Control Systems in the Italian National Health Service and the Maintaining of the Principles of Universality, Equality and Equity: Avoiding Discrimination and "Exit" Phenomena

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ABSTRACT

The Italian National Health Service (NHS) was responsible in 2015 for a public health spending equivalent of 14% of the total Italian public spending. It is funded through general taxation as health is treated as merit good. In recent years the Italian NHS has been subject to numerous restrictions in order to contain spending and rationalize the activity in the name of the efficiency and the effectiveness. The measures enacted at the national level and for each Regional Health Service (independent since the implementation of the health federalism in 2001) have been drawn up in accordance with the founding principles of the NHS in 1978: Universality, Equality and Equity. But the application in specific contexts "has put a strain on the needs of citizens"(Commissione permanente Igiene e Sanità del Senato della Repubblica, 2015). The paper analyzes precisely the system of existing control mechanisms on the implementation at the local level of the national and regional measures to contain spending and rationalize the activity of the NHS. The paper evaluates the effectiveness or "inability" of the control mechanisms to guarantee citizens the rights deriving from the principles of the NHS and to avoid discrimination and "exit" phenomena. The context of the study is the Regional Health Service of Emilia-Romagna with the measures adopted after 2010 to deal with the problems of waiting lists and the control of spending that in the area of the Bologna Local Health Authority it has meant the redirecting of the services of early detection of breast cancer toward the screening of public health (Gatti, 2017).

Key words: Italy, National Health Service; Founding Principles, Policy Changes, Maintaining Control Mechanisms.

JEL Classification: I18, I14, K32

1. Introduction

The Italian National Health Service (NHS) was responsible in 2015 for a public health spending equivalent of 14% of the total Italian public spending. It is funded through general taxation as health is treated as merit good.

According to the law that established the Italian NHS in 1978 it must guarantee to all citizens, in conditions of equality, universal access to the equitable provision of health services, in implementation of Article 32 of the Constitution.

The guarantees of the Italian National Health Service are associated with a high level of taxation on income (and on labor income in particular), fact that characterizes many Western European countries (Heckman, 2009).

This means that for the majority of Italian citizens with low and medium incomes the guarantees of the National Health Service become essential for the economic sustainability of the protection of their health[1].

For this reason in particular the protection of equity in the Italian National Health Service must not refer only to a particular safeguard of people in severe economic difficulty (minimum standard), but it must protect the specific nature of each individual.

Moreover equity in health services operationally should ensure (universally) equal treatment for equal need, equality in health, equality in access to services.

In the policy changes for the rationalization and control of expenditure, all parts of the National Health Service may easily undermine the principles on which the NHS is based (and for which the citizens pay taxes on their income) and create discrimination in several areas that all have the same dignity and need for protection.

Citizens perceive this state of difficulty and may express their discomfort in various ways with exit phenomena from the social contract (Shafik, 2017).

2. Methods and Materials

In the current institutional framework of healthcare federalism, the central government has the responsibility to ensure the right to health for all citizens through a strong system of guarantees, through the Essential Levels of Care (LEA), and at the same time the Regional Authorities have direct responsibility through their Local Health Authorities (AUSLs) for implementation of the government and the expenditure for achieving the country's health objectives. The central and regional governments are entrusted with mandatory duties, which can be traced back to the identification of guarantee mechanisms for the protection of health for the citizen throughout the country with a view to universalism and equity of access. In the changed constitutional framework

[1] In addition to the considerations of the Senate Commission (2015) on the sustainability of private spending, in 2017 OECD and European Observatory on Health Systems and Policies point out that in Italy, despite universal coverage, the access to health care varies largely by region and income group (Graph. 1), a relatively high share of people reports unmet needs for medical care (Graph. 2) and more than one-fifth of health expenditure is paid directly by households (Graph. 3).

of relations between the central and regional governments, the use of the agreement instruments, sanctioned in the State-Regions Conference, has been affirmed to address and solve the issues concerning the protection of health (Ministero della Salute, 2012).

In this context we analyze how health policy decisions are made and how the results achieved are monitored in the Regional Health Service (SSR) of Emilia-Romagna and its AUSLs, highlighting which indicators are used and what objectives they are meant to meet.

