negotiations taking place within the Conference of Presidents of the Regions paved the way for the signing on August 8th, 2002 of a Stability Agreement between the Italian State and the regions which set out the unequivocal rules for health care system management. Most importantly, a platform was set up for ongoing political and technical negotiations between the State and the regions. In fact, as far as the mechanisms of health service reform are concerned, Italy has always adhered to the tradition of negotiations in constant progress, both on an institutional and a political level.

Over the past decades, important developments in legislation have been taking place in the way the NHS in Italy is financed. There has been a move from a centrally-funded, tax-based system to a system financed by the 20 Regions and two Autonomous Provinces. This has implied that tax contributions normally allocated to the National Health Fund have been re-distributed horizontally between the Regions and decided on the basis of a common agreement, and not on the basis of the central power of a higher jurisdiction. Moreover, the concept of accountability of the regions has been reinforced with the introduction of further Stability Agreements, whereby regions and local authorities endeavour to streamline, cut costs, and reduce deficits. The phrase “Chi sbaglia, paga” (“you err, you pay”) was readily coined by government ministers meaning that at every level of government - from central to regional, to provincial to municipal - there would be direct accountability for direct and indirect debts.

3. Challenges posed in allotting funds to the Regions and ensuring the ELHC
It was the Reform of the 5th Chapter of the Italian Constitution (November, 2001) that really brought home to policy makers the urgent need to define criteria for establishing the essential levels of health care provision (ELHC). Under this Reform, the State would guarantee exclusively the determination of the ELHC as regards civic and social rights, whereas areas pertaining to human health would fall within the legislative and concurrent authority of the Regions.

It is also widely acknowledged that the Italian regions are faced with a reduction in the budget allocation to regional health services. An imbalance between resources allocated and real needs among the regions has also been witnessed, leading to the application of new prescription charges (“ticket”) and to modifications of the surcharge on the personal income tax (“IRPEF”). The average budget (or quota) per capita (“quota capitaria di finanziamento”) represents the national mean value per-person needed to finance the essential levels of health care. Given the existing regional economic imbalances, differences in demographic and health indicators are particularly marked in the Italian regions. Criteria have so far been selected according to the size of the resident population, to levels of consumption of goods and services, to age and sex, to death rates, and to contextual and epidemiological health indicators. Much cause for concern remains about the capacity of health care systems to guarantee citizens’ equal rights of access to health care across the Italian Regions, and to ensure greater homogeneity in the ELHC provision.

The process of estimating the ELHC in the Regions presents challenges, especially when attempting to identify indicators capable of quantifying health care needs, be they human, technological, or structural. These indicators take into account: demographic characteristics; the costs of health care services; the constant ageing of the regional population; modifications in disease patterns in terms of incidence; a prevalence towards chronic illnesses (degenerative, cardiovascular and neoplastic); the emergence of new types of diseases; and continuous technological development (scientific innovation, improved diagnostic techniques, and the implementation of biomedical technologies) which implies increased costs for regional health care systems. A new factor which has to be taken into account when defining health indicators is the growing needs of the immigrant population in Italy (mainly from Eastern Europe, N. Africa, the Middle East and
Asia), which is on the increase due to the phenomenon of globalization, and the health care needs of European citizens on the move within the EU for purposes of business and tourism.

4. **Future perspectives for decentralization in Italy.**

The process of decentralization of the Italian Health Service will hinge on five main areas: greater rationalization of the health and social care network, i.e. hospices, residential and care homes, home care; the drafting of a regional health service plan with emphasis on the renewed regional role in the social services sector; the reinstatement of local health authority territories together with the development of a regional government structure; financial re-adjustment of the institutional and hospital trust model; and the promotion of health care integration with particular emphasis on policies of prevention.

