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The Italian NHS, the Public/Private Sector Mix and the Disparities in Access to Healthcare

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Abstract

The Italian healthcare system is based on a combination of the public and private sectors. The public component is represented by the National Health Service (NHS), financed through general taxation. One third of the NHS budget, however, is used to finance private providers.

Albeit the Italian National Health Service resolves to be universalistic and comprehensive, it fails to finance all the healthcare needed by Italians, who bear out-of-pocket costs for part of their pharmaceutical treatments, dental and other specialist care. The private component corresponds to 23% of the total healthcare expenditure, and is largely out-of-pocket.

Healthcare users who have more disposable income can afford additional services to those provided by the NHS, shorten waiting times and have greater freedom of choice of provider. Conversely, individuals on low income must settle for the healthcare services provided by the public system, and in some cases are unable to afford certain types of care.

In addition to disparities related to income, there are also regional disparities: the quality of the services provided indeed varies depending on the region of residence, and the gap is especially large between the central-northern and the southern regions.

Keywords

Italy – Universal Health Care – Low Income Groups – Access to Healthcare – Public/Private Mix – Equity.

The Italian NHS, the Public/Private Sector Mix and the Disparities in Access to Healthcare

1. The 1978 Healthcare Reform and its Guiding Principles

The Italian National Health Service (NHS) was established pursuant to Law No. 833 of 1978. Before that, Italy operated in a typical Bismarckian social health insurance system. To grasp some of the current characteristics of the NHS, it may be worthwhile to briefly review how the system functioned before the 1978 reform.

In the mid-Seventies, there were in Italy over 300 sickness funds (Mapelli, 2012). It was not possible to choose one fund over another: workers were assigned to a given sickness fund solely depending on their occupation, and were required to pay a percentage of their wages to the fund. The amount of the contributions varied depending on the sickness fund. Differences were also to be found in the services offered: there were indeed sickness funds that were more generous than others (Toth, 2015).

Healthcare providers were – for the most part – independent from sickness funds, and were reimbursed by the latter. Hospitals were either public or private, and no coordination existed between the different hospital facilities.

The main limitations of the pre-1978 social health insurance system therefore resided in organisational fragmentation and disparity in treatment. We ought to remember that sickness funds managed to cover – at most – 93% of the population (Taroni, 2011): this means that over three million Italians were left without healthcare coverage. To remedy the problems facing the former social health insurance system, in 1978 the Italian parliament approved Law no. 833, which introduced a radical change in the entire healthcare financing and provision system.

As explicitly stated in the text of Law no. 833, the National Health Service was being set up in order to pursue five key objectives (Toth, 2014a):

1. *universality* of coverage;
2. *comprehensiveness* the services provided;
3. *equity* of financing;
4. predominantly *public ownership* and *unity of administration* of providers;
5. *equality* of treatment for all citizens.

Those listed above represent the guiding principles of the Italian National Health Service. Let us analyse them one by one, trying to understand how they were actually implemented.

2. Universality of Coverage: the Rights of Italians and Foreigners

Let us start from the first objective: universal coverage of the population. A system is considered to be universal if the right to healthcare is guaranteed to the entire population; all citizens are therefore granted the healthcare they need.

One may ask if the Italian NHS is truly universal and one might reply that the Italian healthcare system is not merely universal, but «more than universal»: indeed, it not only provides healthcare to all Italian citizens, but also to foreigners present within the national territory for various reasons. Let us see how, starting from the simplest case, meaning that of citizens from the European Union, who are entitled to the same treatment as Italians (just like Italians are entitled to healthcare in other EU countries).

Some non-EU countries (including Switzerland, Norway, Argentina, Brazil and Australia) have signed specific agreements with the Italian government, under which the citizens of these States – by exhibiting a certificate issued in their country of origin – are entitled to full healthcare provided by the Italian NHS. They, too, are therefore granted coverage.