3. Results

To do its part in guaranteeing health protection for all citizens in a framework of universalism and equity of access, the Emilia-Romagna Region, one of Italy's most advanced local healthcare systems, has implemented a plan that is both healthcare- and socially-oriented. The Social and Health Plan of Emilia-Romagna for the three-year period 2017-2019 (Regione Emilia-Romagna, 2017a) defines the tools necessary to tackle the new needs and the profound transformations taking place in today's society, betting on the integration between health and welfare. The Plan has "Intervention sheets" (Regione Emilia-Romagna, 2017b), which define the objectives and actions to be developed and detail the recipients and indicators for measuring the results (Tab. 2). These indicators, which we might consider as the tool for verifying the application of the objectives, do not contain exhaustive checks with regard to the maintaining of the principles underlying the National Health Service for the protection of the health of each individual tax-payer.

The sheet 32 on the "Promotion of the equity of access to healthcare services" best represents the issue of equity of access to health services and of waiting lists that have been the basis of the reorganization of breast cancer early detection in Bologna. But the indicators taken into consideration do not analyze the "equity" effects of the measures carried out in its name (Gatti, 2017).

The monitoring of interventions, also carried out through the indicators set established for assessing the achievement of the objectives, is entrusted to a group composed of all the most significant actors of the Welfare System and which for the fulfillment of its mandate may use participatory comparison methods (Regione Emilia-Romagna – Portale E-R Salute, 2017).

The Regional Government together with the general managers of the AUSLs defines corporate mandate objectives (Tab. 3) (Giunta della Regione Emilia Romagna, 2015) according to the fundamental guidelines for the Regional Health Service that the Regional Government has set down

for itself. Therefore they do not deviate from the approach given to the Health Plan presented here. The Regional Government provides for the verification of the objectives of the mandate, and failure to achieve the objectives entails the termination of the contractual relationship. Recently, however, the Italian government intervened with the Madia Decree on the Reform of the Public Administration to state that these general managers must be subject to stringent verification and evaluation of the activities carried out and the results achieved, in light of the economic-financial objectives set by the Region, and in light of the results achieved for the Essential Levels of Care and the National Outcomes Evaluation Program, with automatic removal in case of failure to achieve the objectives or in case of serious and proven reasons (*mala gestio*), violations of laws or regulations or the principle of sound administration and impartiality (D.Lgs. 171/2016).

4. Discussion

The Emilia-Romagna Region has a consolidated approach to the protection of social issues. However in both its Social and Health Plan and its relationship with the AUSLs, it does not develop *ex ante* automatic instruments for monitoring the fundamental principles of the NHS in the implementation of policies and in particular for reorganizing services and controlling spending. It pays attention to the protection of equity [especially for poverty], but it does so by means of participatory or equity auditing instruments[2] or, at most, by using mixed consultative committees.

The individual citizen can protect himself in a defensive action after the changes have already gone into effect, by communicating with the Public Relations Office of the AUSL and in the second instance by asking to activate the Mixed Conciliatory Commission. In other words, actions external to the management process of the SSR and the AUSL.

The tool for verification of the maintenance of the NHS principles remains the monitoring of the LEA by the Ministry of Health. It is an *ex post* instrument with indicators (Tab. 4) what do not specifically address each policy of reorganization of services or spending containment.

At the present time the last possibility for each citizen to protect himself is to appeal to the new rules of transparency for the Public Administrations (D.Lgs. 33/2013 and D.Lgs. 97/2016) and to the commitment of the National Anti-corruption Authority (Autorità Nazionale Anticorruzione, 2016).

[2] A Health Equity Audit was applied to the breast care pathway (PDTA) of the AUSL of Bologna from 2012 (Agenzia sanitaria e sociale regionale della Regione Emilia-Romagna, 2017).

5. Conclusions

A National Health Service, that bases its existence on the nature of merit good of the individual health, may have difficulty making itself considered reliable by citizens-taxpayers, offering only participatory tools to protect its fundamental principles. Today the phenomena of discrimination and exit seem to be connected more with a discomfort experienced as individual than with a feeling of belonging to a specific group which is well organized for its own protection.