The streamlining and downsizing of hospital services will be the first in a series of co-ordinated actions to unfold in the Italian regions. In line with the current National Health Plan adopted by the Regions, the revision of hospital services will imply the adoption of the standard of 4.5 hospital beds per 1000 inhabitants for the entire nation and a reduction in health care expenditure from 50% to 45.5% over the next 3 years.

The theme of the rationalization of the health care budget will continue to be a major priority for policy makers. Advances in technology, know how, new therapeutic approaches, and innovative medical treatment will inevitably lead to increased costs, but will also imply an improved efficiency and quality of the system. With this in mind, some regions have set up regional health care agencies which corroborate with academic bodies to analyze and perform surveys on the use of resources, as well as carry out methods of management control and institutional accreditation.
The Veneto Region

1. The territory, the economy and the population.

The Veneto Region is situated in the North-East of Italy and is part of an important border area linking it to Austria and Slovenia, with a mountainous zone lying to the north and a 120 km coastline to the South. The Veneto Region is divided into 7 provinces covering an area of 18,390.7 Kmq, and has 4.6 million inhabitants with an average population density of 252.5 per kmq.

Demographic patterns are characterized by a continuous and constantly increasing resident population, thanks to well established and ever growing population settlements. The over 65 group amounts to 16% of the population of whom 2.3% have reached 80 or over. The index for the elderly stands at 135.7 standing above the national Italian average (133.8).

The Veneto region shows immigration rating above national standards, and migratory levels towards foreign countries stand at 50,455 individuals for the year 2003. The number of foreigners resident in the Veneto is 153,074 (Census 2001), with the highest
The Veneto Region is an autonomous territorial organization with legislative powers which, together with the other nineteen Regions, the State and the Autonomous Provinces, make up the Italian Republic. It is situated in the north-east of Italy and has a population of almost 4.88 million or 7.7% of the total Italian population. The Veneto Region is a rich, industrialised and highly developed one. The regional capital is Venice and its major cities are Verona, Vicenza, Padua and Treviso. Veneto is currently the Region which coordinates health matters for all twenty Italian Regions and it is a leading light in Italian reforms.

As decentralization of health and health systems increases so Regional authorities are playing a greater part in improving health status. Veneto is at the forefront of efforts to ensure the regional perspective is taken into account in national and European policy-making and that empirical evidence and analysis reaches both national and sub-national stakeholders and policy-makers. It is involved in the area of hospital reform; with purchasing, payment systems and contracting as tools for restructuring; and in comparing health care systems across European Member States as a way of improving the health of their citizens.

Veneto is also one of Europe’s most vocal Regions in the area of health. It plays a leading role in the EU and in research and policy development; is at the heart of the Regions for Health network; and supports other Regions across Europe. It has been particularly active in addressing the implications for Regions of an ever closer Europe and in exploring responses to the sometimes competing challenges of an enlarged Europe, with its greater freedom of movement for patients and health workers, and the theme of decentralization.
2. Politics

The Politics of Veneto takes place in a framework of a parliamentary representative democracy, whereby the President of Regional Government is the head of government, and of a pluriform multi-party system. Executive power is exercised by the Regional Government. Legislative power is vested in both the government and the Regional Council. The constitution was promulgated on 22 May 1971. Once a stronghold of the Christian Democracy, Veneto was a stronghold of the centre-right House of Freedoms coalition, which had governed the region since 1995, under President Giancarlo Galan (Forza Italia). After recent regional elections at the end of March 2010, Veneto has voted for a new President Luca Zaia representing the centre-right party called the Lega Nord or Northern League. During these elections the Northern League gained 60.1% of the votes, representing by far the strongest party in the region since Forza Italia in previous elections.

Veneto is also home for Venetism, a political movement that appeared during the 1970s and 1980s, demanding autonomy for the region, considered as a nation separated from Italy, and promoting Venetian culture, language and history. This is the political background in which the Liga Veneta (leading autonomist party, founding member of Lega Nord in 1991) was founded in 1979.