Finally, there remain the non-EU countries that have not entered into an agreement with Italy with respect to healthcare: the citizens of these countries are nonetheless entitled to public health services in Italy. Non-EU citizens who hold a valid stay permit may apply to their local health agency (ASL – Azienda Sanitaria Locale) and register, at no cost, with the NHS: registering grants them the same treatment as Italian citizens. In Italy, even foreigners without a stay permit are entitled to healthcare. In theory, they are required to pay for the services received. There is, however, the possibility to make a self-certification of poverty, stating that the applicant does not have the means to pay. In doing so, the foreigner without a stay permit is assigned a «STP» code, i.e. a «Temporarily Present Foreigner» code which entitles one not only to free emergency care, but also to most procedures which are considered essential. What the STP code does not grant is the possibility to register with a family doctor, thus excluding access to some primary and preventive healthcare.

All in all, anyone in Italy, may it be for work, study, tourism or other reasons, can access the services provided by the public health service. At least on paper, healthcare in Italy is not denied to anyone.

Having mentioned foreigners residing in Italy, it is worthwhile to provide some data peculiar to the Italian scenario. Foreigners in Italy are slightly over 5 million, corresponding to 8.2% of the resident population (Istat, 2015a). Twenty-nine percent of foreigners come from European Union countries, with a substantial portion from Romania.

The density of foreign residents varies considerably depending on the region. The regions with the highest incidence of foreigners are Emilia-Romagna (12.1% of the population) and Lombardy (11.5%). The density of foreigners is scanty in Sardinia (2.7%) and Apulia (2.9%). In general, in the central and northern regions there is a greater presence of foreigners (they are 10.7% of the population) than in the south (where foreigners are only 3.6%).

3. The Comprehensiveness of the Services Provided: the Essential Levels of Care

The second principle which the National Health Service should abide by regards the comprehensiveness of the services provided. To wit, the public service is required to offer a vast array of healthcare services covering all of the population's healthcare requirements.

One wonders whether the Italian NHS really offers users an all-comprehensive healthcare package.

To answer this question, one can start by saying that in Italy the public health service provides a wide range of health-related services. Indeed, the sphere of competence of the NHS is not limited to the diagnosis and treatment of diseases or illnesses, but spans healthcare from prevention to rehabilitation, from food hygiene to veterinary services, from protection of motherhood to workplace safety, from school health to mental health, from assistance to the handicapped to the fight against drug addiction. And the list could be even longer. The National Health Service would therefore seem to have adopted a comprehensive approach to healthcare.

There are, however, some healthcare services that are not financed by the Italian NHS. Over the past years, it has become obvious that the "give all to all" formula is not financially sustainable. It is unrealistic to think that the NHS, given the resources at its disposal, can guarantee all possible health-related services to the entire population. Hence, a list was made of all the services that public healthcare is committed to ensure, in a uniform manner, to all recipients: these are the so-called «essential levels of care» (LEA – Livelli Essenziali di Assistenza). The LEA therefore constitute the services that Italians are entitled to receive from the NHS free of charge or at the most by making a co-payment.

The Ministry of Health is responsible for defining and updating the LEA list. This list was made for the first time in 2001, and currently includes more than 5,700 procedures (Gasparro, 2009). It being easier to enumerate which services are excluded from the LEA, to avoid misunderstandings the Ministry of Health has prepared two additional lists: one for the *partially* excluded services

(provided only in given circumstances or to particular categories of users), and the other for services that are *totally* excluded from the LEA.

Outpatient physiotherapy and dental care are an example of *partially excluded* services. The NHS is committed to providing dental care only to children up to 14 years of age and to some specific categories of adults in particularly vulnerable health conditions (i.e., those affected by serious illness) or those requiring social aid (social vulnerability criteria are established by the individual regions); for the rest of the population the public service only guarantees emergency coverage (i.e., in the presence of acute infections) and diagnostic examinations in cases of cancer of the oral cavity. In all other cases, dental care is the responsibility of the individual citizen.

