European Commission

Health system performance assessment – Integrated Care Assessment (20157303 HSPA)

Health system fiche | Italy

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Contact: Anne-Marie Yazbeck

E-mail: anne-marie.yazbeck@ec.europa.eu, CHAFEA-HP-TENDER@ec.europa.eu

Directorate-General for Health and Food Safety, Directorate B — Health systems, medical products and innovation

Contact: Filip Domanski

E-mail: filip-michal.domanski@ec.europa.eu

European Commission
B-1049 Brussels

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Italy

Population size (thousands): 60,731 (State of Health in the EU, Italy, 2017)[1]

Population density: 201 inhabitants / km^2 (Eurostat, 2015)[2]

Life expectancy: 82.7 years (State of Health in the EU, Italy, 2017)

Fertility rate: 1.3 births / woman (State of Health in the EU, Italy, 2017)

Mortality rate: 10.4 deaths / 1,000 people (Central Intelligence Agency, 2017)[3]

Total health expenditure: 9.1% (State of Health in the EU, Italy, 2017)

Health financing: government schemes (75.5%), compulsory contributory health insurance schemes and compulsory medical saving accounts (0.3%), voluntary health insurance schemes (1.5%), financing schemes of non-profit institutions serving households (0.4%), enterprise financing schemes (0.3%), household out-of-pocket payments (22%) (Eurostat, 2015)[4]

Top causes of death: circulatory diseases, malignant neoplasms, and ischaemic heart diseases (State of Health in the EU, Italy, 2017)

The Italian healthcare system

The Italian healthcare system, the Servizio Sanitario Nazionale (SSN), provides universal coverage largely free of charge at the point of delivery. It is highly de-centralised system, organised into three levels – national, regional and local. The 19 Italian Regions and two Autonomous Provinces are responsible for the organisation, planning and delivery of health services, through local authorities, whereby the only roles of the national government are to set fundamental principles and objectives of the SSN, determine the core benefit package of health services guaranteed across the country, and allocate national funds to regions (European Commission, 2017h). Local health authorities, Aziende Sanitarie Locali (ASLs), deliver public and community health and primary care directly; secondary and specialist care is delivered either directly or through public hospitals and accredited private providers (European Commission, 2017h). Since 2016, many regions have merged local ASLs to improve the efficiency and quality of care through better integration. The de-centralisation of service organisation, planning and delivery results in different health outcomes across the country (European Commission, 2017h).

The regions and provinces share financing and planning responsibilities with the national government in the State-Regions Conference. Moreover, they are exclusively responsible for delivering public health and healthcare services through their regional health systems. The executive functions of regional governments with regard to healthcare include: (i) drafting the three-year Regional Health Plan; managing ASLs by defining their catchment areas and resource allocation profiles; coordinating health and social care provision through a Standing Conference for Regional Health and Social Care Planning; and defining the authorisation criteria for accrediting private and public care providers (European Commission, 2017h).

Integrated care policies

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[1] https://ec.europa.eu/health/sites/health/files/state/docs/chp_it_english.pdf

[2] Population data, Eurostat http://ec.europa.eu/eurostat/tgm/table.do?tab=table&init=1&language=en&pcode=tps00003&plugin=1

[3] https://www.cia.gov/library/publications/the-world-factbook/fields/2066.html

[4] http://appsso.eurostat.ec.europa.eu/nui/show.do?dataset=hlth_sha11_hf&lang=en

In Italy the universal national health system is organised at three levels: National, regional (responsible for the organisation and governance of the system), and local health units (delivering services) (Calciolari and Ilinca, 2016). Each LHU / ASL is responsible for hospital and community care services, with an institutional orientation toward their coordination. In the last decade, a number of legislative interventions have been implemented in Italy to foster the coordination and integration of health and social services (Calciolari and Ilinca, 2016). National initiatives are complemented by regional ones, notably in Emilia-Romagna, Veneto and Lombardy.

In this context, a wide variety of regional-level integrated care initiatives can be found in Italy, mostly at the intervention and model levels. This wide variety of integrated care initiatives, however, does not apply directly to integrated care policies and strategies. Indeed, only three initiatives at policy or strategy level can be found in Italy, all with a focus on preventive health: 'Regional Plan for prevention of heat related health effects' in the Lazio Region;[5] PDTA (Percorsi Diagnostico Terapeutico Assistenziali) in Brescia (European Commission, 2017a); and 'A sustainable, active, primary prevention strategy for cardiovascular diseases in Italy for Adults older than 50' in Veneto.[6]

Implementation of integrated care in Italy: initiatives in Lombardy

- Telemedicine for real-life integrated care in chronic patients[7] in the Lombardy region;
- Buongiorno CREG,[8] in the cities of Milan, Bergamo, Como and Lecco;
- The 'Walk to School' and 'Walking Groups' programmes[9] in the whole of the Lombardy region;
- The Lombardy Workplace Health Promotion Network,[10] in the Lombardy region;
- PDTA (Percorsi Diagnostico Terapeutico Assistenziali) (European Commission, 2017a), in the city of Brescia.

