

The Italian Health Care System: W.H.O. Ranking Versus Public Perception

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The World Health Organization (WHO) in World Health Report 2000 ranked the Italian health care system second among 191 countries (France was first) with respect to health status, fairness in financial contribution, and responsiveness to people's expectations of the health system.¹

The U.S. health care system, which spends more per person on health care than any other country, was ranked 37th, last among industrialized countries.¹ The WHO report, based on measures developed by public health experts, has been strongly criticized because neither individual experience nor overall public satisfaction with health systems was used in the evaluation;² nevertheless, it raises crucial questions. What makes the Italian health care system so appealing? What important health outcomes has the Italian health system accomplished? And what perceptions and expectations does the Italian population have of its health system? With this overview of the Italian health care system, we will try to answer these questions. By describing the socioeconomic and political issues of the country, we will illustrate the principles on which the Italian health system is grounded, examine its structure and organization, and define achieved health care outcomes. Finally, focusing on the results of recent surveys aimed at assessing population satisfaction we will discuss the main issues raised by the current Italian health care policy.



would dramatically raise the prevalence of chronic diseases and subsequently the need for health services. Considering that the national public health system is financed by general taxation, a reduction of the active labor force could have a major effect on the availability of funds and resources.

Italy, one of the founding members of the European Union, is a parliamentary democracy with a growing decentralization of power to its 20 regions. Each region has directly elected governments with wide legislative and administrative powers. A major political issue in Italy is an increasing socioeconomic regional disparity. For instance, whereas many areas in the South are extremely poor, some north-central regions have per capita incomes one and a half times the national average, which in 1999 was \$20,170 in U.S. dollars (U.S. \$).³ This disparity is even more evident with regard to the unemployment rate: in 2000, the average rate in the northern regions was 5.4%, whereas it peaked at 22% in the south.⁴

The two most widely used measures to assess health care outcomes—life expectancy and infant mortality—indicate that Italy has a very healthy population. Life expectancy at birth has increased over the last 20 years. In 1999, the average life expectan-

THE COUNTRY AND ITS PEOPLE

In 2000, Italy had a population of 57.7 million people, densely distributed in a land area three quarters the size of California, which had only 33.8 million inhabitants (Table 1). The Italian population's structure has changed over time; its most striking feature is the decline in the younger age groups. The World Bank 2000 Report shows 1.2 births per woman, the lowest total fertility rate in the world.³ Consequently, the birthrate has fallen well below replacement levels. Based on current trends, it is estimated that (excluding immigration) the population will decrease 3% by 2020, and 20% by 2050.⁴ Moreover, the population is aging at an accelerated rate. Recent research has confirmed that the speed and intensity of the aging trend in Italy is the highest in the world.⁵ The number of citizens over age 60 could rise from 24.2% in 2000 to 46.2% in 2050, which would have an enormous impact on health care resources, as well as on the entire health system. An increased number of elderly

Table 1 Italy and the United States: Country Profiles

Indicators	Italy	U.S.
<i>People</i>		
Population (millions)	57.7	278.2
Surface area (sq. km)	301,338	9,370,000
Population growth (annual %)	0.1	1.2
Population density (people per sq. km)	196	30.4
Urban population (% of total)	66.9	77
Life expectancy at birth - male (years)	75.8	73.8
Life expectancy at birth - female (years)	82.0	79.7
Fertility rate (births per woman)	1.2	2.1
Infant mortality rate (per 1,000 live births)	5.4	7.2
<i>Economy</i>		
Gross Domestic Product (current U.S.\$)	1.2 trillion	9.2 trillion
Gross National Income per capita (current U.S.\$)	20,170	31,190
Unemployment rate (percent)	11.4	4

Source: Adapted from the following databases: 1) World Health Organization;¹ 2) The World Bank Group;³ 3) ISTAT-Istituto Nazionale di Statistica;⁴ 4) National Center for Health Statistics;⁵ 5) Bureau of Labor Statistics.³⁸

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cy was 75.8 years for men and 82 years for women.⁴ With a considerably larger reduction over the last 10 years, the infant mortality rate within the first year per 1,000 live births was 5.4 in 1999 (Table 1).³ In addition, when asked in the early 1990s how they perceived their state of health, 78% of Italy's adult population defined it as "good", 17% evaluated it "fair", and only 5% rated it "poor."⁶ However, efficiency and effectiveness of the health care system reflects the regional differences. Health services are commonly better in the north and center of the country than they are in the southern regions, both in terms of quality and quantity.⁷

ORGANIZATION OF HEALTH CARE

The extension of universal health care coverage to the whole population is a key characteristic of the Italian health care system. Mandatory health insurance was established in 1943. This system was replaced in 1978 by the institution of the Italian National Health Service (NHS), Servizio Sanitario Nazionale.⁸ The NHS was created to achieve the objective in article 32 of the Italian Constitution, which declares that the Italian state has the responsibility of safeguarding the health of each citizen as an individual asset and a community interest. Moreover, article 32 affirms that the Italian state guarantees free care to the indigent.

