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Veneto Region, Italy

Health system review

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Preface

The Health Systems in Transition (HiT) series consists of country-based reviews that provide a detailed description of a health system and of reform and policy initiatives in progress or under development in a specific country. Each review is produced by country experts in collaboration with the Observatory's staff. In order to facilitate comparisons between countries, reviews are based on a template, which is revised periodically. The template provides detailed guidelines and specific questions, definitions and examples needed to compile a report.

HiTs seek to provide relevant information to support policy-makers and analysts in the development of health systems in Europe. They are building blocks that can be used:

- to learn in detail about different approaches to the organization, financing and delivery of health services and the role of the main actors in health systems;
- to describe the institutional framework, the process, content and implementation of health care reform programmes;
- to highlight challenges and areas that require more in-depth analysis;
- to provide a tool for the dissemination of information on health systems and the exchange of experiences of reform strategies between policy-makers and analysts in different countries; and
- to assist other researchers in more in-depth comparative health policy analysis.

Compiling the reviews poses a number of methodological problems. In many countries, there is relatively little information available on the health system and the impact of reforms. Due to the lack of a uniform data source, quantitative data on health services are based on a number of different sources, including

the World Health Organization (WHO) Regional Office for Europe's European Health for All database, data from national statistical offices, Eurostat, the Organisation for Economic Co-operation and Development (OECD) Health Data, data from the International Monetary Fund (IMF), the World Bank's World Development Indicators and any other relevant sources considered useful by the authors. Data collection methods and definitions sometimes vary, but typically are consistent within each separate review.

A standardized review has certain disadvantages because the financing and delivery of health care differ across countries. However, it also offers advantages, because it raises similar issues and questions. HiTs can be used to inform policy-makers about experiences in other countries that may be relevant to their own national situation. They can also be used to inform comparative analysis of health systems. This series is an ongoing initiative and material is updated at regular intervals.

Comments and suggestions for the further development and improvement of the HiT series are most welcome and can be sent to info@obs.euro.who.int.

HiTs and HiT summaries are available on the Observatory's web site (http://www.healthobservatory.eu).

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Bank, the World Bank, UNCAM (French National Union of Health Insurance Funds), the London School of Economics and Political Science, and the London School of Hygiene & Tropical Medicine.

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List of abbreviations

Abbreviations	English name	Italian name
AO	Hospital enterprise (public hospital)	*Azienda ospedaliera*
ARSS	Regional Agency for Health and Social Care	*Agenzia Regionale Sociosanitaria*
ASL	Local health enterprise	*Azienda sanitaria locale*
DRG	Diagnostic-related group	–
EU	European Union	–
HIV	Human immunodeficiency virus	–
HTA	Health technology assessment	–
GDP	Gross domestic product	–
GP	General practitioner	–
IRA	Rehabilitation facilities for the elderly	*Istituti di riabilitazione per anziani*
IRCSS	National hospital for scientific research	*Istituti di ricovero e cura a carattere scientifico*
IRPEF	Personal income tax	*Imposta sul reddito delle persone fisiche*
ISTAT	National Institute for Statistics	*Istituto nazionale di statistica*
IT	Information technology	–
LEA	Nationally defined basic health benefit package (i.e. basic levels of care)	*Livelli essenziali di assistenza*
OECD	Organisation for Economic Co-operation and Development	–
OSS	Health and social care support staff (i.e. support staff without formal qualifications)	*Operatori socio sanitari*
OTA	Technical health care support staff	*Operatori tecnici addetti all'assistenza*
VAT	Value added tax	–
WHO	World Health Organization	–

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Abstract

The Health Systems in Transition (HiT) profiles are country-based reports that provide a detailed description of a health system and of policy initiatives in progress or under development. This HiT is one of the first to be written on a subnational level of government and focuses on the Veneto Region of northern Italy. HiTs examine different approaches to the organization, financing and delivery of health services and the role of the main actors in health systems; describe the institutional framework, process, content and implementation of health and health care policies; and highlight challenges and areas that require more in-depth analysis.

The Veneto Region is one of Italy's richest regions and the health of its resident population compares favourably with other regions in Italy. Life expectancy for both men and women, now at 79.1 and 85.2 years, respectively, is slightly higher than the national average, while mortality rates are comparable to national ones. The major causes of death are tumours and cardiovascular diseases.

Under Italy's National Health Service, the organization and provision of health care is a regional responsibility and regions must provide a nationally defined (with regional input) basic health benefit package to all of their citizens; extra services may be provided if budgets allow. Health care is mainly financed by earmarked central and regional taxes, with regions receiving their allocated share of resources from the National Health Fund. Historically, health budget deficits have been a major problem in most Italian regions, but since the early 2000s the introduction of efficiency measures and tighter procedures on financial management have contributed to a significant decrease in the Veneto Region's health budget deficit.

The health system is governed by the Veneto Region government (Giunta) via the Departments of Health and Social Services, which receive technical support from a single General Management Secretariat. Health care is provided by 21 local health and social care units, 2 hospital enterprises, 2 national hospitals for scientific research and private accredited providers.

Major national health reform legislation in the 1990s started the process of regionalization of the health system and the introduction of managerial methods and quasi-market mechanisms into the National Health Service, a process that has been consolidated since the early 2000s under the framework of fiscal federalism. Future challenges for the Veneto Region include the sustainable provision of the basic health benefit package; the adaptation of services to meet changes in demand, particularly those associated with the ageing population and the incidence of chronic diseases; and the ever-present problem of keeping the regional health budget balanced.

Executive summary

Introduction

The Veneto Region, located in the north-eastern part of the country, is one of Italy's richest regions, although it has suffered from the effects of the global financial crisis, with a subsequent decrease in gross domestic product (GDP) and an increase in unemployment, especially among young people. Politically, the Veneto Region has always been governed by centre-right governments. The current government is a coalition between the Popolo della Libertà (People of Freedom Party) and the Lega Nord (Northern League). The president is the head of the regional government (Giunta), which comprises the heads of government departments.

The health of the Veneto Region's resident population of 5 million inhabitants compares favourably with other regions in Italy and within Europe. The population has grown in recent years, partly through the increase in average life expectancy for both men and women (now at 79.1 and 85.2 years, respectively, slightly higher than the national average) and partly through immigration, which has contributed to an increase in the regional birth rate. Population ageing has important consequences for health and social care as it leads to increased demand for services. The major causes of death are tumours and cardiovascular diseases.

Organization and governance

Under Italy's National Health Service (*Servizio Sanitario Nazionale* (SSN)), the organization and provision of health care is a regional responsibility. Like other regions, the Veneto Region is linked to the national government via the Standing Conference of the State and the Regions and Autonomous Provinces, known in short as the State-Regions Conference (*Conferenza Stato-Regioni*). This meets monthly with the regional presidents, the Italian Minister of Health

and other national ministers whose portfolios directly or indirectly affect health policy. Objectives for the health system are established by the Regional Health and Social Care Plan, which also reflects the priorities and requirements laid out in the National Health Plan, and the agreements reached at the State-Regions Conference. In addition, a Regional Development Plan (*Piano Regionale di Sviluppo*) coordinates policies with other relevant departments such as environment and urban planning.

Planning directives originate from the Giunta via the Departments of Health and Social Services, which receive technical support from a single General Management Secretariat. Regulation of the health system is divided among different organizations, for example those that govern the accreditation of facilities, the registration of health professionals and the regulation of the use of medicines and medical devices. Joint efforts are underway to improve information systems, and the Veneto Region is one of the few Italian regions that has established a unit for health technology assessment (HTA).

The well-being of patients is fundamental to the health system, both in terms of the services delivered and patient rights. Over the last few years, a system has been implemented to evaluate the quality of services provided to patients through the Health Services Charter and the client care offices (*ufficio relazioni con il pubblico*), which enable patients to obtain information about various treatments and how to lodge complaints.

Financing

In 2007, the Veneto Region spent a total of 7.1% of its GDP on health care, a moderate rise from 2001 when the total was 6.7%. This compares with an Italian average of 9.0% of GDP for 2007. In term of the public share of total health care spending, in 2007 for the Veneto Region this figure was 76.0%, slightly below the average (79.0%) for all the Italian regions that year.

The SSN covers the whole population and regions must provide a nationally defined (with regional input) basic level of care (i.e. a health benefit package) to all of their residents; this is known as the *livelli essenziali di assistenza* (LEA). Extra services may be provided if budgets allow. The reforms of the 1990s, the latest innovations regarding fiscal federalism introduced with the State-Regions Conference Agreement in 2001 and the subsequent definition of the LEA, have contributed to a reversal in the trend that saw increasing debt levels in the health sector. In the last few years, resources earmarked for health policies have also

increased. Coupled with the introduction of efficiency measures and tighter procedures for financial management, regions, including the Veneto Region, have successfully cut their budget deficits.

Following intense discussions between the national government and the regions over the National Health Fund (*Fondo Sanitario Nazionale*), which finances the provision of the LEA, resource allocation criteria are established by the State-Regions Conference at the national level. The nationally set allocation guidelines stipulate that 5% of a region's National Health Fund funding should go to public health, 44% to hospital care and 51% to district-level (primary) care.

Statutory user charges applied to secondary care and outpatient prescription drugs account for 2–3% of total spending on health care. Most private spending is through direct payments for privately provided health care. Supplementary voluntary health insurance has only recently been introduced and does not play a major role in the Veneto Region or in Italy as a whole.

Physical and human resources

In the last few years, the Veneto Region has reviewed the organization of facilities in order to meet the need for fewer hospitals and more primary and community care. There has been an ongoing process to turn small hospitals into post-acute care and community health facilities. Hospital beds are not evenly distributed across the region and further rationalization will be required in some areas. In 2009, there were 19 672 accredited hospital beds (an average of 3.4 beds for every 1000 inhabitants). Standard medical equipment is purchased at the discretion of individual local health and social care units (*unità locali socio sanitarie* (ULSS)), the Veneto's Region's name for local health enterprises (*azienda sanitaria locale* (ASLs)), while expensive items need authorization from the Giunta.

The total number of people employed within the region's health care enterprises in 2010, including administrative staff, was 61 246 (or 57 692 full-time equivalent). There has been a slight increase (2.2%) in the number of health care personnel in recent years but as the population has also increased over this period, the per capita ratio has remained more or less the same. There is a general undersupply of nurses.

Provision of services

Health care is provided by 21 ULSSs, 2 hospital enterprises (*aziende ospedaliere* (AOs)), 2 hospitals in the national hospitals for scientific research (*istituti di ricovero e cura a carattere scientifico* (IRCSS)) scheme and private accredited providers, all of which deliver services across three broad programme areas: public (preventive) health care, district-level primary and community care, and hospital care.

The Region's Directorate for Prevention deals with public health matters and is also tasked with monitoring and surveillance activities, enabling it to deal with any public health emergencies that may arise. Access to primary care does not differ from the framework established nationally as primary care is delivered by general practitioners (GPs) and paediatricians; ambulatory (outpatient) services are provided by public and private accredited facilities (with a co-payment). Patients who wish to use ambulatory services exclusively in the private sector incur the full cost of care. Acute hospital care in the SSN is delivered by public and private accredited facilities. Currently, the hospital sector is being restructured, with the conversion, merger or closure of smaller hospitals, in order to deliver services more efficiently and to improve the response to population needs. Ambulance and emergency services are directly managed by the Medical Emergency Service (*Servizio di Urgenza ed Emergenza Medica*), in cooperation with the region's other emergency services.

The network of services for long-term care of older people focuses on achieving a balance between residential-based care and home care, both of which have undergone a significant process of reform since the early 2000s. In particular, residential services have been reorganized to guarantee access to services based on needs. Health-related long-term care services are covered by the regional health services, while accommodation in residential facilities is paid for by the user or by municipalities. Home care and community-based services are delivered either as direct services within the home or through financial support (social benefits), support (health and social) for family carers, and temporary respite services.

Principal health reforms

Since the early 1990s, health care in Italy has undergone many changes both to adapt to new patient needs and to achieve financial sustainability. Major national health reform legislation in 1992, 1993 and 1999 started the process of regionalization of the health system and the introduction of "managerialism" (business-like practices) and quasi-market mechanisms into the SSN. The decentralization process was confirmed by the Constitution (Chapter V) in 2001, which identified the respective competencies of the central government and the regions under a federalist-style framework. The reforms of the 1990s also established the LEA, and the Pacts for Health signed in 2001 and 2009 defined the delivery of the LEA and sanctions for non-implementation. The 2009 Law on Fiscal Federalism (Law No. 42) outlined important innovations for health care financing. Future developments will focus on the implementation of the annual Pacts for Health between the central government and the regions and the adaptation of services to meet new health system challenges, particularly those associated with the ageing population, the incidence of chronic diseases and the ever-present problem of keeping the regional health budget balanced.

Assessment of the health system

Generally speaking, the population's health status is good and citizens' needs are, in large part, satisfied; however, improvements are always necessary, particularly in making use of local resources and other structures. The population enjoys a good degree of financial protection and there are measures to ensure access to care for vulnerable groups. Access to health services is fairly equitable, but some areas, particularly alpine areas, need to have their level of services strengthened to reach optimum standards. Technical resources are also distributed equitably, especially the more expensive medical equipment. From an organizational point of view, there are differences among the ULSSs, and the Veneto Region is working towards cooperation to share good practice and optimize services for patients. The overall number of hospital beds has been rationalized and the Region is consolidating the number of suitable facilities for the treatment of various diseases. With regard to human resources, questionnaires reveal that the majority of the population is satisfied with the level of service it receives, but more nurses are needed.

1. Introduction

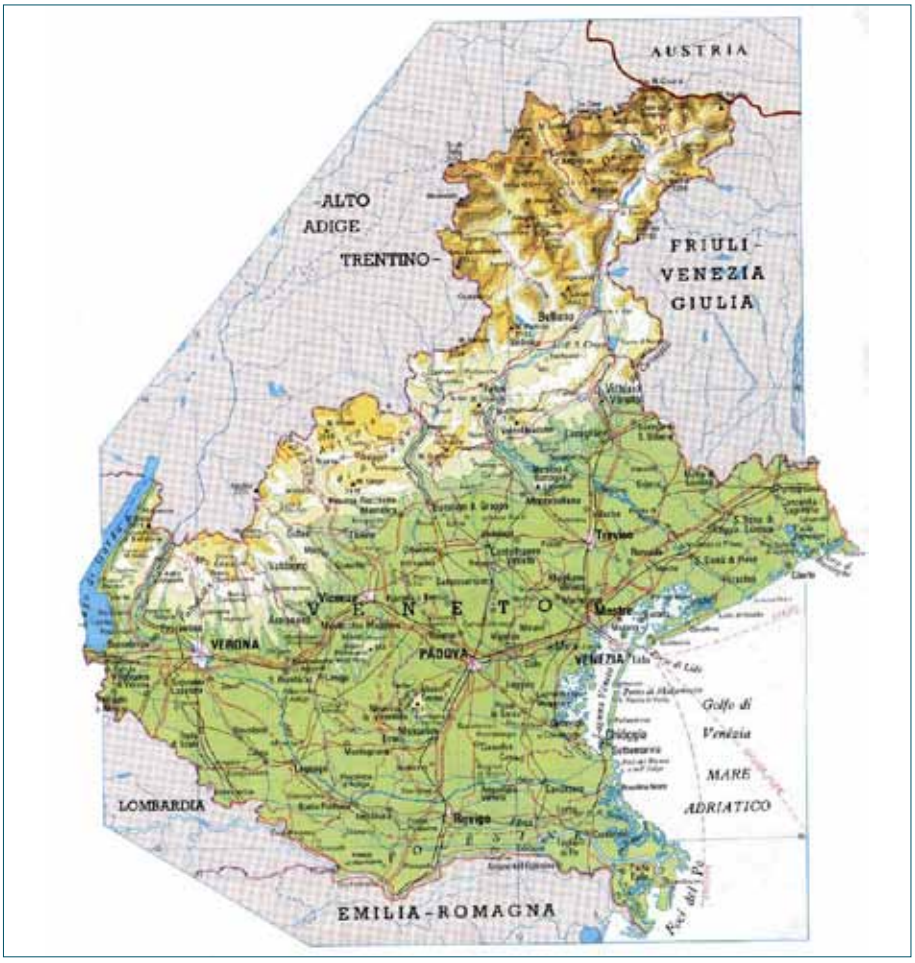
The Veneto Region, located in the north-eastern part of the country, is one of Italy's richest regions, although it has suffered from the effects of the global financial crisis, with a subsequent decrease in GDP and an increase in unemployment, especially among young people. Politically, the Veneto Region has always been governed by centre-right governments. The current government is a coalition between the Popolo della Libertà (People of Freedom Party) and the Lega Nord (Northern League). The President (from the Lega Nord) is the head of the Giunta, which comprises the heads of government departments.

The health of the Veneto Region's resident population of 5 million inhabitants compares favourably with other regions in Italy and within Europe. The population has grown in recent years, partly through increases in the average life expectancy for both men and women (now at 79.1 and 85.2 years, respectively, slightly higher than the national average) and partly through immigration, which has contributed to an increase in the regional birth rate. Population ageing has important consequences for health and social care as it leads to increased demand for services. The major causes of death are tumours and cardiovascular diseases.

1.1 Geography and sociodemography

The Veneto Region is located in the north-eastern part of Italy and covers an area of about 18 399 km^2. It borders in the south with the Emilia-Romagna Region, to the west with Lombardy and the Province of Trentino, to the north for a small part of the border with Austria, and to the east with the Friuli-Venezia Giulia Region and the Adriatic Sea (Fig. 1.1). It is made up of seven provinces: Venice (the region's capital), Belluno, Padova, Rovigo, Treviso, Verona and Vicenza. The region's central area in the south is flat while in the north the Alps connect with Austria.

Fig. 1.1
Map of Veneto Region



Source: Author's own compilation.

In terms of population, the Veneto Region is the fifth-largest Italian region (after Lombardy, Campania, Lazio and Sicily) with just over 4.9 million inhabitants, with a slight majority of women (51% of the total) (Table 1.1). The distribution of the population among local government units, known as *comuni* or local councils, is very heterogeneous with more than half not reaching 5000 inhabitants while approximately one-fifth have 10 000. Since the late 1990s, there has been a demographic increase of 0.9%, but this figure should be considered in conjunction with the fact that more than one-fifth of newborns are not of Italian origin and that there has been an increase in the ageing of the population equal to 2.3%. Therefore, in common with the rest of Italy, the

main demographic characteristic of the Veneto Region is its ageing population. This is explained, on the one hand, by the total decrease in births and, on the other hand, by the increased longevity of the average life: in 1990, average life expectancy was 73.2 years for men and 80.7 for women, while in 2009 it had risen to 79.1 and 85.2, respectively (see Table 1.3, below). About 9.5% of the population is aged 75 years and older, and this is the group that is most exposed to the risk of disease (Table 1.1).

Adults of working age represent 66% of the population, while those younger than 15 years form 14%; this gives an age dependency ratio of approximately 51% (Table 1.1). Factors such as the ageing of the population, low fertility and young people's inclination to postpone leaving home or to start their own families are the sources of increasing numbers of people living alone and of couples without children.

There are approximately 454 000 immigrants who reside in the Veneto Region, forming 9.8% of the total population in 2010. These immigrants come mainly from Romania (18.7%), Morocco (11.1%), Albania (8.3%) and the Republic of Moldova (5.3%). The immigration trend has remained more or less constant and is not projected to change significantly in the years to come, with important consequences for social policy.

Table 1.1

Trends in population/demographic indicators

	1990	1995	2000	2005	2009
Total population	4 398 114	4 433 060	4 540 853	4 738 313	4 912 438
Population female (%)	2 263 178 (51.5)	2 278 535 (51.1)	2 325 304 (51.2)	2 417 156 (51.0)	2 507 717 (51.0)
Population aged 0–14 years (% of total)	650 045 (14.7)	589 412 (1.3)	607 239 (13.4)	657 917 (13.9)	697 564 (14.0)
Population aged ≥65 (% of total)	644 988 (14.6)	745 307 (16.4)	815 669 (17.8)	908 936 (18.9)	975 729 (20.0)
Population aged ≥75 (% of total)	286 849 (6.5)	290 845 (6.5)	358 686 (8.5)	421 828 (8.9)	277 546[a] –
Population growth (%)	0.30	0.25	0.65	0.80	0.55
Population density (km^2)	239	241	247	258	267
Birth rate (per 1000 people)	8.9	8.6	9.5	9.8	9.7
Death rate crude (per 1000 people)	9.3	9.4	9.3	9.1	9.1
Fertility rate total	1.4	1.3	1.22	1.35	1.47 (2008)
Age dependency ratio[b]	42.1	43.1	45.6	49.4	51.7

Source: Veneto Region Directorate of the Regional Statistical System, 2010.
Notes: [a] Population aged 80 and above; [b] The age dependency ratio is the ratio of the combined child population (aged 0–14 years) and the elderly population (aged ≥65 years) to the working age population (aged 15–64 years).

1.2 Economic context

The financial situation in the Veneto Region reflects the Italian situation with respect to the financial crisis, which has been dominating since 2008, and the new challenges that the economic system needs to face. In the economic context, a number of factors need to be considered: the increased age of the population and the retirement age, and the rate of unemployment, which, although lower than in other Italian regions, is worrying, above all, for young people (Table 1.2). Compared with the national average, the Veneto Region has fared better, both generally and in relation to regions such as Lombardia, Piedmonte and Emilia-Romagna, its traditional competitors. In 2009, the fall in GDP in both the Veneto Region and in Italy was significant: a fall of 4.8% in 2009 followed a reduction in 2008 of 0.8% in the Veneto Region and of 1% in Italy. Data for 2010 showed a slight improvement, with regional GPD increasing by 1.6% (Unionecamere Veneto, 2011). However, this rise must be seen in the context of the sharp fall in the previous year and the uncertain economic climate created by the current Eurozone crisis and the austerity measures imposed to contain Italy's spiralling public debt.

Table 1.2
Macroeconomic indicators, Veneto Region, 2000, 2005, 2009

	2000	2005	2009
GDP (€, million)	111 712	116 917	113 725
GDP per capita (€)	24 843	28 433	28 890
Value added in industry (€, million)	36 499	36 916	33 484
Value added in agriculture (€, million)	2 835	2 619	2 518
Value added in services (€, million)	61 254	66 221	66 531
Labour force (total)	1 917 000	2 063 000	2 112 000
Unemployment, total (% of labour force)	3.75	4.2	4.8

Source: Veneto Region Directorate of the Regional Statistical System, 2010.

The last two years in the Veneto Region have seen diminished added value in the manufacturing industry (a fall of 13%) and the building sector (a fall of 4.5%) (Prometeia, 2011). The service sector suffered less, with a decrease of 1.4%. In the Veneto Region, the fall in GDP mainly reflected a fall in exports (estimated at a reduction of 17%) and in investments (reduction of 13%), while a fall in domestic consumption also played a modest role (1.6%). Compared with 2008, the fall in production in the Veneto Region in 2009 reduced the workforce by 2.6%, a fall that was more or less the same as that for Italy as a whole (2.4%).

Unemployment has been rising, although there is some variation in trends across sectors. The cost of social services has gone up, reaching almost €2 billion in 2009, or 1.69% of GDP. Half of this expense was for unemployment benefits.

1.3 Political context

The Veneto Region was established as a self-governing body in 1972. It has seven provinces – Venice (the capital), Belluno, Padova, Rovigo, Treviso, Vicenza and Verona – and 581 local governments (councils). The Veneto Region has always been ruled by centre-right governments. Up to 1990, every election had been won by the (now defunct) Christian Democrats, a party which had governed Italy for almost 40 years. Following a series of corruption scandals and legal prosecutions that affected all political parties in the early 1990s, the Christian Democrats and the Socialist Party were dissolved, giving way to the formation of other parties, among which emerged Forza Italia (later renamed Popolo della Libertà), led by Silvio Berlusconi. This party governed the Veneto Region for 15 years with Giancarlo Galan as President, winning consecutive elections in 1995, 2000 and 2005. In the most recent election in 2010, the Lega Nord, led by Umberto Bossi, won the most seats, forming a coalition with Popolo della Libertà, and the new President of the Veneto Region is now Luca Zaia, who was previously Minister for Agriculture and Forestry Heritage in the national government headed by Silvio Berlusconi.

The Regional Council is the region's legislative body and is made up of 60 members, called *consiglieri* (regional councillors). The Region's political and regulatory powers are ratified by Art. 117 of the Italian Constitution and by Art. 8 and Art. 9 of the Veneto Code of Law. Regional councillors are elected directly by the people; they represent the Region and exercise their functions without restraint. Regional councillors cannot be prosecuted for their opinions or for the votes they cast while exercising their legislative functions; they have powers to interrogate, consult and introduce motions. Each regional councillor has the right to obtain information and data, and to examine all documentation regarding the region's activities, government bodies, companies and agencies. Under Art. 21 of the Veneto Code of Law, the Regional Council has seven permanent committees, which specialize in related fields of research. The fifth of these committees deals with social security, hygiene, health and social care and is made up of regional councillors from the government majority and the opposition. Committee members examine government bills, regulations and other measures, and when necessary they consult directly with local

government bodies, citizens, trade unions, and other social, financial and professional organizations. The fifth Permanent Committee also voices its opinion on legislative proposals to the Region's executive's arm, the Giunta.

The Giunta is the region's executive organ, pursuant to Art. 21 of the Constitution; it is a collegiate body whose decisions are passed by majority votes. The Giunta is made up of the president (since 30 March 2010, Luca Zaia) and 12 councillors (*assessori*), who are appointed (and dismissed) by the president. They also receive from the president the mandate to perform their executive functions and duties.

The Giunta's duties include responsibility for the region's administration, presenting legislative proposals and preparing and presenting the regional budget. The Giunta also has the power to submit proposals before the national Constitutional Court and to comment on national laws or the laws of other regions (subject to prior consultation with the Regional Council) that are seen to impinge upon its own competence. The Departments of Health and Social Services are served by a single technical General Management Secretariat, in line with the region's traditional preference for integrated health care and social services.

The Veneto Region makes use of the structures in place to monitor other bodies, such as the network of "social observatories" (reorganized in 2003), the Regional Epidemiology Service (*Servizio Epidemiologico Regionale*) and the Regional Agency for Health and Social Care (*Agenzia Regionale Sociosanitaria* (ARSS)), which is responsible for developing and defining the tools to monitor the quality of services and the performance of the Regional Health and Social Care Service (*Servizio Socio Sanitario Regionale*) (see Chapter 2). All these structures report to the General Management Secretariat.

All of Italy's regions confer with one another via a formal structure known as the Regions Conference (*Conferenza delle Regioni*) and with the national government via the State-Regions Conference (see Chapter 2 for more details). These were established in 1983, 11 years after the creation of the regions in 1972.

1.4 Health status

Mortality in the Veneto Region, measured by the crude death rate, is on average lower than the national average, although when broken down by gender only the female rate is significantly lower while the rate for males is higher. There has been a significant decrease in the incidence of cardiovascular diseases. Infant

mortality rates are among the lowest in Europe. Regarding the standardized mortality rate, there has been a decrease of 25% among men and 21% among women since the mid-1990s, with a total net decrease above all among young people (Table 1.3).

Table 1.3
Mortality and health indicators, Veneto Region and Italy, selected years

	1990		1995		2000		2005		2008	
	Veneto	Italy	Veneto	Italy	Veneto	Italy	Veneto	Italy[a]	Veneto	Italy
Life expectancy at birth (years)										
Total	77.0	77.2	78.3	78.2	80	79.7	82.9	81.6	82.1	81.9
Male	73.2	73.8	74.6	74.8	76.7	76.6	78.4	78.6	79.1	79.09
Female	80.7	80.5	81.9	81.4	83.2	82.7	84.5	84.3	85.2	84.5
Crude death rate (per 1000 population)										
Male	na	10.06	15.02	10.39	13.31	10.18	11.83	9.66	11.16	9.78
Female	na	8.83	8.36	9.23	7.69	9.52	6.82	9.31	6.54	9.66
Infant mortality rate (per 1000 live births)[b]	5.7	8.0	4.2	6.2	3.0	4.5	2.8	3.4	3.1	3.5

Sources: WHO Regional Office for Europe, 2011[b]; ARSS, 2010; Veneto Region Directorate of the Regional Statistical System, 2010.
Notes: [a] Data for 2006; [b] In the Veneto Region, data on infant mortality are not available after a baby is 12 months old; na: Not available.

The main causes of death are tumours and cardiovascular diseases (Table 1.4). This is mainly because the region is one of Italy's most industrial, with negative consequences for work environments and behaviour. With reference to cardiovascular diseases, acute myocardial infarction (heart attack) represents the most frequent medical emergency; its incidence is greater among men, mainly because it affects them at a younger age than women. Recovery from cardiac conditions is the second most common cause of hospitalization after childbirth.

With regard to morbidity, there is an increase in diabetes in the population. The spread of the human immunodeficiency virus (HIV) is more prevalent among men, women accounting for around 29% of cases. Since 2006, 40% of all new cases of HIV infection have been attributable to people with risky heterosexual behaviour. For females, such risk behaviour represents 73% of these cases while for males it is 33% (Veneto Regional Epidemiology Service, 2010).

The public health challenges facing the Veneto Region reflect those in many European countries. The percentage of obese people in 2009 was 9.4% (a decrease compared with 2006, but the rate has been rising since the mid-1990s) and there is an increase in the number of adult smokers, approximately 22.5% of the Veneto population (WHO Regional Office for Europe, 2011b).

Table 1.4

Main causes of death per 100 000 residents, Veneto Region, 1990–2008, selected years

Causes of death (ICD-10 classification)	1990		1995		2000		2005		2008 (latest)	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
Communicable diseases										
Tuberculosis (A15–19)	2.1	0.6	3.3	0.9	1.9	1.0	1.7	0.9	1.7	0.4
HIV/AIDS (B20–24)	4.4	1.1	12.4	3.1	1.6	0.3	1.6	0.6	1.7	0.5
Non-communicable conditions										
Circulatory diseases(I00–99)	637	431	584.3	374.2	494.3	330.8	428.7	275.8	396.9	254.3
Malignant neoplasms(C00–C97)	64.5	38.5	63.9	38.0	62.7	38.0	56.4	34.2	54.5	30.6
Colon cancer (C18)	47	26	42.9	24.5	42.9	21.5	42.8	21.2	37.9	22.3
Cancer of larynx, trachea, bronchus and lung (C32–34)	156	21	141.2	22.5	127.6	24.1	105.2	22.0	99.1	22.8
Breast cancer (C50)	42	39.1	35.6	35.5	33.1	–	–	–	–	–
Diabetes (E10–14)	29.7	35.4	21.7	21.7	21.7	20.3	21.6	18.1	30.2	20.7
Mental and behavioural disorders (F00–99)	17.1	12.8	20.5	17.8	25.7	22.9	26.8	24.3	29.2	28.8
Ischaemic heart diseases (I20–25)	236	123	221.7	108.5	180.3	94.4	169.2	90.5	166.8	91.0
Cerebrovascular diseases (I60–69)	148	112	139.2	105.0	116.0	88.3	94.6	68.2	83.3	61.6
Chronic respiratory diseases (J00–99)	137	54	65.5	20.1	54.8	21.5	48.2	17.7	40.2	14.3
External causes										
Transport accidents (V01–99)	37	9	34.0	8.3	23.6	7.2	18.3	4.6	16.1	4.3
Suicide (X60–X84)	14	5	13.2	3.3	12.6	3.6	11.2	3.0	10.9	3.1

Sources: WHO Regional Office for Europe, 2011b; ARSS, 2010.
Note: ICD-10: WHO Classification of Mental and Behavioural Disorders.

One area that deserves special attention is the increase in birth rate (reflecting increases in the number of births among women over the age of 35 and in the birth rate among female immigrants). This rise in births requires greater policy attention and will involve increased levels of assistance, not only because of the increased risk factors associated with maternity in older age but also because of the social factors (language and cultural awareness) relevant to migrant women.

2. Organization and governance

Under the SSN, the organization and provision of health care is a regional responsibility. Similar to other regions, the Veneto Region is linked to the national government via the State-Regions Conference, which meets monthly and comprises the regional presidents, the national Minister of Health and other national ministers whose portfolios directly or indirectly affect health policy. Objectives for the health system are established by the Regional Health and Social Care Plan, which also reflects the priorities and requirements laid out in the National Health Plan and the agreements reached at the State-Regions Conference. In addition, the Regional Development Plan coordinates policies with other relevant departments such as environment and urban planning.

Planning directives originate from the Giunta via the Departments of Health and Social Services, which receive technical support from a single General Management Secretariat. Regulation of the health system is divided among different organizations, such as those that govern the accreditation of facilities, the registration of health professionals and the regulation of the use of medicines and medical devices. Joint efforts are underway to improve information systems, and the Veneto Region is one of the few Italian regions that have established a unit for HTA.

The well-being of patients is fundamental to the health system, both in terms of the services delivered and patient rights. Over the last few years, a system has been implemented to evaluate the quality of services provided to patients, through the Health Services Charter and client care offices, which enable patients to obtain information about various treatments and how to lodge complaints.

2.1 Overview of the health system

The Veneto Region's health system is based on the fundamental values underpinning the SSN as a whole, such as universality, free access, freedom of choice, pluralism in provision and equity; the system is characterized by a strong orientation towards meeting the needs of individuals as well as the community through the integration of health and social services. From an organizational point of view, health and social care services are centralized and officially governed by the Giunta via the Departments of Health and Social Services, which receive technical support from a single General Management Secretariat. The Secretariat, in turn, is made up of six directorates (Fig. 2.1). There is also a Regional Committee for Health and Social Care Planning, which oversees the participation of regional associations and local councils such as the National Association of Italian Councils (*Associazione nazionale Comuni Italiani*), the Union of Italian Provinces (*Unione Province Italiane*), the Union of National and Alpine Councils (*Unione Nazionale Comunità Enti Montani*) and representatives of the Mayors' Council.

The Veneto Regional Health Service (*Sistema Sanitario Regionale*) is a complex mix of 21 public ULSSs, each covering approximately 216 000 inhabitants, as well as two AOs (in Padova and Verona) and a public IRCSS that focuses on oncology research. Together these cover 56 public hospitals. There are also 30 private and accredited hospitals, of which one (San Camillo in Venice) is an IRCSS that focuses on motor, communication and behavioural neurorehabilitation.