3. Legislative authority

The Veneto Region is an autonomous, territorial organization invested with legislative powers which, along with the other nineteen Italian Regions, the State and the Autonomous Provinces, make up the Italian Republic. The twenty Italian Regions, five of which have a special statute, were instituted by the Constitution in 1948. Radical modifications applied to the Constitution by constitutional laws have granted the Regions statutory autonomy, as well as new and broader legislative powers.
4. The Veneto Regional Health Care System

Italy’s national health care system is funded mainly through general taxation. Structurally, it is a regionally based health service that provides universal coverage free of charge at the point of service. The system is organized at three levels: national, regional and local. The national level is responsible for ensuring the general objectives and fundamental principles of the national health care system. The parliament approves the legislative framework which lays out the general principles for organizing, financing and monitoring the NHS. In particular, a 3-year National Health Plan prescribes the principles according to which the whole NHS has to be organized (principles of human dignity, the health requirement, equity, protection, solidarity with the most vulnerable people, the effectiveness and appropriateness of health interventions, and cost-effectiveness of such health interventions).

Regional governments, through the regional health departments, are responsible for legislative and administrative functions, planning health care activities, and ensuring the delivery of a benefit package. The local level, with a network of population-based health management organizations and public and private accredited hospitals provide the health care.

As regards the regional health system, the Veneto Regional Government, like most other regional governments, is responsible for legislative and administrative functions:

**Legislative functions:** the legislative power devolved to the regions is shared between the regional council and the regional government. Regional legislation should define:
- the principles for organizing health care providers and for providing health care services;
- the criteria for financing all health care organizations (public and private) that provide services financed by the regional health departments;
- the technical and management guidelines for providing services in the regional health departments, including assessing the need for building new hospitals, accreditation schemes, and accounting systems.
**Administrative functions:** these aim to plan health care activities, organize supply in relation to population needs, and monitor the quality, appropriateness and efficiency of the services provided.

Regional governments, mainly through their respective departments of health, draw up a 3-year Regional Health Plan. Regional governments use this plan, based on both the National Health Plan indications and on the assessed regional health care needs, to establish strategic objectives and initiatives, together with financial and organizational criteria for managing health care organizations (allocating resources; coordinating health care activities; monitoring the efficiency, effectiveness and appropriateness of the services; appointing the general managers of local health units).

**5. The organizational structure**

The regional level provides health and social services to the resident population through the so-called Local Level, a network of population-based health care organizations (Local Health Authorities) and public and private accredited hospitals. In the Veneto region the health care system is made up of:

- **21** Local Health Authorities (LHA);
- **2** Hospital Trusts: (Az.Ospedaliera di Padova and Az.Ospedaliera di Verona);
- **1,076** Specialist health care service providers (approx. 65 million service provisions/year);
- **1,307** Territorial Pharmacies;
- **3,600** General Practitioners;
- **250** Residential homes for the elderly (for approx. 22,000 patient beds, both for self-sufficient and non-self-sufficient patients).

The number of hospital beds in the public health system is **19,429** (85.85% of the regional total) with 3,470 private hospital beds, (15.15%) [2007 data]. Health costs in the Veneto are estimated at 5.05% of the gross regional product, with costs per capita running at € 1,149.5.
On a general level, this network of public and private health care facilities and providers is operating at the local level and can be divided into four different categories: Local health Authorities (LHA), which are geographically based organizations responsible for assessing needs and providing comprehensive care to a defined population. Public hospital trusts, which have a national or at least an interregional catchment population and are financially and technically autonomous, and provide highly specialized tertiary hospital care (inpatient and outpatient).

National Institutes for Scientific Research (IRCS), are research-oriented hospitals operating at the local level. They are distributed all over Italy, and are financed directly by the Ministry of Health which also appoints their general managers. In addition to research funding, the Institutes receive a global budget that covers inpatient and outpatient care and specific health care services, such as intensive care and transplants.

