THE ITALIAN NHS (NATIONAL HEALTH SERVICE)

The Italian health care system was reformed in 1979. It is now based on a national health service and structured in order to allow regional planning and local managerial control. There are three levels of public authority: the central government, the 20 regions and the Local Health Authorities (LHAs).

The Ministry of Health, advised by the National Health Council, is in charge of political planning and regulation, overseeing the health regions and reviewing regional legislation.

The regions are the main administrative level of the NHS and are responsible for implementing decisions taken by Parliament and for providing health services. Each region has an elected council and a large administrative department for public health. Regional activities must be covered by regional laws that have to be approved by Parliament, although these can vary greatly from one region to another. The LHAs are responsible for the daily management of the health services and for coordination between hospitals. They are also in charge of the delivery of primary care, including contracts with general practitioners (GPs), provision of occupational health services, health education, disease prevention, pharmacies, family advice, child health, and information services. Each LHA has a general director nominated by the president of the regional government.

One of the aims of the reform was to achieve geographical equity through:

- uniformity of regulation
- provision of adequate health services
- resource allocation.

The resource allocation mechanisms operate as follows:

The health budget is determined centrally and financed partly by employers and employees contributions (despite the expressed intention in 1979 to finance it out of general taxation) with the Government paying the balance directly.

Funds are allocated to the regions according to a formula. This has been changed several times since it was first implemented and now includes the type of health expenditure, the population structure, and adjustments for demand and supply factors.

The following laws aim at reforming different aspects of the health care system:

- Law 111/1991 was designed to foster the drive for financial, technical and functional efficiency of the LHAs through the introduction of managerial accountability. LHA directors were designated, i.e. sole special administrators. However, the power of the regional authorities, to which the LHA directors are accountable, was increased.
- Law 412/1991 and subsequent reforms have greatly increased the responsibility of regional authorities. They are now in charge of everything that is not the clear responsibility of central government (i.e. planning and setting of funding parameters for national standards of care), and they now have to fund any over-spending out of their own resources. The reforms emphasize the principle of a minimum standard of health care delivery throughout the country rather than equal access to services for all citizens, and define the minimum guaranteed services more restrictively as hospital services and vital life-saving drugs.
- Law 502/1992 reduced the number of LHAs and introduced self-managing hospital trusts under the increased power of the hospital chief executives. The latter, nominated by regional health authorities, appoint hospital health directors and administrative directors. Hospitals are evaluated on the results of their management.

Law 502/92 introduced a new system of funding for the LHAs by the regions on a capitation basis, with a different system of compensation for the treatment of patients from other LHAs.

Law 502/92 and 517/93 transformed the LHAs and the main hospitals into "public concerns" with their own budget to manage.

Ambulatory care and day hospital care are paid for by a system based on diagnosis-related groups.

Hospital services are mainly free at the point of use but patients pay a proportion of the costs of non- hospital services (dental care, drugs, diagnostic examinations). However, essential drugs are free, as are most drugs for poor people. As well as the NHS there is an important private sector

which accounts for 20% of total health expenditure, but people wishing to use private facilities have to take out private insurance in addition to their obligatory NHS contributions. However, there are also several private services with contracts with the public sector and patients can use these services as they would use public facilities. There are too many GP's and a relative lack of community nurses, social workers and hospital nurses, especially in public hospitals.