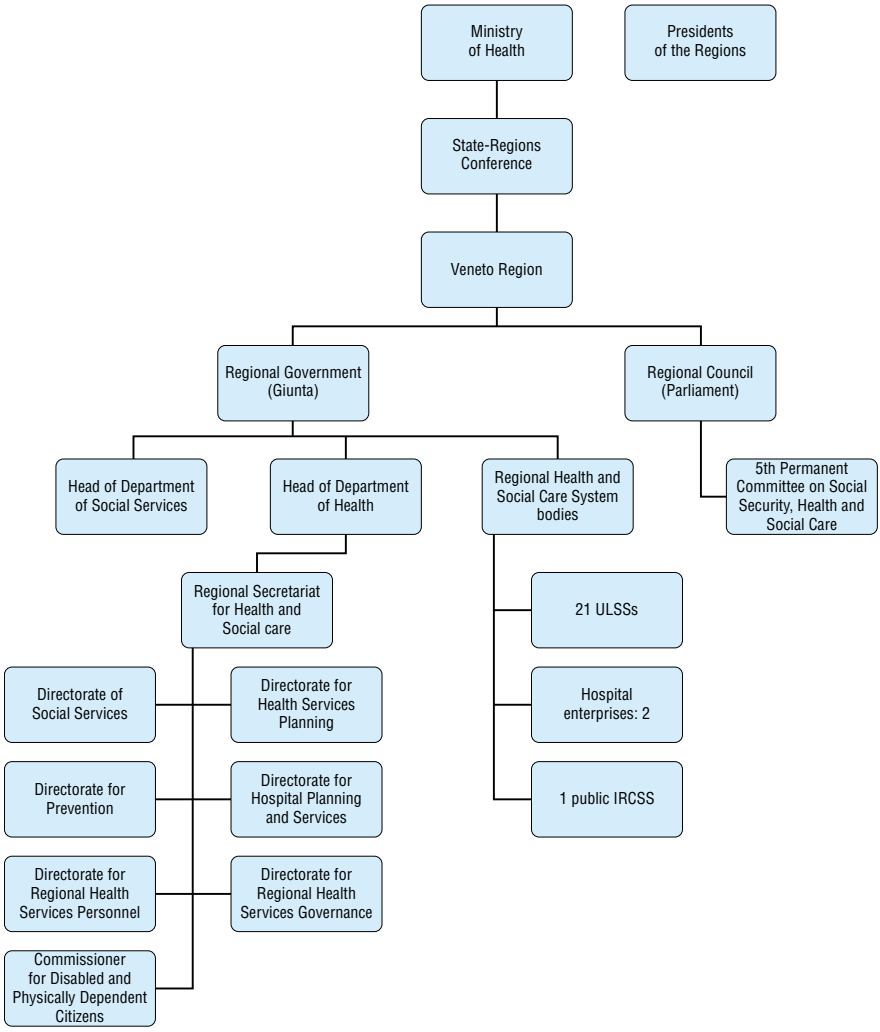
In 2010, there were 3.9 beds (public and private accredited) per 1000 inhabitants. The population's level of satisfaction with health care services is generally higher than the national average (Ministry of Health, 2010). Moreover, the Veneto Region is also able to satisfy demand for services from patients living in other regions: in this regard a higher number of out-of-region patients are treated compared with the reverse process of Veneto inhabitants seeking treatment in other Italian regions (see below).

The geographical distribution of hospitals is quite broad, not only in response to citizens' needs but also as a result of a significant rationalization that has occurred in recent years, resulting in a redistribution of resources from large hospital structures to district-level services that encompass ambulatory care. The situation reflects, on the one hand, a significant functional differentiation based on the evaluation of each hospital's specialty areas and, on the other, the establishment of a wide geographical network of care, with additional positive results in achieving economic efficiencies.

Regions directly finance ULSSs, AOs and university hospitals (excluding IRCSSs), and indirectly also finance private accredited facilities via the ULSSs. Approximately 70% of the regional budget in the Veneto Region goes towards financing the Regional Health Service (see section 3.3).

Fig. 2.1

Structure of the Veneto Region health care system



Source: ARSS, 2010.

2.2 Historical background

The first real national health care reform was in 1978 (Legislative Decree (*Decreto legislativo*) No. 833, 1978), six years after the creation of the regions as independent administrative bodies. The reform outlined the principles, general objectives and citizens' rights under the newly established SSN, but it lacked details on the organization of the health system, the delineation of responsibilities and oversight and monitoring functions. Generally, there was a need to make the whole of the state's public administration more efficient and to contain the public debt, to which the health care sector had contributed. Concrete reform innovations were introduced with Legislative Decree No. 502, 1992 and No. 517 in 1993 (known as the "second reform"). The main characteristics of the "second reform" were the separation of politics and management, by making health care organizations more independent of political influence and party-political control, and a renewed focus on health care planning with the launch of the National Health Plan (adopted by the national government in agreement with the regions and relevant parliamentary committees). The old management committees of local health care organizations, which were made up of political appointees, were abolished and new public entities were established, known as ASLs, which had legal, financial, managerial and technical autonomy. ASLs, which in the Veneto Region are called ULSSs, were required to ensure the delivery of the LEA within budget.

In line with the "second reform" of 1992/1993, ULSSs are now headed by a managing director appointed by the regional president. A committee of auditors was also established. The managing director is assisted by a director of administration, a director of health care and a coordinator of social services (in line with regional and local council regulations and the eventual delegation of social care responsibilities to municipalities). In addition, at the level of the ULSS, there are elected health committees, headed by the ULSS's Director of Health Care, and whose membership includes doctors (the majority of members), other health care professionals (with degree-level qualifications), as well as representatives from nursing personnel and health care technicians.[1] The role of these local-level health committees is to provide technical and health policy advice. Local councils (municipalities), which do not form part of this management structure, have contact with ULSSs through their representatives in the mayors conferences or through one of the district presidents or mayors themselves (depending on local arrangements), through general planning processes and through the provision of services.

[1] Only health care personnel working for the ULSS (i.e. public sector) can be members of ULSS health committees.

The "second reform" established the LEA, which had been first mooted in 1978 in Legislative Decree No. 833 and which was eventually fully implemented in 2001. It also introduced a new system of accreditation of private and public health care organizations (aimed at giving citizens free choice of health care provider) and, in theory, competition among these providers was actively encouraged. In addition, a new regime of health care management principles was defined via the establishment of contractual work agreements with providers, outlining responsibilities and introducing accountability mechanisms; all of this was in keeping with the general reform of public sector management that was occurring at the time.[2] But the main innovation of the "second reform" was the transfer of the SSN's administrative functions to the regions, while legislative powers were to be shared between the national (central) government and the regions. Regions became responsible for the following:

- division of the region into local health units (coinciding roughly with the geographical boundaries of provinces); in the Veneto Region these are the ULSSs;
- determination of the organizational principles for the delivery of services and other activities aimed at promoting health;
- criteria for the financing of ASLs and AOs on the basis of population needs and services delivered;
- technical activities, promotion and support to ASLs and AOs;
- management of health care organizations with the introduction of innovative methods and instruments; and
- evaluation of the quality of services.

A further evolution of the SSN followed with Legislative Decree No. 229, 1999 (the "third reform"), which contained several major innovations:

- linkage of the basic health benefits package to financial resources – the national government and the regions now deciding on the level of financing via the National Health Fund,[3] and the regions then distributing financial resources to the ASLs; this process occurs under a framework of regional fiscal autonomy in terms of their resource allocation decisions but they are also now held responsible for any budget deficits incurred;
- integration of health care and social care services;

[2] Legislative Decree No. 29, 1993.

[3] Although the National Health Fund was formally abolished in 2000 by Legislative Decree No. 56, 2000, the Fund *de facto* still operates. Efforts to make its successor, the National Solidarity Fund, operational have been impeded by the inability of the central and regional governments to reach agreement on the equalization formula.

- increased weight given to the role of the regions in proposing and discussing actions for inclusion in the National Health Plan and the role of local councils (municipalities) in preparing the Regional Plan;
- definition of the criteria to confirm or propose new AOs and IRCCSs;
- proposals for the accreditation of public and private health care facilities;
- the possibility to set up integrated funds to provide services over and above those listed in the LEA;
- experimentation with using public and private providers to make the delivery of services more varied and flexible;
- new regulations requiring doctors to choose whether they work exclusively in the public or the private sector and to make that choice irreversible (the latter was contested by doctors); and
- ASLs would focus on three main areas set out in the LEA, prevention, hospital care and district-level primary and community care.

However, many aspects of the "third reform" of 1999 went unimplemented.

2.3 Organization

Each region has responsibility for planning, setting the strategic direction, monitoring and coordinating ULSSs and AOs. The region manages the relationships between ULSSs, AOs, public and private health care facilities and health care professionals through regional planning norms and instruments. These relationships are based on the accreditation criteria for health care organizations, on payment methods for services, and on the system of quality monitoring and evaluation. The Giunta exercises supervisory functions to ensure that citizen's rights with regard to health care are met and also monitors the achievement of quantitative and qualitative outcomes set out in the Regional Health and Social Care Plan.

The Veneto Region's health system has to take account of national arrangements. The national government has exclusive competence to define the LEA, equal access to which must be guaranteed throughout the country. The national government is also primarily responsible for setting the general objectives and fundamental principles of the SSN. All the regions, including the Veneto Region, are responsible for delivering the LEA within their regional territories and organizing health care services. Health and social care planning is implemented via the Regional Health and Social Care Plan, which is approved

by the Regional Council. Each three-year plan (a) defines the objectives of the regional planning process and the standards of services, guaranteeing equal access to all citizens of the region; and (b) covers specific programmes and interventions to protect health, including in other sectors that implement health-related objectives outlined in the Plan.

The ULSSs and AOs ensure that citizens have equal access to the services outlined in the Health and Social Care Plan, either through their own facilities or through accredited private facilities and health care professionals. The region implements integration of health and social care by promoting the delegation of management for social care services by local councils to the ULSSs, and providing specific funding for this purpose.

Ten regions, including the Veneto Region in 2001, set up their own ARSSs to provide technical and scientific support not only to the Giunta and the Regional Council but also to the regional Departments of Health and Social Care, and to the ULSSs and AOs. The ARSS's tasks include accreditation of health care structures, performance measurement, evaluation of health care technologies and analysis of innovative management models.

The regional health system also includes four observatories:

- observatory for palliative care and the fight against pain
- epidemiological observatory for childhood diseases
- observatory for complementary and alternative medicine
- observatory for social policies.

2.4 Decentralization and centralization

2.4.1 State-Regions Conference

The current division of competencies between different levels of government is set out in legislation for constitutional reform (Law No. 3, 2001), which gives the regions powers over several policy areas, including health care and social care (the latter, properly speaking, falls under the responsibility of local councils (municipalities), coordinated by the region).

The major instrument for the implementation of the LEA and for monitoring equal access to this basic health benefit package is the State-Regions Conference. The State-Regions Conference is a crucial element in

the coordination of policies between the state and the regions. Within the Conference, the regions have only one interlocutor – the Office of the Prime Minister – instead of individual ministers or national ministries, so giving them an equal standing and allowing them to confer on broad policy matters with the central government. In addition, this is a way for the national government to acquire useful suggestions and proposals with regard to exercising its administrative functions and implementing policies at the subnational level, also via a single representative who can present unified policy positions. This is certainly advantageous for intergovernmental relations and for fostering discussion. The State-Regions Conference is not just a place where agreements between the state and the regions are confirmed but it is also a proper body in its own right, belonging neither to the state nor to the regions, with its own autonomy and authority.

2.4.2 The Regions Conference

The Regions Conference was set up in Pomezia, Italy, on 15–16 January 1981. Partly based on similar experiences abroad, this body was established as an instrument for political coordination for regional presidents. Such coordination is necessary to meet various needs:

- acting as a permanent forum for interregional exchanges;
- helping to foster the development of common policy positions to be presented to the state (central government, national parliament, etc.); and
- giving voice and weight to the "System of the Regions" in the European Union (EU).

The Regions Conference is composed of the presidents of Italy's 20 regions, and the body has its own organizational structure, defining the role of the presidency and that of its various sectorial committees. The Regions Conference, having defined common ground, formulates documents and proposals to be submitted to the government, parliament, EU bodies and other institutions. The Conference, among other things, prepares draft opinions, presents agreements and designates representatives to various government administrative committees, commissions and so on.

2.4.3 The LEA

Legislation stipulates that the SSN must guarantee the basic health benefit package through public funding.[4] Known as the LEA, the basic health package is defined by the National Health Plan and is based on the principles of human dignity, health needs, equal access to care, appropriateness and quality of care, and cost-effectiveness (good financial management of resources). The LEA represents the minimum level of public health care services (in terms of quantity and quality) that must be delivered uniformly across the country, with each region, including the Veneto Region, being legally required to provide them to their citizens.

The LEA is delivered in terms of three main areas of intervention: preventive public health care (in both life and work environments); integrated district-level health care, which incorporates primary and specialist care; and hospital care (see section 2.8.2 for more a detailed description). The process of allocating funding to the regions for the LEA takes place during the intergovernmental meetings to discuss the financial budget document (*documento di programmazione economico e finanzaria*), which accompanies the government's annual budget and also includes a broad outline of the National Health Fund's distribution. The regional presidents, with the help of three committees (Health, Social Services and Finance), formulate a funding distribution proposal, hopefully on the basis of unanimity, to be submitted to the government. The proposal should reflect the agreement reached during the State-Regions Conference and the government's annual legislation concerning distribution of the National Health Fund. This multi-tiered process may seem simple and straightforward but it often involves many rounds of discussions and tough negotiations, which take up a lot of time for the regions, both internally and in their relations with the government and sometimes the parliament.

2.5 Planning

The main planning instruments are the National Health Plan, the Regional Health and Social Care Plan plus local ASLs' general plans and budgets.

The National Health Plan is prepared and adopted by the government and covers a three-year period. It sets out the fundamental objectives of prevention, care and rehabilitation; the general direction of the SSN; the LEA, which must be guaranteed uniformly across the country; and related financing arrangements.

[4] Legislative Decree No. 502, 1992 (Art. 1, clause 2), as modified by Legislative Decree No. 229, 1999 and Law 405, 2001.

The Regional Health and Social Care Plan is approved by the Veneto Regional Council and also covers a three-year period. It defines the objectives of the regional planning process and the standard of services, guaranteeing equality of access and treatment for the region's citizens. General plans are three-year plans adopted by the directors of ULSSs and AOs. They set the planning objectives of the particular health enterprise, in conformity with those outlined in the Regional Health and Social Care Plan. The general plan then adopts the strategic objectives formulated by other relevant local public administration bodies and becomes known as a "local action plan" (*piano attuativo locale*).

ASLs are required to refer systematically to budget forecasts in order to achieve their operational objectives and to utilize financial resources effectively. In effect, each health enterprises' annual general budget, distributed among its three main programme areas (prevention, community-level primary health care and hospital care) constitutes its annual planning document. Financial and capital planning by ASLs takes explicit account of the budget forecasts contained in their three-year general plans and their annual general budgets. All ASL planning documents must be approved by their Giunta to ensure that they are congruent with wider planning objectives (*visto di congruità*).

2.6 Intersectorality

The Veneto Region prepares its Regional Development Plan on the basis of a model where all policies are compared and coordinated. The Regional Development Plan is a regionwide strategic plan that coordinates various policy areas including health and social care, education, environment, transport and so on. The Regional Health and Social Care Plan forms one of the detailed parts of the Regional Development Plan. In particular, the Veneto model envisages a strong integration between health and social policies. Integration and coordination among sectors to implement services means making interactions between the producers of services and their users as efficient as possible. This entails not only having a network in place but also guaranteeing efficient access to information to the parties involved. The region plays a fundamental role in promoting infrastructural investment and also creating a communication system based on common standards, rules, modes of access, and clear and reliable means of interfacing with the public administration.

It is necessary to encourage local administrative bodies to join together to develop programmes through common strategies and methods. Moreover, policy interventions must address new needs that emerge from the region's complex social pattern, delivering health and social services efficiently. Priority areas include increasing birth rates; support for mothers; infant and family services; development of social services for the elderly; measures to help working women, minors and young people; prevention and recovery services for drug addicts; and supporting innovation. To support these areas, regional legislation lays out the planning principles for social services, identifying for each ULSS the optimum territorial size for delivering specific services.[5] In addition, area plans (*piano di zona*) have been established as the primary instrument to integrate and deliver the network of health and social services. These plans are fundamental planning instruments the aim of which is to coordinate public and private services within the same district in order to meet population needs and to guarantee high-quality services.

The same legislation established a new financial instrument, the Regional Fund for Social Policies, that contains national funds earmarked to the region for social services as well as the Veneto Region's own funds for this purpose. The effective delivery of social services requires regions to have in place information systems that allow the ongoing identification and monitoring of data on residents' needs. In line with this aim, Regional Decree (*Decreto di Giunta Regionale*) No. 2946, 2003 approved the reorganization of the integrated network of social observatories; there are also plans to establish a single regional committee, coordinated by the manager of the Directorate for Social Services, to coordinate the activities of the regional observatories in line with the strategic directions set by the Giunta. This regional committee will also have to approve the social observatories' action plans.

Returning to the Regional Development Plan, coordination among different policy areas also takes into account the impact of environmental factors, which need to be monitored and protected in the interest of securing citizens' and public health. There are two main instruments for this purpose, which apply both nationally and regionally as they are part of EU regulations: Environmental Impact Assessment (*Valutazione d'Impatto Ambientale*) and Strategic Environmental Assessment (*Valutazione Ambientale Strategica*). Both procedures aim to ensure that environmental assessment takes place prior to the approval or authorization of projects or public programmes in order to protect the environment and to reduce environmental impact. A third national-level

[5] Regional Law (*Legge Regionale*) No. 13, 2001.

instrument, the Integrated Environmental Authorization,[6] requires certain large-scale projects to be subject to the Giunta's prior authorization in order to prevent and reduce pollution.

In terms of workplace environments, it is worth remembering that prevention is managed by the region's Department of Health and not the Department of Employment. The Veneto Region promotes health in the workplace using a coordinated approach, implementing action plans to improve the health conditions and safety of workers. All activities in such spheres are implemented by the Region via the Occupational Preventive Health and Safety Service (*Servizi per la Prevenzione Igiene e Sicurezza negli Ambienti di Lavoro*) overseen by ULSS's prevention departments. In addition, veterinary facilities are managed by the Department of Health and not the Department of Agriculture.

In the agricultural sphere, the Occupational Preventive Health and Safety Service promotes prevention by:

- monitoring farms and checking farm equipment;
- carrying out legal investigations of all serious and fatal accidents; and
- vigilance over producers and sellers of agricultural machinery to guarantee safe production and sale.

Finally, the Region operates a detailed network of civil protection mechanisms designed to deal with emergencies within its territory in a timely and efficient way. The existing national system of civil emergency centres, supported by the national Department of Civil Protection and the regions, has in the pipeline the creation of a network of operational centres for forecasting, monitoring and surveillance to support the various authorities that supervise the different components of the national civil protection system. Law No. 225, 1992 identifies the competent institutions responsible for the civil protection system at different levels, including local bodies, the fire brigade, the police and citizens (who can participate through membership of voluntary organizations). The Veneto Region, through specific measures, has implemented a strategic civil protection framework that includes all of the above.

[6] Legislative Decree No. 59, 2005.

2.7 Health information and management

2.7.1 Information systems

Regional Law (*Legge Regionale*) No. 56, 1994 recognizes the development of the regional health services' information systems as "essential" to efficient and effective planning. The New Health Information System (*Nuovo Sistema Informatico Sanitario*), approved in February 2001, is as an instrument to support and monitor the delivery of the LEA. An integrated data system on patients and health care facilities aids the process of decentralization to the regions and also creates a common information management system that highlights national territorial differences. Each ASL has data on highly specialized medical devices, management systems and in-house data (datawarehouse) to support the regional government, but there is not enough cooperation or data sharing. Within clinical practice, the use of technology is uneven and needs better integration to improve the delivery of the LEA and to increase patients' participation in, and awareness of, diagnosis procedures and treatment options.

Other initiatives in this area include the development of electronic health cards, which is to be rolled out nationally. The policy document "Strategy for E-Health", issued by the State-Regions Conference on E-Health in March 2006, establishes some fundamental objectives. Above all, information on patients should be readily available at any time and at any level of the health system so that a patient's clinical history is readily accessible by relevant and authorized health care personnel, including when moving from one health care enterprise to another. Moreover, adequate standards of data security and privacy must be guaranteed. The process of establishing the electronic health cards platform is ongoing.

2.7.2 HTA

HTA, or the evaluation of health resources, is a process of complex evaluation of existing health technologies. Currently, Italy has no national agency that is responsible for financing and coordinating HTA and very few Italian regions have structures in place for it, although, overall, approximately 50% of regional health departments have started to implement policies for its development. Together with the Regions of Emilia-Romagna and Friuli-Venezia Giulia, the Veneto Region has implemented the most important HTA activities aimed at creating integrated systems of technology assessment utilizing epidemiological,

clinical and economic perspectives. Actors from different parts of the health system are brought together to design a common methodology, foster a culture of research and to develop instruments for problem solving.

In 2008, the three-year Programme for Research, Innovation and HTA (*Programma per la ricerca, l'innovazion e l'HTA*) was established. The Programme is made up of a panel of experts, comprising a health economist, a clinical engineer, a doctor with research methodology expertise, an information technology (IT) expert in statistics and a member of ARSS. It identifies priority areas and develops protocols for public-private partnerships and for collaboration with national and European bodies to contribute to HTA. In addition, it also plans to develop a standardized evaluation framework (HTA reports) to be adopted uniformly in the introduction of new technology. The Veneto Region is also part of a network of organizations that collaborate in HTA initiatives at the European level: EUNetHTA, the European Network for Health Technology Assessment. Consequently, it has access to information on the most advanced European HTA systems, enabling it to improve existing policies and to develop new ones.

At the regional level, the principal use of HTA methodologies is the evaluation of requests by ULSSs to purchase very expensive medical equipment. All such investments over a given threshold are subject to prior regional authorization based on standards of proven clinical efficiency, sound budgetary basis for the investment and compliance with regional strategic plans. Evaluations are undertaken by the Regional Commission for Technology and Infrastructure Investment (*Commissione Regionale per l'Investimento in Tecnologia ed Edilizia*),[7] which employs HTA to undertake its functions.

2.8 Regulation

2.8.1 Regulation and governance of third-party payers

The regions have legal, budgetary and administrative authority to deliver the entire spectrum of health care services to the population. Therefore, regions have been devolved the tasks of planning health services, organizing their delivery on the basis of population needs and monitoring the quality, appropriateness and efficiency of the services delivered. The Veneto Region has the following functions:

- allocating resources to ULSSs and AOs;

[7] Established by Giunta Resolution No. 1455, 6 June 2008.

- defining the criteria for authorization and accreditation of health care facilities;
- providing guidelines, via HTA, for the introduction of new technology;
- coordinating health and social care services via a Health and Social Care Planning Committee;
- defining ULSSs' geographical areas of operation and the criteria to define districts within each ULSS; and
- establishing levels of autonomy of directors-general in implementing regional plans and policies.

According to Mapelli (2007), four models characterize the way different regions have organized the governance structures of their health care enterprises. The classification reported here uses one of the more significant parameters – the direct management of hospital beds – to determine the model type (see below). The Veneto Region belongs to the first group, the integrated system model, due to the integration of health and social care services and to the integration of hospitals within the Region's territorial units.

Integrated system. More than 66% of beds are directly managed by local health enterprises (known as ASLs in other regions). In Italy, seven regions/autonomous provinces, including the Veneto Region, follow this model, of which five have small populations.

Mixed, semi-integrated system. Between 40 and 60% of hospital beds are directly managed by ASLs. Ten regions follow this model, of which six have small populations.

Mixed system, semi-separated system. Between 20 and 40% of hospital beds are directly managed by ASLs. In Italy, three medium-large regions adopt this model.

Separated system. Fewer than 1% of beds are directly managed by ASLs. Only one region in Italy, Lombardia, follows this model.

2.8.2 Regulation and governance of providers

Until 1992, local units providing health care were managed by local councils.[8] Following a major reform in 1992, regions became responsible for the management of the units and these were transformed into public health

[8] Prior to 1992, they were known as local health units (*unità sanitarie locali*).

enterprises (ASLs, known as ULSSs in the Veneto Region). There are three types of public enterprise in the Veneto Region:

- ULSSs
- AOs
- IRCCS.

ULSSs

ULSSs are public local enterprises (similar to British local health authorities), which are in charge of delivering the services prescribed in the LEA to citizens. The Veneto Region determines the geographical boundaries and organizational structure of ULSSs, directs their activities and monitors their performance. In general, an ASL's general manager is appointed by the president of the region on the basis of his or her technical and professional skills, and appointments are for three to five years. General managers are responsible for ensuring the sound financial management of the ASL and for implementing the objectives of the regional health plan. The performance of general managers is assessed regularly and they may be dismissed from their posts if they fail to meet predetermined targets and objectives. General managers are assisted by an administrative director and a medical director as well as a social care director/coordinator if the system is integrated or semi-integrated. The Veneto Region has 21 ULSSs (Box 2.1).

Box 2.1
USSLs in the Veneto Region

ULSS 1, Belluno	ULSS 12, Mirano
ULSS 2, Feltre	ULSS 13, Chioggia
ULSS 3, Bassano del Grappa	ULSS 14, Alta Padovana
ULSS 4, Alto Vicentino	ULSS 15, Padova
ULSS 5, Ovest Vicentino	ULSS 16, Este
ULSS 6, Vicenza	ULSS 17, Rovigo
ULSS 7, Pieve di Soligo	ULSS 18, Adria
ULSS 8, Asolo	ULSS 19, Verona
ULSS 9, Treviso	ULSS 20, Legnago
ULSS 10, Veneto Orientale	ULSS 21, Bussolengo
ULSS 11, Veneziana	

Each ULSS is responsible financially and technically for the delivery of health care services within its macro-area. These services fall under three main categories.

Public health: preventive health care and health promotion (living and working environments)

Preventive health care and health promotion are delivered via the Department of Prevention of each ULSS and are managed by the Region. The Department also oversees functions relating to environmental risks, health education and promoting healthy lifestyles. The functions of monitoring and prevention reflect the national requirements of the SSN.[9] Departments of Prevention work with several other institutions that are legally tasked to participate in preventive health functions, including the local authority dealing with sanitation matters (the mayor of a municipality/local council), regional agencies for environmental protection, work inspection departments and facilities for veterinary health research.

The area of public health care is further divided into three sub-categories.[10]

Collective prevention. This covers four sub-areas;

- public health and hygiene, which is subdivided into intervention and prevention of infectious diseases, protection from health risks connected to environmental pollution, and protection of the population and the individual from lifestyle-related health risks;
- food hygiene and nutrition (e.g. regulation of food and drink production);
- health and safety in the workplace; and
- public veterinary health, which includes the health of animals, animal breeding and animal production hygiene, plus health protection related to food of animal origin.

Preventive services for the population. This concentrates on compulsory vaccinations (also recommended for children of non-EU immigrants who are not formally registered as residents), organized screening programmes and early diagnosis, and special services and diagnosis for public health protection that are legally compulsory or required locally in epidemic situations.

[9] Defined by Art. 7, Legislative Decree No. 502, 1992.

[10] The statutory basis for the division is to be found in Prime Minister's Directive, 29 November 2001.

Legal medicine. This includes certification for workers absent for health reasons and other types of certification (excluding activities explicitly indicated by national legislation and different provisions in each Italian region).

Primary and community care: integrated district-level health care

Each ULSS is divided into one or more health district, with an average population of 100 000. District-level primary and community care is delivered in two ways, either directly when health services are provided by the district's own facilities (referring patients to other care in hospitals or other facilities if required) or through services supplied by other parties, private or public, (e.g. GPs, specialists) who work for the ULSS (and, therefore, the SSN) under contracts. Health care services fall into three basic types.[11]

General health care. This involves primary care delivered by GPs and paediatric services (i.e. general medical care for children up to 14 years of age). National agreements, adopted at regional level, govern these physicians' payment levels, duties and contractual responsibilities within the SSN. The SSN allows these physicians to work either individually or in teams (group practice), through various modes of "association" designed to promote integration of primary care services with other district-level services (such as social care, home care, etc.) and to enhance continuity of care (see Chapter 6). Care by GPs and paediatricians is free of charge. The SSN also guarantees out-of-hours care (known in Italy as "the medical guard" (*guardia medica*) or "continuous medical care" (*servizio di continuità assistenziale*), which is free of charge. GPs or paediatricians cover these services when they are not working their ordinary hours, thus providing 24-hour medical assistance to the population.

Pharmaceutical care. Registered pharmacies provide pharmaceutical care. Patients, with a doctor's prescription, can obtain medicines and other health products covered by the health benefit package. Medicines covered under the LEA package are contained in a pharmaceutical handbook, which lists and classifies medicines within the SSN. In addition, the SSN also covers certain other products, for example dietary products, medical devices for particular categories of patients, prostheses or other

[11] As outlined in the classification of the LEA in Art. 3, Legislative Decree No. 502, 1992, and Legislative Decree No. 229, 1999.

technical devices to aid the recovery and functioning of people suffering from physical and sensorial disabilities,[12] and certain forms of thermal therapies.

Specialized ambulatory medicine. These services, delivered by district physicians, include ambulatory diagnostic services and laboratory analyses; health services for patients with disabilities, drug users, terminally ill patients, persons with HIV, and prisoners; and residential or home care for the elderly and the mentally ill.

Hospital care

Hospital care includes all ambulance and emergency services; treatments delivered during "ordinary" hospitalization (i.e. hospitalization of more than one day), including hospitalization for rehabilitation and post-acute long-term hospital stays; day hospital and day surgery (day stays); as well as domiciliary surgery; blood transfusion services; taking of blood samples; and conservation, distribution and transplantion of organs and tissues. Regional regulations cover all aspects of these services, in particular their delivery, tariffs (including those concerning the out-of-region mobility of patients) and access to care. The most recent national regulations have promoted the rationalization of hospital activities. From the mid-1990s onwards, many regions concentrated on setting targets for hospitalization rates and for the number of beds per inhabitant, which now stands at 4 per 1000 population, including 0.7 per 1000 for long-term and rehabilitation beds. Small hospitals (those with fewer than 120 beds), in particular, are targets for the reorganization of hospital activity since they are often not well equipped to deliver high-quality services with adequate safety and cost controls. Consequently, these are often converted to different purposes (e.g. to outpatient or social care facilities), merged or closed down altogether.

AOs

Prerequisites for AOs were introduced under Legislative Decree No. 502, 1992. These facilities provide inpatient and outpatient services, normally with medium to high specialization. The criteria to become an AO are an organizational structure based on departments, at least three highly specialized clinical units and an emergency department with an intensive care unit. AOs are managed by a managing director, an administrative director and a medical director. The Decree grants the managing director the power to define the objectives of the AO through a three-year strategic plan to implement the guidelines of the Regional Health Plan. Planning and management have to take into account the

[12] Limits and tariffs are outlined in Ministerial Decree (Health) No. 332, 27 August 1999.

presence of university faculties of medicine and surgery, which are responsible for activities such as teaching and research. The Veneto Region has two AOs, the University of Padua Hospital Enterprise and the Integrated University Hospital Enterprise of Verona.

IRCSS

An IRCSS can be a public or private hospital that predominantly carries out activities for particular diseases. They were reformed in April 2008 and are located in 13 different Italian regions – with a concentration in Lombardia. The national Minister of Health is responsible for the accreditation of IRCCSs, monitoring their scientific activities through the nomination of their scientific directors and the provision of core funding. The Veneto Region has two IRCCSs, one public and one private:

- the (public) Veneto Oncology Institute (*Instituto Oncologico Veneto*) in Padua deals with prevention, tumour diagnosis and treatment, and cancer research (in collaboration with Padua University); it ensures the coordination and implementation of the region's network of oncological activities; and
- the private San Camillo Institute in Venice specializes in motor, communication and behavioural neurorehabilitation.

Private accredited providers

Regional Law No. 22, 2002 sets out the authorization and accreditation processes for health and social care facilities, both public and private. The Law confirms two fundamental principles: equality between public and private providers and the equality of health and social care facilities in relation to authorization and accreditation procedures. The Law has two objectives: first, to guarantee the principles of effectiveness, efficiency, equality, equal access and appropriateness of care; and, second, to implement continuous improvements in the quality of health and social care facilities through the process of authorization and accreditation.

Authorization refers to the process by which a health care facility is granted permission to operate (undertake its activities).[13] In contrast, accreditation refers to the process through which public and private facilities, and individual professionals (on request), are recognized as suitable to provide health and social care services on behalf of the SSN. The ARSS provides technical support for the authorization and accreditation process.[14]

[13] Pursuant to Regional Law No. 22, 2002.

[14] Pursuant to Regional Law No. 32, 2001.

2.8.3 Registration and planning of human resources

Health care professionals must register with the relevant professional college or association in their province of residence once they have successfully completed their qualifications (see section 4.2). The staff training services of the regional health services are responsible for coordinating activities for the training of staff who are directly employed or work under contract with ULSSs, AOs and other bodies of the health service, including training connected to continuing medical education (*educazione continua in medicina;* see section 4.2.3). Universities, in cooperation with the regional health services, provide core training for doctors, nurses and other health professionals to obtain their professional qualifications. In Italy, health professionals trained abroad can also exercise their profession if they have the necessary qualifications and are officially recognized by the Department of Health, with guidelines from the regions. For example, the Veneto Region is authorized to investigate and give guidance on the qualifications of medical radiologists, technicians and nurses obtained in countries that do not belong to EU.

The European Directive on the recognition of professional qualifications (Directive 2005/36/EC), which came into force in 2007, was intended to bring flexibility to the labour market (including the health sector), to facilitate the performance of professional services among EU countries and to promote mobility of both men and women between EU countries. The Directive's provisions apply to all citizens of a Member State who intend to work legally in another EU country instead of the one where they obtained their qualification. It applies to both self-employed and employed staff. Member States are able to opt-out of the Directive's provisions in situations where the professionals are linked with the exercise of public order, for example the police force. With regard to health care professionals (doctors, nurses, obstetricians, pharmacists, etc.) criteria related to knowledge and behaviour are set out for the automatic recognition of qualifications. Health assistants and auxiliary staff (essentially staff who help nurses with less-demanding care tasks) can make a request to the national ministry of health to have qualifications obtained abroad recognized and be allowed to practise in Italy.[15]

[15] The profiles and roles of such staff were defined by State-Regions Conference on 22 February 2001 and formalized by the Veneto Region in Regional Law No. 20, 16 August 2001, and subsequent amendments.