The Italian NHS follows a model similar to that developed by the British National Health Service in that it provides universal health care coverage throughout the Italian State as a single payer. However, the Italian NHS is more decentralized, because of a recent strong policy of *devolution*, which shifts power to the regions. National legislation from 1992 to 1993 and subsequent reforms in 1997 and 2000 have radically transformed the NHS, giving the 20 regions political, administrative, and financial responsibility regarding the provision of health care.⁹ The Italian state retains limited supervisory control and continues to have overall responsibility for the NHS to assure uniform and essential levels of health services across the country.⁹

The basic principles underlying the Italian NHS are presented in Table 2. Universal coverage entitles all citizens, regardless of their social status, to equal access to essential health care services, services that are necessary and appropriate to promoting, maintaining, and restoring health in the population (*universalism*).¹⁰ Essential health services are provided free of charge, or at a minimal charge, and include general medical and pediatric services; essential drugs and those for chronic diseases; treatments administered during hospitalization; rehabilitation and long-term post-acute inpatient care; instrument and laboratory diagnostics, as well as other specialized services for early diagnosis and prevention. Finally, the NHS guarantees that the system is subject to popular democratic control at the national, regional, and local level (*participation*).¹⁰ The Italian NHS is structured into three different levels of public authority: the central government, the regions, and the local health care agencies (LHAs)—Agenzie Sanitarie Locali.

THE CENTRAL GOVERNMENT

As the main organization of the NHS,¹¹ the Ministry of Health is responsible for national health planning, including general aims

Table 2 The Italian National Health Service Principles

Human dignity: Every individual has to be treated with equal dignity and have equal rights regardless of personal characteristics and role in society.

Protection: The individual health has to be protected with appropriate preventive measures and interventions.

Need: Everyone has access to health care and available resources to meet the primary health care needs.

Solidarity: Available resources have to be primarily allocated to support groups of people, individuals and certain diseases that are socially, clinically and epidemiologically important.

Effectiveness and appropriateness: Resources must be addressed towards services whose effectiveness is grounded and individuals that might especially benefit from them. Priority should be given to interventions that offer greater efficacy in relation to costs.

Equity: Any individual must have access to the health care system with no differentiation or discrimination among citizens and no barrier at the point of use.

Source: Ministry of Health of Italy.⁸

and annual financial resources to be spent on health, and rules the commercialization of drugs and medical equipment in accordance with the European Union regulations.¹² In addition, the Ministry of Health is responsible for monitoring and taking measures to improve the health status of the population and assure a uniform level of services, care, and assistance to the population. The Ministry of Health also negotiates and monitors the labor contracts of medical and paramedical NHS personnel.¹³

The Regions

Recent national legislation has transferred several important administrative and organizational responsibilities and authority from the central government to the 20 regions. These measures, the results of which are still unclear, aim to make the regions more sensitive to the need for controlling expenditures and promoting efficiency, quality, and citizen satisfaction. The 20 regions define a regional plan in accordance with central government guidelines.¹² Regional activities must be covered by regional laws approved by Parliament, although these laws may vary from one region to another. The regions have significant autonomy on the revenue side of the regional health budget, and are required to fund any deficit that might occur from their own resources, beginning with the 1992–1993 reforms.⁹ The regions organize services that are designed to meet the needs of their specific populations, define ways to allocate financial resources to all the LHAs within their territories, monitor LHAs' health care services and activities, and assess their performance.¹⁰ In addition, the regions are responsible for selecting and accrediting public and private health services providers and issuing regional guidelines to assure a set of essential health care services in accordance with national laws.¹³

