2013 Italy Study Tour

The Global Health Perspective

Author: Joanne Greco, Vice President of Infrastructure
Closing the Gap Healthcare Group

Nov. 2013
The Organization of Healthcare in Italy

Central Government
The National Health Service (SSN = Servizio Sanitario Nazionale) which is organized under the Ministry of Health is responsible for national health planning, including general aims and annual financial resources to be spent on health, and rules the commercialization of drugs and medical equipment in accordance with the European Union regulations. The Ministry of Health is also responsible for monitoring and taking measures to improve the health status of the population and to ensure a uniform level of service for care and assistance to the population of Italy.

The Ministry of Health allocates funds to 20 different regions in Italy. It sets the general objectives and principles of the healthcare system that need to be met by these regions, including the definition of the basic benefits package. Principles of universal coverage, dignity, equity, effectiveness and cost-effectiveness are enforced at this level. 6

Regional Government
Regional governments define a regional plan in accordance with central government guidelines. The regional level (Regional Health Authorities – RHA) is where regions receive funding and are responsible for allocation of funds and delivery of healthcare at a regional level. Regional authorities have a considerable degree of power to legislate on a regional basis and allocate funds from the central government.

They are also responsible for any deficit that might occur from their own resources. The regions organize services that are designed to meet the needs of their specific region, define ways to allocate funds to all Local Health Authorities (LHA) within their territories, monitor LHAs health services and activities and assess their performance. Regions are also responsible for selecting and accrediting public and private health service providers and issuing regional guidelines. 6

Local Government
The local level (Local Health Authorities) consists of local health units which are managed by the CEO that is appointed by the region and are responsible for the delivery of primary care, hospital care, public health, occupational health and social healthcare (The Commonwealth Fund, 2012). LHAs can operate simultaneously as a payer and a supplier of services with public hospital management and operation. To prevent a conflict, all providers regardless of whether they are private or public, are expected to compete on cost and quality for services.

Each LHA has three main facilities: one department for preventative health care, one or more directly managing hospitals, and one or more districts. Through the districts, the LHAs provide primary care, ambulatory care, home care, occupational health services, health education, disease prevention, pharmacies, family planning, child health and information services. 6
**Population & Demographics**

Italy’s population is 61,377,635 and consists of one of the oldest populations in the world, second only to Japan. It is expected that by 2100 the average life expectancy will grow to 82 years and by the end of the century will increase further to 89 years in developed countries like Italy. 14

According to the United Nations World Populations for 2012, Europe’s population is projected to decline by 14% and fertility in Europe as a whole is projected to increase from 1.5 children per woman in 2005-2010 to 1.8 in 2045-2050 and to 1.9 by 2095-2100. Despite this increase, childbearing is expected to remain below the replacement level, leading a decline in population size.

As fertility declines and life expectancy rises, the proportion of the population above a certain age increases. This phenomenon, known as population ageing, is occurring throughout the world. By 2013, it is expected that the proportion of older persons in the more developed regions will surpass that of children (23 versus 16 per cent), and in 2050, the proportion of older persons is expected to be about double that of children (32 versus 16 per cent). 14

Italy consists of 20 regions with a North and South division. The Northern regions are one of the most advanced industrially in the world. Conversely, the southern regions (Campania, Molise, Basilicata, Calabria, Puglia, Sicily, and Sardinia) are one of the most economically depressed areas in Europe. 8

Italy and Canada have primarily publicly-funded health care systems that are rooted in similar values of universality and comprehensiveness – providing all citizens with access to health care regardless of age, means or health care needs. However, other than the similar values noted, there are distinct differences in the healthcare system in Italy resulting in a tiered system – public and private.

**Healthcare Finance and Expenditures**

**Healthcare System Financing**

The Italian national healthcare system (Servizio Sanitario Nationale – SSN) was founded in 1978 and is based on the Beveridge Model. It supports universal coverage for all, financial solidarity, and freedom of choice for either public or private hospital care. The national SSN defines a minimum statutory benefits package to be offered to all residents of all 20 regions: the “essential levels of care” (livelli essenziali di assistenza – LEAs). Each region enjoys significant autonomy in determining the macro structure of their healthcare systems. Local health units are managed by a CEO appointed by the region and are responsible for the delivery of primary care, hospital care, public health, occupational health and social health care. 13

**Healthcare Benefits**

The SSN covers all citizens, legal foreign residents and, since 1998, illegal immigrants for basic services. Services covered (positive lists) must meet the criteria of medical necessity, effectiveness, human dignity, appropriateness, and efficiency in delivery. Services not covered (negative lists) include ineffective services; services that are covered only on a case-by-case basis (i.e. Laser eye surgery); and inpatient services where admission is not appropriate (i.e. Cataract surgery).