2.8.4 Regulation and governance of pharmaceuticals

The Veneto Region also pursues regional planning objectives via instruments known as "regional coordinations"; for example, Regional Decree No. 3977, 2008 set up the regional coordination for pharmaceuticals, which has the following functions:

- to ensure communication and dialogue between the pharmaceutical services in a geographical area and hospital pharmacies;
- to disseminate at the regional level initiatives that have demonstrated effectiveness in improving the appropriate use of medicines and quality of care delivered;
- to collect the requests and questions of doctors, patients and citizens, health associations, ASLs and other bodies and to analyse solutions to be presented to the health system's pharmaceuticals department;
- to support information gathering on medicines and medical devices in order to guarantee uniformity, equal access to treatment and the ongoing monitoring of quality of services;
- to ensure the availability of communication and operational networks through the development of functional links among the various services of ULSSs and AOs;
- to ensure the systematic monitoring of pharmaceuticals and medical devices and their risk profiles; and
- to provide technical and scientific support to the region's HTA commissions.

Regional coordination of pharmaceuticals takes place within three units: the Evaluation of Pharmaceutical Effectiveness Unit (*Unità di Valutazione dell'Efficacia del Farmaco*), which evaluates medicines; the Pharmaceutical Information Unit (*Unità di Informazione sul Farmaco*), which assesses the efficacy of therapeutic interventions and promotes appropriate prescribing; and the Pharmacovigilence Unit (*Unità di farmacovigilanza*), which monitors medicines in use. The Evaluation of Pharmaceutical Effectiveness Unit supports the assessment activities of the Commission for the Hospital Therapy Manual and the Technical Commission for Medical Devices (*Commissione Technica per i Dispositive Medici*) (see below). It deals with clinical risk activities and involves the Region's network of hospital pharmacies. In addition, it updates information on medicines and medical devices that have recently received market authorization (or where authorization is imminent). The Pharmaceutical

Information Unit manages and monitors drug prescriptions and undertakes clinical and infrastructural research activity. Finally, the Pharmacovigilence Unit is the Veneto Region's pharmacovigilence centre, accredited by the Italian Medicine's Agency (*Agenzia Italiana del Farmaco*), which is the national body for pharmaceutical policy; it undertakes information and training activities on the risk profiles of medicines.

The Veneto Region's *Hospital Therapy Manual* (*Prontuario Terapeutico Ospedaliero della Regione Veneto*) contains a list of pharmaceuticals that have proven therapeutic effectiveness and is used by the Region's hospitals to rationalize the use of medicines in hospitals on the basis of rigorous scientific criteria. Initially seen as a guideline, it now represents a compulsory instrument for ULSSs, AOs and IRCSS, with the aim of establishing uniformity within individual hospital therapeutic committees.[16] A drug not listed in the *Hospital Therapy Manual* may be included when it is considered to be indispensable and not substitutable, following a request by a doctor for specific patients and conditions. The *Hospital Therapy Manual* is a dynamic instrument that undergoes periodic review – thanks to the scientific contributions of hospital therapeutic committees and doctors – bringing it up to date with new developments in pharmaceutical products and therapies.

2.8.5 Regulation of medical devices and aids

The Regional Technical Commission for Medical Devices[17] uses HTA to evaluate medical devices (excluding the technology evaluated by the Regional Commission for Technology and Infrastructure Investment). This Commission supervises the risk connected to the use of medical devices through the monitoring of accidents, near accidents and product recalls in hospitals, and through specific inquiries or commissioned studies. It also coordinates technical committees for medical devices at subregional areas (known as "wide areas") with the objective of setting up an integrated HTA and surveillance network between ASLs and the region. In the Veneto Region, five "wide areas" have been identified with relevant ULSSs acting as project leaders (i.e. the ULSS in the provincial capital, with the exception of Belluno and Rovigo).

[16] Regional Decree No. 4690, 22 October 1996.

[17] Established by Regional Decree No. 4534, 28 December 2007.

2.8.6 Regulation of capital investment

Capital investment funding requires separate sources of funding to those used for the provision of the LEAs. These are national-level funds earmarked for infrastructural assets and technology, regional funds, profits from good management[18] and private funds (donations, capital loans).

2.9 Patient empowerment

2.9.1 Patient information

The Veneto Region guarantees the protection of citizens' rights to use health services. Each ULSS, AO and IRCCS has a client care office.[19] These offices have two principal tasks: (1) to supply information on various treatments and health care services and how to access them; and (2) to gather and act upon suggestions to improve the operational and logistical aspects of the health service and to advise patients on how to lodge complaints. In addition, since 1995, it has been compulsory for all health care providers in the public sector to issue a Health Services Charter (*Carta dei Servizi*) informing the public about their health services, quality indicators, waiting times, the complaints system and quality assurance programmes (Lo Scalzo et al., 2009). Almost every Italian region, including the Veneto Region, has widened the compulsory reporting obligations of the Health Services Charter to the private sector, making it a fundamental requirement for the accreditation of private health care suppliers.

The Veneto Region has placed particular emphasis on surveying patient satisfaction, developing a regional project in 2004 to evaluate the quality of its Regional Health Service and a regional database to promote best practice. This includes indicators that refer to the region's *Handbook for a More Patient-centred Management of the Health Care System* (Veneto Region, 2005c). In 2008, the Region, through the ARSS, launched a project to implement an integrated regional system for the study and development of quality care from the patient's point of view. Patients were surveyed on their views about the quality of services, with the technological support of the Picker Institute. Following a pilot programme in four ULSSs in 2009, this quality-monitoring tool was introduced in all ULSSs, with a survey of patients discharged from

[18] Where good management practices result in cost savings in budget lines, it is possible to use these savings for capital investment purposes.

[19] Pursuant to Art. 12, Legislative Decree No. 29, February 1993, and successive amendments.

hospital (via 19 000 questionnaires). The survey had a satisfactory response rate of 67%, demonstrating a real interest on the part of patients to express their opinions about the health services they received. Overall, the evaluations were generally positive, although there were differences and challenges among individual ULSSs (see below). With regard to hospital admissions, 89.5% of the responses described the care received as being excellent, very good or good, while only 1.7% expressed a negative opinion. The positive result can be attributed to the relationship of trust established between patients and the health care professionals who cared for them, particularly doctors.

Comparing the responses of each ULSS and the whole region highlights statistically significant differences, indicating that it is up to the ULSSs to find adequate solutions to the specific needs of the populations they serve. Some of the most significant results from the survey are outlined below.

- With reference to information about their health status and intended treatments, 83.9% of patients thought that they had been adequately informed and more than 70% were satisfied with the way privacy issues were dealt with.

- However, with respect to participation in the treatment decision itself, only 40.7% felt fully involved and 22.4% felt they were not involved. By comparison, only 54.8% of patients said that they received complete information, while 16.1% said they had not received any.

- Regarding information on the undesired side-effects of drugs, dangerous symptoms to watch out for or who to refer to when in doubt or worried, information was not received by 50.2%, 43.6% and 33.2% of patients, respectively.

- Finally, only 56.7% of patients reported that full information was given to their families on how to care for them after their discharge from hospital; while 22.1% confirmed that no information was given at all.

2.9.2 Patient choice

Patients have free choice of GP or paediatrician within their ULSS area and register on the physician's patient list. They may change doctor if they wish. For hospital care, patients may be referred by their doctor to either public or private accredited facilities, following consultation between the referring physician and the patient. The Health Services Charter and the client care offices, mentioned

above, promote awareness among citizens. One of the major problems highlighted by patients is long waiting lists, which act as an incentive for those who have the financial means to go to private doctors or accredited private facilities for diagnosis and treatment in order to avoid queues. This phenomenon is also facilitated by doctors who engage in dual practice: legally practising privately outside of their contracted SSN hours. Over time, various solutions have been proposed to tackle long waiting lists, including, for example, trying to regulate dual practice activities, measures on appropriate prescribing and establishing innovative appointment management systems. Often, however, the problems arise from bad organization and management of human resources: for example, the restrictive work timetables of outpatient departments and hospital specialist departments and the lack of flexibility in work contracts, which currently do not allow ULSSs – apart from a few exceptions – to recruit more staff (even on a temporary basis) to address this problem.

The State-Regions Conference has intervened decisively on this problem with two measures. First, the agreement of 4 February 2002 established that regions had to find a common strategy for setting minimum and maximum waiting times. A subsequent agreement in 2010 identified priority-setting criteria for accessing health care services and established a monitoring system for waiting lists. The primary criteria for establishing priority of access are those related to clinical severity and conditions that are expected to worsen in the short-term in terms of pain or functionality. Other criteria cover assessment of the impact of waiting on the patient's quality of life, disorders that need treatment within a precise time frame and specific patient characteristics.

2.9.3 Patient rights

In Italy there has been a great deal of debate over patient rights, particularly on how to define what treatments should be financed by the SSN and what criteria should be adopted to determine co-payment exemptions. The principle of universal provision of services, regardless of ability to pay, was introduced in 1978 by the first health care reform, which established the SSN. While the first National Health Plan was approved only in 1994, the second National Health Plan in 1999–2000 set out some minimum requirements that had to be followed by every region. Finally, in 2001, the LEA was defined. The LEA established the fundamental health care services that have to be delivered to patients, without excluding the possibility that regions may provide additional services at their own cost (see Chapter 3).

At the national level, ethical committees were first established in 1998. These are independent, intersectoral structures that are responsible for guaranteeing the quality of drug testing, verifying the appropriateness of experimental procedures and addressing ethical questions regarding patients. More generally, in terms of patient rights, the deontological code covering doctors establishes the principles of informed consent.

2.9.4 Complaints procedures (mediation and claims)

ULSSs and AOs have the duty to follow up complaints, as agreed with patients' associations, so that they can be used by management to improve the health service. In addition, each ULSS organizes a health services conference (*conferenza di servizi*) every year aimed to promote dialogue between stakeholders and assess the quality of services. Other mechanisms to highlight dissatisfaction with services are the Health Services Charter and using the client care office to lodge a complaint. Finally, many ULSSs in the Veneto Region have formulated a "Public Protection Regulation", which sets out how citizens can complain when they feel that they have been treated inappropriately or received bad service from the ULSS or one of its staff.

2.9.5 Population participation

The Veneto Region is one of the Italian regions assigning great importance to citizen participation in the management of health services. There are diverse methods of participation, among which the most basic and immediate is the opportunity to take part in the evaluation of services through surveys. Another method is active participation in the decision-making processes of stakeholder associations (such as patient associations), notwithstanding that while formally possible, the latter is not always effective as it is not efficiently implemented in all areas.

2.9.6 Patients and cross-border health care

In terms of cross-border health care between the Italian regions, Table 2.1 lists the main Italian regions whose citizens utilize health services in the Veneto Region and those supplying health care services to Veneto Region residents. As can be seen from Fig. 2.2, the balance of interregional mobility has been positive for the Veneto Region since 2004; that is, the number of out-of-region patients served is greater than the number of Veneto residents seeking health care services elsewhere. However, the ratio of interregional mobility has been diminishing over the last few years.

Table 2.1

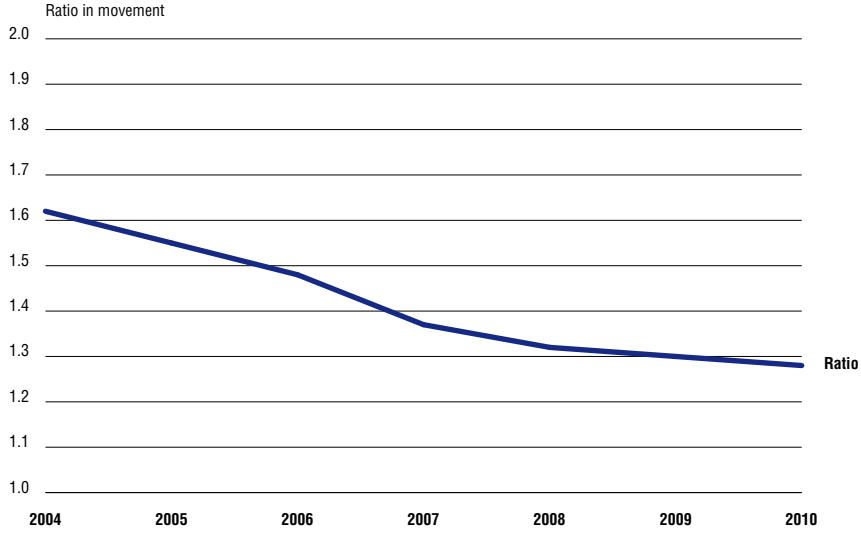
Main Italian regions whose citizens utilize health services in the Veneto Region and those regions supplying health services to Veneto Region residents, 2010

Region	No. people	% of total	No. Veneto Region residents treated	% of total
Lombardia	13 601	21.46	10 158	20.45
Friuli-Venezia Giulia	9 070	14.31	15 638	31.48
Emilia-Romagna	8 910	14.06	11 577	23.31
Provincia di Trento	7 354	11.60	3 777	7.60
Sicilia	5 217	8.23	–	–
Campania	3 095	4.88	–	–
Puglia	3 084	4.87	–	–
Lazio	1 984	3.13	–	–
Total extra-regional activity	**52 315**	**–**	**41 150**	**–**

Source: Veneto Region Health Datawarehouse, 2011.

Fig. 2.2

Mobility in and out of the region for health services



Source: ARSS, 2010.
Note: Ratio in movement is the ratio of the total number of out-of-region residents treated in the Veneto Region to that of Veneto residents treated in other regions.

3. Financing

In 2007, the Veneto Region spent a total of 7.1% of its GDP on health care, a moderate rise from 2001 when the total was 6.7%. This compares with an Italian average of 9.0% of GDP for 2007. In terms of the public share of total health care spending, for the Veneto Region this figure was 76.0% in 2007, slightly below the average (79.0%) for all the Italian regions that year.

The SSN covers the whole population and regions must provide a nationally defined (with regional input) basic health benefits package to all their residents (known as the LEA); extra services may be provided if budgets allow. The reforms of the 1990s, the latest innovations regarding fiscal federalism introduced with the State-Regions Conference Agreement in 2001 and the subsequent definition of LEA, have contributed to a reversal in the trend that saw increasing debt levels in the health sector. In the last few years, resources earmarked for health policies have also increased. Coupled with the introduction of efficiency measures and tighter procedures for financial management, regions, including the Veneto Region, have successfully cut their budget deficits.

Following intense discussions between the national government and the regions over the National Health Fund, which finances the provision of the LEA, resource allocation criteria are established by the State-Regions Conference at the national level. The nationally set allocation guidelines stipulate that 5% of a region's share of the National Health Fund should go to public health, 44% to hospital care and 51% to district-level (primary) care.

Statutory user charges applied to secondary care, and outpatient prescription drugs account for 2–3% of total spending on health care. Most private spending is through direct payments for privately provided health care. Supplementary voluntary health insurance has only recently been introduced and does not play a major role in the Veneto Region or in Italy as a whole.

3.1 Health expenditure

In 2007, the Veneto Region spent a total of 7.1% of its GDP on health care, a moderate rise from 2001 when the total was 6.7% (Table 3.1). This compares with an Italian average of 9.0% of GDP for 2007, with expenditure of other regions ranging from a low of 6.6% (Lombardia) to a high of 13.1% (Calabria) (Fig. 3.1).

Table 3.1

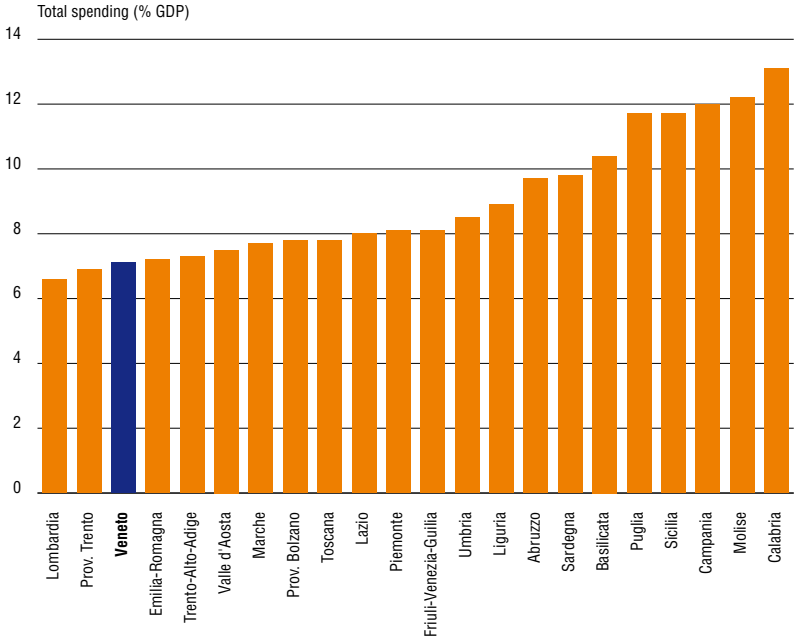
Health expenditure, Veneto Region, 2001, 2005 and 2007

Expenditure [a]	2001	2005	2007
THE (€, PPP per capita, 2000 prices)	1 663	1 765	1 800
THE (% regional GDP)	6.7	7.2	7.1
Mean annual real growth rate, total	na	+10	+14
Mean annual real growth rate in GDP	na	+4	+8
Public expenditure on health (% THE)	73.7	75.7	76
Private expenditure on health (% THE)	26.3	24.3	24
Regional government health spending (% total regional government spending)	59.0	54.5	67.91
OOP payments (% THE) [b]	26.3	24.3	24.0
OOP payments (% private expenditure on health)	100	100	100

Sources: ISTAT, 2011a; Veneto Region, 2001, 2005a, 2007 (*Budget in brief*).
Notes: [a] Reference values are based on the year 2000; [b] Out-of-pocket (OOP) payments include private expenditure on health by households, co-payments for publicly provided health service, the private purchase of all types of health service and private health insurance premiums; PPP: Purchasing power parity; THE: Total health expenditure; na: Not available.

In terms of the public share of total health care spending, this figure was 76.0% for the Veneto Region in 2007, slightly below the average (79.0%) for all the Italian regions that year (Fig. 3.2). In the Veneto Region, public sector health expenditure has increased moderately since the early 2000s, as demonstrated in Table 3.2, which shows public health spending as a percentage of GDP for the period 2001–2006. This trend is consistent with other regions, some of which have also experienced moderate increases. It is worth noting that, in 2006, average public health expenditure as a percentage of GDP by northern regions, including the Veneto Region, was less than half that of regions in the south (an average of 5.56% compared with 9.78%) (Table 3.2). In general, over the period 2001–2006, the Veneto Region's public sector spending on health has remained around 1 percentage point below the Italian average (Fig. 3.3).

Fig. 3.1
Total health care spending in the Italian regions as a percentage of GDP, 2007



Source: ISTAT, 2011b. Group 10. Health Resources, Health Resources Section 1, Financial (9043).

In 2007, per capita spending (purchasing power parity) on health care was €1800, up from €1663 in 2001 (Table 3.1). Using slightly more recent Ministry of Health (*Ministero della Salute*) data on the distribution of expenditure by the SSN as a whole, we can see that in 2008 the Veneto Region's share was slightly below the national average, amounting to €1754 per capita (Table 3.3).

Looking at the different health service programmes that deliver the LEA in the Veneto Region, expenditure trends were as follows.

Public health (preventive health care and health promotion). Approximately 5% of resources[1] were spent on public health in the 2009 financial year, equal to €368 million. Expenditure specifically dedicated to preventive health care increased from €234 million in 2006 to €290 million in 2009 (an increase of 24.1%); in the same period, per capita spending on preventive health care increased by 20.5%.

[1] This figure only covers funding of the LEA. The same distribution level is also set out in the "Pact for Health" agreement signed by the regions and the State for the period 2010–2012.

Hospital care. Approximately 44% of resources were spent on hospital care in 2009, equalling €3.8 billion. This represents a 5.9% increase since 2006, when expenditure was €3.6 billion. Between 2006 and 2009, per capita spending on hospital care rose from €752 to €772, an increase of 2.7% (Fig. 3.4).

Primary and community care (integrated district-level health care). Approximately 51% of resources were spent on primary and community care in 2009, amounting to €3.9 billion. Progressive increases in expenditure assigned to district-level primary and community care were achieved through parallel reductions in hospital care. There are three main sub-areas where spending occurs.

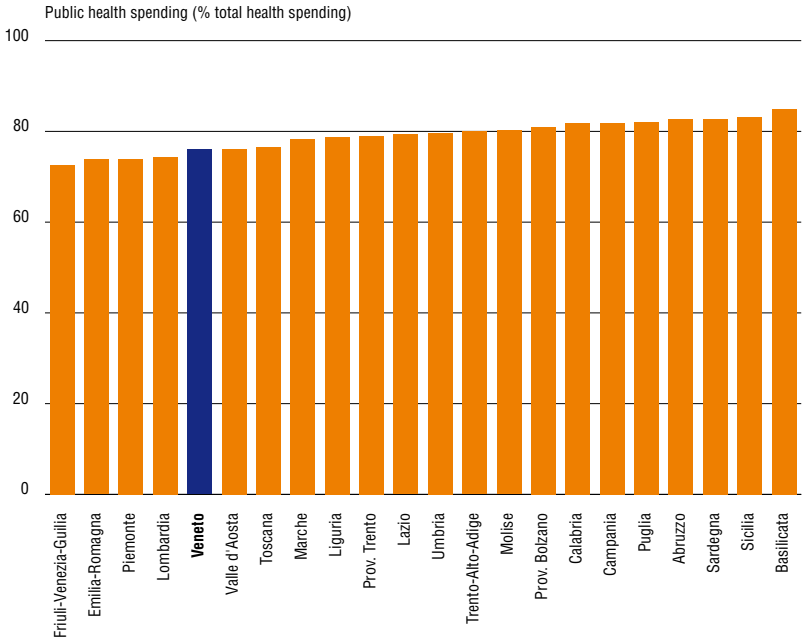
- Specialized ambulatory care: the majority being for laboratory diagnostic services. Expenditure in this category increased from €1.2 billion in 2006 to over €1.4 billion in 2009, an increase of 20.8%. The per capita increase during the same period was 17.3%, from €251 in 2006 to €294 in 2009 (ARSS, 2010).

- Pharmaceutical care: the cost of pharmaceutical care rose from €970 million in 2006 to €1.1 billion in 2009, an increase of 13.5%. During the same period, per capita spending in this category rose by 10.2%, from €204 in 2006 to €224 in 2009 (ARSS, 2010).

- Primary care: mainly delivered by GPs and paediatricians. Expenditure rose from €430 million in 2006 to approximately €490 million in 2009, an increase of 14.4%. During the same period, per capita spending rose by 10%, from €90 in 2006 to €100 in 2009 (ARSS, 2010). The rising costs are partly explained by the policy of promoting greater use of primary care services as a means of containing inappropriate demand for hospitalizations, specialist care and pharmaceutical prescriptions.

Fig. 3.2

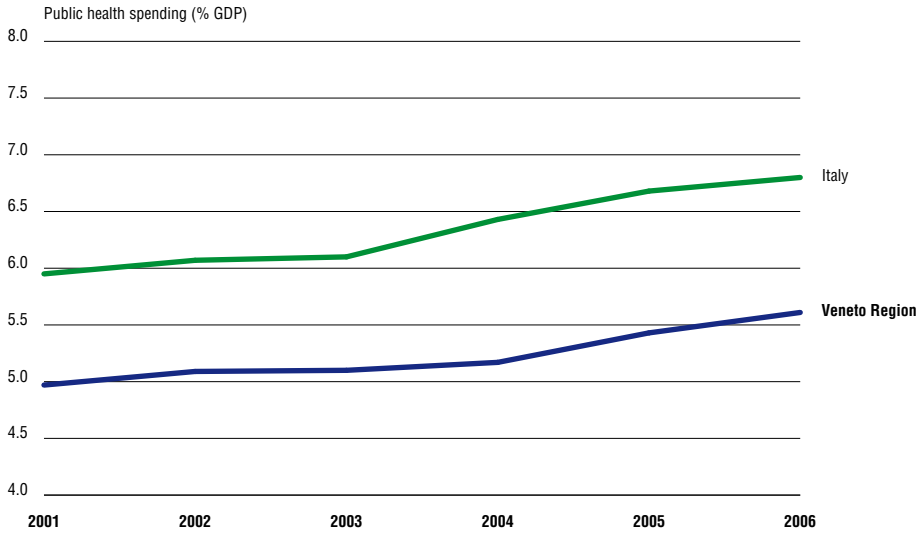
Public health care spending as a percentage of total health care spending, Italian regions, 2007



Source: ISTAT, 2011b (Group 10. Health Resources, Health Resources Section 1, Financial (9020)).

Fig. 3.3

Public health care spending as a percentage of GDP, Veneto Region and Italy, 2001–2006



Source: ISTAT, 2011b (Group 10. Health Resources, Health Resources Section 1, Financial (9041)).
Note: Data for GDP relate to regional GDP for the Veneto Region and national GDP for Italy as a whole.

Table 3.2

Public expenditure on health (% GDP) in the Italian regions, 2001–2006

Region	2001	2002	2003	2004	2005	2006
Piemonte	5.24	5.44	5.54	5.95	6.10	6.27
Valle d'Aosta	5.31	5.44	5.32	5.72	5.73	5.81
Lombardia	4.43	4.61	4.40	4.69	4.82	4.97
Trentino-Alto Adige	5.33	5.59	5.86	6.09	6.00	6.01
Veneto	**4.97**	**5.09**	**5.10**	**5.17**	**5.43**	**5.61**
Friuli-Venezia Giulia	5.54	5.61	5.75	6.12	5.92	5.72
Liguria	6.68	6.53	6.75	7.10	7.53	7.27
Emilia-Romagna	4.81	5.07	5.13	5.41	5.47	5.55
Toscana	5.57	5.64	5.53	5.92	5.99	6.15
Umbria	6.15	6.64	6.72	6.86	7.01	7.24
Marche	6.00	6.00	5.88	6.10	6.22	6.66
Lazio	5.67	5.55	5.95	6.31	6.71	6.80
Abruzzo	7.34	7.52	8.06	7.99	8.43	8.56
Molise	8.61	8.73	9.37	9.35	10.93	9.87
Campania	9.26	9.03	9.20	10.00	10.49	10.14
Puglia	8.50	8.44	8.33	8.72	9.42	9.63
Basilicata	7.65	7.93	8.19	8.44	8.88	9.00
Calabria	9.19	9.15	8.76	8.75	9.50	9.35
Sicilia	8.20	8.86	8.85	9.57	9.86	10.64
Sardegna	7.73	8.07	7.94	8.19	8.53	8.51
Area						
North	**4.91**	**5.07**	**5.04**	**5.32**	**5.46**	**5.56**
North-west	4.84	4.99	4.90	5.23	5.39	5.51
North-east	5.00	5.18	5.25	5.44	5.55	5.64
Centre	**5.71**	**5.70**	**5.86**	**6.20**	**6.44**	**6.61**
South	**8.51**	**8.65**	**8.68**	**9.16**	**9.67**	**9.78**
Southern mainland regions	8.72	8.65	8.72	9.16	9.76	9.65
Islands	8.07	8.64	8.60	9.17	9.49	10.04
Italy, total	**5.95**	**6.07**	**6.10**	**6.43**	**6.68**	**6.80**

Source: ISTAT, 2011a.

Table 3.3

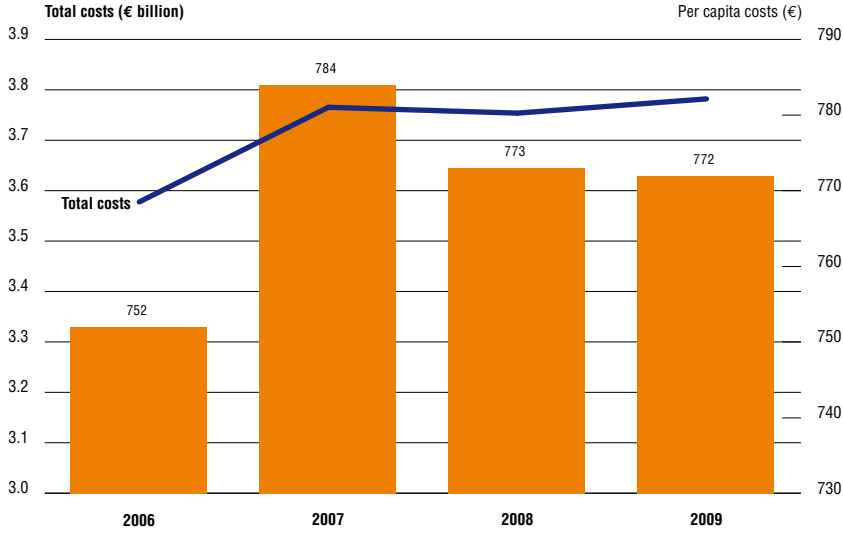
Distribution of per capita expenditure by the SSN by region, 2008

Region	Expenditure (€ million)	Per capita (€)
Bolzano Province	1 111	2 263
Valle d'Aosta	261	2 079
Molise	651	2 033
Lazio	11 093	2 007
Liguria	3 179	1 976
Trento Province	994	1 948
Friuli-Venezia Giulia	2 328	1 912
Emilia-Romagna	7 937	1 868
Piemonte	8 068	1 843
Toscana	6 642	1 816
Abruzzo	2 338	1 775
Umbria	1 557	1 772
Veneto	**8 426**	**1 754**
Lombardia	16 678	1 738
Puglia	7 022	1 724
Basilicata	1 012	1 712
Marche	2 637	1 707
Sardegna	2 816	1 694
Campania	9 689	1 670
Sicilia	8 345	1 661
Calabria	3 320	1 658
Italy	**106 104**	**1 787**

Source: Ministry of Health, 2009.

Fig. 3.4

Total and per capita (inhabitant) hospital costs, Veneto Region, 2006–2009



Source: ARSS, 2010.

Table 3.4 reports data on the health system's main cost categories over the period 2000 to 2009.

Table 3.4
Breakdown of main health system cost categories, 2000–2009

Costs (€ million)	2000	2005	2009	2009 as % of total
Purchase of goods	597	898	1 167	13.6
Purchase of non-health services	342	483	625	7.3
Purchase of health services from private providers	2 058	3 264	3 741	43.7
Staff costs	2 187	2 754	2 760	32.3
Amortization of capital expenditures (depreciation)	120	199	260	3.1
Total costs	**5 305**	**7 599**	**8 553**	**100**

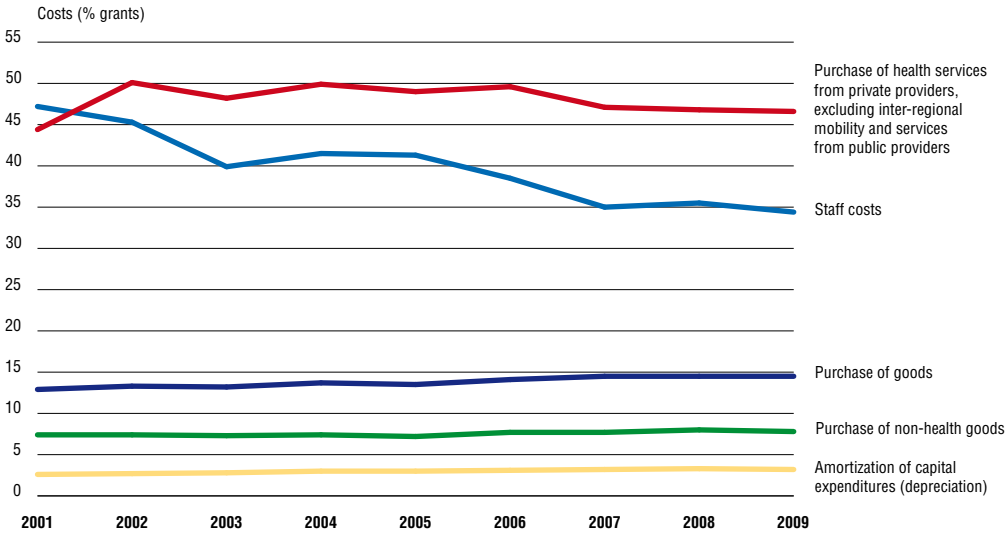
Sources: Veneto Region, 2000, 2005b, 2009 (*Budgets of health care enterprises*).

Fig. 3.5 shows the main "macro-categories" of expenditure in relation to what is known in the Italian accounting context as the "grants for current expenditure" (*contributi in conto esercizio*) for the period 2000–2009 in the Veneto Region. The grants for current expenditure represent a region's annual allocation of resources from the National Health Fund in order to guarantee the delivery of the LEA for that year. These resources represent the principal source of financing (over 90%) for the region and thus for ULSSs. The analysis of these data is interesting in that "grants for current expenditure" approximate the regional health system's ability to finance its current expenditure. In this regard, it is important to highlight expenditures, such as certain categories of health services that show growth rates above those of the grants for current expenditure. It is also important to note the trend showing a progressive reduction in health personnel costs as a proportion of total expenditure, in contrast to the rising proportion represented by services bought from private providers. The growth in the cost of goods (both health and non-health goods) results mainly from expenditure on pharmaceuticals, both in numerical terms and as a proportion of the total cost of goods.

ULSSs buy services from private accredited providers; consequently, citizens can go directly to any local health care supplier who has a contract to supply services to the SSN and then the local ULSS reimburses the provider for the services delivered. This system works to guarantee citizens the choice of accessing public or private health services. For the period 2000–2009, Fig. 3.6 shows the disaggregated costs associated with purchasing services from private providers and which are paid for by ULSSs. The data exclude health services purchased directly by citizens from private providers that do not have a contract with the SSN.