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The Local Health Agencies

The LHAs form the basic elements of the Italian NHS. In 1998, there were 196 LHAs in Italy providing health care services to the population.⁸ Each LHA is financed from its region under a global budget with a weighted capitation system (see the NHS financing system section).⁹ In addition, in 2000, there were 98 public hospitals qualified as “hospital trusts.”⁹ Hospital trusts work as independent providers of health services and have the same level of administrative responsibility as LHA.⁸

Based on criteria of efficiency and cost–quality, the LHAs might provide care either directly, through their own facilities (directly managed hospitals and territorial services), or by paying for the services delivered by providers accredited by the regions, such as independent public structures (hospital agencies and university-managed hospitals) and private structures (hospitals, nursing homes, and laboratories under contract to the NHS).¹⁴ Patients can freely choose among the public or accredited private providers. They can also choose to be treated either in the LHA in the area where they reside or in another LHA; if they choose the latter, the cost of care will be paid by the other LHA.¹⁵ Therefore, LHAs operate simultaneously as a payer and a supplier of services, and patients’ choices of providers might indirectly affect the services delivered. These two elements, introduced by recent reforms, create a model in which providers, regardless of public or private status, are expected to compete on cost and quality, and the NHS, through the LHAs, acts as a third-party payer, creating what is called a *quasi-market*.¹² The purpose of a quasi-market is to make the LHAs more accountable for the provision of services.¹³ Indeed, by law, the LHAs must guarantee the quality of all services directly delivered or externally acquired, as well as control the overall expense, so that it does not exceed the budget.¹⁴

The LHAs must ensure three levels of care planned by the central government and reported in the National Health Plan: community health care at home and at work, district health care, and hospital care.¹⁶ To provide these levels of care, each LHA has three main facilities: one department for preventive health care, one or more directly managed hospitals, and one or more districts.¹⁶ Through the districts, the LHAs provide primary care, ambulatory care, home care, occupational health services, health education, disease prevention, pharmacies, family planning, child health and information services.¹⁶ Each LHA is governed by a general director, who is appointed under private contract by the president of the government of the region. The contract is renewable every five years. The general director has full autonomy in terms of organizational, administrative, financial, accounting, managerial, and technical responsibilities, but must operate within the limits of the yearly health budget determined by the regional government.¹⁷

Health Care Services

The Italian NHS is a huge organization with almost 650,000 employees, over 1,000 hospitals, and 16,000 ambulatory facilities. It also relies on private accredited health structures and

Table 3 Organization of the Italian Health System

Total number of NHS employees	642,000 ^c
Number of public hospitals in the NHS	942 ^c
Number of private accredited facilities	537 ^a
Number of General Practitioners (GPs)	54,510 ^b
Pediatricians	5,687 ^c
On-call Physicians	18,000 ^c
Physicians working in hospitals	95,000 ^a
Practicing physicians per 1,000 inhabitants	5.5 ^c
GPs per 1,000 inhabitants	1.0 ^b
Nurses per 1,000 inhabitants	5.3 ^a
Health personnel per 1,000 inhabitants	11.2 ^a

Source: Adapted from the following databases: 1) Ministry of Health of Italy;^{8,18,19} 2) Mapelli V. Il sistema sanitario italiano;¹⁴ and 3) OECD.²⁴
Key: a=1997; b=1998; and c=1999.

different types of health professionals under contract with the NHS (Table 3).^{14,18} The Italian NHS provides free primary care, hospital care and community health and hygiene, including diagnosis, treatment, and rehabilitation, as well as prevention, health promotion and educational activities. Primary health care is provided mainly by general practitioners (GPs) and pediatricians, and on-call physicians (Guardia Medica) for after-hours medical care and services. All of these professionals work within the LHA districts, which also include home care and pharmacies.⁸

In addition to providing primary care, GPs and pediatricians act as “gatekeepers” for the system, assessing the needs of citizens, prescribing pharmaceuticals, ordering diagnostic procedures, and referring patients to specialists and hospitals. Each LHA resident is required by law to enroll with one of the LHA’s GPs or pediatricians, who has completed a two years of postgraduate training specific to his/her duties within the NHS.¹⁵ The services of the GPs and pediatricians are free at the point of use, and the relationship between patient and GP/pediatrician can be terminated by either party at any time if it is considered unsatisfactory.¹⁵ GPs and pediatricians are paid on a capitation basis with a maximum of 1,500 patients per GP and 1,000 per pediatrician.^{18,19}

There are 3,036 Guardia Medica stations employing about 18,000 doctors in Italy (Table 3).⁸ On-call physicians are available during holidays, nights and weekends, providing after-hours medical care and services when GPs and pediatricians are not available. As NHS employees, on-call physicians are not allowed to take extra contracts. If necessary, on-call physicians refer patients to hospitals. Alternatively, patients may go directly to the hospital emergency departments.