Prescription drugs are divided into three tiers according to their clinical effectiveness and cost-effectiveness. The SSN covers the first tier in all cases, second tier in hospitals only, and does not cover the third tier at all. Dental care is not covered by the SSN. In Italy, users pay out-of-pocket100% of all dental care unless they have additional insurance coverage. 13
Co-Payments & Insurance
Primary and inpatient care are paid by SSN. Procedures and visits must be prescribed by a GP or specialist for SSN funded access to care. To address rising public debt, various co-payments were introduced as of 1993. Patients have to pay a €37.15 co-payment per prescription for care (i.e. diagnostic procedures, specialist visits and pharmaceuticals) and a €25 co-payment for unwarranted (deemed to be noncritical or non-urgent) use of emergency services. A second type of out-of-pocket payment is direct payment by users to purchase private healthcare services, over-the-counter drugs and dental care. Cost-sharing and direct payments by users represent 17.8% of total health spending and 83% of all private health care expenditure. Both public and private health care providers funded by the SSN, are not permitted to charge above the predetermined fee schedules. Cost-sharing exemptions exist for various groups, including those less than 14 years of age, elderly people over 65 years of age who pay over €129 out-of-pocket payments per year. These individuals are eligible for a tax credit of approximately one-fifth of their spending.

Due to the near universal coverage, voluntary health insurance (VHI) does not play a significant role in funding healthcare in Italy. Spending on VHI, as a total expenditure is less than 5%. When purchased, complementary insurance policies cover co-payments, non-reimbursed services, dental care and hospital per diems for private rooms while supplementary insurance allows patients to access choice of provider and have increased access to private providers.

Healthcare Spending
In Italy 77.8% of health spending was funded by public sources in 2011, above the average of 72.2% in other OECD countries. In 2011, the share of public spending was well over 80% (OECD, 2012). Total health spending accounted for 9.2% of GDP in Italy in 2011 which is below the OECD average of 9.3%. In addition, Italy ranks below the OECD average in terms of health spending per captia, with spending of $3012 USD in 2011, compared to the OECD average of $3339 USD.

Overall healthcare expenditures in Italy comprise of 48% public in-patient care, 10% private in-patient, 11% pharmaceuticals, 9% other facilities, 13% prevention, 4% rehabilitation, and 5% administration. Between 1998 and 2008, Italy closed 40.3% of inpatient acute care hospital beds in order to manage overspending in healthcare.
Healthcare Delivery System

Primary Care
Primary care is provided by General Practitioners (GPs) who are self-employed and independent physicians working under a government contract. They are paid a combination of capitation (based on the number of registered patients) and fee-for-service (sometimes related to performance). GPs are regulated under both national and regional contracts. Most GPs in Italy function in solo practices, however due to incentives by government to share clinic premises with their colleagues, group practices are becoming more common.

GPs function as the gatekeepers and are the only way for patients to access specialists, diagnostic tests, and admission to hospital, home care, and long term care. All residents must register with a GP and are able to choose a physician based on a list of GPs who have not reached their maximum number of rostered patients. (1,500 for GPs and 800 for pediatricians).  

Italy has implemented a model of on-call physicians during holidays, nights and weekends, providing medical care and services when GPs and pediatricians are not available. This program is regionally deployed with some variability and is called Guardia Medica.

Out-Patient Care
Outpatient specialist care is provided by local health units or by public and private accredited hospitals under contract with local health units. Patients must be referred by their GP or a specialist and once referred can choose any public or private accredited hospital to obtain funded care. Specialists outside of hospital that see patients on an out-patient basis are paid hourly. Hospital based physicians are salaried.
Public Health
Due to the regional variation throughout Italy, the role of health promotion is not clearly defined. In some regions, hospitals provide support to the public in schools and communities, while in other areas, GPs and nurses provide support. Overall public health and health promotion is not well organized. Regions focus on regional needs as identified, however there is not an overall national agency responsible for the coordination of public health across Italy.

Secondary & Tertiary Care
Hospitals provide inpatient care for conditions that cannot be treated on an outpatient basis. Hospital services are free or at nominal charge for basic services – general medicine, surgery, pediatric, gynecology, and oncology in most hospitals. Hospital physicians are paid by salary as employees and specialists for inpatient or outpatient services are paid fee-for-service via a contract with the region.

Hospitals in the different regions throughout Italy can fall under one of three models;
1. Privately owned and funded with no government funding,
2. Publicly owned and funded with government funding, or
3. Privately owned and funded by government funding and private funding combined

In order to obtain any government funding, hospitals must be accredited and therefore meet specific standards set by the national government but allocated by the local health unit. A Diagnosis-related group (DRG)-based prospective payment system is used across Italy, however is not generally applied to hospitals run by (publicly owned) local health units. There is interregional variation on how fees are set and which services are excluded across regions in Italy. Caps are assigned to the volume of public care that can be provided as an effort to control spending.\textsuperscript{13}

Residents of Italy have the right to choose to access either public or privately-funded healthcare services (i.e. – specialists, diagnostic tests, hospital care, etc.). Public healthcare services are free, however do not allow the patient to choose the physician and often result in long waiting periods for care or treatment. Private healthcare services are paid either fully by the patient out-of-pocket or subsidized by health insurance and offer the patient the right to choose a physician and to access the care without waiting.