Fig. 3.5

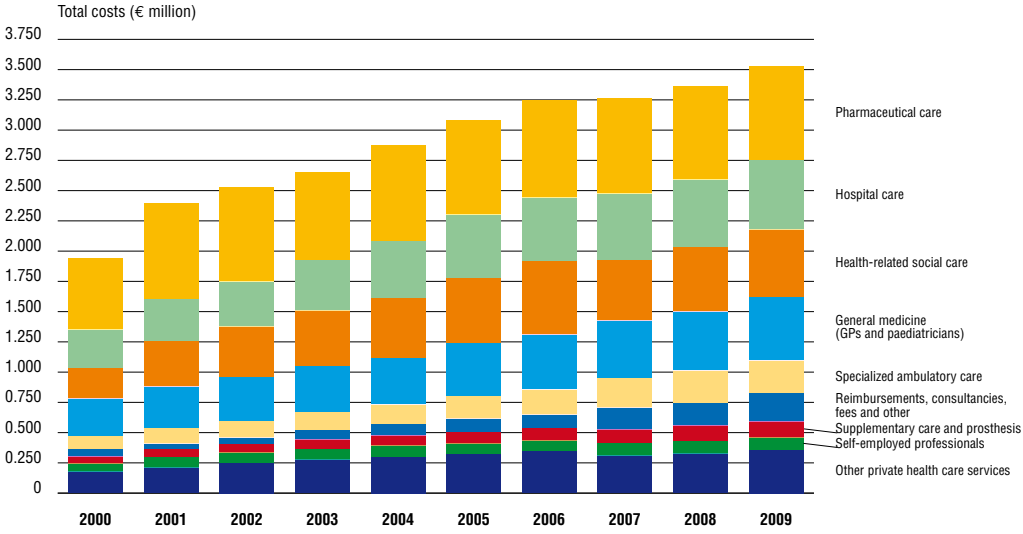
Principal health care costs as a percentage of grants for current expenditure, Veneto Region, 2000–2009



Source: ARSS, 2010.

Fig. 3.6

Breakdown of health care services from private providers, 2000–2009



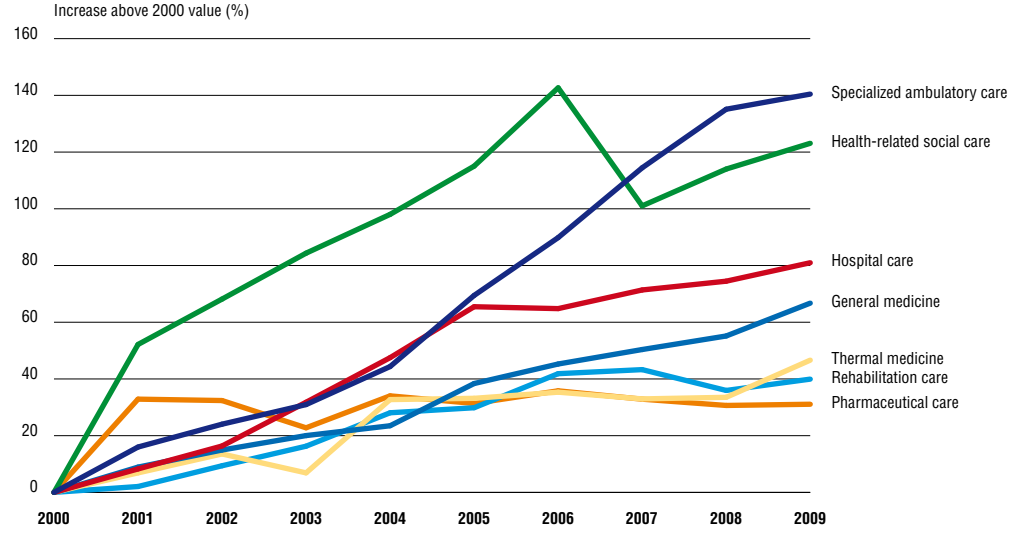
Source: ARSS, 2010.

Fig. 3.7 highlights the cost increases for some of the main items that are purchased from private providers. It is clear that in the last few years the most significant increases have been in the cost of purchasing specialized ambulatory care and health-related social care (e.g. care for the elderly, the disabled and those with drug addictions), while hospital care experienced a more contained rate of increase.

Expenditures for health care personnel during the period 2000–2009 are reported in Fig. 3.8. The variation in the trend during the period reflects, on the one hand, periodic contract renewals and on the other, a block on new recruitment. As already noted, an interesting element is the decisive reduction in health personnel expenditure as a proportion of the "grants for operating expenditure", falling from 50% to 35% (Fig. 3.9).

Fig. 3.7

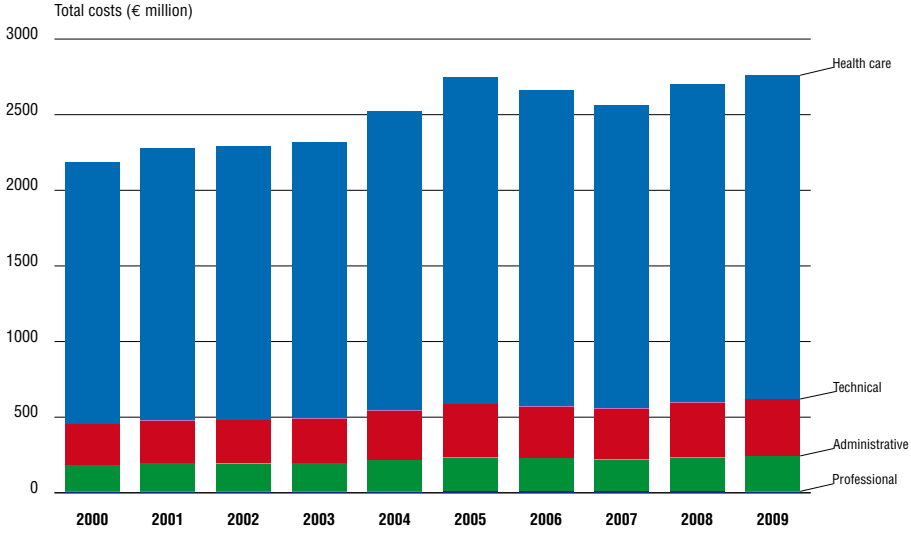
Increases in the purchase of health services from private providers: increases to 2009 from a base year of 2000



Source: ARSS, 2010.

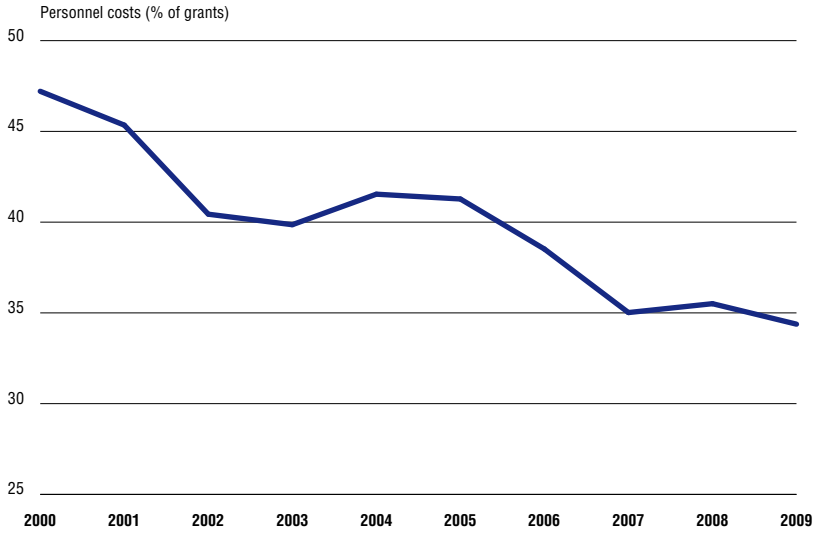
Fig. 3.8

The cost of health system personnel, 2000–2009



Source: ARSS, 2010.

Fig. 3.9
Health care personnel costs as a percentage of grants for operating expenses, 2000–2009



Source: ARSS, 2010.

3.2 Sources of revenue and financial flows

The 1978 reform formally assigned the entire financial responsibility for the SSN to the central government which, nevertheless, had only limited powers to control its expenditure. With reference to health funding and cost control, the 1992–1993 reform established new principles on how to distribute the resources of the National Health Fund on a capitation basis. Regions would receive allocations that would allow delivery of the LEA, adjusted according to the following criteria: resident population, the out-of-region (i.e. non-resident) patients cared for (and conversely the number of patients who seek health services outside their region of residence) and the number of health facilities, technical equipment and medical instruments. The reform also introduced new ways of financing hospitals based on fixed tariffs for each hospitalization episode rather than the previous method of paying for the number of days spent in hospital. The regions were given the task of defining the prices of these diagnostic-related groups (DRGs) in reference to the tariffs established

at national level. Moreover, in recognition of the differences between regions, they were granted greater autonomy to find appropriate and efficient solutions to meet the health needs of their populations, but keeping to balanced budgets.

Law No. 662, 1996 established the relative capitation weights for regional funding allocations: resident population, health services consumption by age and sex, mortality rates, specific indicators useful for defining a region's particular health care needs, and regional epidemiological indicators. Thus, the Law resolutely abandoned "historical spending" as a criterion and adopted distributive criteria no longer predominantly tied to supply but rather to the demand represented by waiting lists, the needs of the resident population and age groups, on the one hand, and to the LEA on the other. Establishing the correct capitation weights is still the subject of controversy in Italy, given the diverse number of variables that need to be taken into account.

In terms of defining the LEA, the regions asked the government for a specific commitment to set out what needs to be delivered. The issue was particularly pressing as the regions had also become responsible for any budget deficits incurred by ASLs. An important agreement between the central government and the regions was signed on 8 August 2001. The accord recognized the rights and the duties of both parties. On the one hand, the agreement forced the government to define the LEA in relation to the financial resources also set out in the accord within a short time frame (by November 2001); on the other hand, it set the SSN's resource allocation and established the need for a new equilibrium in distributing resources between the regions, taking into account the "need to incentivize good behaviour, remove disadvantages and improve the quality of services" (Art. 16). In return, the regions gave their commitment to review the capitation criteria outlined in the 1996 legislation.

Thus, the LEA was defined with the State-Regions Agreement on 22 November 2001 and passed into law on 29 November 2001. Its main objective was to confirm and guarantee existing health care services while removing those that were not clinically effective, appropriate or cost-effective. Underlying the definition of the LEA is an acknowledgement of the cost of each category and subcategory of care. These costs were set in May 2001 at a Round Table Meeting of the Secretariat of the State-Regions Conference, which also analysed whether designated funding for LEA provision was adequate. There has always been much debate in Italy over the exact causes of health budget deficits.

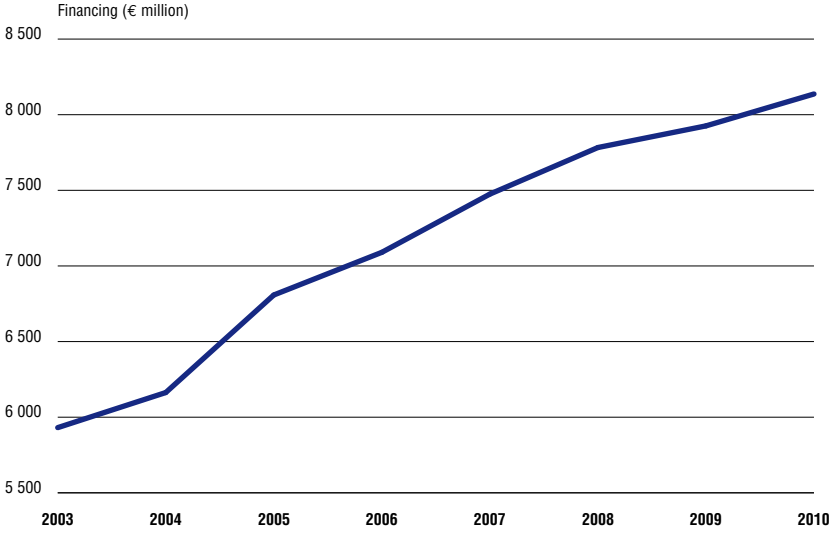
Regional Law No. 56, 2004 (Art. 25) provides for the financing of the regional health service via the region's share of the National Health Fund, also taking into account interregional flows of patients for different services. The apportioned regional funds should ensure (Art. 26):

- implementation of the objectives and other health activities on behalf of the ULSSs, achieved through centralized regional management;
- financing to the ULSSs, AOs and the public IRCSS (Veneto Oncology Institute); and
- financing of the investment programmes defined by regional planning instruments.

Fig. 3.10 shows the trend in funding from the National Health Fund to the Veneto Region from 2003 to 2010. While resources to the region have increased, the rate of increase has been slowing down over the last few years. A response to the need to achieve savings has been to improve the efficiency of the Veneto Region health system through restructuring services and introducing innovation. The combination of increased funding – albeit more modest in recent years – and management innovations has reduced the budget deficit of the Veneto Region's health system over the last decade. In 2010, the Region's health budget was still in deficit but the annual loss was not large.

Fig. 3.10

Financing from the National Health Fund to the Veneto Region, 2003–2010



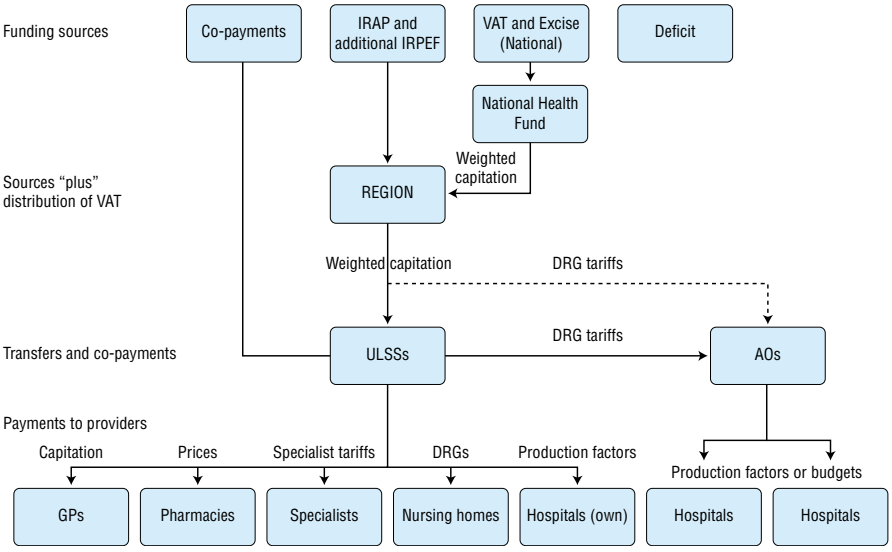
Source: Decisions by the Joint Committee of the Regions on the National Health Fund, 2003–2010.

3.3 Overview of the statutory financing system

The 1978 health reform changed the previously fragmented system based on social insurance funds to one that guaranteed more homogenous coverage for all citizens and created the National Health Fund. Before 1978, the health service covered 93% of the population (in different ways); the reform was able to implement universality, with coverage for the whole population (with equal rights for everybody). This brought about a substantial increase in per capita health expenditure during the successive decade linked to both the expansion in the number of citizens covered and the uniform extension of services. The resources within the Fund were fixed annually by the central government and were financed mainly through insurance contributions and general taxation, but also in part by regional taxation or local taxation and by private services. With numerous legislative measures (including Legislative Decrees No. 446, 1997 and No. 56, 2000), the government rationalized the sources of financing, which remain almost totally based on taxes. That is, the National Health Fund is now essentially financed through a regional corporation tax imposed on the value-added of companies and on the salaries paid to public sector employees (*imposta sul reddito delle persone fisiche*); a regional piggy-back tax, which is imposed on top of the personal income tax (known as the "additional IRPEF"); plus set amounts from indirect taxes such as value added tax (VAT) and petrol excise tax. These taxes are set nationally but regions are allowed to vary the total "additional IRPEF" rate from 0.9% to 1.4%. The National Health Fund also receives resources from central government transfers (Lo Scalzo et al., 2009).

To complete the process, recently new rules were set on the allocation of funding to the regional health services. Fig. 3.11 summarizes the process.

Fig. 3.11
Financing of the Regional Health Service



Notes: IRAP: regional corporation tax imposed on the value-added of companies and on the salaries paid to public sector employees.

The 2009 "Pact for Health" summarizes all previous such agreements between the state and the regions, covering all operational aspects from financing to implementation standards. In terms of financing, the National Health Fund has increased for the current cycle: for the years 2010–2011, there was an additional €4.5 billion and for the year 2012 there is a 2.8% increase compared with 2011, with any savings achieved by regional health services being kept by the regions. In addition, funding for investments has also increased for the three-year period 2010–2012 by €4.7 billion. Additional funding for long-term care is set at €400 million and there is also an increase of €30 million in the Fund for social care policies (increases that are very modest compared with needs). A new regulation is also in place to guarantee proper implementation by the regions, namely to balance their budgets and to deliver the LEA. Finally, penalties are in place for situations where regions are faced with health care budget deficits: initially, an automatic increase in their contributions to the National Health Fund's source taxes ("additional IRPEF" and regional corporation tax[2]) but also a prohibition on spending on non-LEA and non-essential services. Regions can also be required to implement other cost-containment measures such as introducing co-payments for health services and freezing health personnel recruitment. It should be noted that the 2010

[2] Since 2006, regions are required to increase the rate by 1% if they are faced with health expenditure deficits.

budget – under the Finance Minister Tremonti – made some cuts to that year's National Health Fund resources, causing strong protests from all the regions. Where measures to cut deficits fail, the president of a region has the power to impose additional sanctions such as suspending funding for non-LEA services and dismissing managing directors of ULSSs and the head of the regional department of health.

The criteria for allocating resources from the National Health Fund are still cause for much debate among the regions and between the regions and national Ministry of Health. This is because the relevant legislation does not specify these criteria in detail (and this cannot be done in accordance with respecting regional autonomy). The Minister of Health's task is to outline the allocation of health funding to the regions, which is then debated by the State-Regions Conference. Every year the various criteria used in the allocation process are heavily debated and negotiated and even if they vary only minimally (e.g. in the weight attributed to the elderly population) they can make quite significant differences to funding levels compared with the previous year.

Once the Veneto Region has received its health funding allocation, resources should be split according to nationally set parameters, also taking into account the regional health plans, which allow for slight variations. In 2010, the national and Veneto Region levels, respectively, were as follows:

- 5% national for public health (preventive health care and health promotion) and Veneto Region 4.9%;
- 51% national for district-level (primary) care and Veneto Region 50%; and
- 44% national for hospital care and Veneto Region 45.1%.

3.3.1 Coverage

Breadth

The Veneto Region guarantees the right to health to all residents, in accordance with the Italian Constitution and in line with several reforms of the SSN. The main criterion for the allocation of resources is the resident population of the region. Access to health care services is guaranteed by the Region to its resident population and also to non-residents, on the basis that the region will be compensated financially for services provided to non-residents by the regions of these patients' origin. Thus, the universality of the regional health system excludes the need to rely on any compulsory insurance by the citizen-user.[3]

[3] Although voluntary health insurance is sometimes bought to cover elective surgery.

Scope

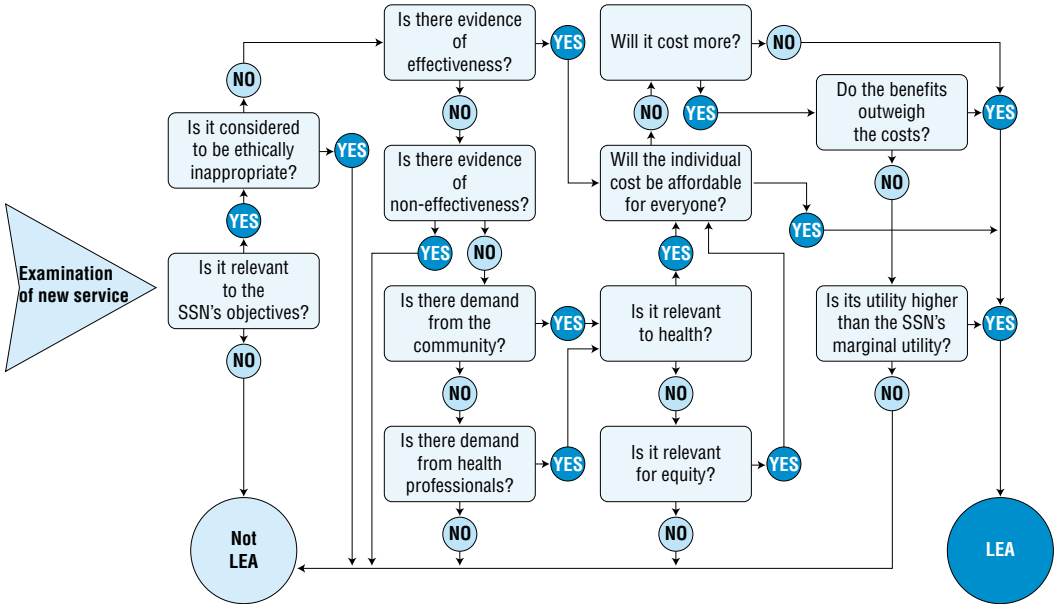
The LEA is defined nationally and covers the health services that are paid for by the SSN. The whole population has guaranteed access to this basic health benefits package. The SSN is required to provide health care services that can demonstrate, for particular clinical conditions and risk categories, scientific evidence of significant health benefits, either at the individual or collective level, based on the resources utilized. The LEA does not cover three categories of treatments, which are judged to be inappropriate. The first group is treatments that are deemed not essential from a clinical point of view (e.g. plastic surgery for aesthetic purposes); the second category covers conditions that are inappropriate for hospital admissions (e.g. cataract surgery or carpel tunnel release), which must be treated at different levels of the health system such as day surgery in an ambulatory setting; the third group of treatments is considered to be inappropriate in terms of cost-effectiveness (Lo Scalzo et al., 2009). In addition, there is a list of "inessential" medicines not included in the SSN reimbursed list, whose prices can be set freely and paid in full by patients.

Other factors that determine the inclusion of health care services in the basic health benefits package are:

- there is no evidence of ineffectiveness and there is demand from either the community or health professionals;
- relevance to public health;
- relevance to equity; and
- benefits outweigh the costs, or where this is not the case the benefits are greater than the marginal utility of the SSN.

Fig. 3.12 outlines how the LEA is defined. In addition to the LEA, every region is allowed to introduce additional health care services for its citizens that are not covered by the basic health benefit package (extra or additional LEA). This includes, among other things, plastic surgery, male circumcision, complementary and alternative medicine, certain categories of physical rehabilitation and outpatient rehabilitation services, pharmaceutical products for people with rare diseases, care for patients with severe pain caused by a degenerative tumour, care for patients with coeliac disease and care for patients with allergies and food intolerances. Thus, the health care services that are excluded from guaranteed provision are those that do not meet the national prerequisites outlined above and do not form part of the "additional LEA" list; in effect these are services that have only a marginal utility compared with the services covered.

Fig. 3.12
Process for defining the LEA



Depth

User charges policy is defined nationally. Some health care services require a contribution (co-payment) by users. In Italy, such co-payments are known as a "ticket"[4] and are levied on certain types of specialist care and medicine. Exemptions from co-payments are established for people with certain health conditions and for disabled people, older people and those on low income (based on the previous year's gross income). All citizens who are not exempted must contribute to expenses for specialized ambulatory outpatient visits, diagnostic procedures and laboratory analyses. For example, outpatient visits currently incur a flat-rate co-payment of €10 per visit. Box 3.1 outlines the categories of people who are totally exempt from co-payments for specialist services, while Box 3.2 lists those who are exempt from co-payments for specialist services connected to a particular disease.

[4] The term is taken from the French term *ticket moderateur,* which refers to patient co-payments.

Box 3.1

Categories totally exempt from co-payments for specialist services

- War invalids under Categories I–V, holding a pension for life and who were deported to an extermination camp
- Civil invalids (100% invalidity)
- Civil invalids with two-thirds invalidity or greater (67–99%)
- Civil invalids with financial support
- Severe occupational accident invalids (80–100% invalidity)
- Occupational accident invalids with two-thirds invalidity or greater (67–99%)
- Severe armed services invalids (belonging to Category 1 and holding special pensions)
- Armed services invalids belonging to Categories II and V
- Blind people (defined by Law No. 68, 1999)
- People who are profoundly deaf (defined by Law No. 68, 1999)
- Citizens under 6 years of age or over 65 years with a total declared (family) annual income under €36 151.98
- People who have a state pension and family dependants
- People who have a minimum pension, are 60 years old or older, have family dependants and an income below €8263.31 per annum or €11 362.05 if not legally but effectively separated, plus €516.46 for each dependent child
- Unemployed people who are looking for work and are enrolled with the Unemployment Office, who have family dependants and an income below €8263.31 per annum or €11 362.05 if not legally but effectively separated, plus €516.46 for each dependent child.

Box 3.2

Categories totally exempt from co-payments for specialist services connected to specific diseases

- People who have been irreversibly injured due to complications following a compulsory vaccination, transfusion or administering of blood derivatives as per Art. 1, Law No. 210, 1992
- People with infectious diseases or conditions listed in Ministerial Decree No. 329, 28 May 1999
- War invalids under Categories VI to VIII who have a pension for life
- Occupational accident invalids with less than two-thirds invalidity
- Armed services invalids under Categories VI to VIII
- Occupational accident invalids or those with a professional syndrome (the exemption only covers the period of the accident/disease's duration)
- Services connected to preventive interventions or prevention campaigns
- Public health measures ordered by the regional minister of health
- Services in the interest of public health (e.g. donations of blood, organs and tissues; health care in schools; special neuropsychiatric care for infants; services for people with HIV or suspected HIV infection)
- Victims of terrorism or criminality with invalidity above 25%
- Pregnant women (Ministerial Decree, 10 September 1998)
- Children under the age of 18 who are starting a professional sports career (Ministerial Decree, 18 February 1982)
- People with rare diseases (Ministerial Decree, 18 June 2001).

From 1 January 2001, in accordance with Law No. 388, 2000 (Art. 85), the following services do not require a co-payment:

- mammography every two years for all women aged 45 to 69
- pap smear test every three years for all women aged 25 to 65
- colonoscopy every five years after 45 years of age or for those at risk
- diagnostic test for tumours in early age (i.e. for patients under 45)
- services utilized by people who donate blood, bone marrow or body organs.

Emergency care in hospitals is also subject to a co-payment, except where the emergency intervention ends with hospitalization or a period of observation in the admissions ward, in cases of accidents at work or where in the doctor's judgement care cannot be deferred. In 2007, a co-payment of €25 was introduced for non-urgent visits to hospital emergency departments (i.e. those deemed to be an inappropriate use of emergency departments), with an exemption for children under 14 years of age.

Blanket exemptions from co-payments are also given to groups on the grounds of low income (Ministerial Decree (*Decreto Ministeriale*) 11 December 2009 from the Minister of Finance). These groups include children under 6 years of age, those over 75 who are part of a family with a gross annual income under the limit set by law and those over 75 years of age who have a full or minimum social pension and are part of a family (i.e. not living alone).

Co-payments for pharmaceuticals are also levied. These are €2 for each packet up to a maximum of €4 for each prescription (including single-dose antibiotics and medicines taken only via intravenous drip up to six packets per prescription). For medicines that are not covered by patent and are part of the reference pricing system for reimbursement, the patient will pay the full fixed price of the medicine if a doctor prescribes a medicine that costs more than the reimbursement price (and indicates that a substitute is not available) or the patient rejects the substitution of the more expensive medicine with a cheaper reimbursable one. War invalids who hold a pension for life are exempt from this requirement. Box 3.3 lists those who are exempt from the pharmaceutical co-payment of €2 per packet.

Out-of-pocket payments also include payments made directly to private providers. These are discussed in section 3.4 below.

3.3.2 Collection

Taking the latest year for which data are available (2010) as a reference point, funding for the regional health care services came exclusively from national-level financing sources (the National Health Fund) and there were no extra resources from local taxes. Any end-of-year health budget deficits are usually met by the region, and sourced from the region's discretionary power to increase the rates of regional corporation tax and "additional IRPEF" levied.

Box 3.3
Categories exempt from pharmaceutical co-payments

- Civil invalids with 100% disability
- Blind people (defined by Art. 6, Law No. 482, 1968)
- Severe occupational accident invalids
- Armed Services invalids in Category I
- People damaged by compulsory vaccinations, transfusions or administration of blood derivatives
- Victims of terrorism and organized criminality
- Patients receiving treatment with analgesic opiates as pain killers (pursuant to Law No. 12, 8 February 2001)
- People with a rare disease
- People suffering from a chronic and debilitating disease (since 1 July 2003 the exemption is limited to medicine prescriptions to treat only the disease)
- People who are profoundly deaf (since 1 February 2003)
- Minors under the age of 18 with no limits (since 1 July, 2003)
- People whose annual family income does not exceed €12 000 (since 1 April, 2005).

3.3.3 Pooling of funds

Each year, the State-Regions Conference negotiates the health financing proposal set out by the national Interministerial Committee for Economic Planning and establishes the division of resources among the regions for the delivery of health care. Each region then distributes its share of resources to the ASLs/ULSSs in its jurisdiction. Table 3.5 outlines the distribution of the Veneto Region's health care resources by broad service categories for the year 2010.

Table 3.5
Resource distribution from the Regional Health Fund in the Veneto Region health care system, 2010

	2010 (€, thousand)	% of total
Public health	378 813	4.7
Primary and community care (district-level health care)	3 788 644	46.6
Pharmaceutical care	808 946	9.9
Specialist care	1 008 411	12.4
General health care (GPs)	1 133 820	14.0
Care for the disabled and for the elderly	686 210	8.5
People with dependencies	25 000	0.3
Emergency services	68 660	0.8
Health enterprise specificities	57 597	0.7
Hospital care	3 359 140	41.3
Implementation of objectives	153 604	1.9
Other specific funds	214 774	2.6
Regional priorities and other activities	242 453	2.9
Total resources	**8 137 428**	–

The financing criterion, in line with Legislative Decree No. 502, 1992, is based on a per capita quota, adjusted to take into account differences in the "needs" of the population groups served by each ULSS. Regions have the autonomy to establish the most appropriate adjustments to the per capita quota; that is, they are not bound by national-level criteria. However, per capita funding is not the only way that the Veneto Region finances its ULSSs. National and regional regulations also allow for financing based on different criteria such as "by function". Some examples include emergency care, transplants and university research. In addition, the Veneto Region's two AOs and the IRCCS are financed according to DRG tariffs, with some funding "by function". Table 3.6 shows the distribution of resources among the Region's specific ULSSs, AOs and IRCCS.

Table 3.6

Distribution of resources from the Veneto Regional Health Fund, 2010

ULSS [a]	Finance (€, thousand)							Resident population
	Public health care	District-level primary care	Hospital care	Implementation of objectives	Total distribution for LEA	Other funds	**Total**	
01 Belluno	10 728	116 277	89 112	3 964	220 081	9 972	**230 053**	129 073
02 Feltre	6 800	75 928	57 589	2 609	142 926	1 034	**143 960**	84 949
03 Bassano del Grappa	13 945	143 079	115 566	5 513	278 103	1 632	**279 735**	179 497
04 Alto vicentino	14 463	142 772	121 658	5 771	284 664	1 893	**286 557**	187 902
05 Ovest vincentino	13 811	131 747	116 359	5 546	267 463	1 566	**269 029**	180 577
06 Vicenza	24 184	243 895	207 258	9 780	485 117	30 009	**515 126**	318 436
07 Pieve di Soligo	16 658	167 247	145 145	6 722	335 772	1 945	**337 717**	218 853
08 Asolo	19 045	179 836	159 889	7 702	366 472	1 326	**367 798**	250 762
09 Treviso	31 480	311 139	269 127	12 731	624 477	26 181	**650 658**	414 503
10 Veneto Orientale	16 375	155 380	142 286	6 622	320 663	1 658	**322 321**	215 610
12 Veneziana	24 495	265 649	216 450	9 451	516 045	28 720	**544 765**	307 721
13 Mirano	20 255	186 773	171 805	8 192	387 025	2 455	**389 480**	266 705
14 Chioggia	5 603	56 885	46 277	2 118	110 883	1 254	**112 137**	68 961
15 Alta padovana	19 199	176 765	160 160	7 764	363 888	19 880	**383 768**	252 797
16 Padova	36 983	386 080	320 321	14 956	758 340	6 424	**764 764**	486 962
17 Este	14 512	141 977	122 327	5 694	284 510	2 099	**286 609**	185 382
18 Rovigo	14 146	154 829	119 984	5 379	294 338	11 545	**305 883**	175 129
19 Adria	6 068	64 072	52 372	2 298	124 810	697	**125 507**	74 805
20 Verona	35 995	360 351	306 638	14 517	717 501	6 284	**723 785**	472 661
21 Legnago	12 111	119 942	101 665	4 752	238 470	1 435	**239 905**	154 705
22 Bussolengo	21 957	208 021	185 295	8 831	424 104	3 399	**427 503**	287 535
A O Padova	0	0	63 875	1 304	65 179	18 000	**83 179**	0
A O U I Verona	0	0	61 726	1 260	62 986	35 366	**98 352**	–
IOV IRCCS	0	0	6 256	128	6 384	0	**6 384**	–
Total	**378 813**	**3 788 644**	**3 359 140**	**153 604**	**7 680 201**	**214 774**	**7 894 975**	**4 913 525**

Source: Regional Government (Giunta) Decision No. 3473, 2010.
Note: [a] The numbers indicate the official identifier assigned to each ULSS.

3.3.4 Purchasing and purchaser–provider relations

Health services are purchased by the Giunta via the ULSSs. As established by Regional Law No. 56, 1994 (Art. 2) the Region has the following tasks.

1. The Region undertakes operational planning, strategic planning, regulation and coordination of ULSSs and AOs.
2. The Region regulates the relations between the ULSSs, AOs, public and private health facilities and contracted health care professionals, through the instruments and regulations of regional planning. These relationships are based on the accreditation of health care facilities, the payment methods for services and on the system of quality monitoring and improvement.
3. The Giunta monitors the services delivered in terms of ensuring minimum requirements, the classification of health care providers and the extent to which citizens' needs are met; it also verifies whether objectives are achieved in terms of the quality and quantity of services as established by the Regional Health and Social Care Plan.
4. The Giunta, making use of ULSSs and AOs and having consulted the representative bodies of municipalities, alpine communities, provinces, universities, organizations representing social stakeholders and health care professionals, the provincial chapters of the National Federation of Doctors, Surgeons and Dentists, voluntary organizations, citizens and citizens' rights associations, adopts the Regional Health and Social Care Plan and sends it to the Regional Council (legislature) for approval.

In addition, Legislative Decree No. 502, 1992 (Art. 3, clause 5) states that the regions set the general evaluation criteria for the performance of managing directors, taking into account the objectives defined within the regional planning framework, with particular reference to the efficiency, effectiveness and functionality of health services. Regions define and allocate to each managing director their health and health care objectives, in light of available resources.