Assessment of the maturity of the health system

Maturity Model – Italy (Lombardy)	
Readiness to Change to enable more Integrated Care	
Self-assessment	3 – Vision or plan embedded in policy; leaders and champions emerging
Justification	In the Lombardy Region, the last two resolutions on the Chronicity Plan

[5] A detailed description of this integrated care strategy can be found at https://ec.europa.eu/eip/ageing/repository/regional-plan-prevention-heat-related-health-effects-lazio-region_en

[6] A detailed description of this integrated care policy can be found at http://platform.chrodis.eu/clearinghouse?id=1405, under projects 'CUORE' and 'CARDIO 50'

[7] A detailed description of this integrated care intervention can be found at https://ec.europa.eu/eip/ageing/repository/telemedicine-real-life-integrated-care-chronic-patients_en

[8] A detailed description of this integrated care model can be found at http://www.buongiornocreg.it/buongiorno-creg/

[9] A detailed description of these integrated care interventions can be found at https://ec.europa.eu/eip/ageing/repository/%E2%80%9Cwalk-school%E2%80%9D-programme_en and https://ec.europa.eu/eip/ageing/repository/%E2%80%9Cwalking-groups%E2%80%9D-programme_en

[10] A detailed description of this integrated care intervention can be found at https://ec.europa.eu/eip/ageing/repository/lombardy-workplace-health-promotion-network_en

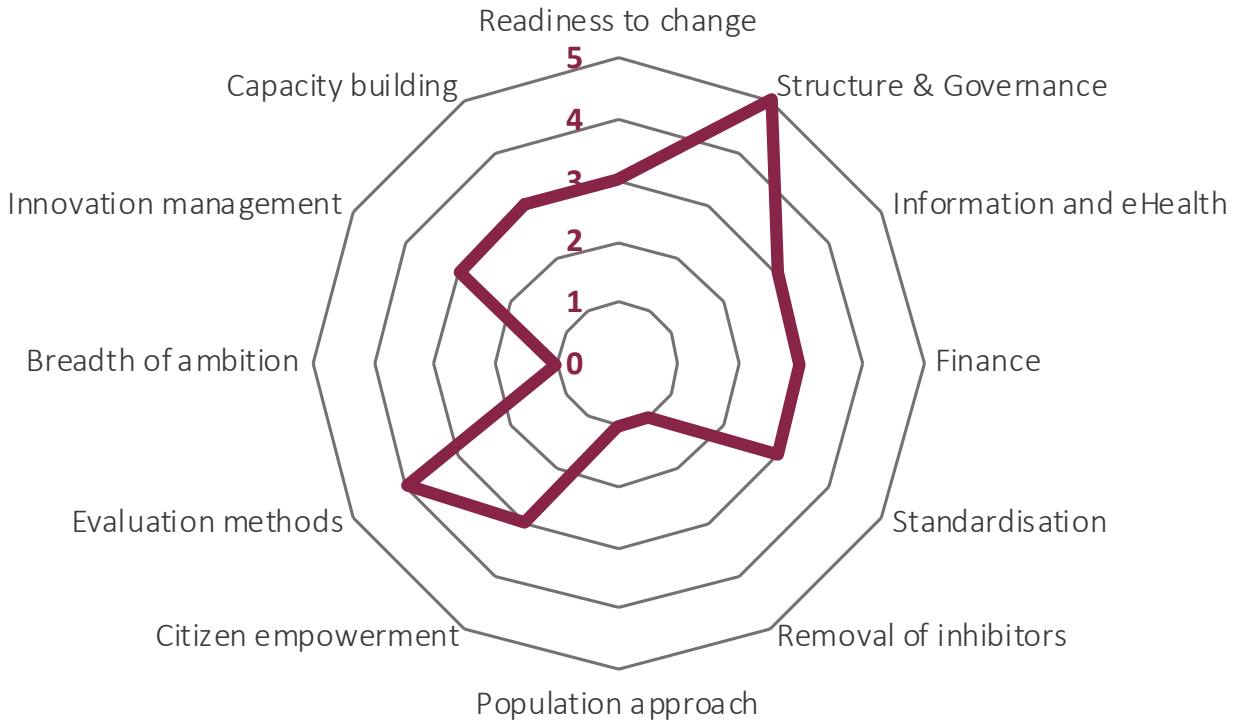
	(X/6164 of 30/01/2017 and X/6551 of 04/05/2017) outline a revolutionary proposal for the chronic patient, regarding the interactions of patients with organisations (hospitals, public or private providers, associations of general practitioners).
Structure & Governance	
Self-assessment	5 – Full, integrated programme established, with funding and a clear mandate
Justification	The resolutions of the Lombardy region explain in full the criteria for organisations' accreditation and the programmes for the different levels of patient chronicity that have been identified by the Region on the basis of the current condition of Lombardy citizens, and the funding for patient management at different levels.
Information & eHealth Services	
Self-assessment	3 – ICT and eHealth services to support integrated care are planned and deployed widely at large scale but use of these services is not mandated
Justification	The situation is not homogeneous. The differences arise from the fact that not all hospitals in the region adhere in the same way to the accreditation scheme set out by the regional government in 2006 and updated in 2010. While some hospitals have developed full-fledged call centres and electronic patient records, other hospitals only provide a simple telephone service. The accreditation system only requests a minimum dataset describing what has been done to receive the grant, but the requirements of telemedicine and tele-surveillance are not clearly stipulated.
Finance & Funding	
Self-assessment	3 – Regional/national (or European) funding or PPP for scaling up is available
Justification	Providers participating in the NRS, Nuove Reti Sanitari (new healthcare networks) receive a reimbursement for every patient of EUR720 every six months for high-intensity patients, and around half that amount for low-intensity patients. In addition to these networks, there are other projects run by the European Commission, the Region and the national government providing funding.
Standardisation & Simplification	
Self-assessment	3 – A recommended set of agreed information standards at regional/national level; some shared procurements of new systems at regional/national level; some large-scale consolidations of ICT underway
Justification	The situation is not homogeneous: stakeholders chose the answer 3 for the 'NRS, Nuove Reti Sanitari' (new healthcare networks) and for the CREGs in the Lombardy Region. Regarding the 'FSE, fascicolo sanitario elettronico' electronic health record, the answer 2 would be the correct one.
Removal of Inhibitors	
Self-assessment	1 – Awareness of inhibitors but no systematic approach to their management is in place
Justification	First, to ensure the reduction of barriers to this process, university training should be adapted to this end. There is strong resistance to change especially in the medical profession.
Population Approach	
Self-assessment	1 – A population risk approach is applied to integrated care services but not yet systematically or to the full population
Justification	Regional laws exist. The problem is that health professionals are unlikely to implement risk stratification and propose an integrated approach, but instead direct the patients to private visits.
Citizen Empowerment	
Self-assessment	3 – Citizens are consulted on integrated care services and have access to health information and health data