Hospitals are not evenly distributed across regions in Italy. Southern regions have fewer beds (4.3 /1000 inhabitants) than northern regions (5.6/1000 inhabitants). Hospitals are available in most regions and are not organized in any designated specialty model. However there are hospitals in some regions that are well known for speciality services such as orthopedics, cardiac care, or cancer care, but are not always exclusive to providing this service in the region.\textsuperscript{11}

Most hospitals have 24-hour emergency departments where patients can access care. A triage system is used in most hospitals to denote the level of urgency for care. Teaching and research hospitals are scattered throughout Italy and regions and such institutions are usually located close to universities.

Pharmaceuticals
Pharmacies are privately owned by pharmacists who act as independent contractors under the SSN. There are also public pharmacies that are owned and operated by municipalities where pharmacists are paid by salary. Consumers can only purchase pharmaceuticals if they have a prescription from their GP.\textsuperscript{14}
Co-payments have been introduced as part of a cost containment strategy. Co-payment can be exempted on the basis of income, medical conditions or disability status. The prices for tier 1 and 2 medications covered by SSN are fixed centrally. Industry, wholesale and pharmacy margins are fixed by law as a percentage of the overall price before the value-added tax (VAT). Local Health Authorities are responsible for reimbursement of medications to pharmacies, industry and wholesale suppliers for their portion of the price.  

**Mental Health Care**

Mental health care is provided by SSN through a variety of community-based, publicly funded settings (community mental health centres, community psychiatric diagnostic centres, hospital inpatient wards, and resident facilities). Local health units are responsible for the promotion and coordination of mental health prevention, care and rehabilitation. A multi-disciplinary model of care is used to support these patients. Co-payments apply to diagnostic procedures, medications and specialist visits to support care.

**Long Term Care, Home Care & Hospice Care**

Long Term Care is provided to patients in residential or community home care settings, however there is significant regional variation on how long term care and home care are organized and delivered in Italy. The allocation of long term care beds is regionally determined based on funding and regional population needs. A GP or specialist must refer a patient for long term care and this is then followed by the need to complete an application process.

Access to long term care is complex with long extended waits as a result of complex, multi-level application and assessment procedures. Due to regional variations, there is poor coordination, a lack of clarity and consistency in application processes as well as a tendency for public services to be directed only towards the most indigent families.

Similar to hospitals, long term care homes can be; (1) privately owned and privately funded or (2) privately owned and funded by the government. Government-funded homes must meet accreditation standards and hold a contract with the Regional Health Authority. Different levels of care are assigned eligibility criteria and funded to a set standard related to staffing, care and time for care on a daily basis. See Table 1.0 for details of program funding, eligibility and services.

Home Care is coordinated differently in each region. Some regions have home care services coordinated and provided by hospitals, while others use long term care homes. Due to the regional variation in coordination and lack of overall system integration, home care services are not well utilized or accessed. See Table 1.0 for details of program funding, eligibility and services.

Hospice care can be provided in various setting in Italy. Some programs are provided in long term care homes while others are in hospital settings. Regional governments pay 100% of costs and access to patients is made by referral by the GP or specialist and must be accompanied with a prognosis of 3-6 months (variability in prognosis timeframe by region). See Table 1.0 for details of program funding, eligibility and services.
Table 1.0: Long Term Care & Home Care Details

<table>
<thead>
<tr>
<th>Category &amp; Eligibility</th>
<th>Level of Care</th>
<th>Time For Care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Home for Disabled (RSD)</strong></td>
<td>Basic Assistance Education, Rehab, Nurse MDs, psychology, social assistance</td>
<td>40% 40% 20%</td>
</tr>
<tr>
<td>- &lt;65 years of age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Mental health or physical disability</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- 100% paid by RHA</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Home for Aged (RSA)</strong></td>
<td>Health care assistance MD, nurses, PT, educator</td>
<td>901 min/week</td>
</tr>
<tr>
<td>- &gt;65 years of age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Co-payment paid by resident</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Vegetative State</strong></td>
<td>Health Care assistance Nurse, MD</td>
<td>2000 min. / week</td>
</tr>
<tr>
<td>- Any age and permanent vegetative state</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- 100% paid by RHA</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Hospice</strong></td>
<td>Nurse, basic assistance Social Work Psych, social work MD</td>
<td>1260 min/week 35 min / week 35 min / week 150 min / week</td>
</tr>
<tr>
<td>- Prognosis &lt;6 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- 100% paid by RHA</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Home Care</strong></td>
<td>MD, nurse, assistants, PT Palliative Care</td>
<td>Unknown</td>
</tr>
<tr>
<td>- All ages</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Diseases that can be treated at home</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- GP or specialist referral required</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- 100% paid by RHA</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Wait Times
Wait times are not published for public knowledge in Italy. Although there are national standards for access to services, regional variation exist. There is significant controversy related to publishing wait times and other publicly reported metrics in Italy.