The Veneto Region's health and social care system is mainly public but it also allows private health care facilities, which can deliver services once accredited.[5] Within this framework, the autonomy of health care enterprises is preserved (and the benefits that this entails) and the region exercises a stewardship function through which specific objectives are defined for each health care enterprise and their results can be evaluated.

[5] Pursuant to Legislative Decree No. 502, 1992.

The monitoring of health care enterprises' performance, in terms of both service delivery and efficiency, also satisfies the Pact for Health signed by the regions and the central government for the three-year period 2010–2012. This agreement underlines the need to improve the quality of health services, promote appropriate care and guarantee the unity of the system by keeping health expenditure under control. More precisely, the Pact for Health (2010–2012; subsection 1, Art. 1) states that the regions have to ensure balanced health care budgets while delivering efficient and appropriate care. The Pact also provides (in Art. 2) for the establishment of a health expenditure and health services monitoring system (through a technical body supported by the State-Regions Conference) based on efficiency and appropriateness indicators. The strategic areas targeted for actions to achieve improvements in the Veneto Region's health and social care system, to guarantee population needs and to control costs are:

- reorganization of the regional network of hospital care
- pharmaceutical care
- management of personnel
- training of specialized care staff
- mechanisms to regulate the market and public-private relationships
- agreements on interregional mobility of patients
- post-acute care
- strengthening administrative and accounting procedures
- promoting preventive activities
- implementing an adequate internal audit system.

In particular, the internal audit system will allow a more efficient control of processes via the adoption of risk management strategies to identify and evaluate risks and to formulate appropriate solutions.

ULSSs are both suppliers and purchasers of health care as they deliver care via their own public sector facilities or reimburse private facilities or other ULSSs/AOs that are contracted to deliver care to its residents. The Giunta is responsible for setting the financial principles and criteria for the delivery of hospital services by public and private accredited health care facilities. The regional councils also define the criteria that set the tariffs to be paid for hospital services, taking into account agreed annual activity volumes and expenditure ceilings. In cases where private providers do not comply with expenditure ceilings or activity volumes established at a regional level, the region can reduce

(by a considerable amount) the tariffs it pays for the services they deliver. This so-called "regression" mechanism involves a percentage reduction in the fees paid for services that are above the agreed budget.

Legislative Decree No. 502, 1992 (modified by Legislative Decree No. 229, 19 June 1999), which radically reformed the structure of the Italian health system, also introduced the process of institutional accreditation of health care facilities, both public and private, and gave the regions responsibility for this function. The Decree also introduced new payment methods for health services and a new system for quality monitoring and evaluation. Health care providers that operate on behalf of the regional health services need to have received both authorization to operate in the region and accreditation to provide services on behalf of the SSN (see section 2.8.2). They are then allowed to provide services under precise contractual agreements. Health care providers that are totally private only require authorization. Authorization entails meeting minimum structural, technological and organizational requirements, while the accreditation process includes the assessment of a facility's organizational, technological and managerial infrastructure and assessment of the services provided and their value-added in terms of regional planning and the services to be delivered. However, having authorization and accreditation is not sufficient; in order for ULSSs or other health enterprises to reimburse a private provider for services, these services must be precisely outlined in a contractual agreement.

Across Italy, the new system of accreditation and contractual agreements outlined above is gradually being completed, with time needed for the adoption and implementation of legal provisions both at national and regional level. The Veneto Region passed legislation (Regional Law No. 22, 16 August 2002 on the Authorization and Accreditation of Health and Social Care Facilities) and published an implementation manual (Regional Giunta Decree No. 2501, 6 August 2004, with consequent modifications and additions) and, therefore, has a fully operational authorization and accreditation system.

Health care can be delivered in different ways, as follows:

- by ULSSs and AOs using their own premises;
- via contracted staff, as is the case with GPs, paediatricians and pharmaceutical care; here the ULSS delivers services indirectly through health care professionals and/or companies connected to them holding contracts that conform to national and regional regulations;
- via private accredited providers that have contractual agreements with the relevant ULSS;

- via *sperimentazioni gestionali* or similar entities; these are alternative health care institutions, overseen at regional level, with more innovative management structures for the delivery of services, based on public-private partnerships; and
- through partial reimbursement of the cost of the service when patients access health care from private providers, if this is permitted by regional regulations; this includes health care received abroad in highly specialized health care facilities if this has received prior authorization by the region, with patients receiving partial reimbursement of costs for care that requires highly specific staff qualifications, unusual technical procedures or advanced technology that cannot be adequately obtained in Italy.

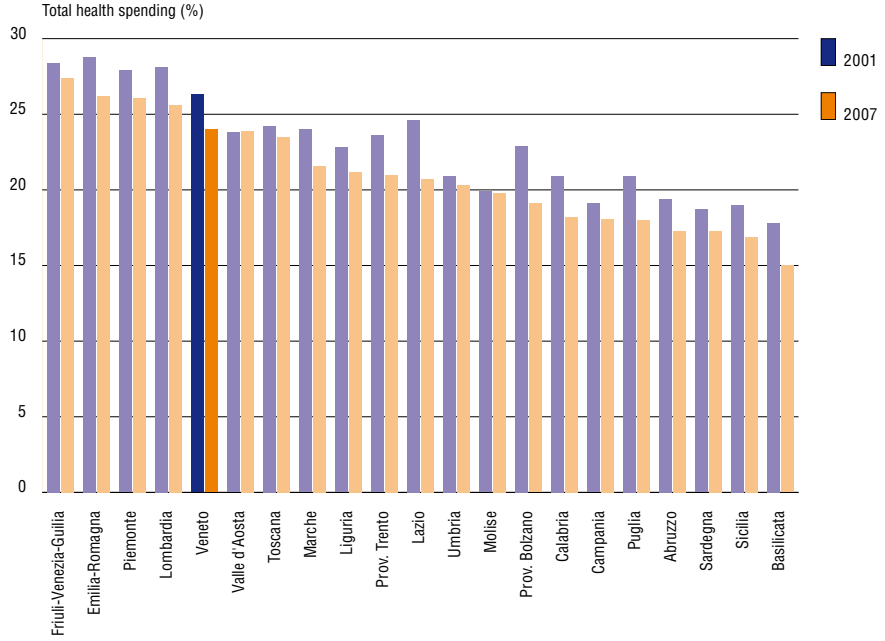
3.4 Out-of-pocket payments

In addition to co-payments for pharmaceuticals, specialized health services and emergency care, another form of out-of-pocket payments is care received from a private provider and paid for in full by the patient. Non-reimbursable payments have always been the subject of heated debate at national level. Such payments, as well as co-payments, were not foreseen by the 1978 reform of the national health system, but they were introduced a few years later, also as a means of balancing the health budget. In the Veneto Region, co-payments represent approximately 2–3% of total health expenditure (see also section 3.3.1).

Direct out-of-pocket payment takes place only for private medical visits and for pharmaceutical products that are not reimbursable. Although access to regional health services is universal and free, waiting lists can be quite long. This is one of the factors that may encourage people to opt for privately paid services.

Fig. 3.13

Out-of-pocket health spending by families as a percentage of total health spending, Italian regions, 2001 and 2007



Sources: ISTAT, 2001, 2007.

In 2007, out-of-pocket payments were estimated to total approximately 21% of health expenditure nationwide and around 24% in the Veneto Region (Fig. 3.13). Table 3.7 gives a slightly different perspective, highlighting the expenditure on health care by households as a percentage of GDP. In the Veneto Region, household expenditure on health care remained almost stationary at around 1.7% of GDP between 2001 and 2007.

3.5 Voluntary health insurance

In the Veneto Region, as in Italy as a whole, the SSN delivers the LEA that is quite comprehensive and, therefore, citizens make little use of voluntary health insurance. However, there are some difficulties in accessing services, particularly with the current financial crisis and austerity measures to restore public finances. Consequently, the role of voluntary health insurance in Italy and in the Veneto Region can be defined as "supplementary"; that is, voluntary health insurance allows faster access to the same services guaranteed by the LEA, allowing people to bypass any waiting lists. However, there are no data available on this sector.

Table 3.7
Health expenditure by type of expenditure and region (% GDP), 2001, 2005, 2007

Regions	2001			2005			2007			Difference 2001–2007		
	Public	By households	**Total**	Public	By households	**Total**	Public	By households	**Total**	Public	By households	**Total**
Piemonte	5.2	2.0	**7.2**	6.1	2.1	**8.2**	6.0	2.1	**8.1**	0.7	0.1	**0.8**
Valle d'Aosta/Vallée d'Aoste	5.3	1.7	**7.0**	5.7	1.6	**7.3**	5.7	1.8	**7.5**	0.4	0.1	**0.5**
Lombardia	4.4	1.7	**6.1**	4.8	1.8	**6.6**	4.9	1.7	**6.6**	0.5	0.0	**0.4**
Liguria	6.7	2.0	**8.7**	7.5	2.1	**9.6**	7.0	1.9	**8.9**	0.3	-0.1	**0.2**
Trentino-Alto Adige	5.3	1.6	**6.9**	6.0	1.6	**7.6**	5.9	1.5	**7.4**	0.5	-0.1	**0.4**
Bolzano/Bozen	5.5	1.6	**7.1**	6.5	1.7	**8.2**	6.3	1.5	**7.8**	0.8	-0.2	**0.6**
Trento	5.1	1.6	**6.7**	5.5	1.6	**7.1**	5.4	1.4	**6.9**	0.3	-0.1	**0.2**
Veneto	**5.0**	**1.8**	**6.8**	**5.4**	**1.7**	**7.1**	**5.4**	**1.7**	**7.1**	**0.4**	**-0.1**	**0.4**
Friuli-Venezia Giulia	5.5	2.2	**7.7**	5.9	2.3	**8.2**	5.9	2.2	**8.1**	0.3	0.0	**0.3**
Emilia-Romagna	4.8	1.9	**6.7**	5.5	2.0	**7.5**	5.3	1.9	**7.2**	0.5	-0.1	**0.4**
Toscana	5.6	1.8	**7.4**	6.0	1.8	**7.8**	5.9	1.8	**7.8**	0.4	0.0	**0.4**
Umbria	6.2	1.6	**7.8**	7.0	1.7	**8.7**	6.8	1.7	**8.5**	0.6	0.1	**0.7**
Marche	6.0	1.9	**7.9**	6.2	1.9	**8.1**	6.0	1.7	**7.7**	0.0	-0.2	**-0.2**
Lazio	5.7	1.8	**7.5**	6.7	1.8	**8.5**	6.4	1.7	**8.0**	0.7	-0.2	**0.5**
Abruzzo	7.3	1.8	**9.1**	8.4	1.8	**10.2**	8.0	1.7	**9.7**	0.7	-0.1	**0.6**
Molise	8.6	2.1	**10.7**	11.0	2.3	**13.3**	9.8	2.4	**12.2**	1.2	0.3	**1.5**
Campania	9.3	2.2	**11.5**	10.5	2.2	**12.7**	9.9	2.2	**12.0**	0.6	0.0	**0.6**
Puglia	8.5	2.2	**10.7**	9.4	2.3	**11.7**	9.6	2.1	**11.7**	1.1	-0.1	**1.0**
Basilicata	7.7	1.7	**9.4**	8.9	1.6	**10.5**	8.8	1.6	**10.4**	1.2	-0.1	**1.1**
Calabria	9.2	2.4	**11.6**	9.5	2.4	**11.9**	10.7	2.4	**13.1**	1.5	0.0	**1.5**
Sicilia	8.2	1.9	**10.1**	9.8	1.9	**11.7**	9.7	2.0	**11.7**	1.5	0.1	**1.6**
Sardegna	7.7	1.8	**9.5**	8.5	1.8	**10.3**	8.1	1.7	**9.8**	0.4	-0.1	**0.3**
Area												
North-west	4.8	1.8	**6.6**	5.4	1.9	**7.3**	5.4	1.8	**7.2**	0.5	0.0	**0.5**
North-east	5.0	1.9	**6.9**	5.5	1.9	**7.4**	5.5	1.8	**7.3**	0.5	-0.1	**0.4**
Centre	5.7	1.8	**7.5**	6.4	1.8	**8.2**	6.2	1.7	**7.9**	0.5	-0.1	**0.4**
Centre-north	5.1	1.8	**6.9**	5.7	1.9	**7.6**	5.6	1.8	**7.4**	0.5	-0.1	**0.4**
Southern	8.5	2.1	**10.6**	9.7	2.1	**11.8**	9.5	2.0	**11.5**	1.0	0.0	**0.9**
Italy	**5.9**	**1.9**	**7.8**	**6.7**	**1.9**	**8.6**	**6.5**	**1.8**	**8.3**	**0.6**	**-0.1**	**0.6**

Source: ISTAT, 2001, 2005, 2007.

3.6 Other financing

Other sources of financing are not relevant in the Veneto Region as almost all financing comes from public funds or direct payments for health visits. There are EU funds for the creation and maintenance of nongovernmental

organizations and cooperatives operating in the health and social care sphere, but, on the whole, these organizations rely on other types of funding. There is also a network of voluntary organizations that are very active in the Veneto Region, together with organizations such as the Red Cross, which also provide local health and social care services.

3.7 Payment mechanisms

3.7.1 Paying for health services

Payment for hospital care and services is based on DRG tariffs. Regions are also allowed to use additional sources of financing to deliver other extra-LEA services (see section 3.3.1), which receive funds directly from the region. With the 1999 reform, DRG payments and additional extra-LEA services were defined in greater detail, as were payments based on the average costs of specific services (such as prevention, social care, transplants and chronic diseases). Table 3.8 outlines the various payment mechanisms used to pay health care services.

Table 3.8
Provider payment mechanisms

Provider	Payment mechanism
GPs	Capitation
Ambulatory specialists	Fee for service
Other ambulatory provision	Fee for service
Acute hospitals	DRG
Dentists [a]	Fee for service
Pharmacies [b]	Capitation
Social care [c]	Contribution of ULSS to local municipality

Notes: [a] Dentists working within the public health system are paid partly by the patient (co-payment) and partly by the ULSS, whereas those working in the private sector are paid in full by the patient; [b] Pharmacy payment is based on the type of medication and the patient, the medicine being paid for in full by the ULSS or, in most cases, through cost sharing between the patient and the ULSS; [c] Social services payment is shared between the ULSS and the recipient/municipality (e.g. nursing home).

3.7.2 Paying health care professionals

The remuneration of health staff at all levels of the health system is established nationally through the approval of collective agreements, "collective national contracts", which regulate both the salaries and the working conditions

of the relevant personnel. ULSSs and AOs can integrate national contracts into their own local-level contracts for the provision of services by health care professionals.

Doctors

There are two categories of doctor in Italy: GPs and paediatricians (providing primary and community care) and other physicians, namely hospital physicians. The first category can decide to work either part-time or full time and are paid by the ULSS on the basis of the number of patients they have. In addition, ULSSs can decide to make extra payments for the provision of specific services to patients (e.g. for patients with chronic diseases or disabilities). These doctors can also provide services privately as autonomous professionals, activities that are regulated to avoid any conflicts with the prioritized care that must be delivered to the patients on their lists. Their levels of remuneration are established every three years through a collective national contract, which also fixes the number of patients who can be on the lists of GPs and paediatricians. The health reforms of 1992 and 1999 promoted the establishment of different forms of group practice (known as associations) between these doctors in order to guarantee better continuity of care for patients (see section 5.3).

The reforms also divided the payment system into three parts: a fixed per capita payment (based on the number of patients), a variable part (made up of fees for services for specific treatments) and an "additional" part (as a reward for containing costs). Compared with GPs, paediatricians receive a greater per capita payment and have a more limited number of patients.

Hospital physicians receive a monthly salary; remuneration levels are established nationally on the basis of duties performed. Previously, there were two levels (first and second) within this group of doctors based on examinations passed, the type of health services provided and duties performed. However, in 1999 these were merged into a single category, with remuneration according to assigned duties and responsibilities. Hospital doctors may choose to practise privately in addition to their contracted hours in public hospital facilities (dual practice). However, in public hospitals, senior managerial and director positions are reserved only for doctors who have chosen to work exclusively in the public sector. Nevertheless, the majority of doctors continue to undertake dual practice, also working as self-employed professionals in private practice; these activities are regulated through paying a proportion of their extra income to the hospital as reimbursement for using hospital facilities.

Nurses and midwives

In Italy, nurses are not a separate professional category (as are physicians) and instead occupy the higher level of a hierarchy of SSN "nonmedical" staff that includes technicians, clerks and administrative staff (Lo Scalzo et al., 2009). They are by far the most significant personnel resource in this category.

Nurses' salaries and those of the other professional groups in the nonmedical category are defined by a collective national contract renegotiated every three years. Of the four employee classification categories (A, B, C and D), nurses and midwives belong to the two highest, C and D, along with dieticians, technicians and higher-level administrative staff. Apart from specific professional duties, group D staff, including ward managers/head nurses, perform more complex duties and have decision-making responsibilities. Productivity bonuses are also paid on top of base salaries.

Pharmacists and other health care staff

There are two categories of pharmacist, those who work within hospital pharmacies and pharmacies within ULSS's own facilities and those who manage private pharmacies and have a contract to provide services to the SSN. The former group are paid a salary while the latter group are private business owners.

Other health care personnel employed by ULSSs or AOs include biologists, chemists, psychologists, dentists, sociologists, veterinarians, health technicians (e.g. radiologists and rehabilitation staff), administrative staff (statisticians, administrative assistants and administrative managers), technical health care support staff (*operatori tecnici addetti all'assistenza* (OTA)) and health and social care assistants without formal qualifications (*operatori socio sanitari* (OSSs)). The regional health system also includes professionals who are not on permanent contracts – for example staff training for a specialization, who work mainly in AOs; freelance professionals with a freelance contract; and people on internships and bursaries.

4. Physical and human resources

In the last few years, the Veneto Region has reviewed the organization of facilities in order to meet the need for fewer hospitals and more primary and community care. There has been an ongoing process to turn small hospitals into post-acute care and community health facilities. Hospital beds are not evenly distributed across the Region and further rationalization will be required in some areas. In 2009, there were 19 672 accredited hospital beds (an average of 3.4 beds for every 1000 inhabitants). Standard medical equipment is purchased at the discretion of individual ULSSs while big ticket items need authorization from the Giunta.

The total number of people employed within the region's health care enterprises in 2010, including administrative staff, was 61 246 (or 57 692 full-time equivalents). There has been a slight increase (2.2%) in the number of health care personnel in recent years but, as the population also has increased over this period, the number per capita has remained more or less the same. There is a general undersupply of nurses.

4.1 Physical resources

4.1.1 Capital stock and investments

Investment funding

The dynamics of the decision-making process for capital investment in health care structures have to be examined together with the funding mechanisms that underlie them.

Until 1988, a proportion of the National Health Fund was earmarked for capital investment in the health sector (including new buildings, renovations, technologies, etc.), with a central committee choosing which projects to fund.

These funds provided a stable flow of resources and procedural stability that allowed regional planners to implement projects in the medium to long term. Over time, this funding grew smaller and the mechanism was replaced by capital financing through mortgages and an alternative (smaller) programme for infrastructure financing set up by the central government.

In 2001, with the start of the fiscal federalism and related reforms to regional financing, the National Health Fund's capital account was abolished. With increasing regional health budget deficits and less access to central government sources of funding for health infrastructure, investment funding became severely restricted. To meet actual needs, several sources have been explored, including national funds, regional funds, European funds, self-financing by health enterprises (such as mortgages, budget advances and the sale of assets), and non-traditional forms of financing (such as project finance).

In the Veneto Region, the Building Projects Unit, under the joint stewardship of the Department for the Environment and the Department of Public Works, and in close cooperation with the head of the Department of Health, manages the planning processes for capital investment. With the aim of developing an integrated and coherent capital investment strategy, a number of audits have taken place to gauge the condition of the region's capital stock, the results of which have been fed into discussions with health care enterprises on their requirements and regional planning programmes for building maintenance and new construction.

ULSSs and AOs are involved in infrastructure planning through the Three-year Investment Plan. This investment plan is sent to the Region every year together with the strategic planning budget, which specifies the year's objectives, the actions required and the expenditure that these will entail. Specific actions in the Investment Plan must be supported by a technical document that outlines, among other things, operational details and funding requirements for the maintenance of existing facilities or their eventual renovation or replacement.

Detailed applications must be submitted by health enterprises when they intend to acquire, renovate or build new health care facilities. These are evaluated by an interdepartmental technical group both in terms of the region's overall health planning objectives and in terms of costs. Final approval is given by the Giunta and financing from the Region's Health Fund (capital account) is then made available. In this way, the Region exercises strong strategic oversight over capital projects of significant economic importance that will have an impact on the network of available health services.

The Veneto Region has a comprehensive and coordinated financing strategy for capital projects based on its capital fund, which pools various sources, including those from the central government. A 10-year financing plan for the period 2004–2013 is in place to ensure that existing health care facilities meet accreditation requirements and to implement new investments, including the renovation of hospitals built in the 1960s that need upgrading to meet modern needs.

The Region also allows ULSSs and AOs the autonomy to generate their own additional funds for capital projects, leaving them to decide on the best instruments that complement their financial assets. Among the various options available, mortgages/property loans are not used very much while more interest has been shown in generating income from the sale of (surplus) property, project finance and, more recently, finance leasing. However, any form of borrowing or incurred debts requires prior authorization by the Giunta.[1]

The Veneto Region was one of the first Italian regions to promote and use project finance for the building and management of facilities, with new hospital premises in the city of Mestre. This case is particularly interesting because this project is the only one at national level with partial financing from the European Investment Bank. Tenders for the renovation and extension of the hospitals in Catelfranco and Montebelluna will follow. Nationally, these are the most expensive project finance building projects in the health sector. Any capital investment project utilizing project finance must first be evaluated by the Region's Evaluation and Audit Unit. The particular disadvantages associated with project finance (such as procedural complexities, the long loan period (30 years on average) and difficulties in establishing appropriate risk allocations) also have led the Veneto Region to explore leasing contracts as an alternative means of capital investment.[2]

Fixed assets include material assets, such as land, buildings, plants and equipment, and non-material ones, such as patents, brands and shares. Over the last few years, investment in such assets has varied between €300 million and €450 million for each year, equal to around 5% of resources. In 2009, there was a fall in the value of new investments undertaken by the Regional Commission for Technology and Infrastructure Investment. This Commission plays a vital role in supporting the Giunta's decision-making on which building and equipment investment projects to implement, and thus ensuring that choices are relevant to the needs of the health system.

[1] Regional Law No. 56, 1994, Art. 26.

[2] As per Regional Law No. 1, 2004, Art. 37.

4.1.2 Infrastructure

Currently, there are 24 health care enterprises in the Veneto Region: 21 ULSSs, 2 AOs and 1 public IRCSS. The reorganization of the SSN in the early 1990s resulted in a reduction of the number of health care enterprises in Italy. In particular, the number of ULSSs was reduced from 36 to 22 in the Veneto Region and two AOs were established in Padova and Verona. In 1996, the ULSSs in Venice and Mestre were merged.[3] Table 4.1 summarizes the number of health care facilities (inpatient and outpatient facilities) for each province in 2009.

Table 4.1
Number of health care facilities in Veneto Region, by province, 2009

Province	Population	Facility type		Average number of beds by type of facility	
		Public	Accredited private facilities	Public	Private
Verona	914 901	12	8	257	138
Venezia	858 997	10	5	255	138
Vicenza	866 412	10	3	252	80
Padova	925 141	9	4	401	112
Treviso	884 118	7	6	380	91
Rovigo	249 934	3	3	287	97
Belluno	214 022	5	1	200	78
Total	**4 913 525**	**56**	**30**	**291**	**113**

Source: Veneto Region Health Datawarehouse, 2011.

In line with national and regional legislation, there has been an ongoing reorganization of hospitals in the region.[4] The objective has been to gradually reduce the number and fragmented structure of hospitals and their services and to establish a modern, rationalized hospital network. Policies aimed at achieving the restructuring of the existing network of public and private hospitals include:

- reducing the number of hospitals and beds, transforming some hospitals into residential homes for the elderly and the disabled or into other types of health care facility;
- setting up health centres with different organizational levels;
- checking and revising contractual agreements (and accreditations) with private health care facilities; and
- the eventual abolition or transformation of psychiatric hospitals.

[3] In line with Legislative Decree No. 502, 1992 and Regional Law No. 56, 1994.

[4] Regional Law No. 39, 30 August 1993 and Law No. 412, 30 December 1991.

As a result, there has been, on the one hand, a consistent reduction in bed numbers in compliance with national guidelines, including the target of 160 hospitalizations per 1000 inhabitants (in 1998 in the Veneto Region this quota was 200); on the other hand, there has been a reduction in the number of autonomous units, particularly through the closure of small hospitals. These were too numerous, did not adequately meet safety and quality standards and were very costly. Having said that, the preferred restructuring policy in the Veneto Region has not been the closure of hospitals but their transformation (material or financial) into other types of service to meet changing needs (e.g. to provide care for those with chronic diseases or care for the frail and elderly).

As of 1 January 2010, there were 90 hospitals officially registered in the Veneto Region, 59 of which were public and 31 private (the latter including *sperimentazioni gestionali* facilities) (Veneto Region, 2010). In 2009, there were 19 672 hospital beds available to the Veneto Regional Health Service (Table 4.2), amounting to an average of 3.4 beds (public and private accredited) for every 1000 inhabitants (Fig. 4.1). National guidelines set a standard of 4.5 beds per 1000 inhabitants. Beds destined for rehabilitation and long-term hospitalization make up 14.8% of the total, or 0.6 beds for every 1000 inhabitants (Fig. 4.2). The province of Verona has the most beds, while Belluno has the least, but there are also discrepancies within individual provinces (which should be overcome in the next Health and Social Care Plan).

Table 4.2

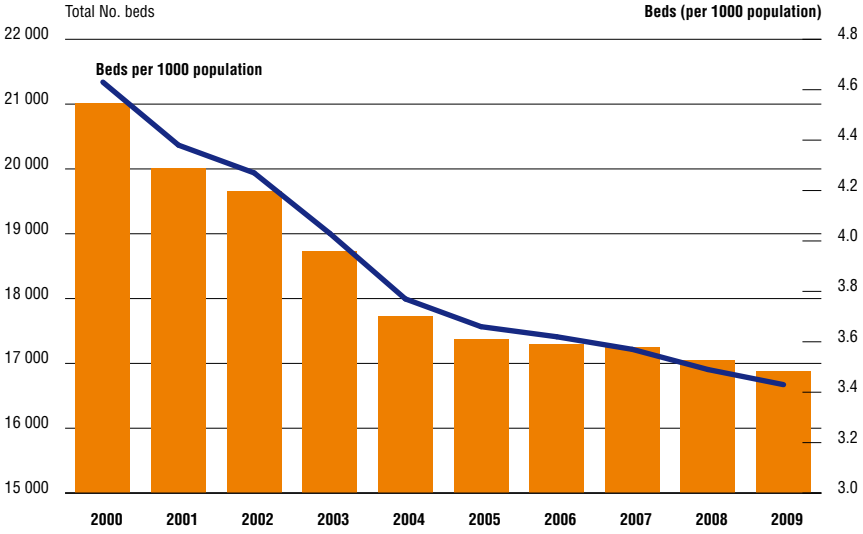
Number of health care beds in Veneto Region, 2000–2009

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Acute	21 010	20 006	19 648	18 732	17 724	17 370	17 292	17 246	17 040	16 876
Of which psychiatric	829	787	805	794	785	800	791	936	936	929
Rehabilitation	2 731	2 716	2 750	2 709	2 780	2 729	2 730	2 751	2 793	2 796
Total	**23 741**	**22 722**	**22 398**	**21 441**	**20 504**	**20 099**	**20 022**	**19 997**	**19 833**	**19 672**

Source: ARSS calculations based on Veneto Region *New Health Information System,* HSP Models 12–13, 2000–2009 (Veneto Region, 2010).

Fig. 4.1

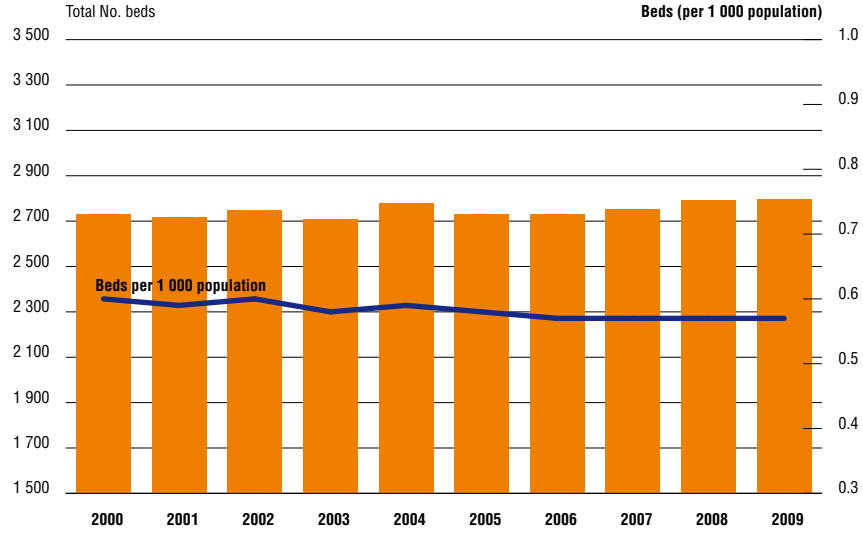
Number of beds for patients needing acute care, 2000–2009



Source: ARSS, 2010.

Fig. 4.2

Number of rehabilitation and long-term stay beds



Source: ARSS, 2010.
Note: The data include long-stay beds and beds for functional recovery and re-education, spinal units and neurorehabilitation.

4.1.3 Medical equipment

Each ULSS and AO has to make its own investment decisions regarding medical equipment according to its care priorities, population needs and the financial resources available.

The capital account of the Regional Health Fund and national government sources are the major sources of financing for investment in medical equipment. The purchase of big ticket items must receive prior authorization from the Guinta, which is responsible for decisions on the territorial distribution and volumes of such equipment; the purchase of all other medical equipment is managed by ULSSs.

As part of the Veneto Region's commitment to improving cooperation and international solidarity within its Regional Health Service, hospital equipment and medical products that are no longer needed or surplus to requirements are sent to developing countries the health systems of which may still make good use of them.[5] The list of available equipment is updated every six months and published on the Veneto Region's web site so that beneficiary countries can submit their requests.

Fig. 4.3 illustrates how investment in health technology and equipment has increased since the early 2000s, particularly the value of fixed assets. Table 4.3 lists diagnostic imaging units available in the Veneto Region in 2009. The average age of these pieces of equipment ranges from 6 to 8 years.

Table 4.3

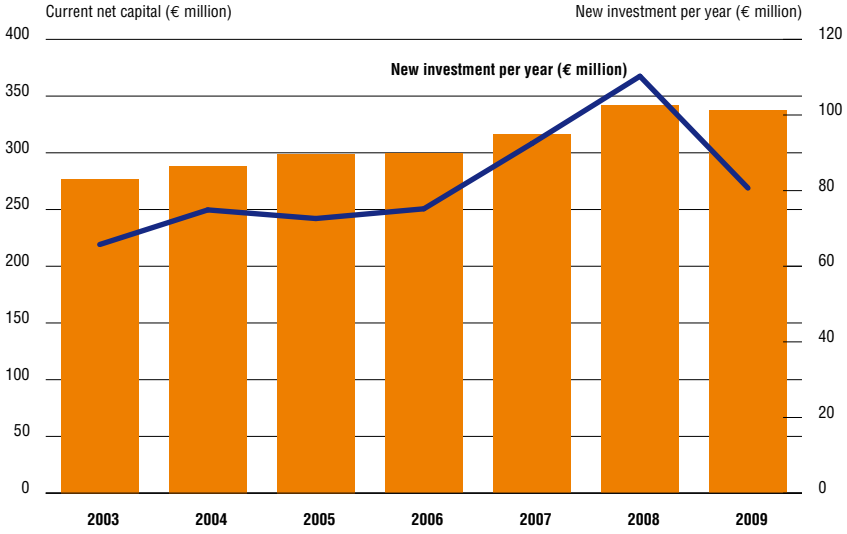
Items of functioning diagnostic imaging technology, Veneto Region, 2009

Technology	2009
Computed tomography scanners	67
Magnetic resonance imaging scanners	47
Positive emission tomography scanners	5
Mammography scanners	63
Gamma cameras	28

Source: ARSS, 2009.

[5] Under Regional Law No. 41, 19 December 2003, Art. 54.

Fig. 4.3
Investment in health equipment



Source: ARSS, 2010.

4.1.4 IT

According to data from the National Institute for Statistics, ISTAT, for 2009, the Veneto Region's access to and usage of IT is growing: more families now own a personal computer, have access to the Internet (55%) and use broadband for their connection. Families with at least one child use more IT; at the opposite end of the spectrum, families with only elderly members aged 65 or over continue to be excluded from the benefits of technology. Searching for health information is one of the main reasons for Internet use by Veneto residents in 2010 (ISTAT, 2010a).

The systematic application of IT to support health services is a work in progress, with ULSSs making a joint effort to improve their systems and to adopt a common methodology. Particular projects are also being implemented to aid citizens' access to health information. For example, the IESS Project (Integration for the Delivery of Health Services) aims to establish a platform that will allow direct access by citizens to some essential regional health services via telehealth. In addition, plans are underway to implement electronic patient records, which would contain information on the care received by the individual and would use the Internet to securely connect patients, GPs, other health professionals and hospital staff, with the aim of strengthening

continuity of care. This project is being implemented within the e-government programmes promoted by the national Ministry of Innovation and Technology. The project foresees the utilization of telecommunications technology to deliver the following services directly to citizens:

- making appointments for health services via patient appointment centres (*centro unico di prenotazione*), pharmacies, districts, GPs (via contact centres) and generally through Internet portals that will allow the user to see the availability of services;
- the secure transmission of results/medical reports; and
- the direct and secure transmission (via Internet) of GPs' prescriptions to pharmacies for pharmaceutical prescriptions and other prescriptions to pharmacies, district health facilities and patient appointment centres for other types of health care services.

This is still a pilot project, involving only the health care enterprises in the provinces of Bassano del Grappa and Mirano. The aim is to define models and standard solutions that can then be rolled out across the regional health system. Part of the project also involves the establishment of a functional datawarehouse to monitor the appropriateness of prescriptions and to control pharmaceutical expenditure. This pilot is expected to supply more reliable data, decrease ULSS workloads and reduce waiting lists.