Totally excluded from the LEA are: 1) procedures whose direct purpose is not the protection of health (like most cosmetic surgery); 2) treatments whose effectiveness is not considered sufficiently proven from a scientific viewpoint, including non-conventional treatments such as phytotherapy, homeopathy, chiropractic, osteopathy; 3) procedures that provide parity of benefits for the patient but are more expensive than others available.

Let us go back to our question: how generous is the package of services offered by the NHS? Albeit promoting an ample array of procedures, the Italian public health service does not explicitly finance certain types of services. We must therefore conclude that the principle of comprehensiveness of healthcare is not fully satisfied.

4. Equity in Financing and Incidence of Out-of-pocket Spending

A distinctive feature of the NHS – not only in Italy, but in all countries that adopt this model – is that it is financed largely through general taxation. This should be a guarantee of the *equity* of the system. As also affirmed by the World Health Organisation, the more expenses are distributed among citizens proportionally to their individual ability to bear them rather than their health

condition, the more a system is equitable (WHO, 2000). To a large extent, this is what happens in Italy: since the NHS is financed primarily through general taxation, the wealthier citizens end up paying part of the healthcare expenditure incurred for the needier ones; in the same manner, the richer regions contribute to the financing of healthcare services provided by the regions with less fiscal capacity. The NHS financing mechanisms indeed have a marked equalising effect.

There are nonetheless at least two elements that contribute to reducing the overall equity of the financing system: 1) the so-called "tickets", or co-pay fees charged to patients; 2) the significant share of private healthcare spending. The first element is strictly linked with the financing of the public health service; the second one concerns the way the Italian healthcare system is organised as a whole.

Let us start from the first issue, namely the so-called "tickets". These are co-pay fees charged to users for specific procedures. From the early Eighties onwards the Italian governments, depending on budgetary requirements, have introduced – at times only temporarily – healthcare co-pay fees of different kinds: over the years, co-pay fees have been set for specialist visits, diagnostic imaging procedures, access to the emergency ward for minor cases, and drug prescriptions.

In principle, the co-pay fees constitute an element of inequity because they are charged only to the sick (that is, those who require given healthcare services as prescribed by their family doctor) rather than to prevent illness and promote health. According to data provided by the Italian Audit Office (Corte dei Conti, 2015), each year Italians pay out little less than 3 billion Euro as co-pay fees. Revenue from these fees correspond to approximately 2% of the total health expenditure, and 9% of private healthcare costs. Not an excessive amount. The average *per capita* spending for the so-called tickets is about 48 Euro a year.

The figure as such, however, is not very indicative, because a large portion of the population is exempt from the co-pay fee. There are indeed different categories of exemption: the fee is not

charged to low-income citizens, the disabled, and those suffering from given chronic or rare diseases.

Being largely established at the regional level, the co-pay fees are not uniform throughout the national territory. The fee applicable to pharmaceutical prescriptions, for instance, is not charged in some regions, whereas in others it is a fixed fee, and in yet others it varies depending on the family income. So, for the same prescription, one can pay 8 Euro in Tuscany, 4 in Lombardy, 2 in Calabria, one Euro in Trento, and nothing in Friuli-Venezia Giulia, Valle d'Aosta, The Marches and Sardinia.

In addition to co-pay fees, the second element that threatens the equity of the Italian healthcare system is the incidence of private spending. In Italy, public and private healthcare spending equals 77% and 23%, respectively (OECD, 2015). Private expenditure comprises two items: 1) the premiums paid for voluntary health insurance policies; 2) the «out-of-pocket» component, namely all the costs that users have to bear directly (including the co-pay fees). In Italy, private and supplementary health insurance is still little widespread; private spending is therefore more than 80% out-of-pocket (The European House-Ambrosetti, 2015).