Hospital Beds & Utilization
The number of hospital beds in Italy in 2011 was 3.4 per 1000 population, which is less than the OECD average of 4.8. The number of hospital beds per capita in Italy has fallen over time. This decline has also coincided in a reduction in the average length of stay and an increase in the number of surgical procedures completed on a same day basis.\(^\text{10}\)

The average length of stay for all hospital admissions in 2011 in Italy was 6.8 days which is identical to Ontario’s acute hospital average length of stay. In 2011 Italy had 8 million inpatient admissions which is significantly more than Canada with 2.8 million admissions in 2011.\(^\text{1}\)

Health Human Resources
Italy had an abundance of physicians and is well above of the OECD average of 3.2 with 4.1 physicians per 1000 population in 2011. Of the total number of physicians (approximately 250,000), 56% work in hospitals. Italy is ranked third highest in the number of physicians per 100,000 inhabitants among European countries.\(^\text{11}\)

There are less practising nurses per capita than the average across OECD countries with 6.3 per 1000 population, compared to the OECD average of 8.7. Italy has the second lowest number of graduating nurses among all European countries.\(^\text{1}\) This suggests an over-supply of doctors and an under-supply of nurses in Italy, resulting in inefficient allocation of resources.\(^\text{13}\)
Healthcare Technology
As technology has advanced over time, Italy has increased the number of MRIs (23.7 per million population in 2011) to be well above the OECD average of 13.3. This same trend can be found with CT scanners (32.1 per million population in 2011) which are well above the OECD average of 23.2.  

How do Canada and Italy Compare?
In 2011, Italy spent 2% less on health care expenditures as a percent of GDP than Canada. As noted earlier, Italy’s spending is below the 9.3% OECD average. Italy has had a significant growth from 2009 to 2011 in private and public health expenditures. The current Italian budget crisis related to all spending signals the requirement for significant reform to manage spending. Italy has more than two times the number of physicians per 1,000 populations than Canada. In addition, Italy has fewer nurses per 1,000 population than Canada. Italy’s population is older than Canada by 1.7 years and Italy also has a lower infant mortality rate. The average length of stay of Italy and Canada is similar, however Italy out numbers Canada in the number of caesarean sections per 1,000 live births. Italy has a significantly higher rate of smokers than Canada and an almost equivalent obesity issue as Canada.  

<table>
<thead>
<tr>
<th>Table 2.0 : OECD Data for Italy and Canada</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Indicator</strong></td>
</tr>
<tr>
<td>Health Expenditures</td>
</tr>
<tr>
<td>Total expenditure on health as % of GDP</td>
</tr>
<tr>
<td>Public &amp; Private Expenditure, annual growth rate in real terms</td>
</tr>
<tr>
<td>Health Care Resources</td>
</tr>
<tr>
<td>Physicians per 1,000 population</td>
</tr>
<tr>
<td>Nurses per 1,000 population</td>
</tr>
<tr>
<td>Total hospital beds, per 1,000 population</td>
</tr>
<tr>
<td>Health Status</td>
</tr>
<tr>
<td>Life expectancy, Total population in birth, years</td>
</tr>
<tr>
<td>Infant mortality, Deaths per 1,000 live birth</td>
</tr>
<tr>
<td>Health Care Activities</td>
</tr>
<tr>
<td>Average length of stay, All causes, Days</td>
</tr>
<tr>
<td>Caesarean section, per 1, 000 live births</td>
</tr>
<tr>
<td>Risk Factors</td>
</tr>
<tr>
<td>Tobacco consumption, % of population age 15+ who are daily smokers</td>
</tr>
<tr>
<td>Alcohol consumption, liters per capita (age 15+)</td>
</tr>
<tr>
<td>Obese population, self-reported, % of total population</td>
</tr>
</tbody>
</table>

(Years 2010 to 2011 Data)  
Source – OECD Data 2012
Introduction – The Italy Study Tour

Oct. 2013, 13 senior health leaders participated in the first Canadian College of Health Leaders (CCHL) Italy study tour. Being the first tour in Italy, the CCHL planning team engaged the Italian Chamber of Commerce to create a study tour itinerary that would provide participants with a rich learning experience. After several months of planning, the CCHL Italy Study Tour planning group and our assigned Chamber representative, Claudia Barbiero who was stationed in Milan, created an excellent itinerary for the study tour. Throughout the planning process, AIOP Giovani, an association of young health leaders in Europe, worked with Claudia to identify appropriate sites, presenters and content to ensure a diverse learning experience for study tour participants.

Study tour participants were senior leaders from Ontario from various sectors including acute care hospital, home care, private healthcare and long term care. The study tour was 5 days long and included site visits to both private and public hospitals, long term care homes, a hospice, research institutes, and specialty / teaching hospitals. Sites were located in Milan, Rome, Mantova and Bologna, Italy. Participants toured a number of healthcare organizations and attended presentations by leadership in the Italian Healthcare System.

The LEADS Framework

The LEADS framework was developed as a leadership competence framework for the Canadian Healthcare System. Creation of this framework is based on the original research by, and collaboration between, the Healthcare Leaders’ Association of BC and Royal Roads University. This framework has been adopted by a number of organizations including the Canadian Health Leadership Network, The Canadian College of Health Service Executives, Closing the Gap Healthcare Group, and the Health Leaders Association of BC as their leadership framework.

