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Examining Disparities in the Italian Public Health System: A Comprehensive Analysis of Fluctuations in Performance Metrics.

In 1946, Italy proclaimed its independence and created the Republica Italiana, where the thirty-second article of the Italian constitution was written. This declared free healthcare a human right for all Italian citizens and residents. However, it was only in 1978 that Italy created a universal Health Care System, called the Sistema Sanitario Nazionale, or SSN for short. This marked the creation of the medico di famiglia or medico di assistenza primaria. The medico di famiglia is a medical professional who understands his patient's state of health well and, when the need arises, guides them throughout the therapeutic process, established by the SSN. This allows patients to access all the services and benefits included in the Livelli essenziali di assistenza (LEA), which the Sistema Sanitario Nazionale (SSN) must supply to all citizens and residents, for free or with a lower fee.

Although a national administration ensures fundamental principles, and general objectives for all nineteen Italian regions, the Italian Healthcare System is regionally based. Each region is almost entirely independent in deciding its priorities and goals. These decisions are usually made by a general manager, who is appointed by a regional governor. The fatal flaw of this region-based system is that the quality and quantity of healthcare facilities and medical staff may vary from region to region. This disparity amongst regions has sadly developed into many different issues that have made it impossible for Italy to fulfill the thirty-second article of the constitution. Unfortunately, this wide range of issues goes mostly unnoticed by international organizations, because of the drastic differences in quality of healthcare between regions which balance themselves out in graphs and international reports. This allows Italy to constantly rank

highly without having factually universal health care. This explains why raising awareness of these issues and making a comparison between the successes and the failures of the system is a fundamental step in fixing the system and avoiding problems like this in the future. In this paper, we will analyze some of these issues in hopes of finding solutions and raising awareness.

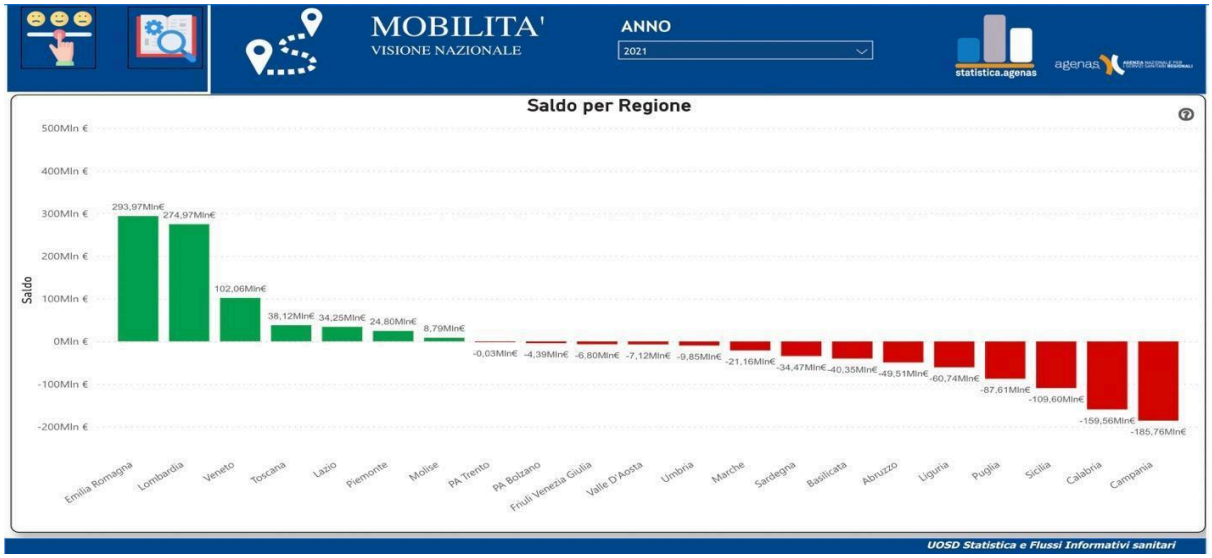
Waiting times for healthcare services, and the vicious circle that characterizes them. The existence of waiting times for healthcare services inevitably characterizes every public system. Waiting lists represent a problem of great importance and relevance for all healthcare systems in advanced developing countries which, at least on a formal level, ensure global coverage of healthcare services. Over the years, the Organization for Economic Co-operation and Development of OECD (2013, 2018, 2020) has already underlined several times how the issue of waiting times is central not only in Italy but in most of the countries that are part of the organization, with rare exceptions. A 2022 analysis run by the GIMBE foundation highlighted that the waiting times for healthcare services constitute one of the main critical issues of the SSN, which citizens and patients encounter daily, suffering serious inconveniences (this leads to a need to resort to private facilities, healthcare migration, increase in out-of-pocket spending, impoverishment), to the point of giving up treatment with serious consequences on health. Additionally, in Italy, there is no centralized system of collection and publication of data representing the trend of healthcare services across all Italian regions. The latest available data relating to waiting times for the services of the various SSRs found have been collected in 2017 research by CREA Sanità with reference in particular to four regions: Lombardy, Veneto, Lazio, and Campania. Some critical points emerged from the research.