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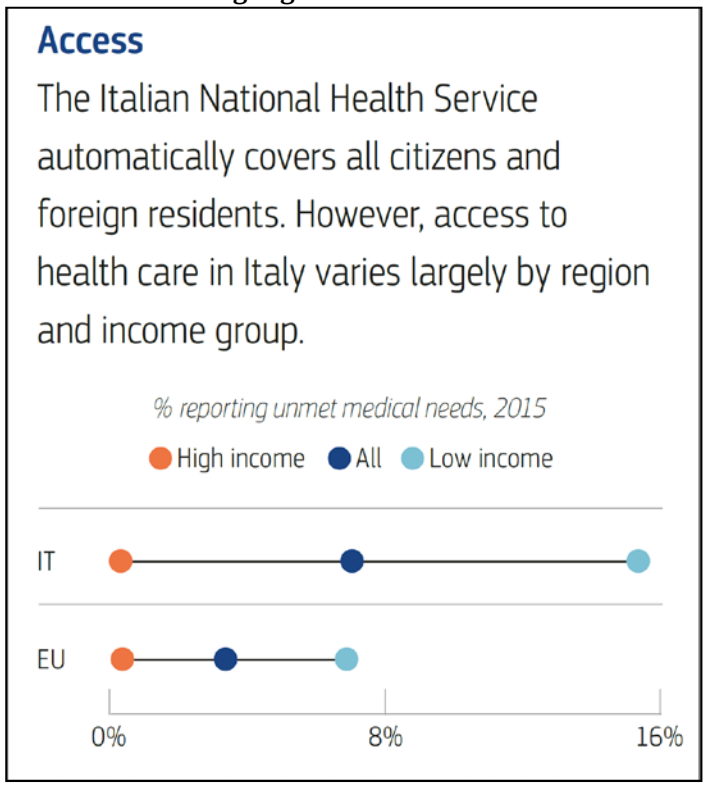
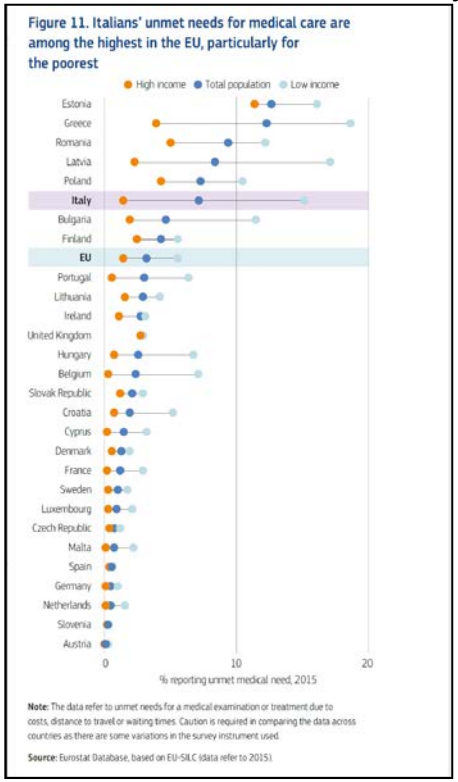
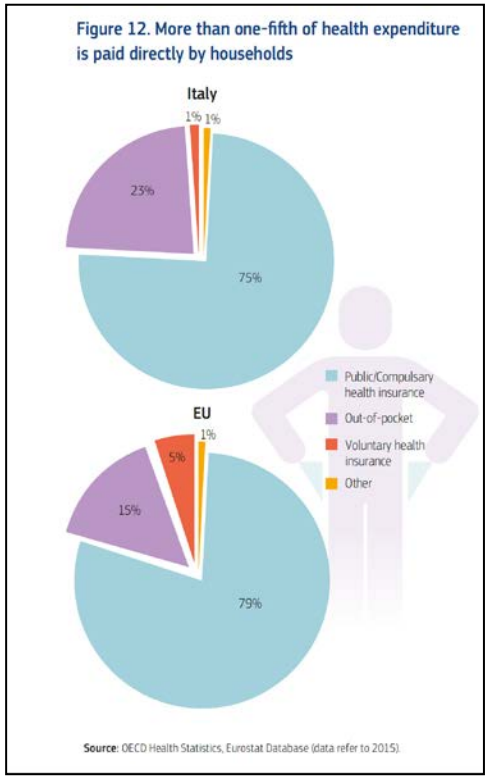
Graph 1. OECD (2017), Italy: Country Health Profile 2017
-Highlights-



Graph 2.- 3. OECD (2017), Italy: Country Health Profile 2017
-Accessibility-





Source: OECD/European Observatory on Health Systems and Policies (2017)

TABLE 2. – Intervention sheets of the Social and Health Plan of Emilia-Romagna (Italy) for the three-year period 2017-2019

