Good Governance Institute

Good Governance in European Healthcare: Italy

In collaboration with Piera Poletti, Director, CEREF Centro Ricerca e Formazione Padova, Italy

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GGI exists to help create a fairer, better world. Our part in this is to support those who run the organisations that will affect how humanity uses resources, cares for the sick, educates future generations, develops our professionals, creates wealth, nurtures sporting excellence, inspires through the arts, communicates the news, ensures all have decent homes, transports people and goods, administers justice and the law, designs and introduces new technologies, produces and sells the food we eat – in short, all aspects of being human.

We work to make sure that organisations are run by the most talented, skilled and ethical leaders possible and work to fair systems that consider all, use evidence, are guided by ethics and thereby take the best decisions. Good governance of all organisations, from the smallest charity to the greatest public institution, benefits society as a whole. It enables organisations to play their part in building a sustainable, better future for all.

Good Governance in European Healthcare: Italy

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This report is part of a growing series of reports developed by the Good Governance Institute (GGI) that consider issues contributing to the better governance of healthcare organisations. GGI is an independent organisation working to improve governance through both direct work with individual boards and governing bodies, and by promoting better practice through broader, national programmes and studies. We run board development programmes, undertake governance reviews and support organisations develop towards authorisation.

Other recent GGI reports and board development tools have considered board assurance, patient safety, clinical audit, quality and safety of telehealth services for people with long-term conditions, diabetes services, better practice in treatment decision-making, productive diversity, the board assurance framework, integrated governance, governance between organisations and of course good governance.

GGI is committed to develop and promote the Good Governance Body of Knowledge

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Background to the piece of work

This short technical briefing paper is one of a series that GGI has produced, exploring good governance in European countries. Throughout these papers, we have been exploring:

- How healthcare organisations are governed
- What are the principles and national drivers of good governance?
- What are the pros and cons of the current governance structure?
- What are the future challenges for governance?
- How will governance adapt to the changing healthcare environment?

These essays have been produced based on GGI's own experience working with healthcare organisations, a review of existing literature, and from our conversations with key contacts.

We have become aware that governance has been developed to varying degrees between different countries, and we feel that some countries have a lot of learning and experience to share, and we wish to support and facilitate this transfer of knowledge.

Next, we wish to further explore these complexities both in the countries already reviewed, as well as, potentially, a wider group of countries, including those in Eastern Europe and Scandinavia. We will be creating a 'task and finish group' in order to collaborate with representatives from each country and work together to create an in-depth, research led paper on good governance in European healthcare. We plan to launch this at the EHMA Annual Conference in 2018.

Introduction

Due to the regionalised nature of the healthcare system in Italy, healthcare governance is relatively complex, and models can vary from region to region. However, there are some key characteristics and common challenges in healthcare governance across the country.

Background to the healthcare system

Following a system similar to the Beveridge model, originating in the UK, Italy has a national health service, known as Servizio Sanitario Nazionale (SSN), which, like the UK NHS, provides universal coverage, mostly free of charge at the point of delivery. However, the Italian SSN is organised into three levels: national, regional and local. The roles and responsibilities of each of the three levels are summarised below:

- National level:
    - The Ministry of Health is responsible for ensuring that all citizens have the right to health, as defined in article 32 of the constitution, as well as for guaranteeing equity, quality and efficiency of the service, and for promoting innovation and improvement. It also has a monitoring role
    - Central government also has responsibility for setting *livelli essenziali di assistenza sanitaria* (LEA), the 'minimum level of health assistance' that all regions are required to deliver to all citizens
    - Health care resources are allocated by the central government to regional governments, according to 'Health Pacts' agreed between the two levels of government
- Regional level:
    - The 20 Regional Authorities and two autonomous Provinces of Trento and Bolzano have responsibility for the governance and organisation of all matters related to the delivery of the health service and health care
    - The regional level has legislative, administrative, planning, financing and monitoring functions, which are based on three-year regional health plans
    - Other responsibilities of regional authorities include allocating resources to the local level; appointing the general managers of local level organisations; defining the regulatory framework; and defining the technical and management guidelines for the delivery of services
    - The level of regional involvement in the direct management of hospitals varies enormously, as regions set health policy independently: for example, the number of hospital beds directly managed by the regional level fluctuates from over 60% to less than 1%
    - Outside of the *livelli essenziali di assistenza sanitaria*, regions have the freedom to decide what additional services to orvide
- Local level:
    - At local level, healthcare services are delivered through *Aziende Sanitarie Locali* (ASLs – 'Local Health Enterprises) and *Aziende Ospedaliere* (AOs – 'Public Hospital Enterprises)
    - Italy has a network of 184 ASLs, which are 'public entities with an autonomous entrepreneurship role for their organisation, administration, accountancy, and management'
    - Services can be delivered through accredited public (AOs and hospitals directly administered by the ASL) or private providers
    - General practitioners have a 'gatekeeping function', whilst specialist care is delivered either directly by ASLs, or by accredited public or private facilities with whom ASLs have agreements or contracts.[1]

Current governance structures

While there has been a trend towards autonomous, region-based governance of healthcare since the 1990s, the highly decentralised nature of healthcare governance in Italy was fully established in 2001. Reforms to Chapter V of the Italian constitution generated a 'decisive' shift towards greater federalisation, as they stated that the Italian state was 'composed of' regions, provinces and communes, rather than 'divided' into them, an important distinction. As part of this, the regions and autonomous provinces were granted concurrent legislative powers alongside the central government, including regarding the organisation and delivery of healthcare.[2] Representatives from the regions have regular meetings in Rome to share views on the most important decision-making.