1. First, the average values of waiting times for services provided under the SSN regime in public facilities are the highest compared to private ones.

2. Second, the average waiting time in these cases for all the services covered by the survey was more than 30 days (the survey takes into consideration the times for services without explicit indication of urgency cases for which the legislation sets the waiting limit in cases of visits at 30 days).
3. Thirdly, these values, especially for some visits (for example, eye examination) were increasing compared to previous surveys carried out by CENSUS in 2014 and 2015.
4. Finally, although on average lower, private waiting times also recorded a slight increase in those years.

Waiting lists are worsening in Italy, specifically in the poorer southern regions, with the private sector doing better than the public sector in any case. It emerges that waiting time depends on a natural imbalance between supply and demand and itself represents an indication of inappropriateness regarding waiting time. However, part of this imbalance often also depends on other factors, such as the poor integration between primary and specialist care, or the fragmentation of local care and models for taking care of chronic conditions that are still being defined.

The heterogeneity across regions generates also a vicious circle, patients whose waiting lists are longer and whose services are poorer “migrate” to more efficient regions. Interregional healthcare exodus from South to North for treatment does not stop with as many as 14 regions showing negative balances and 30% of services for which it was not necessary to go outside the region. The interregional healthcare mobility also leads to a transfer of funding from the poorer regions to those more efficient, as well summarized by the graph below, hence the vicious circle.



14 Regions have negative balances. Bringing up the rear is Campania which in 2021 recorded a negative balance of 185.7 million. Followed by Calabria (-159.5 million), Sicily (-109.6 million), Puglia (-87.6 million), Liguria (-60.7 million), Abruzzo (-49.5 million), Basilicata (-40.3 million), Sardinia (-34.4 million), Marche (-21.1 million), Umbria (-9.8 million), Valle d'Aosta (-7.1 million), Friuli Venezia Giulia (-6.8 million), the PA of Bolzano (-4.3 million) and the PA of Trento (-0.03 million). In 2021, Emilia Romagna is the one earning the most from mobility, displacing Lombardy from the top with a positive balance of 293.9 million. Lombardy follows with a +274.9 million. Also in profit were Veneto (+102 million), Tuscany (+38.1 million), Lazio (+34.2 million), Piedmont (24.8 million) and Molise (+8.7 million).