The LEADS framework has five leadership domains. These include Leads Self, Engage Others, Achieve Results, Develop Coalitions, and System Transformation. Each domain has four measurable capabilities. The LEADS framework will be utilized to explore leadership domains and capabilities identified during the Italy Study Tour.
Leads Self – Istituto Clinico Humanitas

The first LEADS framework domain is Leads Self. This domain has four capabilities which include; being self-aware, managing self, developing self and demonstrating character.

Istituto Clinico Humanitas is a large privately owned and operated, and publically accredited hospital located in the Lombardy region of Italy. Humanitas is recognized by the Ministry of Health and the Lombardy regional government as a centre of excellence in terms of quality of its healthcare services and its ability to translate the results of research and innovation into everyday clinical practice.

The Technit Group owns and manages Humanitas along with five other hospitals; five in the northern region and an oncology centre in southern Italy. The regional services are not well coordinated in Northern Italy with duplication of services among other hospitals. Being aware of the need to ensure that the residents of the Lombardy region are well served, the Technit Group decided to reorganize their services across all 6 hospitals sites. In 2011, a horizontal reorganization took place resulting in specialty services at different sites including; oncology, neurology, orthopedics and cardiovascular services. Multidisciplinary care pathways were also developed to standardize the care provided across sites. This program model approach has not only improved access to specialty services, but also provides focused specialization for staff and research.

Quality is a key component of the ongoing excellence in care provided by Humanitas. Humanitas is not only accredited by the Regional government to have publically funded services available, but also voluntarily achieved accreditation with the Joint International Commission for a 3 year term. The success in accreditation from the Joint International Commission demonstrates the quality focus and of this organization.

The strong quality character and leadership of this organization was also demonstrated through the key performance indicator (KPI) tracking and monitoring using dashboards. Similar to Canadian hospitals, departments have assigned KPIs and must meet established targets. A performance based compensation model is also utilized to incent staff to achieve targets and maintain quality. Benchmarks are set internally and are often compared to other international leaders in the field (example – Mayo Clinic). Although public reporting is not available in Italy, regional comparisons exist among hospitals and is another driver of quality for Humanitas and the Technit Group.

Patient satisfaction is another quality indicator that Humanitas tracks and reports results to departments on a weekly basis. Returning patients is a critical component in Italian hospitals and therefore ensuring the best possible experience is important. Patients are surveyed when on site and
each department has a target number of surveys to complete weekly. Due to the almost real-time surveying, results can be communicated frequently allowing departments to realize gaps and implement improvements ongoing.

**Engage Others – San Pietro Residence**

The second LEADS framework domain is Engage Others. This domain has four capabilities, which include fostering development of others, contributing to the creation of healthy organizations, communicating effectively, and building teams.

**San Pietro Residence** is a privately owned and operated, and publically accredited long term care home located in the Lombardy region of Italy. Cammino SRL is the organization that owns San Pietro Residence and Ospedale Civile di Volta Mantovana. This residence has several units targeted at providing specialized care to the residents. Speciality units exist for resident that are; under 65 years of age with mental health or physical disabilities; over 65 years of age and have care needs associated to aging; residents that are any age but suffer from diseases resulting in a vegetative state requiring full complex care; and hospice care for patients who have a prognosis of less than 3 months.

The San Pietro Residence prides itself on its multidisciplinary approach to providing care based on individualized assessments and plans completed. Staff involved in working with residents and their families include physicians (geriatricians, general medicine, infectious diseases, psychiatry, and palliative care), psychologists, physiotherapists, social workers, music therapists, care assistants, educators and clergy. Individualized Assessment Plans (IAPs) are completed upon admission and ongoing by the team to ensure progress to achieve established goals. Involvement of the resident and family is important to the team and is ongoing during the care at the residents. Creation of a supportive and stimulating environment for the residents is achieved by engaging family, residents in staff in program development, improvement initiatives, and fund raising activities.

The hospice program which is located on a separate wing of the hospital is customized to meet the needs of patients and their families. Families have a separate entrance from the residence and are able to come and stay with family at any time for as long as they like. Family are supported by comfortable and accessible family rooms and kitchen making it comfortable to support long stays. Holistic and multi-disciplinary care is also provided in the hospice not only to the patient but to the family. Social work, psychological support, nursing, and basic assistance is made available to patients and families.

A home care program is also coordinated and provided for community clients through the group that owns San Pietro Residence. People of all ages with home care needs are provided with nursing care, physician care, personal care by assistants, physiotherapy, and palliative care.
The team approach to care delivery has created an environment where staff and residents / families are engaged and very satisfied. Annual resident and family satisfaction surveys have identified a 92% satisfaction rate with 100% of families willing to recommend the residence to others. The supportive care provided in the hospice is also rated very high with a 99% satisfaction rating by families and 100% willingness to refer to others.

Investing and developing staff at San Pietro is a key component to retaining staff and maintaining a high degree of satisfaction. In addition to providing assistants in-house training on specialty skills, the San Pietro Residence also runs an off-site training centre for the region for the training of many health care professionals such as physicians, nurses, physiotherapists, etc. Health care specific skills training and certification is provided by this centre.