Apart from the initiatives outlined above, specific IT objectives for ULSSs, AOs and IRCCSs have been issued for the year 2010–2011 (Table 4.4).[6] The IT objectives aim to improve the efficiency and quality of services, optimize clinical governance of the regional health system and reduce costs.

[6] Regional Decree No. 3140, 14 December 2010.

Table 4.4

IT objectives: Attachment A, Regional Decree No. 3140, 14 December 2010[a]

IT area	Objective	Indicator	Threshold value for 2011	Threshold value for 30 June 2012
B.1[b]	Assignment of digital certificates to identify and underwrite clinical documents (digital signature) to doctors	Percentage of operators who have been assigned a certificate	60%	95%
B.2	Addition of digital signature on reports and clinical documents	Percentage of signed reports by type	Percentage of reports from laboratory, analysis of blood chemistry, pathology, anatomy microbiology, radiology and minutes from First Aid Service to reach a total of at least 95% of total documents	Percentage of resignation letters, continuity of care reports and cards detailing emergency number 118 calls to reach at least 85% of total
		Percentage of reports produced by the immune-transfusion services for patients and donors	Set up of the IT technology for digital signature	90%
B.3	Set up of the registry and repository	Implementation and positive testing of the registry (IT mechanism to retrieve documents) and repository (IT mechanism to memorize documents) as per regional specifications	Implementation of the registry and repository by 30 April 2011	Testing occurred
B.4	IT management of prescriptions for specialized services and pharmaceuticals (e-prescriptions)	Percentage of prescriptions sent within 24 hours, measured by volume, as per Art. 50, Law No. 326/2003	45%	90%
B.5	Digitization of waiting lists for surgical procedures into a specific software, chosen by the health enterprise, to track the entire documentary and administrative pathway of planned surgical procedures	Adoption and use of the software to manage the waiting lists (Yes/No)	Yes	Yes
		Sending timetable of work flow as established, to competent regional structures via specific technical instruments.	Send work flow by 31 March 2012	
B.6	Adoption and usage of a single regional software (Regional General Register) for the management of choice	Adoption and usage of the single software for the Regional General Register as per the timetable which will be established by the competent regional structures (Yes/No)	Yes	Yes
B.7	Meeting information flow deadlines	Observance of specific information flow timetables (Yes/No)	Yes	Yes

Notes: [a] Applicable to ULSSs, Padova AO, Verona Integrated AO, and IRCCS Veneto Oncology Institute. [b] Precedence of certificate allocation is given to the personnel involved in obtaining objective B.2.

4.2 Human resources

4.2.1 Health workforce trends

The total number of people employed within the region's health care enterprises (ULSSs, AOs and IRCCS) in 2010, including administrative staff, was 61 246 (or 57 692 full-time equivalents). Between 2006 and 2010, there was an increase of 2.2% in the number of people employed in public health facilities; however, as the resident population also grew, there was no substantial change on a population basis. Over the same period, the number of doctors employed in the public sector increased by 3.6%, translating into a very slight increase in the ratio of (public sector) doctors to the resident population.

Table 4.5 outlines the total number of health care personnel per 1000 inhabitants in the Veneto Region for various categories of medical staff. As the data are taken from the provincial registers of health professional associations or governing bodies, one limitation is that it will include professionals who are registered but who may not actually be practising, either in the public or the private sectors. According to these (registration) data, in 2009 there were 0.76 GPs, 0.17 paediatricians and 4.06 specialist physicians per 1000 population, illustrating the much higher number of specialist doctors compared with GPs. Registration data for 2010 showed that there were 6.6 nurses and 0.92 dentists per 1000 population registered in the Veneto Region.

Table 4.5
Health care workers registered to practise in the Veneto Region, latest available year

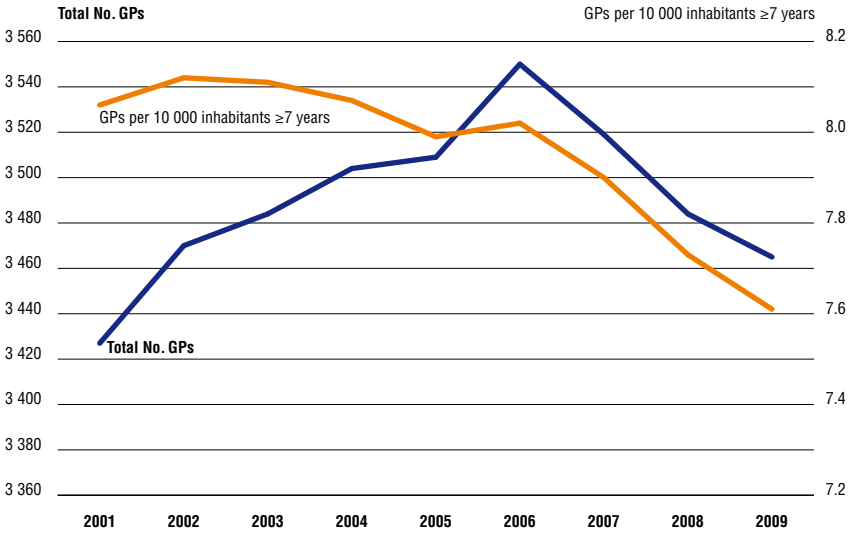
	Headcount per 1 000 population [a] (latest available year)
Primary care doctors [b]	0.76 (2009)
Paediatricians [c]	0.17 (2009)
Specialist physicians [d]	4.04 (2009)
Nurses [e]	6.57 (2010)
Dentists [f]	0.91 (2010)
Optometrists	na
Psychologists [g]	1.47 (2010)
Occupational therapists	na
Radiographers [h]	0.32 (2010)

Sources: [d] FnOmceo (2011) for ambulatory care and hospital-based doctors; [e] National Federation of Nursing Colleges, 2011; [f] FnOmceo (2011) but dental auxiliaries not included; [g] Veneto Order of Psychologists, 2011; [h] National Federation of Colleges of Medical Radiographers, 2011.
Notes: [a] Population in Veneto Region in 2010 was 4 938 282; [b] Only GPs for those ≥7 years of age; [c] Paediatricians for children ≤6 years of age; na: Not available.

Similar data from the ARSS show the number of GPs and paediatricians registered to work in the Veneto health system in the period 2001 to 2009. Fig. 4.4 highlights that there was a steady rise in the absolute number of GPs between 2001 and 2006, from 3427 to 3550, followed by a yearly decline, reaching 3465 in 2009, corresponding to 0.76 GPs per 1000 inhabitants, a slight decline since 2001 (0.81 per 1000 inhabitants). In contrast, for paediatricians there has been a steady increase in absolute numbers from 495 in 2001 to 560 in 2009. Over this period, overall the ratio of paediatricians to 1000 children aged between 0 and 6 years has remained steady (1.72 in 2001 compared with 1.69 in 2009) (Fig. 4.5).

Fig. 4.4

Total number of GPs and number of GPs per 10 000 inhabitants, Veneto Region, 2001–2009

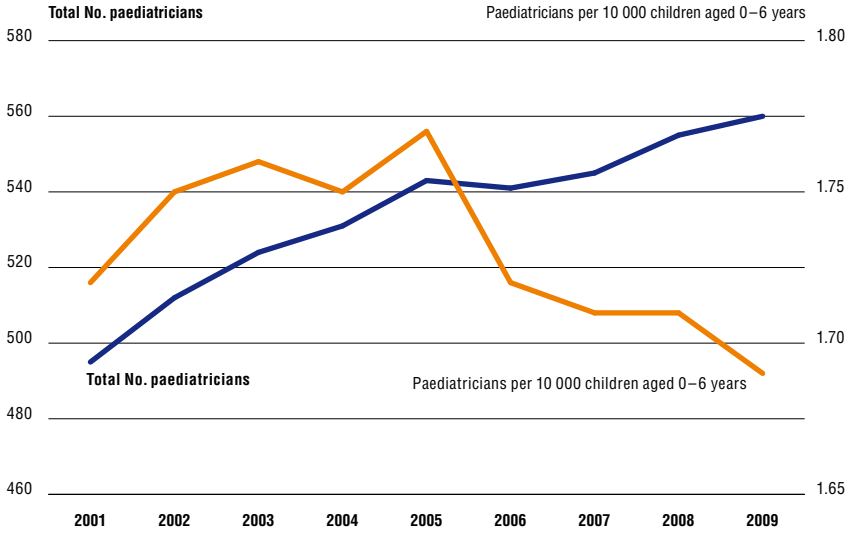


Source: ARSS, 2010.

Table 4.6 shows the number (per 1000 population) of nurses, midwives and other health professionals working in public facilities (i.e. ULSSs, AOs and IRCSS) in the Veneto Region in 2010. No data are available on the numbers of nurses or support staff working in the private sector (in either acute or outpatient facilities).

Fig. 4.5

Total number of paediatricians and number of paediatricians per 10 000 children aged 0–6 years, Veneto Region, 2001–2009



Source: ARSS, 2010.

Table 4.6

Nurses, midwives and health care support staff working in public facilities in the Veneto Region, 2010

Category	Headcount per 1 000 population [a]
Nurses and midwives [b]	4.77
Unlicensed assistants and healthcare support staff [c]	1.44

Source: Personnel records of the USSLs, 2010.
Notes: [a] Population in Veneto Region in 2010 was 4 938 282; [b] Only registered nurses working in public acute trusts and health districts, including midwives and managerial staff included, not nurses working in public nursing homes; [c] Only unlicensed assistants and health care support staff working in public acute trusts and health districts included, not those working in public nursing homes.

The Giunta, via the Regional Secretariat for Health and Social Care (Directorate for Regional Health Service Personnel), is responsible for health personnel planning and for implementing the relevant Collective National Contracts for the health services workforce. Unfortunately, because of a lack of data, it is not possible to evaluate whether staffing levels in different parts of the health system are adequate. In terms of international standards, Table 4.7 shows the total number of doctors per 1000 population and Table 4.8 the total number of nurses per 1000 population in the Veneto Region compared with the Italian average and a selection of European and/or OECD countries. In the case

of doctors, the Veneto Region has slightly more per 1000 population compared with Italy as a whole and generally has the highest quota among the selected countries, after Greece. In contrast, the number of nurses per 1000 population in the Veneto Region, while essentially equal to the national average, is among the lowest of the countries listed.

Table 4.7

Doctors in the Veneto Region and selected European countries, latest available year

Country	No. doctors per 1 000 inhabitants [a]	Year
Greece	6.0	2008
Veneto	**4.9**	**2010**
Austria	4.7	2009
Italy	4.2	2008
Switzerland	4.1	2009
Portugal	3.8	2009
Germany	3.5	2008
United Kingdom	2.7	2009
Spain	3.7	2009
France	3.4	2008

Sources: WHO Regional Office for Europe, 2011a; FnOmceo, 2011.
Note: [a] Population in Veneto Region in 2010 was 4 938 282.

Table 4.8

Nurses in the Veneto Region and selected OECD countries, latest available year

Country	No. nurses per 1 000 inhabitants [a]	Year
Iceland	15.3	2008
Switzerland	15.2	2009
Norway	14.2	2009
Denmark	14.0	2008
Ireland	12.7	2009
Germany	11.0	2009
The Netherlands	10.5	2008
Australia	10.2	2008
United Kingdom	9.5	2008
Canada	9.4	2009
Austria	7.6	2009
Veneto	**6.6**	**2010**
Italy	6.4	2009
Spain	4.9	2009

Sources: OECD, 2011; National Federation of Nursing Colleges, 2011.
Note: [a] Population in Veneto Region in 2010 was 4 938 282.

One workforce trend worth noting is the rise in the number of health support staff. Since the 1990s, factors such as the rising number of elderly people, innovations in science and technology, the reduction in the average number of days spent in hospital (but with a concomitant rise in the complexity of cases), and a general lack of nurses have all contributed to the growth in this category of health care personnel. Such staff groups have gradually relieved nurses of more basic jobs, allowing nurses to focus on the more complex care that is more appropriate to their professional role and training. There are two groups in the health support category – OSSs and OTAs – whose duties are similar to those of unlicensed technical support staff. The OTA category is gradually being phased out. Over the period 2006–2010, the number of nurses employed within health care enterprises has remained more or less constant (with a slight increase, 0.6%) while the number of health support staff and health assistants has increased by 18.1%. In 2006, there were 3.9 nurses for each health support worker while in 2010 this figure was 3.3.

With regard to other professionals (with health and non-health functions) working within the public health system, there was a decrease of 2.3% between 2006 and 2010. This decrease can be attributed partly to a fall in the number of auxiliary technical staff. During the same period, administrative personnel increased by 5.4% and the number of management personnel fell slightly, by 2.4%.

4.2.2 Professional mobility of health care workers

There are no accurate data on interregional trends in the mobility of health care personnel, nor on the number of health care professionals from other countries working in the Veneto Region. At the European level, Directive 2005/36/EC on the recognition of professional qualifications particularly applies to health care personnel. The Directive aims to ensure that a health professional has the requisite skills and capacity, as well as language skills for effective communication, to provide adequate patient care in the host country (see section 2.8.3). However, much needs to be done to fully implement the Directive's provisions, for example implementing mechanisms to evaluate the (Italian) language skills of foreign nurses working in private accredited facilities.

Following recent legislation, the regions are now responsible for granting recognition of health care activities and experience obtained abroad. Health care professionals, Italian citizens and residents in the Veneto Region who have worked in health services abroad must submit an application to have their activities acknowledged. Professional practise should have taken place

within public or private non-profit-making health care facilities in the context of cooperative activities between Italy and developing countries[7] or within international organizations. This recognition procedure aims to equate the health services provided abroad with those delivered within Italy by SSN staff, and also to allow foreign-trained workers to participate in national professional examinations that give access to employment within the public service.

4.2.3 Training of health care personnel

Doctors

In the Veneto Region, doctors are trained at the medical faculties of the universities of Padova and Verona. Doctors must follow an education and training programme that has three stages: a degree in medicine (six years during which students undertake training in hospitals for at least six months), specialization in a medical discipline (four to six years) and continuing medical education during their professional careers.

After university, medical graduates must pass a state examination to be able to register with the relevant medical association in the region where they reside. GPs and specialists (including hospital physicians) follow different training paths for their specialization. GPs must successfully complete a two-year university course while hospital physicians and other specialists must attend one or more specialist courses in a university, lasting from four to six years depending on the type of specialization. There are a limited number of places for admission to specialized courses. Doctors undergoing specialist training must work in a hospital department.

The national programme for continuing medical education was launched in 2000 and requires all health professionals to undertake training equal to a minimum of 150 training credits over a period of five years. The regional Centre for Continuing Medical Education was set up in 2002[8] to carry out at regional level the accreditation of various training courses and programmes; from 2011, the Region will only accredit facilities providing training, not training courses or activities. The Centre is responsible for assessing training needs and for identifying training objectives for the Region. This activity feeds into a national-level exercise that then identifies national training objectives. The Centre's remit has expanded since 2002 and additional functions include the

[7] Law No. 49, 1987.

[8] In compliance with Legislative Decree No. 502, 1992.

accreditation of in-house and distance-learning training courses, the creation of a register of health training professionals and setting up the network of training programmes for the ULSSs and AOs.

The Council of Health Professions in Veneto, chaired by the Head of the Department of Health (or a deputy), comprises representatives of all the relevant medical and health profession associations; it is responsible for analysing training needs and takes part in the accreditation of training programmes.

Nonmedical health professionals (nurses)

In 1994, nonmedical health professionals were regulated by a series of ministerial decrees, which redefined the profiles of various professional groups, including that of nurses. From 1992, the regional professional schools were closed down and substituted by three-year university degrees. Before this reform, nurses obtained a regional nursing diploma (issued by the Minister of Health) after two years of senior secondary school and three years of study in a regional nurse-training school. Nurse training reforms during the 1990s aimed to give nurses more autonomy and a more active role, and the profession is no longer considered to be auxiliary to the medical profession.

After obtaining their degree, nurses must pass a state examination and enrol with the College of Registered Nurses in the province they reside in. Nurses can attend postgraduate programmes (first and second level master's degrees) to specialize in areas such as paediatrics, geriatrics, psychiatry and public health, as well as in nurse management. In 2000, the role of "nurse manager" was established, with a degree in nursing sciences for training managers and teachers in nursing. In addition, in 2004 a postgraduate two-year nursing specialist degree, open only to nurses who already have a three-year nursing degree, began taking enrolments (Lo Scalzo et al., 2009).

Health support staff

The role of health assistant, or OTA, was introduced in 1991 to support nurses and to relieve them of basic non-clinical duties. Since 2001, this role has been replaced by that of the OSS. OSS personnel must successfully attend a course of 1000 hours duration (480 hours of theory and 520 hours of practical training). To be eligible for this course, a middle-secondary school diploma (*diploma di licenza media*) is required. Since health support workers are not considered to be health care professionals, continuing medical education requirements do not apply to them.

5. Provision of services

Health care in the Veneto Region is provided by 21 ULSSs, 2 AOs, 2 IRCSSs and private accredited providers, all of which deliver services across three broad programme areas: public (preventive) health care, district-level primary and community care, and hospital care.

The Region's Directorate for Prevention deals with public health matters and is also tasked with monitoring and surveillance activities, enabling it to deal with any public health emergencies that may arise. Access to primary care does not differ from the framework established nationally, as primary care is delivered by GPs and paediatricians; ambulatory (outpatient) services are provided by public and private accredited facilities (with a co-payment). Patients who wish to use ambulatory services exclusively in the private sector incur the full cost of care. Acute hospital care in the SSN is delivered by public and private accredited facilities. Currently, the hospital sector is being restructured, with the conversion, merger or closure of smaller hospitals, in order to deliver services more efficiently and to better respond to population needs. Ambulance and emergency services are directly managed by the Medical Emergency Service, in cooperation with the region's other emergency services.

The network of services for long-term care of older people focuses on achieving a balance between residential-based care and home care, both of which have undergone a significant process of reform since the late 1990s. In particular, residential services have been reorganized to guarantee access to services based on needs. Health-related long-term care services are covered by the regional health services, while accommodation in residential facilities is paid for by the user or by municipalities. Home care and community-based services are delivered either as direct services within the home or through financial support (social benefits), support (health and social) for family carers and temporary respite services.

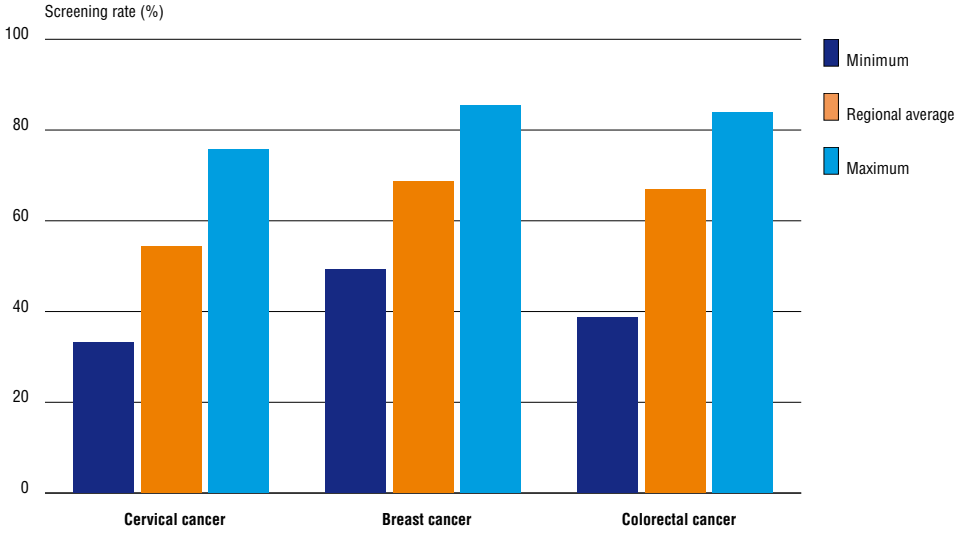
5.1 Public health

The Directorate for Prevention, through its Hygiene and Public Health Service (*Servizio Igiene e Sanità Pubblica*), is responsible for the protection and promotion of public health. It operates in multiple spheres, including prevention of diseases that need vaccination, prevention of infectious diseases, public hygiene, care/vaccinations for citizens travelling abroad, ensuring the welfare of breeding animals and preventing food-related diseases. In addition, the Directorate plays an important role in the prevention of cancer through specific population-based screening programmes, which have been introduced as part of National Prevention Plans to reduce the incidence of selected diseases, such as breast cancer, cervical cancer and colon cancer, within the targeted population groups.[1] Fig. 5.1 presents the screening rates for these conditions in 2007. While minimum and maximum levels vary considerably, the average regional screening rates for breast cancer was 54% while the average rates for cervical cancer and colon cancer were around 68%. Other population screening programmes are conducted for hypertension and high cholesterol in order to help to reduce mortality from ischaemic heart and cerebrovascular disease.

Compulsory vaccinations for infants and children are also monitored and promoted, with an information brochure on vaccinations available to the public. The average vaccination coverage rates for children under 24 months are high: in 2009, vaccination programmes for polio, diphtheria, tetanus, pertussis (whooping cough), and hepatitis B were above 96%, while for *Haemophilus influenzae* type B coverage surpassed the threshold of 95%, which is the minimum level set by the National Vaccination Plan. Protection against measles has also increased compared with previous years. In the mid-1990s, the average coverage rate in the Veneto Region was approximately 80%; by 2009, this had reached 93% as a result of a regional programme for the elimination of measles and congenital rubella, although variations among ULSSs remain (Fig. 5.2). With regard to influenza vaccinations, since 1999, the Veneto Region has cooperated within the National Surveillance Network, based on public health doctors working in ULSSs. During the vaccination campaign against seasonal flu in 2009–2010, 979 833 people in the Veneto Region were vaccinated, 48 216 more than in the previous year's campaign (5.2% increase). Of the people vaccinated, 682 674 (69.7%) were 65 years of age or older.

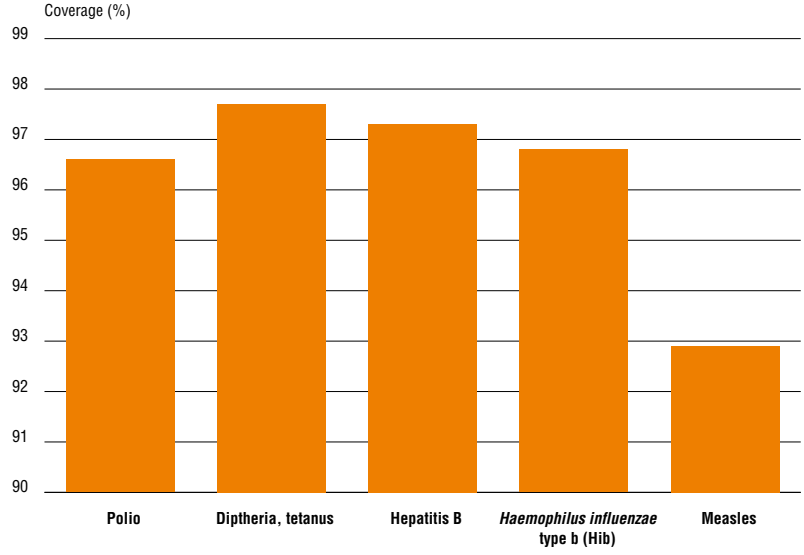
[1] Screening targets for ULSSs have been established through Regional Decree No. 3140, 2010.

Fig. 5.1
Screening rates for selected conditions, 2007



Source: Veneto Oncology Institute, 2009.

Fig. 5.2
Vaccination coverage rates, 2009



Source: Veneto Region Directorate of Prevention, 2007.

The Hygiene and Public Health Service also undertakes activities for the prevention of domestic and road accidents, which unfortunately still represent an important cause of death; it is involved in promoting healthy lifestyles and monitoring activities in order to reduce mortality, disability and chronic diseases. In addition, it is developing protocols to prevent and monitor emerging diseases. Specific competencies connected to environmental pollution have been transferred to the Regional Environment Agency (*Agenzia Regionale per l'Ambiente*), which continues to work in cooperation with the Hygiene and Public Health Service. For the monitoring of infectious diseases, the Region follows European surveillance arrangements in line with decision 2119/98/EC by the European Parliament and European Council, which established an early warning and response system for the prevention and control of communicable diseases.

Health promotion and prevention measures in the sphere of occupational work and safety are implemented in collaboration with provincial coordination committees. Measures include the dissemination of information, training and practical assistance within companies to reduce the incidence of accidents at work and work-related diseases.[2] There are also plans to develop a regional information system for health promotion and prevention of accidents at work, integrating existing archives.[3] In relation to health in public places, monitoring of electrical, magnetic and electromagnetic fields takes place regularly, as does the monitoring of radon gas levels in high concentration areas, with periodic checks in schools.

There are numerous health promotion plans, in particular the "Get Healthier" campaign to improve population health, the regional programme for the prevention of smoking-related diseases, alcohol-related prevention strategies and the programme to promote more active lifestyles. All ULSSs have specific prevention departments that work with other related regional bodies to carry out health promotion and education activities as well as preventive strategies for infectious and chronic degenerative diseases and injuries.

The Regional Plan for Prevention 2010–2011 was not subject to large budget cuts; consequently there has been no major impact on the Veneto Region's ability to deliver services to its citizens. A reduction in preventive services would have a discernible impact on population health, particularly that of future generations. Adequate investment in health promotion and preventive strategies

[2] In line with the Agreement for Health Protection in the Workplace.

[3] Implementing Legislative Decree No. 81, 2008.

results in reductions in hospitalization rates, in use of health care services and in the consumption of medicines, all of which have a positive impact on containing health expenditure.

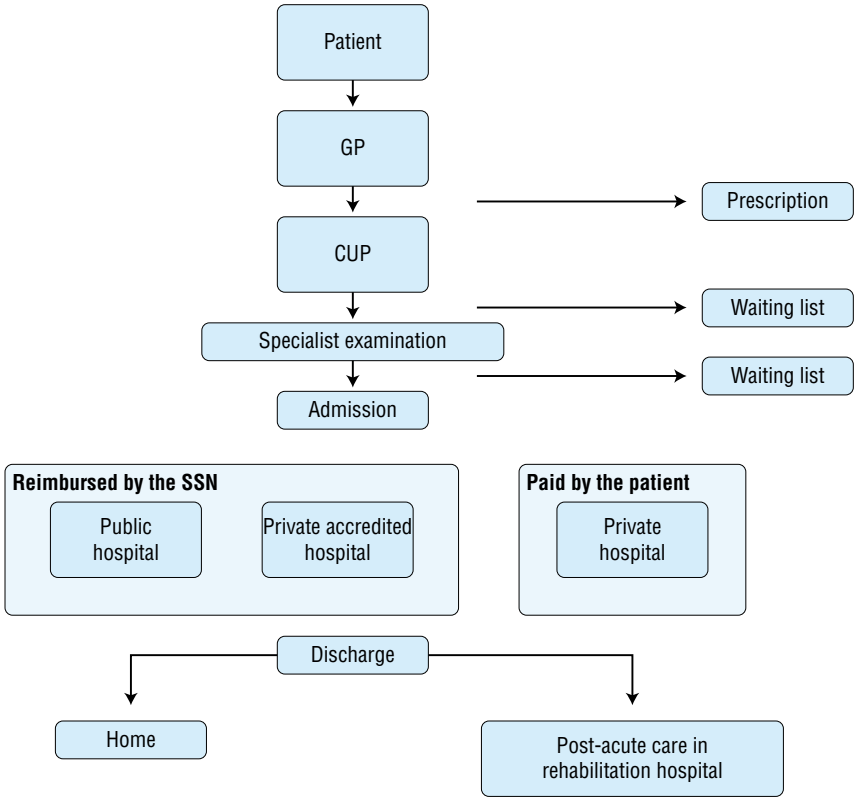
5.2 Patient pathways

The patient pathway in the Veneto Region, as in all other Italian regions, conforms to national arrangements. Patients first visit their GP, normally in a doctor's practice that is shared with other physicians. After an examination, depending on the type of action required, the GP will issue a prescription for necessary medications or write a referral for further tests/examinations that need to be carried out in a (public or private accredited) hospital or in other specialized facilities in the case of specific diseases. Patients then book an appointment via the relevant health enterprise's booking centre. Waiting lists are often medium to long, and so in more urgent cases, many patients who can afford it take the option of going to private specialists. Following their specialist consultation, patients who require hospitalization for their condition are admitted, subject to the relevant waiting list. Fig. 5.3 outlines a typical patient pathway.

Regional Decree No. 3535, 2004 established different classes of priority to access specialist care and Decree No. 600, 2007 set maximum waiting times for these priority categories. ULSSs and AOs are required to carry out information campaigns periodically to inform citizens about waiting lists for various health services. They are also required by law[4] to abide by the established maximum waiting times. Citizens have access to all the health facilities and services within the Veneto Region, paying the relevant co-payment if applicable. Various categories of exemptions apply (e.g. for those on low incomes or suffering from chronic diseases). Emergency cases are treated in hospital casualty and emergency departments, although in some cases citizens use these services for conditions that could be treated via the normal patient pathway described above. This situation requires an effective way of dealing with such patients and directing them towards primary care. At the moment, those who use emergency care inappropriately must pay a co-payment of €25, although those under 14 years of age are exempted (see also section 3.3.1).

[4] Regional Decree No. 3140, 2010.

Fig. 5.3
Patient pathway



Source: Based on ARSS information.
Note: CUP: Patient booking centre.

5.3 Primary care

The regional health service guarantees the delivery of primary care mainly via GPs and paediatricians. Regional coordination of primary care was established on 1 January 2003 to promote training initiatives that were complementary with the development of the regional health care service. The training system (*sistema organizzato di formazione*), the Commission for Continuing Medical Education (primary) and the School of General Medicine Training have been developed over the years. The major aims are to provide the necessary training for the compulsory continuing medical education of GPs, other doctors who work in primary care, paediatricians and specialists working in ambulatory settings; to promote quality of care, research and experimentation with new management models; and to monitor the training needs of health professionals working in the regional health system.

To develop health and social care services at the primary care level and to implement regional strategies in this area, a global approach is required. This has been made possible through the implementation of a network model to manage patients and ensure continuity of care. Since 2000, a framework for monitoring regional policies has been in place to ensure that they are in line with national agreements on the delivery of primary care. In particular, the region's health care districts and local centres for primary care (*unità territoriali di assistenza primaria*) have played a central role in developing a new planning instrument, the Local Primary Care Plan (*Piano Attuativo Locale per le Cure Primarie*). Thus, the monitoring of the strategies of individual ULSSs ensures that they are complementary to the health planning activities undertaken at district level. Regional Decree No. 1575, 2009 formally established the first phase of this planning model for all 21 ULSSs in the Veneto Region, with the aim of improving the relationship between the supply and demand of available resources. In addition, this system has introduced the requirement to measure outcomes through the definition of a series of clinical process and outcome measures.

The planning framework also provides for different primary care organizational models, with doctors and nurses able to come together in various forms of group practice (known as associations). This flexibility is designed to ensure the most appropriate delivery and continuity of care for patients. Table 5.1 outlines the various primary care organizational models used in the Veneto Region and number of patients treated by each in 2010.

Table 5.1

Primary care organizational models, number of doctors and number of patients treated, 2010

Association form	No. doctors	% of total doctors	No. patients treated	% of patients treated
Single practitioners	632	18.8	569 433	15.0
Base group practice (*medicina in associazione*) [a]	1 086	32.4	1 377 876	36.5
Network group practice (*medicina in rete*) [b]	376	11.2	490 049	12.9
Advanced group practice (*medicina di gruppo*) [c]	1 002	29.9	1 328 128	35.0
UTAP	260	7.7	23 992	0.6
Total	**3 356**	**100**	**3 789 478**	**100**

Source: ULSS data.
Notes: [a] From 3 to 10 GPs working in their own offices but sharing clinical experiences, adopting guidelines and organizing workshops aimed at assessing quality and prescribing quality; [b] Similar to the base group practice, but in addition GPs share patient electronic health record system; [c] From 3 to 8 GPs sharing the same office and patient electronic health record system, also providing primary care to patients who do not belong to their catchment area; UTAP: Care given by GPs based in local centres for primary care.

GPs and paediatricians are not employees of the ULSSs but instead are self-employed professionals. They are contracted to work within the SSN through an agreement set at national level, which regulates their professional relationship, functions and tasks. Within primary care, the following services are guaranteed:

- medical consultations, either at the physician's office or at the patient's home, including emergency cases;
- prescribing medications, integrated care, diagnostic tests and laboratory analyses, and other specialist services;
- referrals for spa care (thermal treatments);
- referrals for hospitalization, including day treatments/surgery;
- medical care in the home for those who cannot walk or for those in residential nursing homes;
- home care;
- services that require a health professional to administer care (e.g. sutures, injections, intravenous injections); and
- flu vaccinations during vaccination campaigns aimed at targeted population groups at risk.

Citizens can register with a GP chosen from a list of physicians who operate in their district and can change their choice at any time. Registration takes place at administrative offices located in the district. GPs may also cancel a patient's registration if they feel that the relationship of trust with the patient is no longer viable. Patients also have freedom of choice when it comes to choosing the hospital or outpatient facility in which to be treated; they may prefer to be treated in a hospital that does not belong to the ULSS in their district of residence for a variety of reasons, including proximity to their actual home, the non-availability of a particular specialist in their ULSS district or simply because they wish to choose their surgeon themselves. However, in cases where specialist services are required and a patient chooses a public or private hospital that is not within their ULSS district, they lose the right to benefit from the maximum waiting times for various priority treatments guaranteed by Regional Decree No. 600, 2007.

Recent primary care plans have consistently underlined the need for GPs to go beyond their traditional gate-keeper role for hospital and specialist services and to take on a greater role in coordinating strategies to deal with chronic

and degenerative diseases, which are on the increase; managing the growing complexity of diagnostic and ambulatory (outpatient) services; and playing a greater role in health promotion strategies.

In 2009, there was an average of five patient contacts/visits per capita across the Veneto Region's ULSSs (carried out in public or private accredited facilities) (range, 2.2 to 8.7), if specialized laboratory services are excluded (ARSS, 2010). In 2010, a regional regulation (No. 3140) set a target of four patient contacts per capita for all health care enterprises (excluding laboratory services). The vast majority of services (approximately 90% of cases) is delivered in hospital outpatient settings.