> 'The Ministry of Health plans and evaluates… every decision is negotiated with the regions.'
>
> Piera Poletti

At regional level, the health service is led by the regional government. At this level, the head is the Governor of the region, while there is also a CEO appointed. As mentioned above, the regional governor is also responsible for appointing the 'general manager' of local level organisations. In addition to this, every trust or hospital has a board, with the following roles being commonplace:

- CEO
- Medical Director
- Administrative Director
- Social Director (in regions which feature an integrated health and social care system)
- Nursing Director

The aforementioned general manager of ASLs is appointed by the regional health department based on professional experience and qualifications. They are appointed for five year periods, with their results reviewed every 18 months. General managers' contracts include targets to be met within this five-year period, however, general managers may be dismissed if mid-term targets are not met. That said, the approach to targets and assessments is very variable from region to region.[3]

While regional governments are responsible for the monitoring of health care services and are able to independently establish the regulatory framework, some autonomy is still encouraged at local level, whilst general managers of ASLs and AOs are supported by the regional level in their strategic planning.[4]

> "Legislation provides the general manager with substantial autonomy in managing human, financial and technological resources. This autonomy is expressed in a three-year strategic plan in which the general manager defines the organisation's mission and goals. The general manager selects a financial manager and a medical director for support.'
>
> OECD, Health Systems Review: Italy, 2009

However, there is still considerable variation among regions regarding the autonomy of local organisations. Research inovolving general managers from different regions has shown that, for example, organisations in Emilia Romagna have considerable autonomy, both in day-to-day management and the setting of strategies and targets. On the other hand, Piedmont and Lombardy both have very little strategic autonomy. This seems unusual in Lombardy, which out of all the regions, 'stands out for having promoted the governance model closest to the quasi-markets, in terms of competitive incentives, public-private equalisation and purchaser/provider split but, probably because of this policy choice, it has paradoxically reduced the management role to avoid a situation that could be out of control.'[5]

With the introduction of some private providers and competitive mechanisms into the Italian healthcare system, hospitals have become more 'demand driven'. As a result, while in the past management and governance of healthcare organisations was mainly concerned with the structures and infrastructures of the organisation, and ensuring compliance with regulation, 'now attention is concentrated above all on the health service demands made by patients and on the necessities of the other stakeholders.'[6]

Meanwhile, there is also great variation between regions on the extent to which clinical staff are involved in strategy and decision making, although the most prevalent structure is to have medical staff involved in an organisation's decision making processes. Sometimes, however, there is not a policy of transparency of information, resulting in a lack of sharing of vision, strategy, and organisational objectives.[7]

However, despite the autonomous status that both regional health services and local health care delivery organisations enjoy, there are signs that the national government is beginning to take back some of this freedom in governance. An example of this is accreditation, which is mandatory in Italy, and provided at a regional level. In the past, each region used to have its own model for this (for example, the Canadian model, Joint Commission International, among others). Now, however, common criteria for accreditation has been established nationally, with which all regions have to comply. This may be in response to growing concerns that the decentralised governance structure in Italy is leading to unwarranted variations in the quality of governance in different regions.

There is also evidence that a similar change in the balance of governance is taking place regarding the financial management of trusts and hospitals. According to OECD, despite the granting of autonomy to the regions and autonomous provinces, 'it is widely acknowledged that the necessary information infrastructure and technical capacity to adequately discharge these responsibilities was lacking.' As a result, many regional health budgets ran into deficit relatively quickly, requiring central authorities to impose Piani di Rientro, financial recovery plans, on eight of them (out of twenty). Consequently, the Ministry of Finance, in addition to the Ministry of Health, has become actively involved in the delivery of Italian healthcare.[8]

'At national level a public agency has a very important role: Agenzia Nazionale per i Servizi Sanitari Regionali (AGENAS)'

Piera Poletti

A further national player in healthcare governance is AGENAS, which has a predominantly 'supportive' role in the governance structure. Accountable both to the regions and the central Ministry of Health, AGENAS is a body of the SSN with a responsibility to assist in national and regional health planning, for example through promoting quality and safety of care and spreading learning around innovation and new models of care.[9]

Meanwhile, as, due to the decentralisation of healthcare governance, quality monitoring and improvement frameworks have varied from region to region, this has led to the establishment, as part of the Patto per la Salute (three year healthcare plan) for 2010-12, of the National Programme for the Promotion of Quality in the Permanent National Health Service (PROQUAL). The programme's aim is to promote clinical governance more thoroughly and consistently across Italy in order to drive for continuous quality improvement in healthcare.