**Achieve Results – Ospedale Civile di Volta Mantovana & Policlinico San Donato**

The third LEADS framework is Achieve Results. This domain has four sub-domains which include, setting direction; strategically aligning decisions with vision, values and evidence; taking action to implement decisions; as well as assessing and evaluating.

**Ospedale Civile di Volta Mantovana** is a privately owned by Cammino SRL and privately operated, but publically accredited hospital located in Mantova. The family owned hospital is one of 3 hospitals, a long term care home (San Pietro Residence), a Hospice (San Pietro Hospice) and local ambulance service owned and operated by the company in the region of Mantova. The history of the Ospedale Civile di Volta Mantovana begins with the current site being the previous home of a public hospital owned by an organization that owned other sites and was losing €50 million per year. This site was losing €2.4 million per year. In addition, the site was in disrepair and required over €75 million reconstruction costs to be suitable for ongoing care standards.

The SRL Group saw a regional opportunity to create a rehabilitation centre of excellence that would complement the other hospitals and services they currently owned, resulting in their vision of access to the full continuum of care. The flow of patients across this internal continuum of care would ensure the right level of care and ease of transition and planning. The SRL Group was awarded the contract with the Ministry of Health and was the first private organization to fund the reconstruction of the hospital and privately manage the previously publically managed hospital. The private partner would fund the reconstruction, purchase all equipment, manage all of the health services, manage and coordinate the staff, and pay an annual rental fee to the public hospital.
Since hospital staff were unionized, the private partners strategically established agreements with regional unions to transfer existing staff to be managed by private management. The reconstruction of the hospital was significant and took three years to complete and was re-opened in 2007. Much of the historic architecture and rediscovered al fresco painting dating back to Roman times were restored and maintained. Cost of reconstruction and equipment totalled almost €11 million. In addition to the reconstruction, programs were redefined to meet regional needs.

The Ospedale Civile di Volta Mantovana provides both inpatient, outpatient and day hospital rehabilitation services to the region. Through the creation of a vision and establishing a clear direction to achieve this vision, the XX group was able to implement a well-planned project resulting in a unique management and funding arrangement. This arrangement was resulted in dissolving all debt incurred as well as realizing a growing profit staring in 2012.

**Policlinico San Donato** is a privately owned and operated, and publically funded hospital located near Milan, Italy. The San Donato Group owns this site along with 16 other hospitals in the northern region of Lombardi. As a leader in cardiac surgery, San Donato sees more than 25% of their patients coming from other regions of Italy for cardiac care.

The Donato Group had a vision to become a leader in the region and has experienced significant growth in the Lombardi region due to ongoing acquisitions of other hospital sites resulting in ownership of a total 11% of all hospital beds in the region. In addition The Donato Group sites see more than 34% of the total private admissions in publically accredited hospitals in the region. Second to cardiac surgery, the group is well known for vascular surgery making up 31.5% of their admissions. Affiliation with local universities throughout the region provides the hospital with a large influx of physicians. Annually, 2,690 students attend their hospitals in placements and 170 university professors work in their hospital. The rich and vast learning environment allows for students to gain considerable experience in various areas of specialization at a variety of group sites in the region.

Although there are 17 hospitals owned by the Group, there are 7 CEOs for all sites in total, along with head physicians who manage assigned departments and multidisciplinary staff. Through this model, The Donato Group has been able to be efficient in their administration yet remain a leader in cardiac care, a teaching hospital and have annual revenues of €1,437 million.
Develop Coalitions – Villa Alba & Policlinico Universitario Agostino Gemelli

The fourth LEADS framework is Develop Coalitions. This domain has four capabilities which include, purposefully building partnerships and networks to create results; demonstrating a commitment to customers and service; mobilizing knowledge; and navigating socio-political environments.

**Villa Alba** is a privately owned and operated hospital located in the region of Emilia-Romagna in Bologna, Italy. Villa Alba is owned by the GMV network which owns 30 hospitals across Italy and employs more than 5000 staff. Villa Alba is a 71 bed hospital that is well-known for providing hotel-grad comforts and customer service, advanced technology and access to high quality physicians and medical staff. Patients can chose from private rooms or suites during their care. There is no Emergency Department at Villa Alba and patients can be referred to the hospital for private paid care. The hospital is equipped to perform any type of surgery, has 7 ICU beds and completes approximately 2000 surgical procedures per year including low invasive hip implants and treatments such as Hyperthermic Intraoperative Peritoneal Chemotherapy (HIPEC).

Through the ownership of 30 private hospitals across Italy, the GMV Network has considerable influence providing exclusive medical care to those patients that wish to pay. Strategically, GMV has established two private hospitals in the region of Bologna thereby having access to a critical mass of private physicians supporting various specialities. Physicians in Italy can only choose to work in either private or public healthcare, but not both. This physician network allows both sites to be able to support all patient types while providing care in a hotel-grade hospital setting. Physicians are paid directly by the patient or the insurance for the medical care they provide. The hospital stay portion is paid directly to the hospital from the patient or insurance.