As underscored also by the World Health Organisation (WHO, 2000), a high proportion of out-of-pocket private spending is an element of inequity in a healthcare system. This also applies to the Italian system, at least for services that are not provided by the NHS: if each patient pays for himself, no redistributive effect is achieved. As we will see later, the indigent may not be able to afford given treatments, while wealthier citizens can enjoy greater freedom of choice and minimise waiting time.

Let us try to draw a conclusion on the equity of the Italian healthcare system. Before doing so, we have to differentiate between the public service alone, or the healthcare system in its entirety. In the former case, we can conclude that the NHS, despite the co-pay fees, is financed equitably.

Conversely, if we consider the healthcare system as a whole – therefore also including private spending – the equity of the financing system is partly compromised by the high out-of-pocket spending.

5. The public-private mix

The fourth feature of the NHS should have been the *public ownership* of the factors of production and therefore the *unity of administration* of services by the local health agencies (ASL). The objective of the 1978 healthcare reform was indeed to consolidate the management of all healthcare activities, previously divided between a plurality of public and private actors (Toth, 2015), under a single public entity (the NHS).

This objective – expanding the sphere of the public service, thereby reducing the share of private providers – was largely missed: the Italian NHS indeed has the peculiarity of always having been open to cooperation with private practitioners and facilities and is still highly dependent on them.

We can mention some data regarding the incidence of the private healthcare sector. The average yearly expenditure borne by the NHS for each user totals approximately 1,860 Euro (Armeni and Costa, 2015), 65% of which (i.e., little over 1,200 Euro) are used to finance public providers (public hospitals and outpatient clinics, and NHS personnel). The remaining 35% (655 Euro) are instead intended for providers external to the NHS: private clinics and practices, private practitioners, private laboratories, pharmacies. We should also consider that each Italian citizen spends, on the average, an additional 540 Euro per year for healthcare provided by the private sector and paid out of pocket.

Taken alone, the services financed by the NHS are thus provided as to two thirds by public and one third by private providers. But if we consider the entire healthcare provision system, the incidence of private providers is noticeably greater: based on a rough estimate, it appears that healthcare

provision in Italy is 53% public and 47% private.

The Italian NHS is therefore a mixed healthcare system where the public sector works alongside a thriving private sector. The intent of the 1978 healthcare reform to strengthen the public nature of the system and attain the unity of administration has therefore been achieved only in part.

6. Equal Treatment?

The four principles discussed in the foregoing (universality, comprehensiveness, equity and unity of administration) should all contribute to a fifth, fundamental objective of the National Health Service: equal treatment for all users. Let us imagine a healthcare system: 1) that covers the entire population; 2) in which the package of guaranteed care is all-comprehensive, or at least very generous; 3) which is financed equitably, meaning that everyone contributes in proportion to their means; and 4) where healthcare is provided in a uniform manner throughout the country. If all four of these conditions were met, the result would be a perfect equality of treatment for all users. The same healthcare needs would be provided for in the same way for all citizens. There would be no differences between the young and the old, males and females, the poor and the rich, between users living in Tuscany and those residing in Calabria.

In Italy, is it really so? Does the NHS really guarantee equal treatment for all citizens throughout the country? Unfortunately not. The principle of equal treatment is threatened by at least two factors: 1) the deep territorial disparities; 2) the socio-economic differences. These two aspects are analyzed henceforth.

7. Regional Differences and the North-South Gap

Despite the intent of the NHS to provide equal service throughout Italy, in reality the healthcare offered in the different regions is far from homogeneous. Most of the southern regions offer

healthcare services of lower quality than those provided in the central and northern regions. Various indicators can support this statement.

Every year, the Ministry of Health monitors to which extent regions are capable of providing the essential levels of care (LEA). As mentioned above, the latter are the package of healthcare services to which all those residing in Italy are entitled and which should be provided in a uniform manner throughout the country. The monitoring of the Ministry of Health (Ministero della Salute, 2015a) shows that the central and northern regions are capable of providing most LEA appropriately and with reasonable waiting times (the best regions in this respect are Tuscany, Emilia-Romagna and Piedmont). The regions of the South, in contrast, are largely defaulting on this aspect.

