Social Security Abroad

Italy's National Health Service Plan *

After more than a decade of discussion on the issue, reform of the Italian health care system is now underway. A bill establishing the long awaited National Health Service was approved by the Italian Parliament late last year and went into effect January 1, 1979.

The new health care delivery system gradually replaces the health provisions in the existing social insurance system, which has experienced serious problems. Because the former program was organized around numerous health insurance funds and was thus too fragmented to allow effective coordination of medical services, extensive waste and maldistribution of resources resulted. Health care expenditures rose sharply, and sickness funds and hospital administrations accumulated large operating deficits. Hospitals have been overcrowded and the quality of care has been very uneven. Critical shortages of medical personnel have occurred in various parts of the country, including the South of Italy and rural areas elsewhere. Benefits have varied significantly according to the particular occupational fund; a small proportion of the population has had no coverage whatever. The health insurance funds are now being dismantled.

The goal of the new National Health Service is to deliver equal protection to all citizens, regardless of economic or social status, through a system that eventually will be financed totally out of general revenues. The organization of the national health program is designed to allow considerable local participation in the administration of the national health program.

Background

Approximately 96 percent of the population had some form of health insurance coverage under the old system. Workers, their dependents, and pensioners were covered by one of many participating agencies. Seven major funds covered 89 percent of the population, and 3 percent were covered by more than 200 other private funds.[1] More than half the population came under the single most important fund—the National Sickness Insurance Institute (l'Istituto Nazionale per l'Assicurazione contro le Malattie, or INAM). Government public welfare programs were responsible for furnishing medical care to the indigent.

Benefits varied widely from plan to plan. The more important funds usually provided virtually all necessary medical and hospital care without charge to the patient. Drugs and dental care were covered by most funds. Specialists could be consulted only on a referral basis.

The Italian health care system was financed out of large employer payroll contributions and small employee contributions, which varied according to the fund. Under the INAM fund, the employer paid 14.0 percent of payroll and the worker paid 0.3 percent. These contributions also provided for cash sickness benefits. Employers paid an additional 2.1 percent of payroll for cash and medical benefits under a tuberculosis program administered by the National Social Security Institute.

After a 3-day waiting period, insured workers qualified for cash sickness benefits amounting to 50 percent of earnings for the first 20 days of illness and 67 percent thereafter. A worker received these benefits for up to 180 days after which they were either extended under special circumstances or replaced by disability benefits. Cash maternity benefits were also available to working women at the rate of 80 percent of earnings for up to 18 weeks before and 13 weeks after confinement. Optional leave was available for an additional 6-month period, with the rate set at 30 percent of wages.

Only a few funds used physician-remuneration formulas that involved payment by the patient at the point where care was delivered. "Primary" doctors were usually under contract to the sickness funds or worked in fund-managed clinics. Most of these physicians were paid directly by the funds on a fee-for-service basis, but capitation methods were also used, particularly in rural areas.

Most Italian hospitals are publicly owned. They were separate legal entities paid directly by the sickness funds on a scale determined by the type of service provided. The hospitals charged for physician services according to a fee schedule. Hospital doctors, however, were usually paid by the hospital on a modified salary basis.

Over the years, the increases in the cost of health services, particularly hospital care, have been described as "explosive." According to an Italian authority, the total cost of health services rose from 5.4 percent of gross national product in 1966 to 6.7 percent in 1971—or by an annual compounded rate of 14.4 percent.[2]

Hospital expenditures were the main item in this growth. INAM's total outlay for such expenditures increased from 14 billion lire in 1950 to 1,650 billion lire in 1974—a rise three times greater than the high

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[1] Alan Maynard, **Health Care in the European Community,** University of Pittsburgh Press, 1975, page 158.

[2] Professor Antonio Brenna, "Italy: Few Are Making Bets," in **The Health Care Cost Explosion: Which Way Now?** (David Alan Ehrlich, editor), Hans Huber, 1975.

rate of inflation during the period.[3] Until the mid-1960's, the cost of hospital care grew at roughly the same rate as total medical care expenditures. At that point, however, hospital care expenditures began increasing at a much faster pace, largely because of the higher cost of personnel. Analysts claim that the rise in hospital expenditures resulted from a 1968 legislative change that allowed large pay increases for doctors and hospital staff, which the hospitals passed on to the insurance organizations in the form of higher per diem rates.

By 1974 the situation reportedly had become critical. The sickness funds were deeply indebted to the hospitals and the hospitals, in turn, lacked the revenues to pay for basic supplies. The Government took action to alleviate the crisis and initiate reform of the health care system. Legislation in 1974 set up a special public fund to finance hospital care and transferred the budget and responsibility for providing these services from the various social insurance funds to the Regions, government jurisdictions roughly equivalent to states in the United States. The law imposed a freeze on salaries and the number of medical personnel and provided for the dissolution of the existing health insurance funds by June 30, 1977.