Hospitals provide inpatient care for conditions that cannot be effectively treated on an outpatient basis. Hospital services are free or at nominal charges at the point of use, and four basic services—general medicine, surgery, pediatrics, and gynecology—are available in most general hospitals.¹⁹ Physicians working for

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Table 4 Hospital Structures in Italy and in the U.S.

	Italy	U.S.
Total inpatient care beds	335,000 ^b	1,010,000 ^c
Total inpatient care beds per 1,000 inhabitants	5.3 ^d	3.7 ^c
Public inpatient care beds	263,000 ^b	304,000 ^c
Public inpatient care beds per 1,000 inhabitants	4.6 ^b	1.3 ^a
Total acute care beds	296,000 ^b	842,000 ^c
Total acute care beds per 1,000 inhabitants	5.2 ^b	3.1 ^c
Private accredited beds per 1,000 inhabitants	1.0 ^d	2.7 ^a
Inpatient care occupancy rate (%)	77.5 ^b	65.4 ^c
Average inpatient care length of stay (days)	7.0 ^d	8.0 ^c
Public staff per occupied bed (acute care)	2.1 ^b	4.5 ^c
Nurse per occupied bed	1.0 ^d	1.3 ^c
Nurse/physician ratio	2.6:1 ^d	NA

Source: Adapted from the following databases: 1) Ministry of Health of Italy^{8,18,19}; 2) Mapelli V. Il sistema sanitario italiano¹⁴; 3) OECD²⁴; 4) Health Care Financing Administration (HCFA).³⁹
Key: a=1996; b=1997; c=1998; d=1999; and NA=not available.

NHS hospitals are paid by salary. However, there are some adjunct specialists for inpatient and outpatient services under contract within the NHS that are paid by fee schedule established by the regions.¹³ Italy ranks in the middle among European countries in the number of available hospitals and beds,⁸ with slightly more than the U.S. (Table 4). The hospital beds in public health facilities are not evenly distributed among Italian regions. Southern regions have fewer than 4.3 beds per 1,000 inhabitants, whereas the northern regions have more than 5.6.^{14,18} In 1999, the average length of stay was seven days, continuing the downward trend of recent years.⁴ Italy has half of the average ratio of personnel per occupied bed of the U.S., which raises questions regarding quality of services and personnel productivity.

Pharmacies have the monopoly of drugs sales, but are subject to numerous clauses.⁸ There are 16,000 pharmacies distributed across the country. In general, pharmacies are privately owned by pharmacists, who act as independent contractors under the NHS.⁸ There are only 1,129 public pharmacies, owned mainly by municipalities and managed by pharmacists employed by municipalities and paid by salary.⁸ By law, both private and public pharmacies are licensed to sell commercial products and, on behalf of the NHS, pharmaceuticals, which include medication drugs and dietary goods.⁹ Consumers can only purchase pharmaceuticals if they have prescriptions from their general practitioners. Since the creation of the NHS, drug co-pay rates have been introduced as a cost-containment policy.⁹ However, exemptions were accorded over time on the basis of income, medical conditions or particular status (e.g., disabled people). Prices for pharmaceuticals in classes A and B (see the NHS expenditures section), which are covered by the NHS, are fixed centrally through a complex mechanism that takes into account the average European

prices of the equivalents of Italian products.⁹ Industry, wholesale and pharmacy margins on these drugs are fixed by law as a percentage of the overall price before value-added tax (VAT). According to the most recent rate set in 1996, pharmaceutical industry gets 66.65%, wholesale 6.65%, and pharmacies 26.7%.²⁰ On behalf of the NHS, LHA are in charge of reimbursement. Conversely, prices for drugs in class C, which are not covered by the NHS, are freely established by the private sector.⁹

THE NHS FINANCING SYSTEM

The Italian NHS is funded mainly by general tax revenue.⁹ The annual budget for health financing is established by the government on the basis of the "per capita quota" system, representing the national sum per person needed to cover the essential health care levels guaranteed by the Italian NHS.¹⁶

