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Italy's Health Care System: Reducing Regional Disparities for At-Risk Populations

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I. INTRODUCTION

Nations across the world have implemented innovative health systems. As a global leader, the United States would benefit from modeling parts of its system based on successful policies in other countries. The main objectives of health care reform in the U.S. reside in the areas of cost containment and the expansion of insurance coverage.[1] Whether U.S. citizens should possess a right to health care, similar to many European countries, has also been a social and political debate for the past decade.[2] The U.S. will inevitably face significant political and social barriers in any attempt to adopt different health care structures and policies. However, Italy has achieved success in the areas of cost containment and patient coverage, and the U.S. would benefit from adopting specific elements of its structure and policies.[3]

This article will examine the structure and policies of Italy's health system, and explain how the U.S. should adopt specific strategies that have proven successful in the reduction of regional disparities and cost

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1. EXECUTIVE OFFICE OF THE PRESIDENT COUNCIL OF ECONOMIC ADVISERS, THE ECONOMIC CASE FOR HEALTH CARE REFORM, June 2, 2011, *available at* http://www.whitehouse.gov/assets/documents/CEA_Health_Care_Report.pdf

2. Sandhu, K Puneet, *A Legal Right to Health Care: What Can the United States Learn From Foreign Models of Health Rights Jurisprudence?*, 95 CAL. L. REV 1151, 1154, (2007).

3. Alessandra Lo Scalzo et al., *Italy: Health System Review*, 11 HEALTH SYSTEMS IN TRANSITION 6, 45 (2009), *available at* http://www.euro.who.int/__data/assets/pdf_file/0006/87225/E93666.pdf.

containment. First, this article will begin by discussing the organization and financial structure of Italy's health care system. Second, it will address the regional disparities and cost-containment issues that Italy's health care system faces and the strategies that the country has adopted to reduce inequalities and spending. Finally, this article will identify how the U.S. has addressed inequalities in health care in recent legislative reform and analyze whether the U.S. could effectively replicate certain strategies that have been successful in Italy.

II. ORGANIZATION, FUNDING, AND PATIENT CARE

Italy's health care system, *Servizio Sanitario Nazionale* (SSN), is a regionally based national health service that covers all citizens and legal foreign residents.[4] The Italian system is universal, where residents can go to a public hospital without worrying about insurance coverage.[5] The government pays the majority of the cost and patients are typically only charged a small co-pay without involvement of any insurance companies.[6] As a result, private insurance involvement is minimal.[7] However, this has caused inefficiencies in care.[8] One reason for this is that public hospitals are provided guaranteed reimbursements, which reduce the hospitals' incentive to improve services or keep costs down.[9]

The Italian government attempted to reduce these inefficiencies in 1997

4. COMMONWEALTH FUND, INTERNATIONAL PROFILES OF HEALTH CARE SYSTEMS 32 (2010), *available at* http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2010/Jun/1417_Squires_Intl_Profiles_622.pdf.

5. Margherita Stancati, *Competitive Care: When Italy's Lombardy Region Pitted Private Hospitals Against Public Ones, the Quality of Care Rose Dramatically*, WALL ST. J., Apr. 13 2010, *available at* http://online.wsj.com/article/SB10001424052748704131404575118030576580248.html

6. *Id*. at 1.

7. *Id*.

8. *Id*.

9. *Id*.

through reforms, which resulted in the current structure.[10] This structure gives twenty individual regions control over public money, which is then distributed to hospitals within its own borders.[11] Individual regions have the power to adopt their own quality standards, set their own reimbursement rates, determine the funds allocated to hospitals, and withhold reimbursements if hospitals fail to meet the required standard.[12] Much of the country uses standards of care and reimbursement rates that are recommended by Rome.[13]