As a temporary solution to the financial crisis, the National Government assumed the debts incurred by the sickness funds and made plans to transfer fund resources and personnel to the Regional governments at a later time. Because one of the primary faults of the social insurance approach was perceived to be that the funds collected contributions and paid out benefits without exercising any direct influence over trends in health care costs or on the quality of medical care, Government planners set out to create a totally new system—the National Health Service.

When the first step was taken in 1974, a complete overhaul of the health care system was planned. The new system was widely discussed but not implemented, however, primarily because of legislative delays. Finally, in late 1978, the bill establishing the National Health Service was formally approved by the Italian Parliament.

Organization of New Delivery System

Objectives

By improving administration, the National Health Service is expected to actively control health care costs. Another goal is to rationalize Italy's many divergent health care institutions and merge them into a single structure that will consolidate medical services of all types, extend complete medical assistance to all citizens, and standardize health benefits in all Regions.

The National Health Service is to replace the disconnected system of health care benefits financed by payroll contributions with a unified system offering comprehensive benefits financed out of general tax revenues. In addition to providing diagnostic and medical services, the new system will furnish preventive, convalescent, and rehabilitation facilities. It will also administer veterinary services, research and information activities, the provision of drugs, and all other health services, such as those for public sanitation and health control, environmental and occupational health and safety, and maternity and child care.

Administration

Under the new administrative framework, the National Government, the Regions, and the local governments will share responsibility for the delivery of health care. The National Government will determine the content and the direction of national health planning, coordinate various Regional activities, and issue national directives. Regional governments will exercise the legislative and planning functions for their territory. Local governments will be responsible for the day-to-day operation of the local health departments.

The National Health Service is administered by the Ministry of Health, with the assistance of certain advisory organizations. The principal advisory body is a newly created National Health Council, appointed by the President of Italy for a 5-year term and chaired by the Minister of Health. This council is composed of representatives from the Ministry of Health and various other government ministries, Regional representatives, and experts from national scientific and research institutes. It will make recommendations for national health policy and for the preparation and implementation of the national health plan. The council is also charged with the preparation of an annual health report to be presented to the legislature by the Minister of Health.

Italy's 20 Regions will have legislative authority to modify national norms to fit the regional situation. They will regulate health care and hospital administration and coordinate the health care system with other economic and social measures.

In consultation with the municipalities (communes), the Regions will divide their territory into local health units, each of which will serve a population ranging from 50,000 to 200,000. Where possible, these local health units will be coterminous with existing communal boundaries, but it is expected that some of them will overlap more than one commune. The local health units are to be subdivided into "basic health districts."

[3] Raffaele Iuele, "L'assistenza ospedaliera INAM nel periodo 1950–1974," **I Problemi della Sicurezza Sociale,** Rivista Bimestrale dell'Istituto Nazionale per l'Assicurazione contro le Malattie (September–October 1976), page 497.

The local health units are the key elements in the new system. They will provide a broad range of services for public health and sanitation, disease prevention, rehabilitation, inspection, hospital administration, drugs, veterinary policing, and diagnosis and treatment of sickness at general and specialist levels on an outpatient and domiciliary basis. The basic health districts will function as the technical arm of the local health units, providing primary medical facilities and treatment.

The local health units will be linked to the Regions, which will provide their personnel, equipment, and financial resources, as well as to the communes, which will furnish their operational direction. The units are to be run by a committee with members elected by the municipal councils in a manner that permits representation by minority parties on the management committees.

The new law also anticipates Regional legislation to create various health committees to oversee matters of concern to more than one local health unit. A committee or "presidium," for example, might be established to handle preventive services in an area spanning several local health units or to provide other specialized services. These committees will be under the jurisdiction of the units in which they are located.

Health Planning

Planning receives increased emphasis under the National Health Service, and it takes place on both the National and the Regional levels. A 3-year National Health Plan is to be prepared by the Government, with the advice of the National Health Council, and presented to Parliament. The plan is designed to establish national priorities and to serve as a guideline for the Regions. In addition, it will contain the annual budget for health expenditures and regulate the distribution of funds among the Regions.

Three-year Regional health plans are to be prepared by Regional committees in consultation with local institutions, universities, health workers, and organizations representing social forces within the community. The Regional plans, which require the approval of the Regional legislature, must conform to the objectives of the National Health Plan. Particular emphasis is to be placed on ways of equalizing benefit levels and the quality of care throughout the Region.