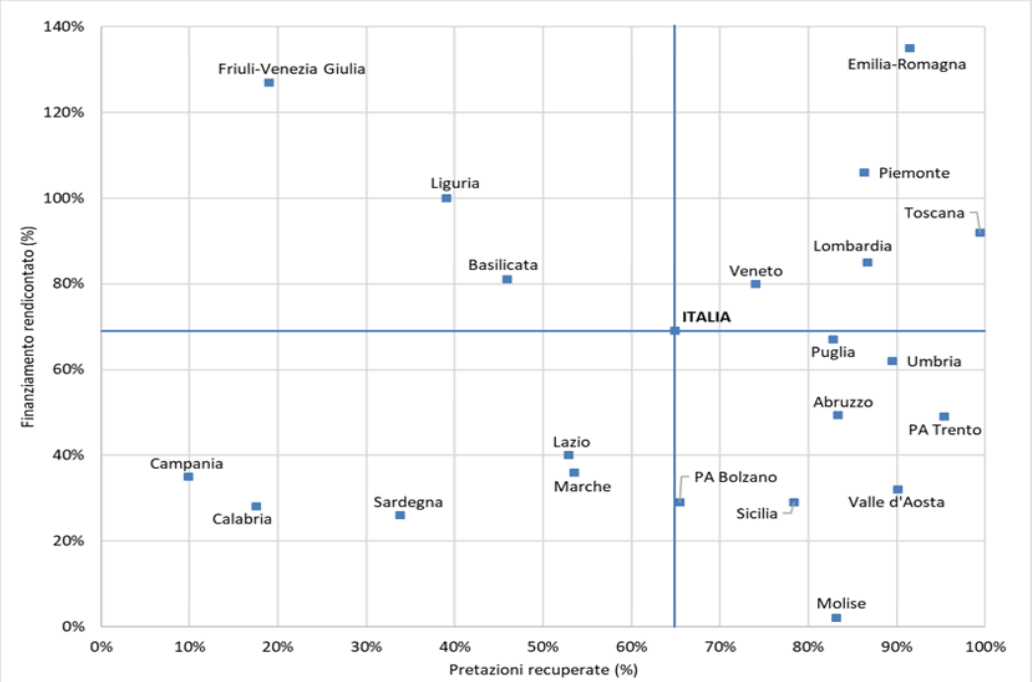
How COVID-19 impacted waiting times, and how it highlighted some of the country's fundamental flaws

The COVID-19 pandemic had a material impact on waiting times forcing millions of appointments to be postponed for months to accommodate the emergencies required by the pandemic. According to data from the Ministry of Health, in 2020 - compared to 2019 - there were over 1.57 million fewer scheduled hospitalizations in Italy; for oncological screenings over

2.53 million fewer services; finally, over 112 million outpatient services were "missed", including specialist visits, laboratory and instrumental tests. To address the problem, the Italian Government allocated 500 million Euros for the recovery of services. The monitoring of the Ministry of Health shows that overall the Regions have not recovered 35% of the services "skipped" during the pandemic for a total of 7.13 million services. Furthermore, the data gives a very heterogeneous picture between the various Regions both on the percentages of services recovered and on the financing used which is not always correlated with the services recovered. To facilitate the recovery of services, the legislation provided that Regions and Autonomous Provinces could involve accredited private providers,

The table below in Figure 7 of the GIMBE Foundation 2022 report, shows the heterogeneity across Italian regions: among those regions that had the lowest recovery rate, poorer regions like Calabria, Campania, and Sardinia leveraged the least on private funding, where richer regions like Friuli Venezia Giulia leveraged the most. It is clear how the economic gap between regions is growing evident in times of difficulty.

Figura 7. Relazione tra percentuale di finanziamento rendicontato e percentuale di prestazioni recuperate dalle Regioni



Emilia-Romagna, Friuli-Venezia Giulia e Piemonte rendicontano oltre il 100%, verosimilmente in ragione dello stanziamento di risorse proprie.

Elaborazione GIMBE da dati Ministero della Salute

GIMBE EVIDENCE FOR HEALTH

Is it possible for the SSN to end this pattern?

Overall, the Italian healthcare system is founded on solid and valuable principles, but the core challenge is in the way it is implemented. This has led to significant disparity of service with the dispersion of resources, ultimately leading to a vicious circle. As a result, solutions aimed at improving the system have to tackle its implementation rather than its constitutional principles. In summer 2023 a debate was started in Italy: some local hospitals in northern Italy suggested offering a paid “fast track” service for less severe injuries, leveraging on private emergency rooms. This would allow for shorter waiting times and less stress for healthcare workers, but there is a very concerning possibility that this could lead the country's healthcare system to become increasingly privatized making the system no longer universal.

Instead, to truly improve the health system's implementation, the priority needs to be on those managing the infrastructures, rather than the medical staff. This could be done by rewarding good performances while identifying and discouraging the bad ones. The Italian government should concentrate funding in struggling regions, while simultaneously monitoring them closely, by setting clear accountabilities for those managing those funds, based on consistent objectives relating to improving services offered in local health infrastructures. The key is that good performances should be rewarded, while those managing poorly should be removed. As an overall policy, all managers should have a limited term in office to avoid affiliations with local crime interested in capturing those very government funds. Such an approach would hopefully generate a virtuous circle with all incentives towards strong health services offered to the local communities.

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