The National Agency for Regional Healthcare Services (Agenas – Agenzia Nazionale per i Servizi Sanitari Regionali) publishes a yearly report entitled "*Programma Nazionale Esiti*" (National Outcomes Programme). This report uses quite a number of different indicators, in order to provide a comparative assessment of the individual regional healthcare services in terms of effectiveness, efficiency, safety and quality of the care provided (Agenas, 2015). On the vast majority of the indicators taken into account, the central and northern regions systematically obtain better performances than those reported in the southern regions.

In addition to those mentioned above, there are other reports that try to assess the quality of healthcare services, drawing up a ranking of the different Italian regions (Lenzi et al., 2013; Mes, 2015; Spadonaro and D'Angela, 2016; The European House-Ambrosetti, 2015). Regardless of the methodology used, all the rankings agree that in Italy the higher quality healthcare services are provided in the central and northern regions, whereas those provided in the South are lower, and at times even much lower in quality.

The citizens are well aware of this difference. As results from a recent report on the country's social situation (Censis, 2015), 83% of southern inhabitants consider their regional healthcare service

"inadequate". This percentage is much lower in the northern regions (around 30%).

Not surprisingly, whenever possible those residing in the southern regions choose to be treated in the North, where they think they can get the best care. This is the phenomenon of inter-regional healthcare mobility (Toth, 2014b): each year, about half a million patients are admitted to hospitals in regions other than that of residence (Ministero della Salute, 2015b). Also from this perspective, the North-South imbalance is striking. For each patient residing in the Centre-North admitted to a hospital in the South, there are six patients that travel in the opposite direction, as they seek treatment in hospitals of the Center-North. Lombardy, Emilia-Romagna and Tuscany appear to be the most appealing regions, whereas patients from the other regions show a tendency to “flee” from their place of residence: this is especially the case for Calabria, Campania and Sicily. When considering healthcare mobility, all southern regions show a negative balance, with the sole exception of the small region of Molise.

The regions in the North and Center not only boast a higher quality of services, but also better health conditions of the residents as compared with the South. As many as 70.5% of the residents of the central and northern regions affirm to enjoy good health; this percentage drops to 68.6% in Southern Italy. Among the southern inhabitants, 20.7% claim to suffer from at least two chronic diseases, compared with the 19.3% registered in the central and northern regions (Istat, 2015b).

Even life expectancy evidences a slight North-South gap: in the central and northern regions, life expectancy at birth hits 80.5 for men and 85.3 years for women; in the southern regions, men have a life expectancy of 79.5, and women of 84.1 (Istat, 2015a).

To conclude our overview on regional disparities, it is worth remembering that the southern regions are less economically developed than the rest of the country. In the South, the gross domestic product *per capita* is 17,200 Euro per year, compared with a national average of 26,700 Euro. The unemployment rate in the South is over 20%, compared with the national average of around 12%.

People living in absolute poverty in the central and northern regions are 5.6% of the population, while in the South they reach 9% (Istat, 2015c). The purpose of these considerations is simply to point out that the gap between the North and the South is not limited to healthcare, but these gaps are congruent with disparities in healthcare.

8. Private Spending, the Poor and the Renunciation of Healthcare

As mentioned above, in addition to taxes Italians pay on average every year about 540 Euro for private healthcare.

Those who are not well acquainted with the Italian healthcare system might be puzzled by this aspect: but was there not, in Italy, a public health service that provided all the essential care to all residents? What leads to private healthcare spending, and why is it so high?

The high private healthcare expenditure, especially the out-of-pocket costs, are essentially attributable to four factors: 1) the categories of services that are either not financed, or financed only in part by the NHS; 2) the co-pay fees (the so-called tickets) charged to healthcare users; 3) the long waiting times in public facilities; 4) the choice by the healthcare user of a given physician or private facility under no special agreement with the NHS. Let us proceed in order, analysing these four elements one by one.