THE SOCIAL AND HEALTH PLAN OF THE EMILIA-ROMAGNA REGION 2017-2019	
The intervention sheets	
A. Policies for proximity and home care	**C. Policies to promote individual self-sufficiency**
1 "Health homes" and "Initiative-based medicine"	22 Measures to combat poverty (SIA/REI, RES?)
2 Reorganization of the integrated hospital and territorial network	23 Job placement for fragile and vulnerable persons (Regional Law 14/2015)
3 Intermediate care and development of community hospitals	24 The home as a factor of inclusion and social wellbeing
4 Healthcare budget	25 Combating of gender violence
5 Recognition of the role of family caregiver in the social services, social-medical, and healthcare system	**D. Policies for citizens' participation and empowerment**
6 "Life Project", "Independent Living", and "After Us" programs	26 Methods for fostering empowerment and the participation of communities
7 Taking on the care of the patient and their family within the framework of the palliative treatment network	27 Health literacy
8 Promotion of health in prison, humanization of punishment, and reintegration of the persons doing criminal sentences	28 Exploitation of experiential knowledge and help among peers
B. Policies for the reduction of inequality and promotion of health	29 Civic participation and cooperation between the public system and third sector entities
9 Gender medicine	**E. Policies for the qualification and streamlining of services**
10 Actions to combat the social exclusion of persons in conditions of extreme poverty or risking marginalization	30 Updating of instruments and procedures for social-medical services
11 Equity in all policies: methods and instruments	31 Reorganization of childbirth assistance to improve the quality of care and increase safety for citizens and professionals
12 Support for the inclusion of newly arrived foreign persons	32 Promotion of the equity of access to healthcare services
13 Supplementary funds for services not covered by the Essential Care Levels (LEA)	33 Improvement of access and paths to emergency/urgency services
14 Promotion of equal opportunities and enhancement of gender, intergenerational, intercultural, and skill differences	34 Methods for innovating organizations and professional practices
15 Strengthening of the interventions in the first 1000 days of life, in particular in the family caregiving and services contexts	35 ICT – Information and communication technologies – as an instrument for a new e-welfare model
16 Support to parenthood	36 Consolidation and development of the Territorial Social Services (SST)
17 "Teen Project": integrated interventions for prevention, promotion of wellbeing, and care of pre-teens and teens	37 Qualification of the reception and treatment system for children, adolescents, and young adults with complex social-medical needs within the framework of protection and defense
18 Promotion of sexual health and reproduction in the fertile years and prevention of sterility	38 New regional vaccination schedule and activities for the support and improvement of vaccination coverage
19 Prevention and combating of pathological gambling	39 Essential levels of social services in the Emilia-Romagna region
20 Actions for active, healthy aging and protection of the fragility of the elderly	
21 Innovation of the network of services for the elderly within the framework of the FRNA: Regional Fund for Non-Self-Sufficiency	

Source: Regione Emilia-Romagna (2017)

Table 3. ASSIGNED OBJECTIVES OF THE GENERAL DIRECTORATE OF THE BOLOGNA LOCAL HEALTH AUTHORITY (AUSL)	
ASSIGNED OBJECTIVES OF THE GENERAL DIRECTORATE OF THE BOLOGNA LOCAL HEALTH AUTHORITY (AUSL)	
1. Objectives for health and the promotion of quality of care	
1.1	Reorganization of hospital care
1.2	Consolidation of primary care, development of “health homes”, hospital-territory integration
1.3	Facilitation of access to day hospital specialist services and hospitalization
1.4	Consolidation of taking charge of and pathways of continuity of care
1.5	Health prevention and promotion activities
1.6	Management of the demand and appropriateness of interventions in hospital, specialist, and pharmaceutical contexts
1.7	Quality, safety, and management of clinical risk
1.8	Social-medical integration
1.9	Research activities
2. Objectives of sustainability and management of services	
2.1	Respect of the economic-financial balance and actions to rationalize and control spending
2.2	Development of administration, support, and logistic service integration processes in the various companies
2.3	Development of the ICT infrastructure supporting the simplification and improvement of service accessibility
2.4	Rationalization in the management of the building-technological wealth and investment management
2.5	Human resource management
2.6	Information flow formalities
2.7	Enhancement of human capital

Source: Giunta della Regione Emilia Romagna (2015)

TABLE 4. Essential Levels of Care - Definition of the set of indicators of the year 2015