5.4 Specialized ambulatory and inpatient care

Specialized ambulatory care includes all types of specialist service, such as specialist physician visits, diagnostic and laboratory tests and rehabilitation care that does not need hospitalization as it can be delivered by hospital outpatient departments, district-level health facilities or by private accredited facilities. In addition to these defined specialized services, the SSN delivers child neuropsychiatric services, rehabilitation services for drug addicts and prosthetic care within ambulatory settings.

Regional Decree No. 3223, 2002 established two types of hospital structure: network hospitals and integrated network hospitals, with the latter normally catering for post-acute and intensive rehabilitation. Network hospitals are acute hospitals catering for patients who need inpatient services to treat acute-stage conditions and need specialized care and various specialized technologies to deliver care. Three levels of acute hospitals have been established according to the level of specialization and capacity to treat emergency cases:

- the AOs in Padova and Verona are acute hospitals with basic, medium- and high-level specialist departments; they form the regional and provincial hubs for hospital services and include emergency departments (medical emergency number 118);
- provincial hospitals are acute hospitals with basic, medium- and some high-level specialist departments for their catchment areas (medical emergency number 118); and
- network hospitals (with catchment areas of approximately 100 000 inhabitants) have basic and usually also medium-level specialist departments as well as first-aid services.

The second category, integrated network hospitals, refers to hospitals where ongoing surgery services for individual patients are not carried out. Instead, these hospitals tend to deliver day-hospital treatments and day-surgery procedures. In addition, outpatient services may also be delivered, particularly in facilities with ambulatory services for physical therapy and rehabilitative care.

The IRCSSs are also important regional hubs that support the hospital network, in particular for oncology and neurological rehabilitation.

The Region manages the relationship between ULSSs, AOs, public and private health care facilities and health care professionals via regional planning instruments and regulations. In 2009, the Veneto Region's formal hospital network contained 56 public hospitals and 30 private hospitals, including two with what is known as "experimental management" status (*sperimentazione gestionale*) (Table 5.2).

Table 5.2
Hospitals (acute, rehabilitation and long term), Veneto Region 2009

Province	No. hospitals			Average No. beds per hospital		
	Public	Private (accredited) + *sperimentazioni gestionali* facilities	**Total**	Public	Private	**Total**
Verona	12	8	**20**	257	138	**209**
Venezia	10	5	**15**	255	138	**232**
Vicenza	10	3	**13**	252	80	**212**
Padova	9	4	**13**	401	112	**293**
Treviso	7	6	**13**	380	91	**247**
Rovigo	3	3	**6**	287	97	**192**
Belluno	5	1	**6**	200	78	**180**
Veneto Region	**56**	**30**	**86**	**291**	**113**	**229**

Source: Calculations by ARSS based on New Health Information System HSP.11, HSP.12 and HSP.03 data (ARSS, 2010).
Note: *Sperimentazioni gestionali* facilities are particular health care facilities that operate under new organizational and management systems designed to make them more efficient.

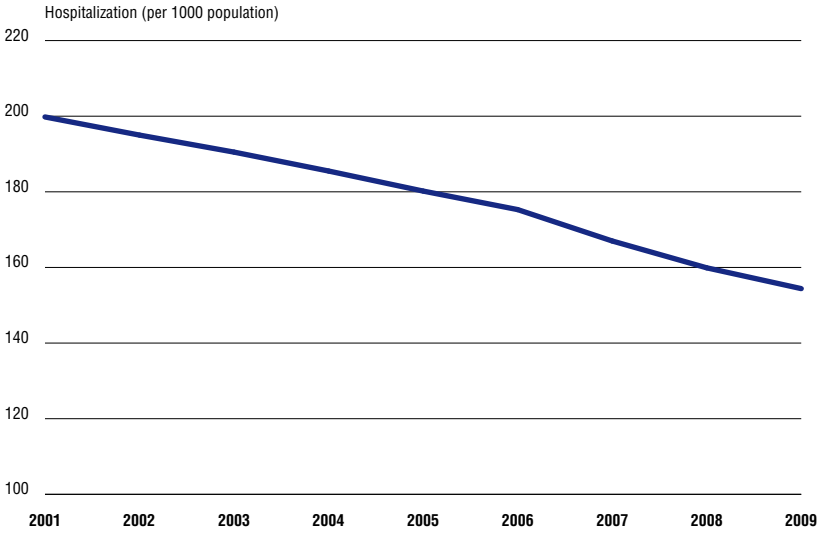
The use of hospital services (both ordinary acute and day care) has been decreasing in line with regional and national policies aimed at controlling hospitalization rates. Instead, patients receive treatment – when safety conditions allow – within district-level primary care settings, which are better at meeting the needs of ongoing and integrated care. Moreover, in recent years, an increasing number of hospital procedures can be delivered through outpatient departments: for example, surgery for cataracts, carpal tunnel, varicose veins and hernia. These types of surgery can now be done without having to resort

to an ordinary (acute) hospital admission; other day service medical treatments also have been phased into ambulatory settings, for example radiotherapy and chemotherapy.

The main indicator to measure utilization of hospitals is the average hospitalization rate for every 1000 inhabitants. Fig. 5.4 shows that the rate of hospitalization decreased to below 160 hospitalizations for every 1000 inhabitants in 2009 (154.4 cases), compared with approximately 200 cases in 2001. This is in line with the national standard set at 160 hospitalizations for every 1000 inhabitants. Fig. 5.5 provides a deeper analysis of hospitalization rates in the Veneto Region by differentiating hospitalizations by type. As highlighted, the containment of the overall hospitalization rate over the period 2001–2009 is a result of a progressive reduction in hospitalizations in public hospitals, compared with a noted stability in the hospitalization rates of private hospitals (which deal with fewer acute cases) as well as in the number of patients who chose to be treated in out-of-region hospitals.

Fig. 5.4

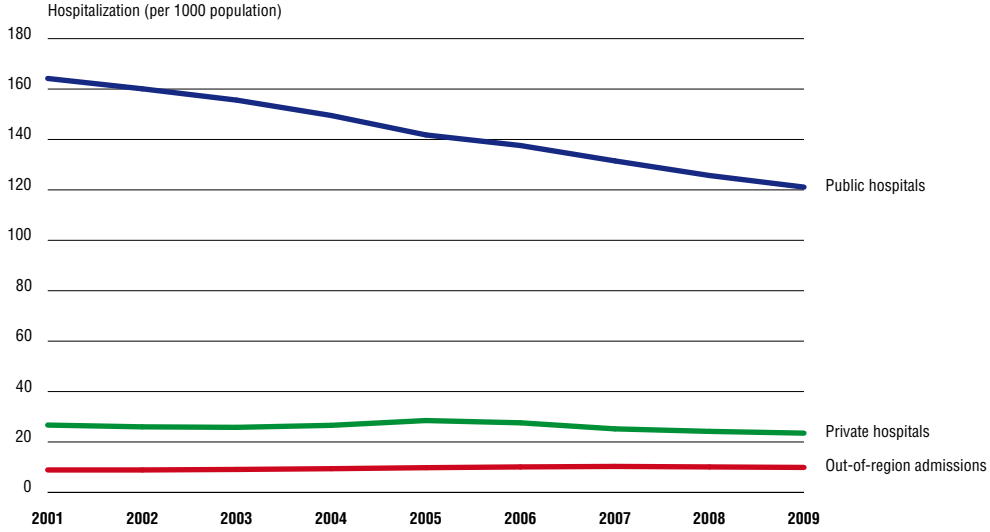
Hospitalization rate per 1000 inhabitants, Veneto Region, 2001–2009



Source: ARSS, 2010.

Fig. 5.5

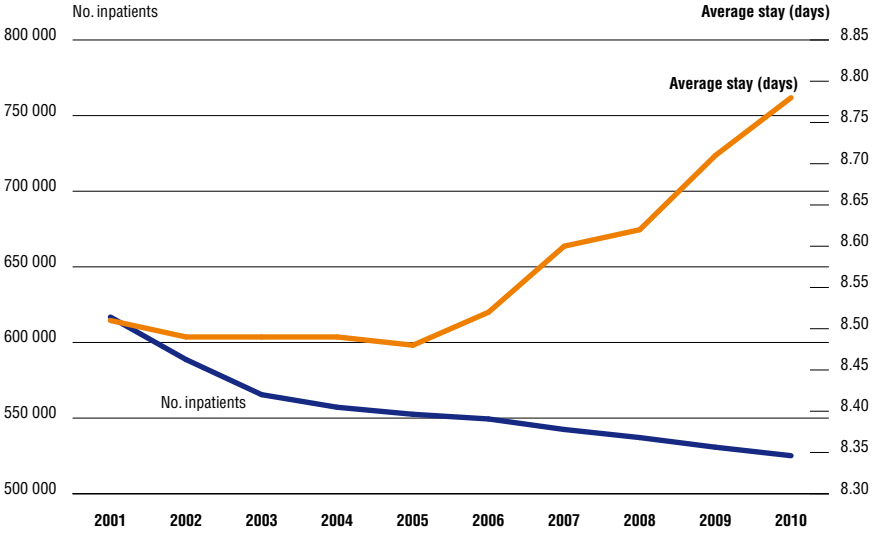
Hospitalization rate per 1000 inhabitants by type of hospital and for patients admitted to out-of-region hospitals, 2001–2009



Source: ARSS, 2010.

Fig. 5.6

Average length of hospital stay and number of inpatient days, 2001–2009



Source: ARSS, 2010.

As previously mentioned, in the last few years there has been a progressive rise in the average length of stay in ordinary (acute) hospitalizations (8.78 days in 2009, compared with 6.8 days nationally (WHO Regional Office for Europe, 2011b), which is the setting most suitable for dealing with more complex cases or treatments (Fig. 5.6).

5.4.1 Day care

In 1998, Regional Giunta Deliberation No. 5272 defined day surgery and day hospital. Day surgery entails the clinical, organizational and administrative option of delivering surgery, diagnostic procedures and/or invasive and semi-invasive treatments during daytime hours under local, regional or general anaesthetic. In contrast, day hospital is defined as the organizational model that every hospital facility must adopt to deliver health care services that according to medical best practice are deemed inappropriate for an ordinary admission to an acute hospital but which cannot be administered in an ambulatory setting. Day-hospital care is characterized by one or more occasions that the patient accesses care, during one part of the day, preferably during daytime hours, for the delivery of a variety of health care and specialist services. This type of care can be delivered by independent departments that have resources and staff exclusively dedicated to day care or through departments of an acute hospital that also treats inpatients, with resources being shared. In terms of hospital activity, day care represented about 26.6% of all activity in 2009. The most frequently delivered day-hospital procedures in 2008 and 2009 are shown in Table 5.3 while Table 5.4 lists the five most frequent day-surgery procedures.

Table 5.3
Most frequent day hospital procedures, 2008–2009

DRG [a]	2009		2008	
	Volume	% activity	Volume	% activity
139 Cardiac arrhythmia and conduction disorders without CC	3 834	6.16	3 738	5.30
412 History of malignancy with endoscopy	3 133	5.03	3 696	5.24
467 Other factors influencing health status	2 065	3.32	2 343	3.32
323 Urinary stones with CC, and/or ESWL	1 927	3.09	1 660	2.35
431 Childhood mental disorders	1 925	3.09	1 965	2.79

Source: ARSS calculations (Qlik Day Surgery) based on hospital admissions forms.
Notes: [a] Numbers indicate the DRG group numbers; CC: Chief complaint; ESWL: Extracorporeal shock wave lithotripsy.

Table 5.4

Most frequent day surgery procedures, 2008–2009

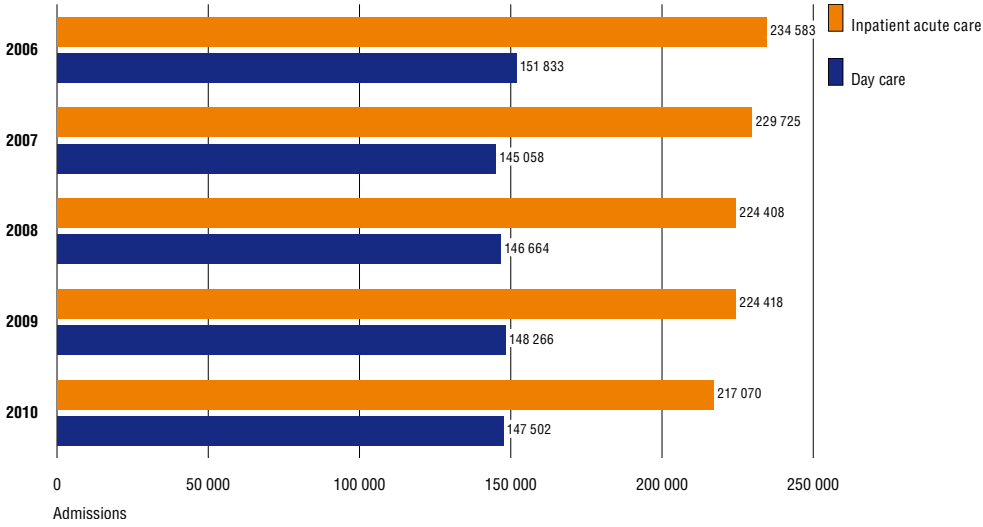
DRG[a]	2009		2008	
	Volume	% activity	Volume	% activity
503 Knee procedures without principal diagnosis of infection	12 617	8.74	12 260	8.61
381 Abortion with dilatation and curettage, aspiration curettage or hysterectomy	10 946	7.59	11 150	7.83
364 Dilatation and curettage, conization except for malignancy	7 369	5.11	7 197	5.06
359 Uterine and adnexa procedure for non-malignancy without CC	7 278	5.04	6 388	4.49
229 Hand or wrist procedure, except major joint procedure, without CC	7 134	4.94	6 991	4.91

Source: [a] Numbers indicate the DRG group numbers; ARSS calculations (Qlik Day Surgery) based on hospital admissions forms.
Note: CC: Chief complaint.

In terms of the number of cases treated, the trend in the different hospitalization regimes over recent years – 2006 to 2010 – is highlighted in Fig. 5.7, which shows that the proportion of day-care cases (day hospital and day surgery) has remained stable at around 40% (39.3% in 2006 versus 40.5% in 2010). In assessing this stable trend, we should take into account the progressive transfer of procedures to ambulatory settings, which, especially in recent years, have delivered an ever increasing number of health services.

Fig. 5.7

Hospital admissions by type of regime, 2006–2010



Source: ARSS calculations (Qlik Day Surgery) based on hospital admissions forms.

Since 2007, the Veneto Region's ARSS has supported a project within the region's health care enterprises (i.e. 21 ULSSs and 2 AOs) aimed at analysing the implementation of day-hospital and day-surgery procedures within the regional health system, evaluating the quality of care delivered (based on criteria of efficacy, efficiency and safety) and studying the technological and organizational assets adopted to deliver these services. The benchmarking phase was recently concluded and aimed to highlight the most efficient solutions, also from a financial point of view, in light of the evidence base derived from the best international experiences. In the context of global trends, which have seen health systems reorganizing in order to maintain levels of care despite rising costs and reductions in available resources, it is probable that in Italy, and in the majority of its regions, there will be proposals to reduce the number of hospital beds and the rate of hospitalization to reach a target below the current rate of 160 hospitalizations per 1000 inhabitants. In the Veneto Region, the new target is 140 per 1000 inhabitants.[5] Therefore, it is a strategic objective to transform productive activities, particularly surgical activity, using new models such as day surgery and outpatient surgery. For some time the Veneto Region has instigated policies to transfer services that previously were delivered in ordinary acute hospital settings to appropriate day-surgery and ambulatory facilities.

5.5 Emergency care

The Medical Emergency Service guarantees ambulance services and emergency health care to the population throughout the region. It is organized into seven operational centres within provinces and can be activated by calling the national emergency number 118. The Veneto Region is also covered by four helicopters (based at Belluno, Treviso, Verona and Padova). A Regional Law in 2002 made funds available to build small helipads within the region for helicopters to land. These small helicopter landing areas are available not only on hospital grounds but also in holiday resorts, mountain areas and other inhabited areas whose distance from hospitals requires the use of helicopters. The training of rescue pilots is a regional responsibility; based on regional health service needs and the needs of other public or private organizations, the region authorizes ULSSs, AOs, public or private institutions and also voluntary organizations to deliver relevant courses. The Regional Emergency Care Centre (*Centro*

[5] Regional Giunta Deliberation No. 3140 on setting the objectives for ULSSs for 2011 and 2012.

Regionale Emergenza Urgenza) coordinates the implementation of these courses. In addition, the provincial committees of the Red Cross have a network of volunteers licensed to administer first aid.

With regard to the health of children and infants, over the years their needs and the complexity of hospital care required to meet these needs has increased notably. It should be noted that in the Veneto Region 5–10% of all newborns need hospitalization in the first 30 days of their life; that there are more than 1000 premature births per year, with ever lower gestational ages (23–28 weeks); and that there has been a progressive increase in the birth of twins and triplets (often linked with assisted fertility procedures). Moreover, at least 300 000 children per year need first aid or emergency treatment for serious conditions. Given this context, the Veneto Region has strengthened the organization of services for its young patients and has defined an integrated hospital network to manage the care of newborns with critical conditions and infants needing emergency care.

The network is made up of three different levels. The third level, which is organizationally and technologically the highest level and treats about 2000 cases per year, consists of Verona and Padova AOs. The second level is made up of the following hospitals: Ca' Foncello Hospital in Treviso, dell'Angelo Hospital in Venice and San Bartolo Hospital in Vicenza. The first level is based on 36 hospitals spread across all of the provinces of the Veneto Region and is connected with the other two levels. All this is accompanied by a sophisticated emergency transport system, which, after stabilization of the patient, aims to transfer the newborn or infant immediately to the nearest and most suitable hospital for treatment. The first level of the integrated hospital network provides for the delivery of paediatric first aid, a paediatrics department and obstetrics department, neonatal care and paediatric emergency care for minor conditions. The second level has all of the services of the first level plus paediatric first aid services delivered in dedicated spaces, paediatric surgery, intensive care for newborns and paediatric emergency care for complex conditions that do not need intensive care. The third level provides, in addition to the facilities of the second level, paediatric first aid within a dedicated department, paediatric intensive care, paediatric neurosurgery, all paediatric specialist services and support for neonatal and paediatric transport services.

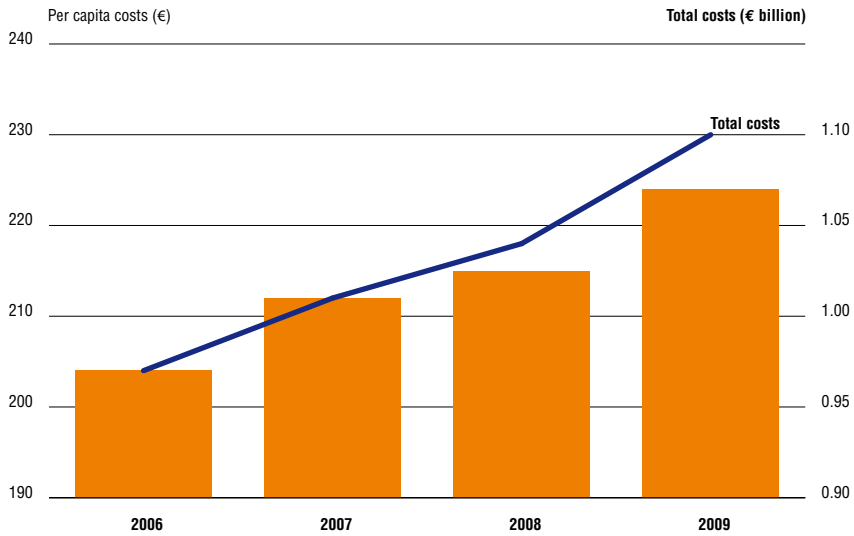
With regard to safety at work, Ministerial Decree No. 308, 2003 on workplace emergency management classifies companies on the basis of their size and risk profile, indicating what types of minimum first aid equipment must be available to employees and the basic training requirements for workers who are designated

first aid officers. While the employer is responsible for first aid arrangements, a link with the local ULSS is necessary. First aid is organized into three different categories: A, B and C. A company is allocated to a particular group according to the first aid equipment it is required to have, the staff training required and the level of communication it is required to have with the regional health service.

5.6 Pharmaceutical care

A comprehensive description of pharmaceutical policy in Italy, including the pharmaceutical industry, regulatory bodies and pricing and reimbursement policies, is provided by Lo Scalzo et al. (2009). In the Veneto Region, pharmaceutical expenditure increased from €970 million in 2006 to €1.1 billion in 2009, an increase of 13.5% during the period, also equating to a per capita increase of 10.2% (Fig. 5.8).

Fig. 5.8
Total and per capita (inhabitant) costs of pharmaceuticals, Veneto Region, 2006–2009



Source: ARSS, 2010.

The Veneto Region's objective in this sector is the effective monitoring of the use of new technologies – pharmaceuticals and medical devices – within the region. Such monitoring is designed to optimize performance and to measure outcomes in order to improve quality of care. In line with Ministerial Decree 4 February 2009, information on pharmaceutical consumption in hospitals

needs to be reported to the national Ministry of Health. In order to comply with this requirement, the staff and databases of the Region's pharmaceutical coordination office are used. In addition, from January 2011, information on the consumption of medical devices, as well as on the procurement contracts used to acquire these, must be sent to the Ministry of Health. There are plans to organize a single database to manage and monitor pharmaceutical expenditure in community pharmacies and hospital pharmacies. So far, a regional datawarehouse has been set up to monitor pharmaceutical consumption in hospitals and within specialist care.

At the same time it is necessary to make the region's network of pharmacies more efficient by revising and updating existing structures and allocating vacant and new pharmacies via a regional competition procedure.

5.7 Rehabilitation and intermediate care

In the Veneto Region, each patient has an individual rehabilitation plan to identify the correct interventions and the level of support required. This process is managed by hospitals' rehabilitation departments. Hospital stays for rehabilitation are designated "intensive" when there is a serious and complex disability requiring treatment of at least three hours per day. "Non-intensive" rehabilitation is designated for patients who do not require intensive therapy because of the clinical instability of their condition but who nevertheless receive one hour of treatment per day. After stabilization of their condition, patients access rehabilitation facilities outside hospitals for intensive rehabilitation (which is fully paid by the ULSS); non-intensive rehabilitation services are provided by outpatient rehabilitation facilities and at home (co-financed by the ULSS and the patient).

5.8 Long-term care (residential care)

The Veneto Region's framework to provide long-term care for people who are infirm or dependent on others to carry out daily activities (and where home care is not appropriate to meet their needs) was defined in 2000 with a series of regulations that completed the regional planning process for residential facilities offering health care, medical care, nursing care, rehabilitation and social care to people who are not self-sufficient. This planning process forms part of health policies that aim to limit hospitalization only to the acute phase

and to deal with successive stages of recuperation and rehabilitation in more appropriate settings, transferring long-term care and rehabilitative treatments to the region's network of residential facilities.

Residential care falls into two broad types. High-level (intensive) care normally involves a person receiving three hours of health care a day, typically delivered in intensive rehabilitation facilities outside of hospital, hospices for terminally ill patients or special (protected) residential facilities for psychiatric patients (*comunità terapeutica residenziale protetta attiva*). The second type, non-intensive care, involves fewer than three hours of daily care provided in facilities classified into three levels, medium, reduced or basic.

Residential care for the elderly

Looking more closely at non-intensive care facilities for dependent elderly people, a new plan was defined in 2006 and included revised criteria to calculate the need or demand for residential places. The formula used was a theoretical estimate, which would be revised annually and took into account the number of residential places to assign and the number of authorized beds per ULSS. This needs quota is calculated by multiplying the different population tiers residing in the ULSS with the following coefficients:

- 0.6% for the resident population aged 0 to 64;
- 0.65% (plus 0.5% for mountainous areas and the islands around Venice) for the resident population aged between 65 and 74; and
- 4.40% (5.5% for mountainous areas and mainland Venice) for the resident population over 75 years of age.

The needs quota has been determined since 2007, and for 2011 it is estimated at 27 244 residential places (in the last four years it has increased by 12.8%).

Another innovation has been the introduction of a citizen's guarantee to a residential or semi-residential place, with freedom of choice of residential facility anywhere in Italy for the user or his or her family. The new planning instrument also includes facilities that look after patients with advanced Alzheimer's disease (*sezioni alata protezione Alzheimer*), services for patients in a permanent vegetative state and temporary support services within residential facilities. The relationship between residential places and need is not uniform in all of the ULSSs, which historically have developed at different paces in terms of the supply of available residential places. Therefore, the new plan foresees

a gradual alignment in the needs quota among ULSSs. Currently, the ratio of residential places to need is, on average, 87 places per 100 units of need. At present, 13 ULSSs have gone above this threshold while eight are below it.

Within the framework of non-intensive residential care facilities, needs are assessed according to the Multi-dimensional Evaluation of the Elderly Scale (*Scheda di Valutazione Multidimensionale Anziano*). First-level care needs refer to people with a needs assessment score of 2 to 13 on the Scale while second-level needs are higher, referring to people with a score of 14 to 17. In terms of total residential places in the Region, and across all care profiles, there are 19 859 places for people with first-level care needs and 3966 places for people with second-level care needs. In religious institutions, there are 795 places for first-level and 24 for second-level care needs. In addition, there are 1211 places in day centres for the elderly, 150 for those with advanced Alzheimer's disease and 165 for those in a permanent vegetative state.

The unit cost for a residential place is made up of two parts. The first comprises the amount paid to the authorized residential facility for the services and personal care assistance it provides; it principally covers expenses for medical care and services by health care professionals, including nurses, as well as social activities. The second part covers accommodation and meal costs ("hotel"), which are paid directly by residents or by the municipality. First- and second-level care residential places absorb the majority of regional expenditure for residential services in non-hospital facilities. Between 2001 and 2010, the cost for first-level care places rose by 46%, going from €33.57 to €49.00 per day, and for second-level care it rose by 54.9%, from €36.15 to €56.00. Multiplying by 365 days, the per capita annual cost of residential places in 2010 equalled €17 885 for first-level care and €20 440 for second-level care.

Within residential facilities, health care is provided by the ULSSs via suitable contracts with municipalities outlining the services to be provided. ULSSs are also responsible for monitoring residents and for ensuring quality of services. A recent study by the Veneto Region's ARSS revealed that, in 2009, the latest year for which full data are available, the Veneto Regional Health Service spent a total of €445 million to cover the costs of long-term care in residential facilities and €67 million for the delivery of medical services, rehabilitation, specialist care, pharmaceuticals and prostheses within these facilities (ARSS, 2010). In terms of delivery, the network of care for the elderly is hugely strengthened by the work of volunteers and charitable organizations, which contribute to providing a plurality of residential services (either permanent or day centres) as

well as home care services. These organizations work with relevant government bodies to integrate their services into regional health and social care policies, which are given formal expression in local area plans.

Residential long-term care for disabled people

Long-term care for disabled people traditionally (at least up to the 1990s) was dominated by institutionalized care, provided via medium- to large-size institutions, which tended to cut residents off from society and their communities. However, with passage of Law No. 104 in 1992, concerted efforts began to establish small-scale residential facilities, group accommodation within the community and family-like groups residing together, all of which initiated the process of social integration and active participation of disabled people within their communities. At present in the Veneto Region, the system of residential facilities for people with disabilities includes 29 facilities, of different types, sizes and characteristics, that accommodate 2867 people: 47% are female and 53% male; 73% are aged between 35 and 64 years (24.5% of these between 55 and 64 years); and 12.5% of the total are over 64 years. The average amount of time spent in these residences is very long; in fact, 1018 (35.5%) have resided in such facilities for over 20 years. Of people living in residential facilities, 19% also attend day centres. The number of people living in residential facilities has increased from 2509 in 2002 to 2867 in 2006, an increase of 12%. Small-scale facilities (community accommodation) make up 57% of the total number of facilities but only house 16% of residents, while three large residential institutions contain 41% of residents. The needs quota for residential services for disabled people has been calculated as 0.7% of the resident population.

Several legislative provisions have shaped the framework of care for disabled people.

- Regional Budget Law No. 9, 2005 (Art. 27 on interventions for the care of dependent persons) established that the financing of health services for the disabled must be based on individuals' needs. Regional Law No. 2, 2007 (Art. 59) established three different levels of financial assistance (the Giunta is responsible for defining the criteria for each level).

- Giunta Decree 1859, 2006 revised regional strategies for the development of an integrated system of health care services for disabled people, determining that details should be incorporated into local disability plans (for home care; postponing to a later date provisions for residential care services).

- Giunta Decree 84, 2007 (implementing Regional Law No. 22, 2002) has defined the following types of residential facility to be made available to disabled people (and which are subject to authorization and accreditation procedures): community accommodation, nursing homes (skilled nursing facilities (*residenze sanitarie assistenziali*)) and residential homes. This spectrum of residential facilities for disabled people is integrated into a larger network that includes "group apartments" and family-type group living, which are designed to accommodate people who have partial autonomy, thus allowing users to receive basic care and to continue to live independently in their own communities.

In 2009, regional financing for residential facilities for the disabled amounted to €47 million, equal to approximately €14 000 per service user. The three large residential institutions for disabled people are excluded from this expenditure total. These large institutions ensure long-term medical and nursing care for disabled people, particularly those with complex needs and requiring at least three hours of care or specialized therapy per day to maintain and improve autonomy in performing daily activities or to prevent the deterioration of their condition. There are approximately 600 residents in these three large institutions. In 2009, the cost to the region was €17.6 million, €35 500 per service user.

Lying between residential services and home care services for the disabled is a network of day centres. These offer semi-residential services during the day and cater for people with disabilities with varying degrees of dependency. These centres offer educational activities, rehabilitation and other forms of care. In 2009, there were 6473 places in such centres, which looked after 6235 people at a cost of €75.9 million (or an average of €12 000 per person).

5.9 Home care and services for informal carers

A large-scale survey by ISTAT estimated that, in 2008, 3% of elderly people in Italy lived in residential facilities while 27% lived alone in their own homes (ISTAT, 2010b). In the Veneto Region, the families of dependent elderly people and disabled people are supported by a system of social assistance and financial support for their conditions, which include Alzheimer's disease, dementia, chronic diseases and blindness. In addition, Law No. 104, 1992 provides for absences from work of family members who care for dependent relatives with disabilities.

The Veneto Region has approved the implementation of local home care plans by municipalities and ULSSs.[6] These plans aim to promote and protect the quality of life of groups at risk, particularly people who risk being excluded from family life. A network of home care and family carer services has been established with the aim of providing access to health and social care services that can support dependent people who choose to stay in their own homes (or those of family members).

The Regional Decree No. 39, 2006 designates three areas of intervention: home care and family support, financial support and respite care.

Home care and family support. This category of services includes social home care (*servizio di assistencza domiciliare*), which provides for meals and assistance with personal care. Regional financial contributions given to municipalities (which deliver these services) are calculated on the number of users who receive either social home care services or integrated home care (*assistenze domiciliare integrata*);[7] in 2009 there were approximately 16 000 users. In addition, there is home health care (which includes prostheses and auxiliary medical devices) and integrated health and social care (the health-related inputs of integrated home care), covering about 11 500 users, as well as tele-medicine and tele-health services for approximately 24 000 users and social care services provided by voluntary and charitable organizations;

Financial support. A "treatment benefit" (*assegno di cura*) and financial assistance for people and families are provided according to the type of care required, type of assistance delivered and the person's financial situation. In 2009, this type of assistance benefited approximately 27 500 users, with a per capita average of €2700. The introduction of the "treatment benefit" in 2007 merged three previously existing benefits, thus simplifying access to this form of support. During the first three years of this new benefit, there has been a notable increase in the number of beneficiaries with Alzheimer's disease, from 1965 in 2006 to 5105 in 2009, signalling families' preference to choose home-based care for their dependent relative rather than residential care;

Respite for families. Day centres, temporary hospitalization and spa treatments, among others, are provided for dependent people needing care, thus providing respite for family carers.

[6] Regional Decree No. 39, 2006.

[7] Integrated home care consists of services in kind including both home help and health care inputs, such as home nursing, physiotherapy and GP and specialist visits at home. The health-related inputs are provided free of charge.

Home care services are coordinated and delivered by the Social Care Service (*Servizio Social Professionale*) of each municipality, either directly or delegated to ULSSs, alpine communities or municipal unions. Access to home care services and assistance for both the elderly and the disabled is subject to formal needs assessments. According to an ARSS study, the total cost for home care in 2009 was approximately €231.2 million, of which €127.7 million came from the Regional Health Fund to cover health care provided by doctors, specialists, nurses and rehabilitation staff (ARSS, 2010). The remaining €103.5 million was provided by the Regional Social Care Fund to cover social and personal care costs (integrated home care and social home care services, respite care, independent living services, "treatment benefit" and so on).

In terms of actors in the home care system, it should be emphasized that, since the year 2000, there has been an increase in the Veneto Region's number of informal carers (known as *badanti*), who must now be officially recognized and have official contracts.[8] The national legislation requiring the regularization of this care work extends to migrant workers (often non-EU nationals), who previously worked in the grey economy. In the Veneto Region, an information service (*info badanti*) has been set up, in connection with the project "Work and Services For People", managed by Italia Lavoro Ltd, which is a technical agency of the national Ministry of Labour. This agency advises families and carers on their respective duties and rights.

5.10 Palliative care

In line with Law No. 38, 2010 and Regional Law No. 7, 2009, the Veneto Region has implemented a network for palliative care in cooperation with GPs and paediatricians. The network is made up of outpatient facilities, home-based care and hospice care. Training for health care staff is underway as well as raising awareness among citizens to help to reduce inappropriate hospitalizations in the last 90 days of life and to focus instead on care within the home.

Regional Bill No. 7, 2009 established the framework for regional coordination of palliative care and the fight against pain. The coordination mechanism comprises a team containing a managing doctor with expertise in the organization of health and social care services, a doctor with expertise in palliative services, a doctor with expertise in pain relief therapy, an oncologist, a nurse and administrative staff. The members of this coordination team are elected every three years and can also seek the support of external collaborators.

[8] Law No. 102, 2009.

The coordination team has a number of responsibilities: to define guidelines and make recommendations to achieve uniform levels of access across the region to palliative care and pain relief services; to provide technical support and training to staff working in this field and to regional facilities providing palliative services; to provide advice to ULSSs when they are drafting their palliative care plans; to evaluate the application of standards for the development of palliative care in all regional areas; to provide annual reports to the Giunta containing an analysis of service delivery as well as of programmes and regional initiatives implemented by health care facilities (both public or private); to promote the culture of palliative care and to provide information to the public on patient rights and on the assistance that is available within the region; and to provide incentives for research in the field, both in terms of service delivery and management models.