The first factor – as already stated – derives from the fact that certain procedures are not included in the essential levels of assistance (LEA) list and are therefore not financed by the NHS. For instance, a share of the pharmaceutical expenditure, as well as a large portion of dental care and physiotherapy, are charged to individual citizens. Treatments that are not classified as LEA greatly affect private spending: indeed, pharmaceuticals and dental care account for 53% and 23%, respectively, of out-of-pocket costs (The European House-Ambrosetti, 2015).

The second factor concerns the co-pay fees charged to patients. As explained earlier, these fees nevertheless have a limited impact on Italian family budgets as they account for only 10% of the private health expenditure, and individuals on low incomes are generally exempt from paying them. The third aspect revolves around the long waiting times in Italian public facilities that lead users to opt for specialist care provided by the private sector. For many hospital admissions, specialist visits and diagnostic tests there are, indeed, long waiting lists. This issue is almost exclusively limited to the public sector, as private facilities usually have much shorter response times. Let us mention some examples to appreciate the extent of the problem: the waiting time for a colonoscopy in public facilities averages 87 days vs 8 days in private centres; for an MRI of the knee in private clinics patients wait an average of 5 days vs 74 days in the public sector; for an eye examination, the public-to-private ratio is 69 days to 6 days (Censis, 2015). Faced with such differences, it is understandable that many patients favour the private sector despite the cost. As also confirmed by a recent survey (Censis, 2014), 48% of those who turned to private providers, thus paying out of pocket, claim they did so because of the long waiting lists of public facilities.

The fourth and final element contributing to private healthcare spending is the desire of patients to seek treatment from a particular specialist. In this respect it should be noted that although Italian healthcare users have the right to choose the outpatient clinic or hospital where they want to receive treatment¹, they cannot choose the individual medical practitioner. That is to say, once a user has booked a procedure at a given hospital department, he/she will be examined by the physicians who are on duty on the day of the appointment. If the patient wants to be sure to see one specialist rather than another, he/she will have to book a private medical visit². Indeed, we ought to point out that all

¹ Italian patients are free to choose among all public facilities and the private facilities which have entered into a special agreement with the NHS.

² Our considerations on the choice of an individual medical practitioner only refer to specialist physicians; Italians are entitled to freely choose their family doctor whose medical examinations are always free of charge.

physicians employed by the NHS are allowed to also practice privately outside of the regular working hours (Toth, 2012). Patients who wish to be treated by a doctor in particular must therefore pay a visit out of their own pockets. It so happens that 87% of gynaecological examinations, and over 50% of dietary, dermatological and eye examination are paid privately (The European House-Ambrosetti, 2015).

8.1. The Renunciation of Healthcare for Economic Reasons

What we have just said about the different drivers of private healthcare spending allows us to put into focus the relationships between the public and private sectors in the Italian healthcare system. The Italian NHS is unable to "give all to all", and some medical services remain the responsibility of the individual citizen.

This means that those who have more disposable income can afford healthcare services in addition to those provided by the NHS, shorten waiting times, and have more freedom in the choice of physician or medical facility. The indigent must instead make do with what the public service offers, run the risk of going into debt to pay for healthcare and, in some cases, they are forced to renounce care.

The data provided by the National Institute of Statistics (Istat, 2015d) bring to surface an alarming phenomenon: 4.3% of the Italian population (2.6 million people) claims to have renounced – over the last year – at least one specialist visit considered necessary for health for purely economic reasons. About 2.3 million people have had to renounce buying medicines, again for economic reasons. We must not neglect to add the 7.7 million Italians who have gotten into debt – asking for bank or family loans – to cover medical expenses (Censis, 2015).

Also in this respect, there is a great disparity between the North and South of the country: 2.8% of the population of the central and northern regions has renounced healthcare for economic reasons, compared to 6.5% in the South (Istat, 2015d).