No.	Care level	Definition	Meaning
1	Prevention	**1.1 Vaccination coverage in children at 24 months for basic cycle (3 doses) (polio, diphtheria, tetanus, hepatitis B, whooping cough, Hib)**	*Main indicator for verification of the prevention activity for infective diseases on the population. The indicator distinguishes among the basic cycle vaccinations (3 doses), one MMR (measles, mumps rubella in childhood) vaccine, and influenza vaccine in the elderly.*
		1.2 Vaccination coverage in children at 24 months for one dose of MMR vaccine against measles, mumps, and rubella	
		1.3 Vaccination coverage for influenza in the elderly (≥ 65 years)	
2	Prevention	**2. Proportion of persons who underwent a first-level screening test, in an organized program, for cervical, breast, and colorectal cancers**	*The objective of the indicator is to describe the activities of the organized screening programs and the adherence thereto by the eligible population. The intention is to provide an overall evaluation of the compliance with the "LEA" (Essential Care Levels) for all three screening programs.*
3	Prevention	**3.1 Per capita cost of collective care in the living and work environment**	*Brief indicator of the resources devoted by the Region to collective care activities in living and work environments.*
		3.2 Composite lifestyle indicator	*The indicator describes the respective changes, over time, of the prevalence of individuals with certain behaviors or lifestyles, as proxies of the outcome of the prevention and promotion of healthy lifestyles implemented by the Regions.*
4	Prevention, Protection in workplaces	**4. Percentage of units monitored out of the total to be monitored**	*Indicator established in the Pact for Health and Safety in the Workplace (Prime Minister's Decree of 17/12/2007), which reflects the monitoring activities carried out by the services of the ASL (Local Health Authority)Prevention Department for the protection of health in the workplace.*
5	Prevention, Animal health	**5.1 ANIMAL DISEASES TRANSMITTABLE TO HUMANS – percentage of breeding farms checked for bovine TB and trend of prevalence**	*The indicators measure several animal health aspects that have a major impact on the health of citizens, with the aim of a direct and indirect monitoring of zoonoses and of a traceability of food-producing animals.*
		5.2 ANIMAL DISEASES TRANSMITTABLE TO HUMANS – percentage of breeding farms checked for ovine, caprine, bovine, and buffalo BRUCELLOSIS and, for the regions specified in the Ministerial Decree of 14/12/2006 et seq., the compliance with the rechecking times and with the times for reporting on the lab results in at least 80% of the cases, as well as the reduction of the prevalence in all the species	
		5.3 ANIMAL REGISTRY – Checks on the animal population for animal and human health prevention: percentage of sheep and goat farms checked for the ovicaprine registry compared to the 3% envisaged by EC Regulation 1505/06	
6	Prevention, Food safety	**6.1 CONTAMINANTS IN FOODS OF ANIMAL ORIGIN – implementation of the National Plan for the Search for Residues ("PNR") of drugs, illegal substances, and contaminants in food products and their residues in foods of animal origin: percentage of the samples analyzed out of the total planned samples**	*The indicator measures the percentage of implementation by the regional governments of the National Plan for the search for residues of drugs and contaminants in foods of animal origin – Legislative Decree no. 158/06.*
		6.2 HEALTH CHECKS CONDUCTED ON THE PREMISES OF FOOD SELLING AND SERVING ACTIVITIES: sum of the values of the percentages of inspections of places (public and collective) that serve food, and sampling conducted at places (public and collective) that sell and serve food, out of the total of those planned, Articles 5 and 6 of the Presidential Decree of 14/07/95	*The indicator measures the percentages of the inspections and samplings conducted in places selling and serving food, compared to those envisaged by Articles 5 and 6 of the Presidential Decree of 14/07/95 (elements deducible by means of "form" A of the Ministerial Decree of 08/10/98), for the monitoring of the proper handling and storage of foods by said food sector operators.*
		6.3 CONTAMINANTS IN FOODS OF VEGETABLE ORIGIN – program for the search of plant protection product residues in foods of plant origin (Tables 1 and 2 of the Ministerial Decree of 23/12/1992); percentage of the samples envisaged whose results are made available for forwarding to the EFSA	*The indicator measures the percentage of implementation of the national program for monitoring residues of plant protection products (commonly called "pesticides") in foods of plant origin – fruit, vegetables, grains, oil, and wine – and the proper coverage for each category,*
7	District	**7.1 Standardized hospitalization rate (per 100,000 inhabitants) in the pediatric age group (< 18 years) for: asthma and gastroenteritis**	*Indirect hospital indicators that assess the ineffectiveness of the prevention and specialist services devoted to the treatment of certain pathologies, in the pediatric and adult age groups, respectively.*
		7.2 Standardized hospitalization rate (per 100,000 inhabitants) in the adult age group (≥ 18 years) for: complications (short- and long-term for diabetes), OCBP, and heart failure	

