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2015 Italy Study Tour Report:

Highlights & Key Learnings of Study Participants

Authors: Jonathan Fetros & Joseph Clark

Introduction

In September 2015, health leaders from Canada travelled to Italy for prearranged meetings with 8 healthcare organizations that represented both public and private institutions from the different regions of Italy. These meetings were arranged in cooperation with the Canadian College of Healthcare Leaders, and the Italian Chambers of Commerce of Ontario. We also thank the Italian Association of Private Operators (young division) for their assistance.

The study tour participants were senior leaders from Ontario from various health sectors including acute care, complex continuing care, and private industry. The study tour was 5 days in length and included site visits to several public and private hospitals, a pediatric hospital, a complex continuing care/long-term care hospital, and a health research institute. Sites were located in cities of Rome, Florence, and Bologna. Participants extensively toured these healthcare organizations and attended presentations by leadership of these organizations.

Context

The goal of the tour was to gain a better understanding and of the Italian system while providing an opportunity for knowledge exchange. Objectives of the tour included:

- Comparing and contrasting the Italian and Canadian healthcare systems
- Understand the Illusion healthcare policy and funding models
- Gain insight on how private sector healthcare can function and integrated within a public health system
- Interact with key leaders and clinicians for exchanges of ideas and experiences in delivering health services

The purpose of this report is to summarize learnings and observations of the study tour participants. Each participant was asked to summarize their experience and identify key insights. This report consolidates these summaries and will highlight key themes of the tour.

Study Tour Approach

The study tour approach included: Pre-tour study material review by the participants, logistics and travel arrangement teleconference hosted by the CCHL for all participants; opening dinner socialization and tour logistic review upon arrival; group study at tours via presentation and tour of facilities; periodic formal and informal briefings at close of day to review the day's visits by study participants; sharing of key learnings by participants; and development of final report by two volunteer participants.

Study Tour Participants: Sami Bismarji, Sean Kelly, Marilyn Rook, Gino Picciono, John King, Kathy Sabo, Nancy Savage, Lorenzo…, Jonathan Fetros, Donna Clark, Joseph Clark

Overview of the Italian Healthcare System

National Government Level

The National Health Service (SSN = Servizio Sanitario Nazionale) which is organized under the Ministry of Health is responsible for national health planning. This includes:

- General aims
- Annual financial resources to be spent on health
- 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 (Maio & Mazoli, 2002).

Regional Government Level

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 (Maio & Mazoli, 2002).

Local Health Authorities

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 (Maio & Mazoli, 2002).

Key Learnings & Insights of Study Tour Participants

There were 3 themes identified by the study participants:

- Public and Private Healthcare Organizations
- Culture, Leadership, and Care Models
- Quality Metrics and Public Reporting

Public and Private Healthcare Organizations

The majority of healthcare institutions in Italy are publicly funded, accounting for 90% of the healthcare system. The public system is primarily funded through corporate taxes pooled nationally and a fixed proportion of national value-added tax (VAT) revenue, collected by the national government and redistributed to the regions and LHAs (Donatini, 2012). However, about 10% of health care institutions

in Italy are privately operated. Additionally, about 15% of the population has some form of private insurance which is mainly used to cover services not included in the SSN such as better accommodations during your inpatient stay in the hospital, unrestricted choice of specialist, shorter wait times and covering co-payments for services (Donatini, 2012).

The study tour participants visited several public healthcare institutions including *Policlinico Umberto*, *Policlinico Universitario Agostino Gemelli di Roma*, and *Careggi University Hospital*. The study tour participants also visited privately operated healthcare institutions *such Villa Ranuzzi* and *I'Istituto Fiorentino di Cura Assistenza.*

Anecdotally, it is difficult for the general Italian population to differentiate between public and private hospitals. The main reason is because privately operated healthcare institutions are primarily funded by the National Health Service. A key difference is that funding for private institutions are heavily capped by a certain amount. This incentivizes private organizations to specialize and find efficiencies. While this funding cap also applies to public institutions, it is not as rigorously monitored and enforced. In addition, private hospitals offer a range of services where patients have the option to pay "out of pocket" (eg. hip surgery). The main advantage of these out of pocket services is that they allow for timely access, convenience, and gives patients the ability to choose their physician/care provider. In fact, a doctor's performance and reputation will greatly determine the extent of business and repeat business that privately run healthcare facilities will experience. The public can request a specific doctor I a private facility. In public healthcare in Italy they do not get this choice.