**Policlinico Gemelli** is a fully public hospital that is located in the region of Lazio outside and is the largest hospital in Rome. Public care is provided as is paid private care for patients who wish to access specific selected doctors without waiting for care. Private patients that pay for care receive “private” assistance in hotel-style wards called “Solventi” (Italian for Payers).

Upon entry into Gemelli, visitors are greeted by a large monument of Pope John Paul II at the front of the large hospital. Each Pope keeps a suite of reserved rooms always available for each Pope for any needed medical care. Gemelli is a 1600 bed facility that sees 1,000,000 admissions per year, 73,000 emergency department visits per year and sees over 800,000 patients for ambulatory and diagnostic care per year.
Gemelli hospital serves as the teaching hospital for the medical school of the Universita Cattolica Del Sacro Cuore (the largest privately owned university in Italy located in Milan). The partnership with the university provides both undergraduate and post graduate students in medicine, surgery, nursing sciences, physiotherapy and a variety of other clinical areas. The large hospital campus is also home to university residences for students during their schooling at Gemelli. The creation of the network of students and providing on site education and training of students of all healthcare disciplines provides Gemelli with access to healthcare professionals in all areas of specialization.

Gemelli campus is also the home of the Biological Institute, Institute of Infectious Diseases and Centre for the Medicine of Aging. These areas of specialty along with the partnership with the university set Gemelli apart from other regional hospitals resulting in many out of region patients accessing specialty services and care from Gemelli.

**System Transformation – Policlinico Universitario Campus Biomedico & Rizzoli Orthopedic Institute and Instituto Chirurgico Ortopedico Traumatologica (ICOT)**

The fifth LEADS framework is System Transformation. This domain has four capabilities which include, demonstrate systems and critical thinking; encourage and support innovation; orient self strategically to the future; as well as champion and orchestrate change.

**Policlinico Universitario Campus Biomedico** is a hospital located at the centre of a modern university campus, near the EUR district of southern Rome. This privately owned acute care facility was opened in 2008 with eight wards spread out over four floors, each defined by type of care (e.g. Cardiac, Surgery, ICU). Opus Dei provides the pastoral/spiritual guidance for staff and offers spiritual support for patients and families. It has the potential to service 350 beds although this has been decreased recently down to 250 beds reflecting budget cuts from the regional authority. In response, the institution is focusing on expansion of private-pay clients with the strategy of capturing out-of-pocket/private-pay tariffs or “social fares” directly from the customer rather than through the state. While services are reimbursed based on DRG, another strategy to maximize profits within the budget negotiated with the region is to control that the hospital has regarding their case mix. This is helped by the fact that there is no Emergency Department, thus all admissions are elective, allowing further control regarding the types of cases.

This site is also home to the Campus Bio-Medico University of Rome’s School of Medicine and supports synergies across a range of clinical, teaching and research activities. The interdisciplinary teams are able to draw on a wealth of expertise within individual clinical departments as well as via the biomedical research centre located on campus. The Biomedical Research Centre has 20 people on staff and the tour
group was able to observe research in practice, from an artificial exoskeleton to aid in lower limb rehabilitation of the elderly to an externally controlled arm with opposable digits. The researchers take great pride in their state-of-the-art work environment which also allows for knowledge translation to practice through direct links to patient care areas of the hospital.

**Rizzoli Orthopedic Institute** is a publically owned and operated hospital and is the most important institute in Italy known for orthopedic traumatology and research. In addition, Rizzoli is the only scientific hospital in the Emilia-Romagna Region. Rizzoli is the regional hub for orthopedic oncology, spinal surgery, pediatric orthopedics, and transplants. With over 190,000 admissions per year, 320 beds and over 1400 staff, Rizzoli is a reference point for Italian and Europeans alike for orthopedic care.

Research is a significant component of Rizzoli including 9 biological lab and 3 main technology labs. With over 294 scientific publications, Rizzoli provides leadership and innovation in various areas of research including; orthopedic oncology, reconstructive prosthetic surgery, computer aided medicine, medical ortho pathology, and regenerative medicine. This hospital was the first hospital to have successfully completed a shoulder transplant in 2008. In addition, Rizzoli has the largest musculoskeletal bank in Italy, providing 50% of all musculoskeletal tissues used in Italy. Rizzoli hospital has a strong relationship with the University of Bologna related to research.

Research and innovation in the realm of orthopedics at Rizzoli can be seen in the Movement Analysis Lab always striving to improve the practice and care of orthopedic patients. One of the innovations at Rizzoli (1 of 3 machines in the world) is a machine that is used for non-invasive biomechanical analysis and diagnosis of orthopedic conditions. This device provides the physician and team with the ability to determine real time three-dimensional biomechanical movement of patients prior to surgery to assist in the diagnosis and determination of type and location of prosthesis placement. Research on the use of this device continues to hopefully one day provide this as a standard of practice in the orthopedic area of medicine.

Rizzoli also manages the most compressive Hip and Knee Registries (RIPO) for the entire region. The data within this system provides information on 98% of all implants in the region. The information from this data base is shared with the Orthopedic Commission and with orthopedic surgeons to help inform best practice and selection of prostheses. In addition, this data base provides the region with overall information on survival rates; types of prostheses used and assist with planning and trending information to inform care and funding decisions.