Over the years, the financing of the NHS has undergone important changes. Before the recent fiscal reforms, there were three principal sources of tax contribution, for the national health budget: (1) general taxation, determined each year by the Parliament with the national budget, the so-called National Health Fund (NHF); (2) regional taxes, paid by employers to the region of residence of their employees; and (3) revenues of LHAs, from the so-called "direct" contributions associated with co-pay by users of some service costs, such as prescriptions, outpatient treatments, and diagnostic tests.⁹ The NHF provided the largest portion of money needed for public health care. The NHF was annually allocated to the 20 regions, which, in turn, allocate resources to the Local Health Agencies (LHAs).⁸

As the Italian NHS reforms transferred power to the regions, health care funding has also become a regional responsibility. The two latest reforms in 1997 and in 2000 have in fact further regulated and redefined the process of regional devolution initiated in 1992–1993.⁹ The NHF, which had been the main source of financing since the NHS was established, was abolished in 2001. Co-pay contributions for pharmaceuticals were also abolished in 2001; the other types of co-pays will cease in 2003.⁹ Essentially, regional financing comes directly from regional taxes to make up for the abolition of national transfers.²¹ The new set of taxes, which accrue directly to the regions, include a tax applied on businesses' added value and on the salaries paid to workers in the public sector; a piggy-back regional tax imposed on the national income tax; and a set amount of the per-liter petrol excise tax.²¹ Regions have autonomy on the revenue side of the regional budget and complete freedom over the allocation of funds among the regional functions.²¹ The Ministry of Health, however, maintains overall control. In fact, regional funding needs are defined yearly by the Ministry of Health according to a mix of weighed capitation and historical spending.⁹ Moreover,

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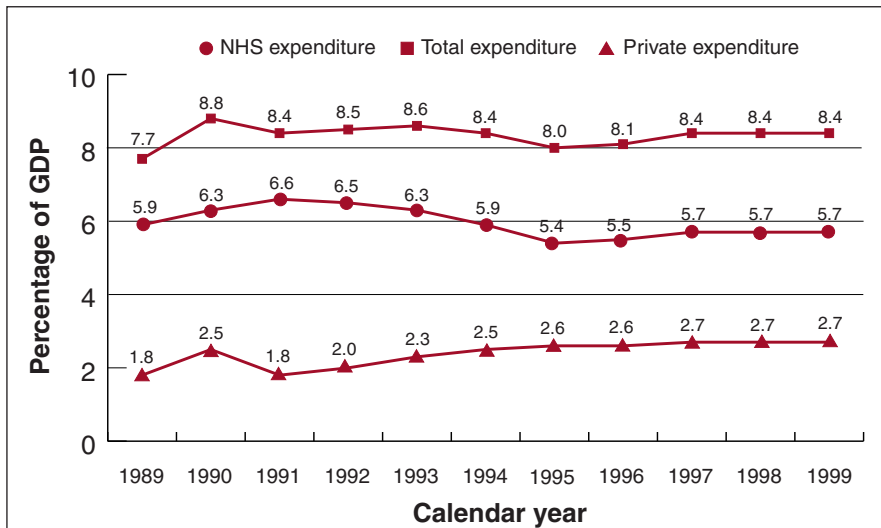


Figure 1 Expenditures on health as a percentage of GDP in Italy 1989–1999.

Source: OECD²⁴
GDP = Gross Domestic Product

expenditure of \$102 billion (in U.S. \$) at purchasing power parity in 1998.²⁴ Per capita health expenditure was \$1,783 (in U.S. \$), with a total health expenditure of 8.4% of the Italian Gross Domestic Product (GDP).²⁴ In 1998, Italy spent slightly more than the European Union members on health services (the average was 8% of GDP), and far less than the U.S., which spent \$4,178 per capita, or 13.6% of GDP.²⁴ Approximately 70% of the total (5.7% of GDP) was spent by the NHS, while the rest was accounted for by private expenditures.²⁴ In 1998, the largest portions of NHS spending were the cost of personnel, including physicians (41%) and hospital care (18%).¹⁴ In 1997, pharmaceutical expenditures represented 11% of total health care costs, similar to what was spent for drugs in the U.S. (10%).^{19,25}

the Ministry of Health continues in part to allocate resources from the global national budget in order to ensure adequate levels of care for all citizens. In fact, because extreme differences in fiscal autonomy exist among regions, a portion of the national tax revenue is used to build a National Solidarity Fund, which is primarily intended to redistribute funds to the regions that are unable to raise sufficient resources.⁹