Study participants found the dichotomy of public and private organizations under one healthcare system to be fascinating. While it is clear that there is competition for patients between public and private hospitals, they are able to effectively co-exist and some regions (eg. Tuscany) have been able to leverage each other's services.

Culture, Leadership, and Care Models

There is variability in the level of care, funding, and infrastructure depending on the hospital and region. Despite national standards defining the essential levels of care, regions and local health authorities are accountable for the delivery and evaluation. Study participants noted that there were several organizations with sophisticated best practices/services, up to date equipment, and state of the art facilities, while others were lacking.

An interesting observation is that leadership positions, from front-line managers to CEOs, are predominantly held by physicians. It is also common for CEO positions in public hospitals to be political appointments.

There were also significant differences in care models. The majority of physicians (approximately 90%) are salary based vs fee for service and are directly employed by the organization. Italy has an abundance of physicians, ranking third in the number of physicians per 100,000 inhabitants (Paterlini, 2013). The concept of inter-professional care is still at its infancy. The core care teams are primarily comprised of physicians and nurses. While allied health roles existed, the services were centralized and comprised a smaller workforce compared to staffing ratios in Ontario. It is also interesting to note that the length of professional schools is shorter in Italy compared to Ontario. For example, the entry level to practice for nursing and physical therapy is a three year diploma in Italy, compared to a bachelor's degree (nursing) and a master's degree (physical therapy) in Ontario.

Another interesting finding is that capital redevelopment of healthcare organizations are primarily funded by the local health region. Few of the hospitals toured had a Foundation department while those that did were relatively small in size. It was discussed that philanthropy in healthcare is still has room to grow in Italy.

Quality & Public Reporting

Study tour participants noted that the overall collection and dissemination of quality and performance data has opportunity for improvement. While many of the leading organizations were setting quality priorities and measure within their organization, the ability to compare and benchmark with other similar organizations is unclear. Based on the presentations and discussions with site leads, it is not apparent how this data is being used to help inform decisions at a local health authority or regional level. It was discussed how a standardized framework to better support this work from an organization, health authority, and regional level would be beneficial.

Conclusion

The 2015 Italy Study Tour was a sounding success and could not have been possible without the assistance of the Italian Chamber of Commerce of Ontario and the generosity of the various site leads. The tour was a fantastic opportunity to gain knowledge and exposure to the Italian healthcare system. It gave participants the chance to witness innovation, creativity, and the passion of Italian healthcare leaders/providers for the work that they do. It was also an affirmation of the commonalities of the challenges we face in healthcare (eg. aging population, fiscal restraint). In addition, Italy provided a unique perspective, particularly on how a thriving sector of privately operated healthcare organizations can effectively integrate within predominantly publicly funded healthcare system.

References

Donatini, A., The Italian health care system*, International Profiles of Health Care Systems*, 2012.

Maio, V., & Manzoli L., The Italian health care system: W.H.O. Ranking versus public perception, 2002.

Paterlini, M., Italy's health system reforms on hold, *The Lancet*, 2013.

The Commonwealth Fund*, International Profiles of Health Care Systems*, 2012.

2015 Italy Study Tour Facilitators

Claudia Barbiero	Italian Office Representative, Italian Chamber of Commerce of Ontario
John King	International Facilitator, Canadian College of Health Leaders
Gino Picciano	Co-Facilitator, Canadian College of Health Leaders

2015 Italy Study Tour Participants

Sami Bismarji	Director of Finance, Telus Health
Donna Clark	Vice President of Patient Services & Chief Nursing Executive, Headwaters Healthcare Centre
Joseph Clark	Energy Solutions Executive, Ecosystems
Jonathan Fetros	Clinical Leader/Manager, St. Michael's Hospital
Sean Kelly	Vice President of Sales, BD Canada
Marilyn Rook	President & CEO, Salvation Army Toronto Grace Health Centre
Kathy Sabo	Senior Vice President & Executive Lead, Toronto Western Hospital
Nancy Savage	Executive Vice President of Patient & Family Experience, Royal Victoria Regional Health Centre