The central government determines the minimum national benefits package, which include the "essential levels of care" or *livelli essenziali di assistenza* (LEAs).[14] Every year, the SSN produces a positive and negative list of LEA services based on effectiveness, necessity, and efficiency of delivery.[15] The positive list includes services such as ambulatory and inpatient care, as well as some prescription drugs.[16] Individual regions may choose to offer non-LEA services such as eye care and dental care, but they must be regionally funded.[17] Although Italy's health care system may seem appealing, long waits and disorganization result in some level of patient dissatisfaction.[18] Italy's health system may seem enticing on the surface due to little or no copayments and wide coverage, but long waiting periods and crowded hospitals force some individuals to travel long distances to receive high quality care.[19]

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10. *Id.*
11. *Id.*; Lo Scalzo et al., *supra* note 3, at 1.
12. Sancati, *supra* note 5.
13. *Id.*
14. COMMONWEALTH FUND, *supra* note 4, at 32.
15. *Id.*
16. *Id.*
17. *Id.*
18. *Healthcare Systems: Focus on Italy*, 5 PERSPECTIVES 2, (Feb. 13, 2011), *available at* http://www.nextgenmd.org/archives/804
19. *Id.*

Italy's health system is publicly funded through two tax systems.[20] First, a business tax is collected into a national pool and then redistributed generally to the source region.[21] Second, with the aim of ensuring that all regions have adequate funding to provide the LEAs, the central government collects a value-added tax that is used towards grants that are distributed to each region.[22] The allocation of resources for the SSN have historically been a source of contention between the central government and individual regions, resulting in delays in the assignment of regional shares for health care.[23] Substantial difficulty arises in the allocation of funds due to the large geographical differences in levels of economic development, size and age of populations, and availability of health services.[24] To address these issues, in 1997, Italy's government implemented a weighted capitation system that took into consideration the current demand for health services, age, structure, and health condition of the population based on the mortality rate.[25] Although private health insurance plays a small role in Italy's health system, accounting for only one percent of overall health spending, roughly fifteen percent of the population has some form of private insurance to cover cost-sharing requirements.[26] Examples of health expenditures that patient's pay out-of-pocket includes prescription drugs, and in some regions, dental and eye care.[27]

III. COST-CONTAINMENT AND REGIONAL DISPARITIES

A major issue with Italy's health system is the significant regional

20. COMMONWEALTH FUND, *supra* note 4, at 33.
21. *Id.*
22. *Id.* at 32-33.
23. Lo Scalzo et al., *supra* note 3, at 58.
24. *Id.* at 10. In central and northern regions, the percentage of the population aged over 65 exceeds 20%, compared with less than 15% in some southern regions.
25. *Id.* at 179.
26. COMMONWEALTH FUND, *supra* note 4, at 33.
27. *Id.* at 32.

disparities and the effect that these inequalities have on the delivery of effective quality health care to the entire population.[28] While the central government regulates the minimum benefit package for citizens and controls the distribution of tax revenue, each region is individually responsible for the organization and delivery of services within its jurisdiction.[29] Individual regions are given significant autonomy in the allocation of funds and responsibilities, and most choose to assign duties to local health authorities.[30] In addition to the taxes controlled by the central government, regions have the power to collect their own respective taxes, leading to financial disparities.[31] The significant regional differences echo two trends in central government policy: (1) "to systematically, although not overtly, underestimate the funding needs of the SSN; and (2) to overestimate the savings to be obtained from expenditure containment strategies."[32]

Recognizing the issue of significant regional disparities, the Italian government took measures to reduce the differences and shortcomings, such as pooling funds and introducing a weighted capitation rate.[33] The autonomy given to the regions was introduced with the objective to make the regions more aware and accountable for controlling expenditures and to promote efficiency, quality, and citizen satisfaction.[34] The regions are responsible for catering to the needs of the specific population, as well as the allocating financial resources and monitoring local health care

28. Lo Scalzo et al., *supra* note 3, at xxiv.

29. Maurizio Ferrera, *The Rise and Fall of Democratic Universalism: Health Care Reform in Italy, 1979-1994*, 20 J. HEALTH POL., POL'Y & L. 275, 281 (1995).

30. COMMONWEALTH FUND, *supra* note 4, at 33.

31. *Id.*

32. Lo Scalzo et al., *supra* note 3, at 40.

33. *Id.* at 59.