The mechanism that allocates funds to the regions and the LHAs has changed several times to more homogeneously distribute resources and decentralize budget responsibilities among regions and LHAs. Since the 1992–1993 reforms, the distribution of funds to the regions has been based on a per capita allocation, which takes into account the regional population age distribution, mortality rates, and indicators of consumption of health care services.^{7,16} The funds provided by the regions to each LHA are established on the basis of the number of residents, the frequency of health consumption per age, and sex, mortality rates, and different epidemiological local indicators.¹⁵ In turn, each LHA finances its own directly managed hospitals and facilities, “hospital trusts” and private accredited facilities in its territory. To improve efficiency and quality of services, payment systems are determined by the type of care provided. The current payment system for acute hospital admissions, introduced in 1995, is based upon Diagnosis Related Groups (DRGs).²² DRG-associated tariffs are established at a regional level, although the Ministry of Health sets the ceiling for the regional tariffs.²² As was true in the U.S., after the introduction of the DRG-based hospital financing system, Italy saw a decrease in the mean length of stay and in the number of hospital admissions.^{22,23}

NHS EXPENDITURES

The Italian NHS is the third largest health care system in the European Union, behind Germany and France, with total

health care increased continuously until 1991, when NHS expenses reached almost \$65 billion (in U.S. \$) at purchasing power parity, corresponding to 6.6% of the GDP (Figure 1).^{8,19,24} Since 1992, various measures have been introduced to reduce NHS expenditures. These cost-containment measures can be classified into two broad groups: (1) those aimed at increasing productivity, such as financial accountability at the regional level, spending ceilings on goods and services, measures to contain personnel expenditure, and closure of small hospitals; and (2) those intended to contain the demand for health care by patients, such as co-pays on drugs and outpatient specialist care.^{26,27} However, most of these measures are short-term, and few are directed at modifying the structure of the health system. As a result, while the trend from 1993 to 1995 showed a decrease of public expense as a percentage of GDP spent on health (from 6.3% to 5.4% of the GDP),²⁴ NHS total spending since 1996 has started to rise again.^{17,24} Moreover, from 1992 to 1998, the balance between the annual NHS budget and actual expenditures resulted in an average deficit equal to \$2.5 billion U.S. per year.¹⁷

Among the cost-containment measures, control of pharmaceutical spending has been an important tool in the recent Italian health care policy. However, the results of the impact of these measures on health expenditures have been even more controversial. The 1994 reform hinged upon the introduction of a new patient co-pay for drugs and a new classification system for drugs.²⁸ According to this policy, regulatory power was concentrated on a national technical body, the *Committee for Drugs* (CUF [Comitato Unico per il Farmaco]), which is made up of 14 clinicians and pharmacologists nominated by the regions and the Ministry of Health. The CUF radically redefined the positive list (national therapeutic formulary [*prontuario terapeutico*]), regrouping drugs into three

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Figure 1. S. Paolo Hospital in Napoli, Italy.

co-pay classes (A, B, and C). Class A includes drugs for essential and chronic diseases that are covered by the NHS except for a minimal flat contribution by the patient (the so-called “ticket”). Class B consists of other drugs satisfying primary therapeutic requirements whose cost is shared at 50% by the consumer. Class C includes all other drugs that: (1) have no clinical documentation supporting their efficacy; (2) are more costly than class A drugs; (3) are used to treat minor or inexpensive illnesses; and (4) do not require a prescription. Consumers are responsible for the total cost of class C drugs.²⁸

Pharmaceutical expenditures, as well as public health expenses, decreased from 1993 to 1996 by about \$700 million (in U.S. \$)—from 13.3% to 11% of NHS expenditures.¹² However, in the last several years, the public pharmaceutical spending has started to grow again, essentially caused by the introduction into the national formulary of new high-cost drugs and an increase in drug consumption.¹³ Moreover, the co-pay system, which proved to be very effective in cost containment, was abolished by the Ministry of Health in 2001.⁹ Many economists have strongly criticized this action, arguing that, without any restriction, drug consumption will certainly increase, creating a new deficit in the health care budget. In fact, recent data showed that in the period from January to September of 2001, the NHS pharmaceutical expenditures increased by 34.7% over the same period in 2000, while the consumption of drugs increased by 19.6%.²⁹ In a preliminary analysis of this data, about half of the increased drug expenditures have been attributed to the economic effects of the abolition of co-pays.²⁹