It is easy to deduce that it is the less wealthy families who renounce healthcare. This conjecture is confirmed by a recent study by the consumers' association Altroconsumo (2015): this research shows that if we consider only households with a monthly income below 1,550 Euro (roughly corresponding to the relative poverty threshold for a family of four), the percentage of those who renounce necessary care exceeds 60%.

8.2. The 'safety net' offered by the third sector

Among those facing serious economic difficulties, a particularly vulnerable group is that of the homeless. It is estimated that in Italy the homeless account for about 0.2% of the resident population (Istat, 2015e): the majority are males and foreign nationals (often without a valid stay permit).

The category of the homeless is especially at risk from a social and healthcare perspective also for merely bureaucratic issues: individuals without a permanent place of residence are not registered with any local health agency (ASL) and therefore cannot select a family doctor. This problem is often bypassed by giving the homeless a fictitious domicile, but this is not always the case. Therefore, many homeless individuals and undocumented foreigners have access to emergency care (especially via the emergency ward), but must renounce a portion of primary care services (Tognetti, 2015).

In any event, the poor, the homeless and other marginalised individuals are not left alone. They are taken care of by third sector organisations, especially religious charities. In Italy, there are thousands of non-profit organisations that assist the poor, homeless and foreigners (with or without

a valid stay permit). It is estimated that several hundred charities also provide medical care, both in outpatient clinics and hospitals (Istat, 2015e). In all larger cities there are outpatient clinics managed by volunteer health workers who provide their services at no cost. They mostly provide dental and dermatological care. There are also non-profit organisations such as the Pharmaceutical Bank (Banco Farmaceutico), that distribute free medicines to disadvantaged groups, or the National Cancer Association (ANT – Associazione Nazionale Tumori), which provide free home care services to cancer patients.

9. Conclusions: the Three Pillars of the Italian Healthcare System

We are finally able to put together all the pieces of the puzzle, giving an overview of the Italian healthcare system in its entirety. We can affirm that it rests on three “pillars”.

The first is, of course, the public pillar, represented by the National Health Service, financed by general taxation. Though it strives to be universalistic and comprehensive, the NHS cannot finance all the healthcare services needed by Italians, who are forced to pay out of pocket a good portion of their pharmaceutical costs, and the expenses incurred for dental care and rehabilitation. There are also differences in the quality of the services provided, especially between the central-northern regions and the South.

The second pillar is the private for-profit sector. Of all health spending, 23% is private: a small share (4.1%) refers to the cost of supplementary insurance policies, while the remaining greater share (18.9%) covers the cost of services not offered by the NHS and therefore sought from private providers (The European House-Ambrosetti, 2015). This is complemented by the fact that the NHS outsources about one third of its volume of activity to private providers. Based on calculations, the overall healthcare provision system is therefore 53% public and 47% private.

The third pillar – smaller than the first two, but no less widespread across the country – is represented by the third sector, composed of a variety of charities and non-profit organisations. Some of these non-profit entities are large and have a national character; others are smaller, local organisations, which rely on few volunteers. These charitable bodies mostly offer their services to individuals, i.e., the poor, the homeless, some categories of patients affected by chronic diseases, and the more vulnerable foreigners, who do not have the financial means to cover their healthcare spending. The private sector, in particular the non-profit organisations, therefore end up filling, at least partially, the deficiencies of the public healthcare service.

In spite of the significant reforms that have been reviewed, the current Italian health care delivery system based on a mix of public and private health services, to the degree that has been noted, disadvantages low-income individuals and poorer regions in achieving the goal of equity in the delivery of quality of health care services. Such poor individuals may be unable to afford timely services and in some instances may be unable to afford needed care.