Justification	There is a strong focus on patient engagement during and following up hospitalisation, to empower them to manage their conditions (e.g. COPD or heart failure). Patients can discuss their situation with professionals using videoconferencing. However, the service is not provided outside the programme and not even all patients suffering from the above conditions are covered by the service. From January 2018, a new law in the Region will make patient engagement of chronic patients mandatory.
Evaluation Methods	
Self-assessment	4 – Most integrated care initiatives are subject to a systematic approach to evaluation; published results
Justification	All the data related to the programme is compiled (e.g. results of echocardiograms, spirometries, as well as information on severity of the patient, telephone calls, adherence to treatment, dosage, secondary effects, examinations, hospital visits). The data collected for the service, as well as for ambulatory service, is analysed and evaluated, including cost-benefit.
Breadth of Ambition	
Self-assessment	1 – The citizen or their family may need to act as the integrator of service in an unpredictable way
Justification	Reality is very uneven. There are some very positive experiences of integration between primary and secondary care, but very often the citizen or his/her family may need to act as an integrator of service in an unpredictable way, especially because of limited information sharing and integration in social services.
Innovation Management	
Self-assessment	3 – Formalised innovation management process is planned and partially implemented
Justification	More needs to be done in terms of innovation management to get the personnel in the hospital to accept the changes to the management practice for the conditions covered by the programme, especially around personal health records, videoconferencing, and the new approach taken by the nurses. Nurses were not previously accustomed to being case managers.
Capacity Building	
Self-assessment	3 – Systematic learning about integrated care and change management is in place but not widely implemented
Justification	Health professionals (doctors, nurses, therapists) are not trained in these new ways of working and of managing patients and need more support to be trained in management of chronic care; for example, in the use of telemonitoring or the fact that now the patient's care is 'shared' with other specialists.

The Lombardy region has made great progress over the past five years in developing policies that are specifically aimed at integrated care implementation. There is a political consensus around integrated care programmes in the region, as highlighted in the Structure and Governance assessment dimension, which was rated as 5. This political consensus in the region also provides the platform for enabling the implementation of integrated care across other dimensions, such as financing of programmes, evaluation methods, and development of eHealth initiatives.

The remaining obstacles to the implementation of integrated care in Lombardy relate to the heterogeneity in integrated care practices across different providers in the region. Moreover, there is considerable resistance from medical doctors with regard to adapting elements of their profession in order to effectively deliver integrated care, which remains one of the most challenging inhibitors of integrated care implementation in the region.

Italy | Lombardy



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