Private accredited providers deliver ambulatory, hospital treatment, and/or diagnostic services financed by the NHS. The regional health departments regulate this participation through the authorization and accreditation system. Authorization for construction of health care facilities is required for:

- acute hospitals providing inpatient and day-hospital care;
- ambulatory care environments (including rehabilitation and laboratory diagnostics);
- centres providing residential care and social care.

Authorized organizations can receive public funding after having been accredited by the departments of health. Accreditation is subject to a number of structural, organizational, and technological prerequisites defined at the regional level.

The basis of the health care system are the Local Health Authorities (LHAs) which also represent the most important purchasers and providers of health care in Italy. They are responsible for managing contracts with GPs and directly manage polyclinics, hospitals and other healthcare and social service outlets, health promotion, and for prevention of communicable diseases in the area they cover. LHAs directly manage acute care and rehabilitation hospitals and provide hospital-based
acute inpatient, outpatient and rehabilitation care. These hospitals usually provide only secondary care. Physicians in these hospitals are salaried directly by the local health unit.

Health promotion divisions are responsible for health promotion, preventing the spread of infectious and other diseases, promoting community care and enhancing people’s quality of life. These divisions also provide services for controlling environmental hazards, preventing occupational injuries, and controlling the production, distribution and consumption of food and beverages.

The Local Health Units, as well as the Hospital trusts, are managed by a General Director who is appointed by the Regional Government. Each LHA is divided into Health districts. They are geographical units, responsible for coordinating and providing primary care, non-hospital-based specialist medicine and residential and semi-residential care to their assigned populations. The number of districts in each local health unit depends on its size and on other geographical and demographic characteristics. The district’s physicians provide home care services and preventive services for drug addicts and people with terminal AIDS. Primary care physicians, paediatricians and other specialists are requested to provide these services as independent contractors to the local health units. GPs are paid mainly by capitation.

According to Legislative Decree 229/1999 and Law 662/1996, local health unit services are financed under a global budget with a weighted capitation mechanism. The global budget is also adjusted according to historical spending, and additional compensation is given for cross-boundary flows, which vary significantly from region to region and within each region. Hospital providers are paid fees for services based on diagnosis-related groups for inpatient activities through various mechanisms for outpatient and other specific health care services, such as intensive care, transplants and chronic patient management.

6. The Veneto Region: a tourist destination

The Veneto Region is intrinsically linked to the seafaring and trading past of the Venetian Republic. The Region holds a strategic, geographical position as it looks out
towards Central and Eastern Europe, and boasts an open attitude towards different peoples and cultures. Consequently, the concept of the tourist resort, be it the Dolomites, the Adriatic Sea, Lake Garda, or the Cities of Art, is a way not only of making financial gains, but also represents an artform, even today, as trading did all those centuries ago during the “Serenissima” Republic of Venice.

The Veneto region, in view of its popular appeal as a tourist destination, may be considered a case study as far as European health care mobility is concerned. The heavy flow of tourists brings with it a series of health care issues which the regional health care services are forced to deal with through specific organisations serving to guarantee the health of European citizens, temporarily resident abroad. These citizens/patients in the event of any medical emergency, having gone beyond their own national borders for reasons of travel or work, find themselves faced with a spectrum of largely differing health services.

The aim of an important European Project entitled “Europe for Patients” was to describe, quantify and analyse the phenomenon of tourism in the Veneto Region, to take a closer look at how this affects three Local Health Authorities (LHA): **LHA 10 in “Eastern Veneto”,** targeted by seaside tourism, **LHA 12 “Veneziana”** characterized by tourism based around both the seaside and the cultural magnet of Venice, and **LHA 22 at “Bussolengo”** targeted by lake tourism.
References

**Anselmi L.**, Accountability, a fundamental need in modern and democratic public administrations (unpublished paper)


**Related link:**

Patient Mobility in the European Union. Learning from experience, European Observatory on Health Systems and Policies.

http://www.euro.who.int/observatory/Publications/20060522_4