**Instituto Chirurgico Ortopedico Traumatologica (ICOT)** is a privately owned and operated hospital that is publically funded in the region of Latina. The family owned Giomi Group also owns various other healthcare institutions across Italy. A combination of public and private funded patients receive their
care at ICOT resulting in 47,000 publically funded orthopedic visits per year, and 18,000 privately paid visits per year. This hospital also has an Emergency Department (ED) only for orthopedic on site that sees 53,000 orthopedic patients per year from across Italy. This specialized ED attracts orthopedic patients from across Italy. There are over 12,000 admissions per year.

ICOT has an affiliation with the University of Rome and is a teaching institute for medical students. Research is an innovation ways to teach and mentor students to ensure excellence in orthopedic care is core to ICOT. The 2013 EKA International Arthroplasty Travelling Fellowship is an example of the innovative approach to developing orthopedic expertise across Italy at all of the Giomi Group institutions. This novel approach creates sustainable orthopedic care in both Northern and Southern regions of Italy.

The ICOT site itself is unique as it includes the orthopedic hospital, a hospice with 9 beds and a nursing home all located on the same campus. The specialization in orthopedics offers the Latina region a centre of excellence in this area coupled with access with rehabilitation, long term care and hospice care. The 80 bed long-term care home has recently received public accreditation and provides multidisciplinary care to residents from the area. The demand for the service has resulted in a waitlist that is over 1 year long.

**Conclusion**

The Italy Study Tour was an overwhelming success that provided participants with exposure to the Italian Healthcare System and the many innovations that it offers the residents of Italy. The tour would not have been a success without the assistance of the Italian Chamber of Commerce of Ontario who facilitated the organization of a diverse view of healthcare in Italy.

The tour provided the group with exposure to the best part of the healthcare system in the Northern regions of Italy and unlike Canada healthcare delivery varies in standards throughout the country. We learned a great deal of how palliative care is integrated in the Italian healthcare system and offers a multidisciplinary approach to care for family and the client. Similar to Canada, family are encouraged to be with their family in a comfortable and home-like environment. Home care in Italy is not well organized and lacking in many regions. Italian healthcare leaders would benefit from examining the home care system in Ontario for future improvements.

Italian healthcare is unique as many hospitals are family-run businesses. This family business approach adds a special dimension of compassion and dedication to the delivery of care and customer service. The Italian healthcare system has demonstrated that private and public sectors can work side by side successfully. As we continue to examine our national healthcare system and sustainability, Italy is a country that Canadians should direct their attention to in the future.
References

5. Lo Scalzo, Alessandra; Donatini, Andrea; Orzella, Letizia ; Cicchetti, Americo; Profili, Silvia; Maresso, Anna; *Health Systems in Transition, Volume 2, No. 6, 2009, Italy Health System Review*.
7. Munizza, Carmine; Argentero, Piergiorgio, Coppo, Allessandro; Tibaldi, Guiseppe; Giannantionio, Massimo Dir; Pivi, Rocco Luigig; Ruci, Paola, *Public Beliefs and Attitudes towards Depression in Italy: A National Survey*, PLoS One 8.5 (May 2013)
10. OECD Health Data 2013, *How Does Italy Compare* – Briefing Note.
12. Sant, Melina; Minicozzi, Pamela; Allemanni, Claudia; Cirilli, Claudia; Federico, Massimo; Capocaccia, Riccardo; Budroni, Mario; Candela, Pina; Crocetti, Emanuele; Falcini, Fabio; Ferretti, Stefano; Fusco, Mario; Giacomini, Adriano; La Rosa, Francesco; Mangone, Lucia; Natali, Maurillio; Leon, Maurizio Ponz De; Traina, Adele; Tumino, Rosario; Zambon, Paola, *Regional inequalities in cancer care persist in Italy and can influence survival*, Cancer Epidemiology 36.6 (2012): 541-547.
2013 Italy Study Tour Facilitators

Claudia Barbiero  Italian Office Representative, Italian Chamber of Commerce of Ontario
Gino Picciano  Ontario Co-Director, Canadian College of Health Leaders
Joanne Greco  Vice President of Infrastructure, Closing the Gap Healthcare Group
John King  International Advisor, Canadian College of Health Leaders

2013 Italy Study Tour Participants

Ben Vozzolo  Director of Operations, Department of Paediatrics, Hospital for Sick Children
Cathy Hecimovich  CEO, Central West Community Care Access Centre
Emily Musing  Executive Director of Pharmacy, Clinical Risk & Quality, University Health Network
Janice Skot  President & CEO, Royal Victoria Regional Health Centre
Liz Ruegg  President & CEO, Headwaters Health Care Centre
Marc LeBoutillier  CEO, Hawkesbury & District General Hospital
Sara Padfield  Vice President & Chief Financial Officer, Chatham-Kent Health Alliance
Sharon McDonald  President, Morrison & Marquise Hospitality, Compass Group Canada Healthcare