The Veneto Region has compiled a list of available palliative care and pain relief programmes and there are plans to define regional guidelines for the organization of integrated care. There are also numerous non-profit-making organizations that operate in this area.

5.11 Mental health care

In the Veneto Region there are 348 psychiatric care facilities, of which 71% are within ULSSs. While the provision of outpatient facilities is almost entirely public, the private sector mainly manages residential and semi-residential facilities (37% and 31%, respectively). There are 3202 places within the region, equally distributed between residential and semi-residential facilities.

According to data from 2009, the Region cared for almost 70 000 psychiatric patients, which represents 17.2 people per 1000 adult inhabitants. In the Veneto Region, mental health problems occurred slightly more often in women (58%) than in men; 83% of psychiatric patients received care in the region's psychiatric facilities while 17% were treated in hospitals. Those treated in designated psychiatric facilities totalled approximately 64 400 in 2009. The most frequent conditions treated in these settings were schizophrenia (23%), depression (18%), nervous syndromes (18%) and psychosis (16%). In hospitals, there were just under 12 000 people admitted for mental health problems, and the most frequently treated conditions were schizophrenia (22%), psychosis (22%), dementia (17%) and personality disorders (12%).

The centres for mental health (*centri di salute mentale*), which are present in every ULSS, provide information and support but also carry out patient monitoring visits, particularly for people with personality affective and nervous disorders. Around 8.2% of care takes place in home settings. In semi-residential facilities, which treat, on average, 3500 patients per year (5.3% of mental health services users), the majority of treatments were rehabilitative or therapeutic. Finally, in residential facilities in 2009, 931 people (1.4% of all psychiatric services users) were assisted within special (protected) residential facilities, with 60% staying at least 6 months and 15% staying one year.

In 2010, there were 3275 personnel working in the Veneto Region's 21 mental health departments, of which 75% were direct employees of the ULSSs. In addition, there were 451 mental health professionals working in the Region's five private accredited psychiatric clinics.

Following approval of the Region's new project on the protection of the population's mental health for the period 2010–2012,[9] there will be new measures to address syndromes related to nutritional behaviour, problems affecting teenagers, early psychosis, psychological problems affecting the elderly, psychological problems connected to substance abuse and problems linked to immigration.

5.12 Dental care

In the Veneto Region, as in the rest of Italy, dental care is mostly provided by private dental practitioners who are paid directly by patients out of pocket. Public provision is not extensive. The LEA provides for orthodontic care (in ambulatory settings) for three categories:

- dental care for children aged 0 to 16 years;
- dental care and prostheses for designated groups of people with particularly vulnerable conditions (e.g. serious cardiovascular diseases, drug addiction, disabilities and rare diseases) and whose annual household income does not exceed €8500; and
- emergency care for dental infections for everyone.

Under these LEA-defined services, the maximum number of services that can be included in a single prescription/referral is four and there is a co-payment ceiling of €160 per year. Laboratory expenses and the cost of materials (e.g.

[9] Regional Giunta Decree 651, 2010.

fixed braces) must be paid directly by the patient while the co-payment for any repairs to such materials and devices is fixed at €30. Services not included in the LEA are delivered through public specialist dental clinics and are paid for in full by the user according to official tariffs.

5.13 Complementary and alternative medicine

In the Veneto Region there are no precise data on the percentage of the population that uses complementary and alternative medicine and there is no formal regulatory framework to oversee it. However, it is a phenomenon that is developing and the Italian Society of Homeopathy estimates that about 5 million Italians use some form of complementary and alternative medicine. In terms of patients' health, a fundamental requirement is that correct information should be given to patients and that health professionals who employ these techniques should be properly trained and be knowledgeable about their effects on patients.

5.14 Health services for specific populations

The Veneto Region has special services for the prevention and treatment of substance abuse, a field that covers complex problems and requires the organization of a network of public information and education, flexible rehabilitation frameworks and strategies aimed at reinserting people into society and the labour market. There is also a need to ensure the equal distribution of residential facilities, to monitor preventive and rehabilitative programmes (as required by the national Anti-Drugs Fund)[10] and to support voluntary groups active in this area.

The Veneto Region has 38 outpatient centres in the outpatient service for drug dependency (*servizi ambulatoriali per le tossicodipendenze*), 31 private accredited therapeutic facilities and 5 public therapeutic day centres. The outpatient service for drug dependency has 789 staff members with different professional profiles: 23.8% nurses, 19.4% psychologists, 17.1% professional educators, 16.6% doctors, 10.4% social assistants, 5.8% administrative staff and 6.8% other health professionals. The region's residential therapeutic facilities have 720 staff members, with a clear majority of residential staff (33.2%), psychologists (17.2%) and educators (12.2%). According to the 2010 *Epidemiological Report on Drugs and Alcohol in the Veneto Region* (ULSS 20 Verona, 2010), from 1991 to 2009 there was a notable increase in the number

[10] Established by Law No. 309, 1990.

of people with drug-related problems cared for by the region's network of public services, increasing from 8484 in 1991 to 15 045 in 2009. In particular, there are a notable number of people who relapse and re-enter treatment after being cared for previously. In 2009, the number of people with addictions treated represents 4.7 per 1000 resident population aged 15 to 64 years. New patients are predominantly those aged between 20 and 24 (for both sexes), while those who relapse are mainly aged 40 years and over. The most prevalently abused substance is heroin (69%), followed by cannabis (13.8%) and cocaine (11.9%). In 2009, there was a total of 3370 people in (residential) therapeutic units. The majority received pharmacological treatment (70.3%), mainly methadone, while 29.7% received psychological and rehabilitation treatments. About half of the people treated (1704) were cared for directly in rehabilitation facilities, while 1112 were treated in prison with non-substitutive (i.e. non-methadone) pharmacological treatments.

With regard to alcohol dependence, 3795 new people were helped by the outpatient centres for drug dependency and for alcohol dependency in 2009, an increase of 6% compared to 2008. Of these, 82.5% were men and 17.5% women. For both sexes, most new alcohol dependents were aged between 40 and 49 years. In addition, there were 10 705 people already known to alcohol care centres and who were assisted in the same year, making a total of 14 500 people. Given that 4542 people were helped for alcohol dependency in 1995, there has been a steady increase in this problem. In terms of the delivery of treatment, the most common support is counselling given to the person or to his or her family (26.4%), followed by outpatient-based pharmacological treatment (26.3%) and joining a help group (11.2%). Hospitalization for alcohol-related conditions was required for 2583 people in 2009: 65.8% for alcohol dependency itself and 34.2% for other alcohol-related diseases.

6. Principal health reforms

Since the early 1990s, health care in Italy has undergone many changes, both to adapt to new patient needs and to achieve financial sustainability. Major national health reform legislation in 1992, 1993 and 1999 started the process of regionalization of the health system and the introduction of business-like practices ("managerialism") and quasi-market mechanisms into the SSN.[1] The decentralization process was confirmed by the Constitution (Chapter V) in 2001, which identified the respective competencies of the central government and the regions under a federalist-style framework. The reforms of the 1990s also established the LEA and the Pacts for Health signed in 2001 and 2009 defined the delivery of the LEA and sanctions for non-implementation. The 2009 Law on Fiscal Federalism (No. 42) outlined important innovations for health care financing. Future developments will focus on the implementation of the annual Pacts for Health between the central government and the regions and the adaptation of services to meet new health system challenges, particularly those associated with the ageing population and the incidence of chronic diseases, and the ever-present problem of keeping the regional health budget balanced.

6.1 Analysis of recent reforms

In Italy after the first health system reform in 1978, two other major reforms took place in 1992–1993 and 1999 (the "second reform" and "third reform"), which for the purposes of this chapter can be discussed together. The main aspects of these reforms do not concern the principles that were confirmed but the new provisions for the management and organization of health services. The regions and Italy's two autonomous provinces were recognized as the level of government that was to have full competency in health policy and delivery of

[1] The process of introducing business-like practices into public enterprises is known in Italy as *aziendalizzazione*.

services, a role taken over from the central state (the process of regionalization). Each region can now organize its own health services via ASLs (ULSSs in the Veneto Region) and AOs and through private accredited facilities according to whatever organizational model it deems appropriate, as long as it can deliver the LEA within budget. However, in reality, national governance is still very strong. For example, the organization of health care enterprises is still subject to national-level regulations, and the process of securing the region's share of health financing is a drawn-out process requiring a great deal of negotiation.

The reforms of the 1990s established public health care enterprises, underpinned by the logic and instruments of private companies: budgets, asset management, responsibility for setting and achieving strategic objectives, efficiency and so on. Health care enterprises are regional structures and are managed by managers nominated by the president of the region. Local councils/municipalities now also play a part in identifying health care needs and provide advice on planning but they are not directly included in any management activities.

The regionalization of health care, like many other policy areas, such as social care, tourism, urban planning and local transport, was confirmed by the reform of the Italian Constitution in 2001. Consequently, the SSN's decentralization is now irreversible and the regions are the linchpin of this reform. Pacts for Health, together with National Health Plans, are developed collaboratively by both the national government and the regions. While National Health Plans are limited to outlining only general principles, Pacts for Health are negotiated and agreed upon every three years. Two of the most significant Pacts were approved in 2001 and in 2009. Pacts for Health give substance to the general objectives of National Health Plans with detailed policies, set the financial allocations for the delivery of the LEA (which always involves difficult negotiations) and set the sanctions for non-compliance. At present Pacts for Health are the main instruments to guarantee the proper functioning of the SSN and represent one way of trying to solve disagreements between the centre and periphery, which are always a feature of federal systems. The last most significant reform, in 2009, concerns the implementation of measures to make fiscal federalization a national reality, and which includes the health sector. The framework legislation for this constitutional reform requires further (implementation) legislation, and the difficult process of negotiating this supplementary legislation is still ongoing.

The most important element for all the decentralized regions and subnational public bodies is to receive the correct distribution of national funding, thus maintaining maximum autonomy in the way their allocated funds are spent in

order to meet the needs of their populations. For the health care sector, the main elements in the financial formula are the standard costs of production based on the best three performing regions; this is then applied to all the other regions. This strategy of using standard production costs will hopefully spur all regions on to overcome their inefficiencies and reclaim savings.

6.2 Future developments

Implementing fiscal federalism and ensuring adequate funding arrangements to deliver health care will remain the most important reform developments to monitor in the future. In addition, the implementation of the latest Pact for Health agreed by the central government and the regions is under question following the emergency austerity budget of the summer of 2010, which Italy, as in other European countries, has had to pass to address the global economic crisis. The current crisis of 2011 and required austerity measures set the context for a difficult few years. In terms of policies, given the financial situation, it is obvious that more financial rigour will be required, as well as more efficiency and efficacy; the aim will be to ensure the appropriateness of care and to reorganize services.

Other challenges that affect all of Italy, including the Veneto Region, are the increases in chronic degenerative diseases, new types of poverty needing more social assistance and health care, and the rising costs of the health system. Therefore, the solution must be more appropriate to the situation: more prevention, more primary care, more rehabilitation and fewer hospitalizations, particularly in ordinary acute services. There is also a need for greater involvement on the part of families, volunteers and the community in general, because the public sector on its own is no longer adequate to cover increasing needs and costs. Therefore, another consequence will be the need for higher cost-sharing on the part of health care users, with the exception of the very poor and those who have chronic diseases. Finally, there will be strong developments in the use of innovative technology, such as the electronic health card and telemedicine.

7. Assessment of the health system

Generally speaking, the health status of the population of the Veneto Region is good and citizens' needs are, in large part, satisfied, but improvements are always necessary, particularly in making use of local resources and other structures. The population enjoys a good degree of financial protection and there are measures to ensure access to care for vulnerable groups. Access to health services is fairly equitable, but some areas, particularly alpine areas, need to have their levels of service strengthened to reach optimum standards. Technical resources are also distributed equitably, particularly very expensive medical equipment. From an organizational point of view, there are differences among the ULSSs and the Region is working towards cooperation to share good practice and optimize services for patients. The overall number of hospital beds has been rationalized and the Region is consolidating the number of suitable facilities for the treatment of various diseases. With regard to human resources, questionnaires reveal that the majority of the population is satisfied with the level of service it receives, but more nurses are needed.

7.1 Stated objectives of the health system

The objectives of the Veneto Region health system coincide with those of the SSN because the Italian regions contribute to defining these objectives during the meetings of the State-Regions Conference. The main principles underpinning the SSN are human dignity (equal dignity and equal rights of all individuals), to meet the health needs of the population, equal access to care, protection and promotion of citizens' health status, solidarity with vulnerable groups, effectiveness and appropriateness of health care and cost-effectiveness (see also Lo Scalzo et al., 2009). Without discussing all of these objectives, some aspects that are particular to the Veneto Region and which often cover overlapping principles will be covered.

Among the policies connected to prevention and health promotion, the Veneto Region has taken an active role, particularly with the WHO Office for Investment for Health and Development (located in Venice), to provide incentives for all stakeholders to work on various fronts, such as promoting healthy life and work environments, functional transport systems, good housing and education on healthy lifestyles. The Regional Health and Social Care Plans and other directives call on local government bodies, companies, workers and associations to create synergies in order to define and implement policies related to the determinants of health. This has been true above all in recent years, which have seen a tumultuous and not always beneficial development of the economy, making the Veneto Region one of the richest regions in Italy but with some costs in terms of living and working environments.

With regard to hospital policies, some of the smaller and inefficient hospitals have been converted and resources transferred to primary care. Medium-sized and large hospitals have been audited and placed within a network of facilities (see section 5.4) with the aim of offering quality services, delivering excellence in care and avoiding duplication and waste. However, this policy has not been fully implemented throughout the region as yet and the objective of the next Regional Health and Social Care Plan is to complete this important and complex process.

Amongst primary care/district-level care policies, the Veneto Region can highlight its health and social care model, which is one of the most advanced in Italy. In fact, there is a strong integration between health policies and social care policies, and a strong relationship between hospitals and district-level primary care that is designed to deliver comprehensive health care to patients and ensure continuity of care. For example, there are now more beds in residential health care facilities than hospital beds, including those allocated to rehabilitation (but excluding activities delivered by integrated home care).

With regard to the efficiency and efficacy of the health system, accounting, control and participation mechanisms have been improved and will continue to be strengthened, as will administrative systems and those geared towards maintaining patient satisfaction levels. In Italy, the SSN's objectives more or less coincide with the task of delivering the LEA within budget. This necessitates having in place services for health promotion, disease prevention, appropriate treatment and rehabilitation, with emphasis on continuity and appropriateness of care and services.

The SSN's health status objectives – a very long list – were specified in the latest National Health Plan and Pact for Health. Regions are responsible for implementing policies and interventions to achieve these objectives. Some of these policies are shared by all the regions, while others refer only to individual regions in order to help them to reach the (mainly financial) objectives set for everyone. Among the first set of objectives is the implementation of actions in specific disease areas (including oncology, transplants and cardiovascular health), as outlined in the National Health Plan. These action areas have separate earmarked financing for their implementation. A second set of objectives concerns cost-containment plans, which outline precise targets on such things as reductions/rationalization of hospitals, greater use of primary care services and achieving greater appropriateness and efficiency of services to balance budgets.

7.2 Health status

The health status of the Veneto Region's population is generally good, in comparison with both national and European standards; the data show generally higher levels of health status, particularly with regard to decreases in mortality rates among both women and men (see Table 1.3). The population is increasing, as is the birth rate, mainly because of the presence of immigrant groups. Life expectancy also has increased; while positive, this development is associated with an ageing population and has necessitated a reorganization of the Veneto Region's health system (see Chapter 4). Over the last few years, there has been an important stress on preventive actions, which are now fairly widespread, including disease-specific screening, a better organization of care and a considerable investment in health and social care policies. Voluntary groups have contributed to raising the quality of life of patients, particularly disadvantaged groups. Having said this, the health system needs to respond to new challenges, such as meeting the health needs of the ageing population and of people with chronic diseases.

7.3 Health system responsiveness

Although there is room for improvement, in large part the Veneto Region's health system responds to the health care needs of its residents. Nevertheless, the scientific community and researchers within the region should be involved

in helping health care professionals understand their roles in making the health system better. Other mechanisms that can lead to greater responsiveness include the use of evaluation forms filled out by patients.

7.4 Financial protection

The Veneto Region lies within a national context in which health care is public and considered to be an inalienable right of citizens. However, patients who use public services participate in health system financing through co-payments unless they are exempt because of their financial situation or because they have a particular condition (see section 3.7). It is important to improve waiting times, which often are too long and act as an incentive for people to use, and pay for, private sector services; this trend is on the increase and not all patients can afford it. The ability of physicians to practise in both the public and private sectors can have the effect of lengthening waiting lists in the public sector (see section 3.7.2). In other sectors, such as dentistry, recently there has been an increasing trend for patients preferring to go to other countries because of the high costs of dental care in Italy.

7.5 Equity

7.5.1 Equity in financing and resource allocation

The health system is predominantly publicly financed to provide access to services for the population. Here the discussion focuses on efforts to ensure an equitable allocation of resources across the regions to health care enterprises to deliver services. Fairness in the distribution of resources relies on the allocation of such resources from the national level to the regions and then from the regions to the health care enterprises. Resource allocation criteria are mainly based on weighted age groups, integrated with other secondary criteria. Intraregionally, other factors are also taken into account, such as areas with sparse populations (mountains, lagoon areas, islands).

To identify and determine what constitutes "standard needs" and "standardized costs" is a complex task. Since the 1990s, the Veneto Region has implemented measures that have allowed it to progressively substitute the criterion of historical spending with a distribution of resources according to weighted population characteristics (see section 3.2). Moreover, since

2007, attention has focused on the costs of production in order to establish a methodology that can determine the costs of hospital and specialist care based on the activity of health care structures and on the level of resources they utilize; this can then be shared across all of the providers in the health system. In 2009, the Veneto Region defined a financing model that reinforces criteria that are linked to the population, to the financing of functions that are not (otherwise) remunerated via DRGs, and to the specific characteristics of ULSSs, aimed not only at eliminating historical expenditures once and for all but also at lowering the gaps in per capita funding among ULSSs. This financing model has entailed the elaboration of criteria to measure the cost of needs, the cost of health care consumption and the cost of production that characterize the activities of the region's health care enterprises. In this process, it is fundamental to identify and evaluate the factors that determine differences in needs so as to properly estimate and measure them.

Among the objectives connected with the concrete implementation of fiscal federalism in the health care sector is a process through which the managers of health care enterprises, in synergy with regional bodies, can ensure that resources are acquired and employed in an efficient and effective way in order to meet the objectives established by the region. Achieving such a management system at regional level is linked to the effective development of data collection and improvements in the regional information system.

7.5.2 Equity in provision of services

Access to health services is a fundamental aspect of the right to health in terms of the ability to make use of preventive, diagnostic and rehabilitative care. Such access should be guaranteed regardless of where a person lives. The Region's Geographical Information System allows for the analysis of comparative access to health services across the Region's health care facilities. In particular, access to ambulance services (one of the principal factors that determine a patient's survival) has been monitored and this can be seen as a proxy for determining adequate access across the Region. A study on the quality of emergency services conducted in 2007 showed that there was a good level of access to health care facilities, with only highly specialized medical and surgical services falling below serving 60% of the population in terms of timely access (ARSS, 2007). Historically, hospitals have been built in very populated areas and traffic congestion can affect real-time access to services, even if distances are shorter. The ARSS study also revealed that those living in mountainous areas and in the Po River delta have reduced access to services. Nevertheless, despite these limitations, 97% of the Veneto Region's population has access to ambulance

services facilities within 20 minutes. In terms of the use of helicopter transport from remote areas to nearby hospitals, 72% of the Veneto Region's population is able to reach a provincial hospital in under 15 minutes.

More generally, access to services is aided by the diffusion of information through client care offices located within each ULSS, AO and IRCSS and the Health Services Charter issued by every health care provider; both of which disseminate key information on the health care services that are available and how to access them (see section 2.9.1).

In the last few years special services have also been set up to help foreign residents, through the publication of guides, brochures and so on in other languages (such as Arabic and Chinese) as well as providing the services of cultural mediators. However, there is still a section of the population – foreigners living in the country illegally – that is difficult to reach and that may forgo accessing health services for fear of the consequences of their irregular status being discovered.

7.5.3 Equity in health outcomes

The direct impact of health systems on health outcomes is difficult to determine with certainty. Generally speaking, the Veneto Region health system does not have notable inequality in access to health care or in health outcomes as all citizens are guaranteed the same rights. Of course, differences in health status exist and these are related to age, sex and life conditions, but policies are in place to ensure that the population is covered by whatever health services it needs. Financially, as mentioned in section 7.5.1, there are no particular problems in coverage, except perhaps those related to waiting lists. More generally, the Region is in the process of improving its IT systems to provide people with more rapid and efficient access to health data.

7.6 Health system efficiency

7.6.1 Allocative efficiency

Allocative efficiency involves many factors, but two of the most important are financial resources and human resources. In Italy, and, therefore, in the Veneto Region, following the reforms of the 1990s and the introduction of regionalization and managerialism into the SSN, the allocation of finances was based initially on the criterion of resident population; this soon changed

to the criterion of "weighted resident population", namely differentiated by age groups. Both approaches sought to evaluate health needs but were not directly related to efficiency and costs. This led to tensions and protests among the Italian regions and between the regions and the central government during the annual negotiations over the allocation of resources from the National Health Fund (see Chapter 3).

With the Law on the Fiscal Federalism (Law No. 42, 2009), from 2013 there will be a new allocation formula based on "standard production costs", taking as its reference point the best performing regions in relation to the three areas of the National Health Fund: prevention (5%), hospital care (44%) and district-level primary care services (51%). This will be applied to all Italian regions (see section 6.2). This new system will entail large-scale reorganization of services and policies in some regions, mainly in southern Italy and less so in other regions such as the Veneto Region, to try and achieve efficiency gains and keep costs down. However, there are the same problems within individual regions as at national level. For example, the Veneto Region has ULSSs that balance their budgets when delivering the LEA but there are others with small deficits and others with large deficits. In 2010, the regional health system deficit was around €430 million (which was covered by the regional budget), and 18 out of the 24 health care enterprises finished the year in deficit. The task of new policies, and the new Regional Health and Social Care Plan, will be to address these differences in financial performance while trying to apply best practices from the better performing ULSSs.

With regard to human resources, the latest Pact for Health (2010–2012) defines precise standards not only for personnel but also for health care facilities, in order to avoid an unequal and inefficient allocation of different groups of health care personnel.

7.6.2 Technical efficiency and quality of care

With regard to the efficient use of health system personnel, one of the SSN's problems is the imbalance in the number of doctors and the number of nurses and midwives: there are too many doctors and too few nurses. In fact the number of doctors per 1000 inhabitants is one of the highest in the EU while the number of nurses per 1000 inhabitants is one of the lowest (see Tables 4.7 and 4.8). This problem, which in the past reached worrying levels, is being solved over a number of years through planned entry to training places for physicians and nurses.

In terms of pharmaceutical policy and expenditure, a good equilibrium has been reached at national level (between 13 and 14% of the National Health Fund) even if there are notable variations between the regions and there is significant underuse of generic medicines. Problematically, there are no particular incentives or sanctions for physicians who do not follow prescribing guidelines. Since doctors and other health professionals are generally monitored by health care enterprises it should be easy to see who is overprescribing and to take steps to ask them to modify their prescribing practices. Only recently, a system of incentives and rewards has been established throughout the entire public administration, including health care. However, it is too early to tell what, if any, effects this system will have. In addition, albeit quite late compared with Anglo-Saxon countries, Italy now has an extensive set of clinical guidelines, formulated by the national Ministry of Health and the regions, with the help of scientific bodies. However, their implementation, primarily at the departmental level of each health care enterprise, is still very uneven.

In the Veneto Region, hospitalization (both ordinary acute admissions and day-hospital stays) has fallen progressively in line with regional policies aimed at decreasing unnecessary hospital care and promoting care in more appropriate settings such as primary care. As described in section 5.4 (and Fig. 5.4), in 2009 the hospitalization rate fell to below 160 for every 1000 inhabitants (154.4 cases), compared with approximately 200 in 2001. This decrease has resulted from the progressive reduction of hospitalization in public hospitals, while accredited private regional hospitals and the number of patients who chose to be treated in out-of-region hospitals has remained more or less stable (see section 5.4 and Fig. 5.5).

Patient satisfaction with health care services is normally evaluated via questionnaires administered at the level of health care enterprises or via research conducted by regional agencies on the quality of services. Patient representative groups also play a role in quality control (e.g. patient rights tribunals, citizens associations). In addition, methods have been introduced in the last few years to evaluate the quality of the services delivered using explicit standards and criteria, supported by the regional ARSS. The indicators used for this analysis are derived from the US Federal Agency for Quality and Health Research "Quality Indicators" programme and are based on hospital discharge cards, allowing for an analysis of the problems encountered and development of solutions.

Finally, regarding patient safety (and that of health care professionals), in addition to the risk management plans that are in place to prevent accidents, there is a complex and expensive insurance system to cover any damages claims. Over the last few years, this has become a more relevant problem and has generated the phenomena known as "defensive medicine".

7.7 Transparency and accountability

The theme of transparency and accountability in the Veneto Region covers two distinctive areas. The first refers to the institutional level: health and social care plans are discussed and debated within the local government bodies and by representatives, in particular the presidents of the mayors' committees. In fact, at local level it is compulsory for the mayors' committee to discuss local health problems, regional planning and the allocation of financial resources with the director-general of the relevant health care enterprise. The second area regards patients: every health care enterprise contains variously named organizations (e.g. patient rights tribunals) that interact with the management of ULSSs and AOs on themes such as accessibility of services, patient satisfaction and so on. Citizens are also involved via specific associations, such as "Active Citizens", together with other civic associations, regarding more general themes connected to the delivery and quality of health care services.

In addition, the reliability of the Veneto Region's health service is based on constant monitoring of LEA delivery and of financial resources. A health and social care review is produced every year by the Giunta and submitted to the Regional Council for discussion. Every quarter, the Giunta undertakes a survey of principal activities and delivery of services according to regional objectives, enabling it to observe any deviations, analyse the underlying reasons and remedy the situation. There are management control offices at the health enterprise level and at regional level through the General Management Secretariat of the Departments of Health and Social Services. The impact of organizational reforms on the Veneto Regional Health Service and the strengthening of systems for quality assurance and expenditure control (which in the past have not functioned properly) are being fine-tuned via new planning and control mechanisms. These include the annual objectives given to the directors general of ULSSs and AOs and the implementation of general and sectoral planning (normally three-year plans).

8. Conclusions

Since the devolution of health care organization and delivery responsibilities to the Italian regions, the Veneto Region has worked to provide high-quality services that meet the specific needs of its resident population. It has done this within a framework in which the minimum health care entitlement, the LEA, is set at national level (with regional inputs) and must be delivered to residents across three programme areas: public health, district-level primary care and hospital care. However, the Region has the authority and flexibility to determine how these health services should be provided, always mindful of the constraints set by its annual allocated health budget. In addition to the LEA, the Veneto Region offers its residents some extra health services, funding the costs through its own regional budget.

This framework presents specific challenges, particularly financial ones, and an ever-present requirement is to increase efficiency and claw back budget deficits where they exist, either at ULSS level or within the health system as a whole. The process of budget balancing is an ongoing one. In trying to meet these challenges, the Veneto Region has striven to be a dynamic "policy-maker", and sometimes innovator, and not merely a "policy-taker" (France, 2009) in developing the organizational, financial, management and quality control models that best suit its health system.

Among the many health system management strategies that the Region has adopted, three in particular stand out. First, the Region has invested heavily in integrated, strategic planning and technical support processes, consisting of detailed three-year Regional Health and Social Care Plans and ULSSs' general plans. This ensures not only that the objectives and standards of all health services are defined and met but that they are integrated with social care policies and services and, where possible, with wider regional policy areas that have an impact on health care. The coordination of health care with social care is also reflected in the Region's governance model, with the presence of a single Secretariat to oversee the Department of Health and the Department of

Social Care. In addition, the remit of the main agency that provides technical and scientific support to the region, the ARSS, extends across these two policy areas. Finally, along with a small handful of other regions, the Veneto Region has been at the forefront of developing fit-for-purpose HTA methodologies to be employed locally.

Second, the last few years has seen a concerted reorganization of the hospital sector, with a two-pronged approach. Where appropriate, some services have been removed from acute hospital settings and reconfigured for delivery at the primary care level; at the same time, a detailed functional and financial audit of the existing hospital stock is already underway with the longer-term aim of converting smaller hospitals that are no longer fit-for-purpose into post-acute care and community health facilities. These measures are designed to better meet population needs and are also a means of containing costs and strengthening efficiency in health care delivery.

Third, in the area of financing of health care, the Region has moved away from historical budgets and implemented activity-based DRG payment methods for hospital services and is progressively implementing "standard production costs" methodology as the basis for other health sector financing, ahead of 2013 when standard production costs will be the national-level basis for determining resource allocation of the National Health Fund.

These strategic policy directions have shaped the Veneto Region's track record for being one of the leading regions for managing its health care sector and delivering required services. Over the next few years, the context of health care financing and provision will be dominated by the deeply uncertain economic climate that currently prevails in Italy. With the Italian Government's pledge to drastically reduce public debt, and the imposition of austerity measures, the implications for SSN funding are, as yet, unknown. Nor is it clear what this will mean for the scope of the LEA that will need to be delivered in the coming years. Running parallel to this economic uncertainty is the continuing transition towards fiscal federalism – and the opportunities and challenges involved. Among other things, the Pacts for Health with the central government set out stringent criteria for LEA delivery and budgetary discipline, with corresponding sanctions where the terms of the agreements are not met. Through the efficient management of the health system and maintaining respect for the annual expenditure plans, the Veneto Region can continue to exert significant discretion in policy-making and freedom of action in policy innovation. The Region has built its past record of achievement precisely on this freedom and ability to tailor its health system to the needs of its residents. This capacity will be required even more to meet the new health care challenges that will arise in the years to come.

9. Appendices

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9.2 Useful web sites

Italian Ministry of Health: www.ministerosalute.it

National Institute of Statistics (ISTAT): www.istat.it

National Plan for Clinical Guidelines: www.pnlg.it

Regional Agency for Health and Social Care: www.arssveneto.it

Veneto Region: www.regione.veneto.it

9.3 Hit methodology and production process

HiTs are produced by country experts in collaboration with the Observatory's research directors and staff. They are based on a template that, revised periodically, provides detailed guidelines and specific questions, definitions, suggestions for data sources and examples needed to compile reviews. While the template offers a comprehensive set of questions, it is intended to be used in a flexible way to allow authors and editors to adapt it to their particular national context. The most recent template is available online at:

http://www.euro.who.int/en/home/projects/observatory/publications/health-system-profiles-hits/hit-template-2010.

Authors draw on multiple data sources for the compilation of HiTs, ranging from national statistics, national and regional policy documents to published literature. Furthermore, international data sources may be incorporated, such as those of the OECD and the World Bank. The OECD Health Data contain over 1200 indicators for the 34 OECD countries. Data are drawn from information collected by national statistical bureaux and health ministries. The World Bank provides World Development Indicators, which also rely on official sources.

In addition to the information and data provided by the country experts, the Observatory supplies quantitative data in the form of a set of standard comparative figures for each country, drawing on the European Health for All database. The Health for All database contains more than 600 indicators defined by the WHO Regional Office for Europe for the purpose of monitoring Health in All Policies in Europe. It is updated for distribution twice a year from various sources, relying largely upon official figures provided by governments, as well as health statistics collected by the technical units of the WHO Regional Office for Europe. The standard Health for All data have been officially approved by national governments. With its summer 2007 edition, the Health for All database started to take account of the enlarged EU of 27 Member States.

HiT authors are encouraged to discuss the data in the text in detail, including the standard figures prepared by the Observatory staff, especially if there are concerns about discrepancies between the data available from different sources.

A typical HiT consists of nine chapters.

1. Introduction: outlines the broader context of the health system, including geography and sociodemography, economic and political context, and population health.
2. Organization and governance: provides an overview of how the health system in the country is organized, governed, planned and regulated, as well as the historical background of the system; outlines the main actors and their decision-making powers; and describes the level of patient empowerment in the areas of information, choice, rights, complaints procedures, public participation and cross-border health care.
3. Financing: provides information on the level of expenditure and the distribution of health spending across different service areas, sources of revenue, how resources are pooled and allocated, who is covered, what benefits are covered, the extent of user charges and other out-of-pocket payments, voluntary health insurance and how providers are paid.
4. Physical and human resources: deals with the planning and distribution of capital stock and investments, infrastructure and medical equipment; the context in which IT systems operate; and human resource input into the health system, including information on workforce trends, professional mobility, training and career paths.
5. Provision of services: concentrates on the organization and delivery of services and patient flows, addressing public health, primary care, secondary and tertiary care, day care, emergency care, pharmaceutical

care, rehabilitation, long-term care, services for informal carers, palliative care, mental health care, dental care, complementary and alternative medicine, and health services for specific populations.

6. Principal health reforms: reviews reforms, policies and organizational changes; and provides an overview of future developments.
7. Assessment of the health system: provides an assessment based on the stated objectives of the health system, financial protection and equity in financing; user experience and equity of access to health care; health outcomes, health service outcomes and quality of care; health system efficiency; and transparency and accountability.
8. Conclusions: identifies key findings, highlights the lessons learned from health system changes; and summarizes remaining challenges and future prospects.
9. Appendices: includes references, useful web sites and legislation.

The quality of HiTs is of real importance since they inform policy-making and meta-analysis. HiTs are the subject of wide consultation throughout the writing and editing process, which involves multiple iterations. They are then subject to the following.

- A rigorous review process (see the following section).
- There are further efforts to ensure quality while the report is finalized that focus on copy-editing and proofreading.
- HiTs are disseminated (hard copies, electronic publication, translations and launches). The editor supports the authors throughout the production process and in close consultation with the authors ensures that all stages of the process are taken forward as effectively as possible.

One of the authors is also a member of the Observatory staff team and they are responsible for supporting the other authors throughout the writing and production process. They consult closely with each other to ensure that all stages of the process are as effective as possible and that HiTs meet the series standard and can support both national decision-making and comparisons across countries.

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