34. Vittorio Maio & Lamberto Manzoli, *The Italian Healthcare System: W.H.O. Ranking Versus Public Perception*, 27 PHARMACY & THERAPEUTICS J 301, 302 (June 2002).

agencies.[35] Regions are also accountable for accrediting public and private health service providers and assuring that their guidelines are in accordance with national laws.[36]

Italy's health system has recognized the problems in the arena of cost containment in light of the growing public deficit and has taken various measures to reduce these problems.[37] Italy has one of the lowest public shares of total health care expenditures among countries in the European Union, suggesting substantial success in the area of cost containment.[38] However, the total public health care expenditure remains a central issue both nationally and regionally.[39] Public expenditure for health care steadily increased until 1991, reaching almost $65 billion – 6.6% of Italy's gross domestic product (GDP).[40] Since 1992, the Italian Government implemented two broad categories of cost containment measures.[41] The first category was aimed at increasing productivity and accountability for regions, such as spending ceilings on goods and services and closures of small hospitals.[42] The second category includes measures intended to reduce the demand for health care by patients, such as increasing copayments on drugs and outpatient specialist care.[43]

Research on public health care expenditure suggests that differences in regional health care are mainly a result of socioeconomic factors such as variations in GDP and the availability of care.[44] Reforms in the system demonstrate progress in both financing health care and reducing regional

35. *Id.*
36. *Id.*
37. Lo Scalzo at al., *supra* note 3, at 68.
38. *Id.* at 45.
39. *Id.*
40. Maio & Manzoli, *supra* note 34, at 305.
41. *Id*.
42. *Id*.
43. *Id*.
44. Lo Scalzo et al., *supra* note 3, at 45.

differences in quality and access, but the drawbacks that result from an unevenly distributed tax base and a demand for poorer regions to increase their tax rates are inevitable.[45] These issues, along with difficulties in reaching an equitable distribution of the National Solidarity Fund, have thwarted the effectiveness of the redistribution formula and demand revisions and adjustments.[46]

The central government attempted to limit the substantial deficits by requiring regions to underwrite annual "Pacts for Health" that "tie additional resources to the achievement of health care planning and expenditure goals."[47] Regional governors are also required to balance the books in health care expenditures yearly.[48] These requirements create accountability, incentives for regions to perform better, and a system in which the central government can monitor regional spending.[49]

IV. A COMPARISON WITH THE UNITED STATES

The challenges that Italy's health system faces regarding regional disparities could be considered comparable to variations among the fifty states, as well as inequalities resulting from location and income. Socioeconomic status and the location of residence inevitably have a strong influence on health.[50] In the U.S., the risk of mortality, morbidity, reduced access and poor quality of care increases as socioeconomic circumstances decrease.[51] The U.S. health care system tends to divide the population by

45. *Id.* at 53-4.
46. *Id.* at 54.
47. *Id.* at 40.
48. *Id.*
49. *Id.* at 41.
50. Gloria L. Beckles & Benedict I. Truman, *Education and Income – United States, 2005 and 2009*, 60 MORBIDITY AND MORTALITY WEEKLY REPORT 13, Jan. 14 2011, at 13, *available at* http://www.cdc.gov/mmwr/pdf/other/su6001.pdf.
51. *Id.*

"insiders" and "outsiders."[52] On one hand, the "[i]nsiders, who have good insurance, receive everything modern medicine can provide, no matter how expensive."[53] Alternatively, the "[o]utsiders, who have poor insurance or none at all, receive very little."[54] For example, a study found that among Americans diagnosed with colorectal cancer, patients without insurance were seventy percent more likely than patients with insurance to die within three years.[55] New technology and medical advancements result in increased funds spent on the wealthy, and as a result, more citizens are consigned to an "outsider" status.[56]