Hospital and Medical Facilities

As noted earlier, the 1974 legislation transferred the responsibility and budget for hospital administration from hospitals and sickness funds to the Regional governments. The law states that hospital facilities are to be considered part of the local health units. Regional legislation is required to ensure that hospitals are adequately provisioned and best serve the needs of the Region. Until new Regional legislation is passed, the existing body of hospital regulations will remain in force.

Most of the facilities of the National Health Service —including hospitals, clinics, laboratories, pharmacies, and dispensaries—are publicly owned. They are being transferred to Regional authorities and will be managed by local health units. Private, religious, and university hospitals and clinics will maintain their independence, but the Regions may conclude standardized contracts with them for services. The same procedure applies to private pharmacies, laboratories, and similar facilities. Voluntary health associations will be allowed to compete with the National Health Service but will not receive any public funding.

Medical Personnel

The Region will now employ their own physicians, nursing and administrative personnel, and auxiliaries at local health units and in the basic health districts. Regions may also retain the services of independent physicians under approved contracts.

The first national contract, lasting for 3 years, recently was negotiated between representatives of government (National, Regional, and local) and trade unions. Under its terms, local health unit personnel will not be permitted to receive any form of compensation other than regular pay. General practitioners and pediatricians are to be paid an annual fee for each patient registered with them (capitation basis). The method of payment for the services of specialists and generalists differs in public and private outpatient clinics. In the former, such physicians will be paid according to the number of hours worked; in the latter, they are to be reimbursed on a fee-for-service basis, depending on the number and type of services rendered. To control the number of physicians under contract with the local health units, the national contracts will specify the doctor/patient ratios for general and pediatric medicine, as well as the total number of working hours for generalists and specialists.

Disease Prevention

Preventive measures and health education play important roles in the conceptual basis for the National Health Service. Through the actions of the local health units, public health activities are to be upgraded, an activity that is expected to contribute significantly to a reduction in disease throughout the country.

The law focuses much of its effort in the area of dis-

ease prevention on measures for controlling occupational health hazards. Firms must disclose the chemicals used in their production processes. Area maps will be drawn to pinpoint the various environmental risks. Public health recommendations must be obtained before any new construction, industrial reorganization, or urban planning is undertaken. Local health units will inspect the workplace and set up committees within factories to monitor the health of workers. The law calls for the creation of a Higher Institute for Prevention and Work Safety, under the Ministry of Health, with a mandate to perform research and experiments and to develop preventive techniques closely connected with changing technology and manufacturing processes. Various ministries are represented in the administration of the new institute, including the Ministry of Labor and Social Security.

Coverage

The 1974 legislation made it possible for those not covered under a sickness plan to enroll for national hospital insurance in their Region. The National Health Service law completes the extension of coverage by making medical insurance compulsory for all citizens as of January 1, 1980. Persons not covered by virtue of a labor-force connection—roughly 4 percent of the population—may insure themselves directly with the National Health Service by paying an annual fee. Those so insured will be eligible for the level of medical benefits formerly provided by INAM, and their enrollment fee will be based on the average per capita cost of providing such benefits, as determined by the Minister of Health.

The health benefits formerly provided by the various sickness funds will gradually be made uniform for all citizens. Eventually, the step will require the levying of an additional contribution, but the total charge will not exceed the average per capita cost of INAM benefit levels. Disabled persons, however, are exempted by law from making any contribution for their health benefits.

Benefits

Persons using the National Health Service register with the local health unit in their community. They are entitled to receive general and specialist care, hospitalization, nursing care, and drugs. All medical and nursing services can be provided in outpatient clinics or at home. Ordinarily, all services are to be rendered within the local health unit. In special cases, however, the patient may go to any local health unit.

The user may select a physician either employed by, or under contract with, the National Health Service. The patient or the doctor may terminate the arrangement at any time, but the physician must show just cause.

Normally, the services of specialists are to be rendered at the clinics of the local health unit in the patient's community or at outpatient clinics under contract with the National Health Service. Such care may also be given at the patient's home if it makes hospitalization unnecessary.

Hospital care will also normally be provided in the Region where the person resides, at a public hospital or other institution under contract with the National Health Service. Regional legislation determines the arrangements under which patients are referred for care outside the Region, if necessary.

Confidential health books containing medical records will gradually be issued to every citizen, beginning with newborn children. Data from these health books may be used by health authorities, in a manner that guarantees confidentiality, for epidemiological studies and for making improvements in the health service.

The cost of providing free drugs has been a major factor in the sharp rise in national health expenditures. A new cost-sharing procedure, which went into effect in 1978, is intended to curb expenditures for drugs without causing patients to forgo the medicines they require.