References

- Agenas (2015). *Programma Nazionale Esiti. Edizione 2015*. Rome: Agenzia Nazionale per i Servizi Sanitari Regionali.
- Altroconsumo (2015). *Sanità cara: gli italiani rinunciano alle cure*. Rome: Altroconsumo. <http://www.altroconsumo.it/salute/diritti-del-malato/news/spese-mediche>. Accessed 8 March 2016.
- Armeni, P., & Costa, F. (2015). La spesa sanitaria: composizione ed evoluzione. In P. Armeni et al. (Eds), *Rapporto OASI 2015* (pp. 143-183). Milan: Egea.
- Censis (2014). *Monitor Biomedico 2014. Informati ed insoddisfatti: verso una sanità minimale?* Rome: Censis.

- Censis (2015). *49° Rapporto annuale sulla situazione sociale del Paese*. Rome: Censis.
- Corte dei Conti (2015). *Rapporto 2015 sul coordinamento della finanza pubblica*. Rome: Corte dei Conti.
- Gasparro, N. (2009). *Diritto sanitario. Legislazione, organizzazione, amministrazione, economia etica e lavoro*. Milan: Gruppo 24 Ore.
- Istat (2015a). *Aspetti della vita quotidiana*. Rome: Istituto Nazionale di Statistica.
- Istat (2015b). *Indicatori demografici. Stime per l'anno 2014*. Rome: Istituto Nazionale di Statistica.
- Istat (2015c). *La povertà in Italia*. Rome: Istituto Nazionale di Statistica.
- Istat (2015d). *Condizioni di salute e ricorso ai servizi sanitari*. Rome: Istituto Nazionale di Statistica.
- Istat (2015e). *Assistenza sanitaria alle persone senza fissa dimora*. Rome: Senato della Repubblica-Commissione Igiene e Sanità.
- Lenzi, J., Rucci, P., Franchino, G., Domenighetti, G., Damiani, G., & Fantini, M.P. (2013). Regional and gender variation in mortality amenable to health care services in Italy. *Journal of Hospital Administration*, 2(3), 28-37.
- Mapelli, V. (2012). *Il sistema sanitario italiano*. Bologna: il Mulino.
- MeS (2015). *Il sistema di valutazione della performance dei sistemi sanitari regionali - Report 2014*. Pisa: Scuola Superiore Sant'Anna-Laboratorio MeS.
- Ministero della Salute (2015a). *Adempimento "mantenimento dell'erogazione dei LEA" attraverso gli indicatori della griglia LEA*. Rome: Ministero della Salute-Direzione Generale della Programmazione Sanitaria.
- Ministero della Salute (2015b). *Rapporto sull'attività di ricovero ospedaliero. Dati SDO*. Rome: Ministero della Salute-Direzione Generale della Programmazione Sanitaria.

- Oecd (2015). *OECD Health Statistics 2015*. Paris: Organisation for Economic Cooperation and Development. <http://www.oecd.org/health/health-data.htm>. Accessed 8 March 2016.
- Spadonaro, F., & D'Angela, D. (2016). *Una misura di performance dei SSR*. Rome: CREA Sanità.
- Taroni, F. (2011), *Politiche sanitarie in Italia. Il futuro del SSN in una prospettiva storica*. Rome: Il Pensiero Scientifico Editore.
- Tognetti, M. (2015). Health Inequalities: Access to Services by Immigrants in Italy. *Open Journal of Social Sciences*, 3, 8-15.
- The European House-Ambrosetti (2015). *Meridiano Sanità. Rapporto 2015*. Milan: The European House-Ambrosetti.
- Toth, F. (2012). *Professione medico*. Bologna: il Mulino.
- Toth, F. (2014a). *La sanità in Italia*. Bologna: il Mulino.
- Toth, F. (2014b). How health care regionalisation in Italy is widening the North–South gap. *Health Economics, Policy and Law*, 9(3), 231-249.
- Toth, F. (2015). Like Surfers Waiting for the Big Wave: Health Care Politics in Italy. *Journal of Health, Politics, Policy and Law*, 40(5), 1001-1021.
- Who (2000). *The World Health Report 2000. Health Systems: Improving Performance*. Geneva: World Health Organisation.