To address the inequalities in health care that result from socioeconomic conditions, the U.S. government put a focus on clinical interventions, counseling and education, and protective intervention in the Patient Protection and Affordable Care Act (PPACA).[57] In addition to a focus on physician-provided medical care, the PPACA is "suffused with provisions that promise to elevate the status of, and national commitment to, disease prevention, wellness promotion, and population-based interventions."[58] The PPACA authorizes Congress to sponsor grants at the state level to assist public health organizations, but is limited to targeted attempts to change behavior and lifestyle at individual and community-based levels.[59] For example, Sections 10503 and 5207 of the PPACA increase funding for community health centers and the National Health Service Corps in rural

52. Paul Krugman & Robin Wells, *The Healthcare Crisis and What to Do About It*, N. Y. REV. OF BOOKS, March 23, 2006, *available at* http://www.nybooks.com/articles/archives/2006/mar/23/the-health-care-crisis-and-what-to-do-about-it/?pagination=false.

53. *Id.*

54. *Id.*

55. *Id.*

56. *Id.*

57. Kenneth Deville & Lloyd Novick, *Swimming Upstream? Patient Protection and Affordable Care Act and the Cultural Ascendancy of Public Health*, 17 J. of Pub. Health Mgmt. 102, 107 (2001), *available at* http://journals.lww.com/jphmp/Fulltext/2011/03000/Swimming_Upstream__Patient_Protection_and.2.aspx#.

58. *Id*. at 102.

59. *Id*. at 107.

and underserved areas in order to increase access to health care services to reduce health disparities.[60] Additionally, Section 4302 aims to uncover and reduce health disparities among racial and ethnic groups through data collection techniques.[61] Through these mechanisms, the PPACA takes measures to reduce disparities by targeting specific at-risk populations and communities.

In the Italian health care system, similar inequalities exist across regional and socioeconomic lines.[62] As previously mentioned, wealthier patients are afforded quicker and more easily accessible care if they pay a fee for private insurance.[63] For example, a patient who enters the Radiology Department for a CT scan must only pay a small copayment, unless he or she is not already exempt.[64] However, it can take up to four weeks to have the exam and the patient will encounter significant chaos and disorganization in the hospitals, which are under substantial pressure to treat a large amount of patients.[65] In another case, an American citizen with private insurance who entered a hospital in Tourino, Italy after a trip and fall accident was seen immediately and avoided long lines of Italian citizens with governmental insurance waiting to be seen.[66] Therefore, those patients who can afford private care can pay a fee to avoid long waits and receive care quickly in a quiet and comfortable environment, thereby increasing the inequity between the rich and the poor on both a regional and an individual

60. Hinda Chaikind, et. al., CONGRESSIONAL RESEARCH SERVICE, PPACA: A BRIEF OVERVIEW OF THE LAW, IMPLEMENTATION, AND LEGAL CHALLENGES 3, (Mar. 2, 2011), *available at* http://www.nationalaglawcenter.org/assets/crs/R41664.pdf; C. Stephen Redhead & Erin D. Williams, CONGRESSIONAL RESEARCH SERVICE, PUBLIC HEALTH, WORKFORCE, QUALITY, AND RELATED PROVISIONS IN PPACA: SUMMARY AND TIMELINE 8-9, (Sept. 2, 2010), *available at* http://healthyamericans.org/assets/files/CRS%20Report%209-2.pdf.

61. 42 U.S.C.A. §300kk

62. Lo Scalzo et al., *supra* note 3, at xxiv.

63. *Healthcare Systems: Focus on Italy*, *supra* note 18.

64. *Id*.

65. *Id*.

66. Telephone Interview with William Young, Chief Executive Officer, Automark Inc., (Mar. 8, 2012).

level.[67] Additionally, the regional organization of Italy's health care system, coupled with the extensive interregional differences in socioeconomic indicators, has resulted in strong inequalities among regions.[68] Southern regions have a "smaller bed stock, a greater presence of private facilities and a poorer endowment of advanced medical equipment," which contributes to "heavy patient flows to central and northern regions and to other European countries."[69]