The recent introduction of generics (non-branded drugs) into the Italian health care market might be beneficial in providing a strong incentive to reduce pharmaceutical expenditures. The law has provided incentives to promote the generic markets over the long term.¹² For instance, a generic marketed at a price that is at least 20% lower than the equivalent

patent product is automatically listed in both classes A and B. Despite the fact that general practitioners have been encouraged to prescribe generics, they account for only 3% of all prescribed drugs sold to date.⁹ However, recent laws will facilitate the full dissemination of generics. In fact, as of December 2001, generics will be taken into account as reference pricing for the reimbursement system and the NHS will no longer cover a drug that has a price higher than an equivalent generic.³⁰ In such a case, consumers will pay the price difference. That notwithstanding, it is interesting to note that consumers cannot choose a generic when a branded drug has been prescribed; only physicians can decide whether to substitute the branded drug prescribed with an equivalent generic at a lower price.

Hospital pharmaceutical spending has also been under control since the institution of the NHS. According to national laws, regions have the power to set up their own regional hospital formularies based on the national therapeutic formulary, with the intention of monitoring and rationalizing the use and consumption of drugs. For instance, in Umbria, a region in central Italy, a regional hospital formulary (*Elenco Terapeutico Ospedaliero del Servizio Sanitario Regionale*) was established in 1982.³¹

It is interesting to note that consumers cannot choose a generic when a branded drug has been prescribed; only physicians can decide whether to substitute the branded drug prescribed with an equivalent generic at a lower price.

In order to establish its own formulary, each hospital within the region refers to the regional hospital formulary. A committee comprised of specialist physicians, pharmacologists, and pharmacists reviews and decides on a regular basis which drugs are to be included in the regional hospital formulary.³² Efficacy and safety criteria are applied for the selection, with priority being given to drugs for acute and chronic diseases. Pharmacoeconomic aspects are taken into account, especially when considering expensive drugs. Clinical physicians can formally request that the committee introduce new drugs into the formulary by providing documentation of cost/efficacy and risk/benefit for the drugs being profiled.³² However, the role of such committees ruling over regional hospital formularies has been diminishing in significance since the introduction of the new classification of drugs in 1994.

As mentioned above, the national therapeutic formulary made by the CUF separates drugs into classes A, B, and C, primarily based on efficacy criteria. This selection, in fact, affects regional committees' choices as to which drugs are introduced into regional hospital formularies. For instance, it is unlikely

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PERCEPTION OF QUALITY IN HEALTH CARE

Although there is no consensus, popular perception of quality may be considered one indicator of how well a health care system operates.³⁵ Moreover, the level of satisfaction of citizens might help evaluate the popularity of specific measures and reforms.³⁵

In 1990, Blendon et al.³⁶ attempted to assess the level of citizens' satisfaction with their health care system through an international comparison among 10 countries. The U.S. and Italy had the highest level of public discontent. Likewise, a survey performed in 1992 among European Union members found that the dissatisfaction of Italians with respect to the efficiency and quality of their health care system was the highest in Europe.¹⁰ In 1996, the Italian Eurobarometer Survey found only 16% of respondents were

In spite of universal coverage, it appears now that citizens rely more on their own financial resources for health care, especially for pharmaceuticals, dental care, specialist consultations, diagnostic examinations, and elective surgery.

very satisfied with the way health care is run.³⁵ Among those interviewed, 76.9% were in favor of a major system reform and almost 75% demanded more health spending.³⁵ A 1998 comparison of citizens' views and satisfaction among industrialized countries found that Italians rated their health care system poorly (Figure 2).² Public opinion is in stark contrast to the experts' conclusions in the WHO Report 2000,¹ which ranked the Italian health system second, reinforcing the controversial nature of how to evaluate the performance of health systems.

Assessing the quality of the health system through citizens' satisfaction is an important task of the Italian Ministry of Health. Ten thousand citizens were surveyed in 1997 about their perception of health care quality:⁸ 34% responded that the system offered "fairly satisfactory" service, whereas 2% of the sample considered it "very satisfactory." However, there was considerable disparity between the southern and the northern regions in respect to satisfaction with health care performance. Satisfaction varied from 19% in Sicily (southern Italy), which had the lowest percentage, to 53% in Emilia Romagna, which is one of the richer northern regions.⁸ Many observers fear that the increase in regional decentralization will fuel already existing interregional disparity in health care and undermine the egalitarian principles of the NHS.²¹