PROQUAL 'plays a central role in quality strategies by targeting five key areas: patient involvement, appropriateness, efficacy, safety, and integrated clinical governance.' It has the following specific objectives:

- Promote involvement of citizens and patients at national, regional and professional levels
- Promote the effective provision and appropriateness of healthcare services
- Promote patient safety and clinical risk management through improved processes, developing and managing an integrated system of services according to a model of clinical governance
- Promote patient safety
- Implement training programmes in clinical governance, clinical audit, and methods of analysis of adverse events.[10]

The increasing role that the national authorities are assuming in quality governance in Italy is related to several governance challenges that the regions and autonomous provinces have faced in recent years.

Pros and cons of the governance structure

Whilst the decentralised system may bring some benefits, there are also governance challenges related to the governance system in Italian healthcare.

Firstly, the benefits: the decentralisation of the system means that the governors of health in regions, and individual local organisations, are able to design and deliver care so that it best meets the needs of individual populations. There may also be a greater emphasis on patient engagement and involvement, and there is evidence, as mentioned above, that stakeholders are key players in Italian healthcare governance. In addition, the fact that those in charge of ASLs and AOs are appointed with professional experience and skills being the most important factor is likely to ensure that those governing healthcare organisations have the appropriate knowledge and ability. This is in contrast with a key governance issue in the Netherlands health care sector, to be discussed later in this paper.

However, as already mentioned, decentralisation has also led to significant unwarranted variation across areas, in terms of the services provided and their quality, and the governance and organisation of health systems. Indeed, hospitals in the north often have to treat patients from the south of the country, who prefer to travel to the higher quality services elsewhere rather than be treated in their local area, while the northern regions must cover the costs of this. As we have seen, some regions have encountered challenges in managing their budgets and have entered into deficit. Meanwhile, quality governance is also inconsistent, with some regions having a well-developed approach, and others paying insufficient attention to it.[11] At the same time, regulation is regional rather than national, meaning that in those regions where governance is less well developed in ASLs and AOs, there may not be sufficient mechanisms to recognise this and ensure that improvement is undertaken.

Related to this issue, the financial challenges faced by regional authorities and individual healthcare organisations, with much effort put into attempts to control healthcare spending, have resulted in financial control being perhaps the primary governance principle, with a risk of healthcare quality being delegated as a less significant matter. The OECD has called on the Italian healthcare system to strengthen the regional approach to healthcare governance, in order to alleviate the regional differences, whilst also 'reframing governance as a whole, such that quality improvement is emphasised as much as financial control… the scaling back of performance management capacity in some regions and autonomous provinces as a result of the crisis underscores the timeliness of this argument.'[12]

This, however, comes in the context of a lack of a sufficient, and consistent, nationwide approach to quality improvement mechanisms.

> 'Implementing decentralized structures in the health sector represents an arena of struggle between a local level wanting more autonomy and power and a central level… not providing adequate coordination'
>
> European Observatory on Health Systems and Policies,
> Decentralisation in Healthcare: Strategies and Outcomes, Open University Press

That said, clear steps are being taken to improve the awareness, and implementation of, effective quality governance and clinical governance across Italian healthcare organisations, as seen with the importance of AGENAS and establishment of PROQUAL, which should help to deliver the appropriate support at local and regional level.

The financial challenges experienced by Italian healthcare organisations have also led to an increasing trend towards mergers, with regions reducing the numbers of ASLs as part of cost-cutting measures. For example, at the beginning of 2017, the number of ASLs in the Veneto region has dropped to ten, whilst there is only one covering Sardinia. Whilst mergers and acquisitions themselves bring about governance challenges relating to merging boards and culture change, for example, questions have also been raised about the effectiveness of such measures.

the governance structure. Accountable both to the regions and the central Ministry of Health, AGENAS is a body of the SSN with a responsibility to assist in national and regional health planning, for example through promoting quality

'Strategic boards and managements are focused on merging…a few years ago there were mergers which were not completely implemented yet, now more mergers… it is much effort [but] for how much cost decrease?'

Piera Poletti

Conclusion: how future proof is the current system?

Although the increased national involvement in healthcare governance, particularly regarding quality governance and clinical governance, is likely to improve the effectiveness of governance across Italy and ensure that it is more consistent, governance challenges will remain that all levels of governance will need to be alive to. The OECD has written:

'Although there may be sound reasons for adoption of a more prominent role by central authorities, it may lead to tensions and inefficiencies in governance, particularly in multi-level governance systems such as Italy's."[13]

To mitigate these potential challenges, healthcare organisations will need to ensure that accountabilities, processes, and roles and responsibilities are clear and well-defined.

While this shift is taking place, the current lack of a national regulatory framework, with regions and autonomous provinces having the independence to define regulation and monitoring of healthcare services by themselves, may not be sufficient to ensure that this runs as smoothly as possible, and may hinder attempts to bring greater consistency to healthcare services across the country.

Progress in this regard will require national and cross-regional approaches, however, to date there seems to have been little appetite for working and collaboration between regions. Further strengthening governance arrangements for cross-regional collaboration may be a step in the right direction for governance of healthcare in Italy.[14]

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