Patients may now have prescriptions filled at local pharmacies without charge for any of the 800 medicines classified as "essential" in a National Drug List. This list also includes "supplementary" medicines provided to the patient for a fee ranging from 200 to 600 lire [4] per prescription. The patient pays the pharmacist directly when the prescription is filled. Under this procedure, patients will pay about 8 percent of the cost of prescribed drugs and, as a result, total public expenditures for free medicines are expected to drop by about 15 percent.

The Italian Government will also continue its recent efforts to control expenditures for drugs by regulating pricing procedures. All forms of public advertising of drugs in the National Drug List have been prohibited by law.

Financing

The law provides that, until the costs of the National Health Service are totally financed out of general revenues, the National Social Security Institute will collect the payroll contributions formerly paid to the health insurance funds. Contributions will flow into a National Health Fund under the control of the Interministerial Committee on Economic Planning, which

[4] On February 21, 1979, 1 Italian lira was equal to 0.119 U.S. cents.

will supervise the distribution of funds to the Regions. Funds to meet current operating expenses will be apportioned to the Regions on a per capita basis. In addition, funds earmarked for capital expenditures will be awarded to Regions according to the National Health Plan, which is to give greater consideration to the needs of backward Regions. Funds will be transferred to the Regions, at the beginning of each quarter. The Regions, in turn, will allocate funds to the local health units on a quarterly basis. The law imposes strict budgetary discipline: Local health units are required to make quarterly reports to the Regions on the status of their financial operations, and indebtedness is strictly forbidden.

A major objective of the new system is to have health care financed totally out of general revenues. The shift away from payroll contributions is seen as a way of reducing labor costs, which have been steadily rising. At present, total social security contributions account for about half of industrial payroll. It is hoped that the use of general revenues will allow the National Health Service to improve the level of health benefits throughout the country without overburdening workers and employers with additional payroll taxes. As part of the effort to reduce labor costs, the Government in 1977 and 1978 assumed a progressively larger portion of the employers' contributions for health insurance.

Another consideration behind the adoption of general revenue financing is that it may simplify controlling Italy's growing public sector deficit. Central funding and appropriations will give the Government greater administrative control and accountability over national health expenditures. In the past, responsibility for health expenditures was scattered among a number of public and private agencies. As a result many observers felt that the system lacked tight fiscal controls.

A ceiling on national health expenditures had been proposed but was removed from the bill before passage. Instead, it was decided that the National Health Service would control expenditures through its administrative reorganization.

With the Regions administering carefully budgeted amounts under the new law, the administrative reform should result in greater cost-effectiveness by utilizing the total health resources of the community. This hoped-for administrative efficiency is reinforced by specific cost-controlling measures such as a national contract for medical personnel and cost-sharing for drugs. The increased efforts in the areas of health education and preventive services are also expected to exercise some downward pressure on long-term costs.

In the short-term, however, the added expenditures to upgrade care in backward areas and to equalize benefit levels throughout the country will certainly result in higher total expenditures. Estimates vary as to how much the reform will cost. The Minister of the Treasury has calculated that implementation of the National Health Service will cost an additional 2,285 billion lire: 900 billion lire for services now financed at a deficit by local governments, 885 billion lire to equalize the benefit levels, and 500 billion lire for the increased effort to provide preventive services and for the new national contract with physicians. In addition, the National Government will have to assume the outstanding health-related debts incurred by the sickness funds and the Regions in 1976–77—about 5,500 billion lire.

The Future

The National Health Service will not become fully operational for some time to come. The actual transfer of personnel and resources from the sickness funds to the Regions will be completed gradually over a period of about 12 months. Moreover, uniform benefit levels may not be achieved until 1982. No timetable has been given for the shift in financing from payroll contributions to general revenues.

The reform of the health care system is so comprehensive in scope that it must generate reforms in other social insurance programs, especially in the area of work-injury and cash sickness benefits. The law requires the Government to issue a revised text of the law on work safety, which will consolidate existing provisions and incorporate new regulations promoting occupational safety in accordance with the goals of the National Health Service. In addition, the cash benefit programs for sickness, maternity, and work injury must be reorganized by 1980. Subsequently, until another planned reform of the pension program is enacted,[5] administrative responsibility for the cash sickness and maternity benefit programs will be transferred from the sickness funds to the National Social Security Institute. Following the reorganization, therefore, the National Social Security Institute—which is already suffering serious staffing and workload-management problems—must assume a new and more demanding role.

[5] For a discussion of proposed social security reforms, see Frank B. McArdle, "Italy's Indexing, Minimum Benefits, and Pension Reform," **Social Security Bulletin,** August 1978, pages 27–31.