PLANNING FOR THE FUTURE

The Italian health care system is considered among the most advanced in the world, with excellent results in terms of health care and well-being. It provides universal coverage for the entire

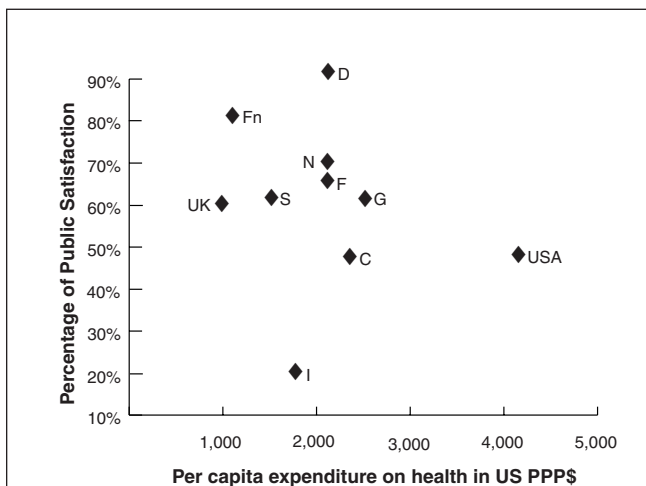


Figure 2 Per capita expenditure on health in U.S. purchasing power parity (PPP)* \$ in 1998 and public satisfaction with the national health system.

Source: Adapted from the following databases: Health spending per capita: OECD;²⁴ Public satisfaction: Blendon et al.²

Key: * PPP is defined as an exchange rate between two currencies such that the same quantity of goods and services could be bought in each country if the cost were converted at that exchange rate.

The original question read: "In general, would you say you are very satisfied, fairly satisfied, neither satisfied nor dissatisfied, fairly dissatisfied, or very dissatisfied with the way health care runs in your country?" The first two response categories were combined to give a measure of satisfaction.² All data were collected in 1998, with the exception of data for the U.S. and Canada; they were collected in 2000.²

Country key:
 C: Canada
 D: Denmark
 Fn: Finland
 F: France
 G: Germany
 I: Italy
 N: The Netherlands
 S: Sweden
 UK: United Kingdom
 U.S.A: U.S.

that drugs in class C will be included in a regional hospital formulary. Most importantly, the CUF rules over a special class of drugs (class H), which are used exclusively in hospitals.³³ Drugs included in class H are selected on the basis of certain types of pathologies and side effects in relation to benefits. Interferon gamma, most agents for treating HCV infection, and most antineoplastic agents are examples of class H drugs, which of course cannot be excluded from hospital formularies.

Unlike most European countries, public health care expenditures in Italy have decreased markedly. In the late 1980s, public expenditures accounted for almost 80% of the total health care cost; in 1999, it accounted for only 70% (Figure 1).¹³ In spite of universal coverage, it appears now that citizens rely more on their own financial resources for health care, especially for pharmaceuticals, dental care, specialist consultations, diagnostic examinations, and elective surgery.³⁴ According to the Ministry of Health, this might be an indicator of inadequate quality and quantity of public health services.⁷ Health experts and public opinion are challenging the Italian State to more clearly define the extent of health care services that the NHS is mandated to provide for all citizens.¹³

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population, with services provided for free or at modest cost at the point of consumption. However, it is characterized by heavy decentralization of power, with the need to ensure a more responsible and efficient use of available resources. Recent reforms have transferred administrative, organizational, and financial responsibilities for health care delivery from the central government to the 20 regions and the LHAs, which represent the fundamental cornerstone of the system. Tight budgets and the need to restrain rising health care expenditures have led the NHS to undertake several cost-containment measures to encourage cost-conscious behavior by consumers and providers. However, these measures

Public opinion is in stark contrast to the experts' conclusions in the WHO Report 2000,¹ which ranked the Italian health system second, reinforcing the controversial nature of how to evaluate the performance of health systems.

along with the strong policy of decentralization of powers that has been taking place since the early 1990s, are accentuating economic and social interregional disparities. In addition, quantity and quality of the services provided is being questioned by citizens, especially in the southern regions of the country. In the 21st century, along with other industrialized countries, Italy will strive to offer quality health care services while undertaking cost-control and rationalization measures. However, because of its fundamental characteristics, the Italian health care system will certainly face other important challenges: to create and develop an efficient system capable of preserving the principles of egalitarianism and solidarity, and to find fair financial mechanisms that overcome regional discrepancies. ■

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