8	District, elderly	**8. Percentage of elderly ≥ 65 years of age treated with integrated homecare**	*The indicator, calculated on the resident population over the age of 65, measures the taking charge of the elderly population by the integrated homecare services of the ASLs (Local Health Authorities). It takes into account the different organizational methods present in the Italian regions.*
9	District, elderly	**9.1 Number of equivalent beds for care to the elderly ≥ 65 years of age in residential structures per 1,000 resident senior citizens** **9.2 Number of beds for care to the elderly ≥ 65 years of age in residential structures per 1,000 resident senior citizens**	*The indicators assess both the quantity of equivalent beds (on the basis of the days of care provided) and of actual beds (supply network) available in the territorial residential structures with respect to the resident elderly population, and may be considered an indicator of the supply of residential territorial care.*
10	District, disabled	**10.1.1 Number of residential equivalent beds in structures that provide care to the disabled per 1,000 residents** **10.1.2 Number of semi-residential equivalent beds in structures that provide care to the disabled per 1,000 residents** **10.2.1 Number of beds in residential structures that provide care to the disabled per 1,000 residents** **10.2.2 Number of beds in semi-residential structures that provide care to the disabled per 1,000 residents**	*The indicators assess both the quantity of equivalent beds (on the basis of the days of care provided) and of actual beds (supply network) available in the residential and semi-residential structures that provide care to the disabled, with respect to the resident population, and may be considered an indicator of the supply of residential and semi-residential territorial care.*
11	District, terminally ill	**11. Existing hospice beds compared to the total number of deaths from tumors (per 100)**	*Indicator of the supply for residential care of terminal patients. It is in relation to the population that prevalently needs such care.*
12	District, pharmaceutical	**12. Percentage of annual consumption (expressed in DDD (Defined Daily Dose) of the drugs belonging to the PHT**	*The indicator makes it possible to measure the direct taking charge of assisted patients characterized by critical diagnoses and treatments and by the need for a periodic follow-up with the specialist structure, and by periodic scheduled accesses in order to ensure a greater appropriateness in the dispensing of these medicines.*
13	District, specialist	**13. Number of outpatient specialist magnetic resonance exams given per 100 residents**	*Indicator of specialist activity based on the number of magnetic resonance exams given with respect to the population. It takes into account both the possible lack of guarantee of the level of care, and the possible waste of resources due to inappropriateness.*
14	District, mental health	**14. Number of patients receiving care at the mental health departments per 1,000 residents**	*Indicator of healthcare activity provided to patients followed by mental health centers.*
15	Hospital	**15.1 Standardized hospitalization (ordinary and day) rate per 1,000 residents** **15.2 Day hospital admission rate for diagnostic purposes per 1,000 residents**	*Indicators of hospital demand and appropriateness of day hospital admissions*
	Hospital	**15.3 Medical type access rate (standardized by age) per 1,000 residents**	*Indicator of hospital demand and appropriateness of day hospital admissions*
16	Hospital	**16. Percentage of hospitalizations with surgical DRG under the ordinary system compared to the total ordinary hospitalizations**	*Indicator of hospital care activity. Verifies the appropriate use of the hospital structure devoted mainly to surgery.*
17	Hospital	**17. Ratio between hospitalizations attributed to DRGs with a high risk of inappropriateness (Annex B of the 2010-2012 Pact for Health) and hospitalizations attributed to DRGs with no risk of inappropriateness under the ordinary system**	*Indicator of inappropriateness of the care setting. Is based on the list of the 108 DRGs with a high risk of inappropriateness if provided under the ordinary system as described in the Agreement of 3 December 2009.*
18	Hospital	**18. Percentage of primary Caesarian sections** **18.2 Percentage of extremely pre-term births which took place in places without a NICU**	*Indicators on the appropriate performance of primary Caesarian sections in Italy and on the access to intensive care for extremely pre-term infants, decisive for the survival and future quality of life of the baby.*
19	Hospital	**19. Percentage of patients (age 65+) with diagnoses of femoral neck fractures who are operated on within 2 days under the ordinary system**	*The indicator is included among the hospital care quality indicator selected by the OECD for comparisons. It assesses the taking charge of the healthcare organization and its response time to the need for care of patients with femoral fractures.*
21	Emergency	**21. Alarm-Target interval of the emergency vehicles (in minutes)**	*Innovative indicator of functionality and rapidity of the healthcare organization in charge of the territorial emergency system. In particular, it assesses the performance of the "118" emergency phone number service.*

Source: Ministero della Salute – Direzione Generale della Programmazione Sanitaria, Ufficio VI (2017)