Italy addressed the regional and socioeconomic disparities in the health care system through the implementation of a regional weighted capitation system.[70] The weighted capitation formula varies annually based on negotiations among regions and aims to ensure equal access to health care for people at equal risk.[71] To serve this purpose, the formula has been constructed to address the relative needs of regional populations.[72] With the adoption of a weighted capitation scheme, individual regions also have the power to implement their own distributive justice model that "takes into account heterogeneity with respect to the resources needed to cover the diverse health care needs of the population."[73] However, the application of the weighted capitation formula has had a tendency to address health requirements within subgroups of a population rather than improving the overall outcome for that population.[74]

Additionally, the government created a National Solidarity Fund to distribute resources to individual regions with the purpose of reducing inequalities between northern regions and southern regions.[75] Northern

67. *Healthcare Systems: Focus on Italy*, *supra* note 18.
68. Lo Scalzo et al., *supra* note 3, at 185.
69. *Id*.
70. *Id*. at 178.
71. *Id*. at 179.
72. *Id*.
73. *Id*. at 184.
74. *Id*.
75. *Id*. at 178.

regions generally need less funding from the National Solidarity Fund because they hold more wealth and have higher own-source tax revenues to contribute to the core benefits package.[76] The reserves in the National Solidarity Fund are allocated based on the following four considerations: "the region's share of total [value-added tax] revenue, its fiscal capability, its health care financing needs and its non-health care financing needs."[77] However, these issues are multifaceted and complex, resulting in difficulties reaching an equitable distribution of the Fund.[78] These reforms represent progress, but have possible drawbacks related to an unevenly distributed tax base, and the greater need for poorer regions to increase tax rates coupled with negative business incentives for business location in poorer regions.[79]

The U.S. may adopt policies from Italy's health system in order to combat regional and socioeconomic disparities in health care on a large-scale level, in addition to focusing on individual communities and populations. The U.S. could create a reserve similar to the National Solidarity Fund to reduce disparities on a large-scale basis. To be effective, the fund must adopt a formula based on population size, current health need, age, and financial necessity to assist poorer states and potentially decrease funding for wealthier states. However, with the adoption of a policy too similar to Italy, the U.S. may experience the same problems that Italy faces such as the inability to nationally agree on the distribution of funds.[80] Therefore, allowing each state to collect an individual fund and the individual autonomy to allocate it would be a more effective structure. With the successful implementation of the PPACA provisions that aim to

76. *Id*.
77. *Id*. at 53.
78. *Id*. at 54.
79. *Id*.
80. *Id*.

reduce disparities in health care, current inequalities in the U.S. will predictably reduce and vary within each state.[81] Creating a fund at a state level would allow the individual states to cater to the unique needs within each state, such as elder care, similar to the way Italian regions hold the responsibility to cater to the distinct needs of the particular population.[82] To effectively decrease the regional disparities in health care that the U.S. faces, it would be most effective for each state to adopt a version of Italy's National Solidarity Fund in addition to the federal community-focused policies presented in the PPACA.

V. CONCLUSION

Italy's health system is organized regionally and offers universal health care for its citizens.[83] The central government determines the minimum level of care required for all residents.[84] A major challenge that Italy faces is inequalities in the delivery and level of care among different regions and populations.[85] The Italian government has implemented policies to reduce regional disparities and contain costs, such as the enactment of a regional weighted capitation system and the National Solidarity Fund.[86] The U.S. faces similar inequalities across regional and socioeconomic lines.[87] Although the U.S. can model some elements after Italy's system, attempts to mimic Italy's system may present the country with similar challenges that Italy currently faces. To reduce the disparities in the U.S., in addition to the policies outlined in the PPACA, individual states could adopt a variation of Italy's National Solidarity Fund to provide funding for the most

81. Deville & Novick, *supra* note 57, at 107.
82. Maio & Manzoli, *supra* note 34, at 302.
83. Stancati, *supra* note 5.
84. COMMONWEALTH FUND, *supra* note 4, at 32.
85. Lo Scalzo et al., *supra* note 3, at xxiv.
86. *Id*. at 178.
87. Beckles & Truman, *supra* note 50, at 13.

at-risk populations. As regional disparities continue to adversely affect the overall health of nations, creative solutions must be explored to provide equal care to all populations.