Executive summary

This report reviews the quality of health care in Italy. It begins by providing an overview of policies and practices aimed at supporting quality of care (Chapter 1). The report then focuses on three areas that are of particular importance for Italy's health system at present: the role of primary care (Chapter 2), improving the training of the health care workforce (Chapter 3) and improving systems for monitoring and improving the quality of care in a regionalised health system (Chapter 4). In examining these areas, this report examines the quality of care currently provided, seeks to highlight best practices, and provides a series of targeted assessments and recommendations for further improvements to quality of care.

The Italian *Servizio Sanitario Nazionale* (or National Health Service, SSN) was established in 1978 to grant universal access to a uniform level of care throughout Italy, free at the point of use, financed by general taxation. The Ministry of Health fulfils the function of the overall steward of the health system and defines the *livelli essenziali di assistenza* (or essential level of care, LEA) to be delivered across the country. Beyond this, Italy's 21 regions and autonomous provinces (R&AP) are responsible for the actual planning and delivery of services. Articulation between central government's steering role and regional government's delivery role is expressed in the *Patto per la salute* (Pact for health), a three-year plan that is agreed jointly between central and regional governments.

In recent years, however, many regional health budgets ran into substantial deficit, leading to central authorities to imposing *Piani di Rientro* (Recovery Plans) on ten of them, of which eight are on-going. These plans signalled the introduction of a dominant new player in national health care policy – the Ministry of Finance. Although the Ministry of Health maintained its role in ensuring that essential levels of care were provided at regional level, the Ministry of Finance became actively involved in designing and approving health care delivery. To a large extent, then, the focus of this abrupt resumption of central control was financial and quality of care risked becoming secondary.

Italy is facing, therefore, two major challenges. The first is to ensure that ongoing efforts to contain health system spending do not subsume health care quality as a fundamental governance principle. The second must be to support those R&AP with weaker infrastructure and capacity to deliver care of equal quality to the best performing areas. A more consolidated and ambitious approach to quality monitoring and improvement at a system level is needed. Over the past decade, a range of quality-related activities have been developed, with varying depth and scope, and with little co-ordination across these approaches by central agencies. Different accreditation models have been developed, for example, and performance management tools used by R&AP are diverse, making comparison against national standards difficult and limiting the accountability of providers toward users. These divergent approaches must now be consolidated. At the same time, other key quality strategies are poorly developed or absent. Requirements for recertification and for professional development are not established and payment systems do not systematically reward improvements in clinical care and patient outcomes. These deficiencies must be addressed to ensure that Italian health care quality architecture is comparable to the best seen in OECD health systems.

Primary health care in Italy performs well – rates of avoidable hospitalisation are amongst the lowest in the OECD. Italy faces, however, a growing ageing population and a rising burden of chronic conditions, which are likely to result in higher health care costs and place further pressures on the primary care sector. Whilst the management of chronic conditions requires a co-ordinated patient-centered response from a wide range of health professionals, the Italian health care system has traditionally been characterised by a high level of fragmentation and a lack of care co-ordination. Italy has made considerable efforts to experiment with new models of community care services (such as community care networks and community hospitals) that aim at achieving greater co-ordination and integration of care. Although the expansion of community care services is an appropriate policy response to meet the growing demand for health care, they are still unevenly distributed across Italian regions. Greater guidance and support from national authorities is needed to ensure a more consistent approach. At the same time, there are other shortcomings in Italy's primary care sector that require attention to guarantee high quality primary care. Efforts are needed to increase transparency, develop performance measurement and strengthen accountability in the sector. The development of a set of standards around the processes and outcomes of primary care, the setting-up of smarter payment system, and increase the involvement of primary care physicians in preventive activities are options that Italy should consider pursuing if it is to meet the challenge of an increasing burden of long-term conditions.

The ***medical workforce*** delivers, in general, care of a high quality. Looking to secure this high performance for the decades to come, and push back against any regional disparities in quality and outcomes, Italy has also been taking important steps towards ensuring nationally cohesive workforce training programmes. However, going forward, good medical education and nationally standardised continuing medical education may not be enough to secure a high quality, high performing medical workforce. There is scope to look to the scientific literature, and the experiences of other OECD countries, to try to maximise the impact of medical education, from the undergraduate level and beyond. This chapter suggests ways that Italy could promote workforce quality when selecting future medical professionals prior to undergraduate education, and ways to improve the quality of undergraduate medical teaching. There are also opportunities to maximise the positive impact of Italy's existing continuing medical education programme, as well as a need for Italy to eventually develop more modern models of workforce quality insurance, including a move to continuing professional development, and using data to encourage health professionals to reflect on their practice.

Italy's ***regions and autonomous provinces*** (R&AP) differ substantially. GDP per capita varies more than two-fold and unemployment rates more than four-fold. Italian health care services, being fully regionalised, reflect this heterogeneity. Whilst it cannot be said that any one region delivers consistently "poor" health care, it is clear that some regions struggle to provide the same quality as others. Large numbers of patients move between regions in search of health care, with northern R&AP being net importers. Italy has established a number of mechanisms to try and ensure an evenness of approach to quality measurement and improvement. These include activities to ensure dialogue between national and regional authorities as well as professionally led initiatives to measure quality consistently. While it would be unrealistic and undesirable to seek complete homogeneity in how regional health systems are configured, more can be done to achieve a more even approach to quality measurement and improvement across R&AP.

Key priorities are to develop a more consistent approach to using information to manage performance and strengthen local accountability. Ensuring that regional resource allocation has a focus on quality, and is linked to incentives for quality improvement, will also be important. Actions that strengthen the regional approach to health care governance and delivery in Italy are also needed. Developing the responsibilities and capacities of the national authorities whose role is to support the R&AP should continue. Reframing governance as a whole, such that quality improvement is emphasised as much as financial control, is also necessary.