THE ITALIAN HEALTH SYSTEM: ACCESS, AFFORDABILITY, AND INNOVATION

Summary of TPG Educational Summit Content

Rome, October 22-27, 2022

James C. Robinson

University of California, Berkeley

James.Robinson@berkeley.edu

Introduction

In October 2022 TPG International Health Academy hosted an Educational Summit for American health care leaders in Rome, Italy, combining discussions of health system trends, site visits to prominent facilities, high-energy tourism in the core of the city, and an enjoyment of the delicious and healthy Mediterranean diet. This summit was one of many that the TPG has sponsored in over 30 nations across its 29-year history. As always, the focus of the Summit was to allow participants to expand their knowledge of health systems in other nations and meet with colleagues from the US.

A tale of two perspectives

Americans love Italy and Italians love America but the perspectives on the respective health systems are nuanced. Italians envy the dynamism of the American biomedical innovation ecosystem but not the high costs and uneven access to care. For their part, American observers of Italy and other foreign

health systems come to different assessments depending on how they count and combine the different dimensions of health system performance. As discussed in the Summit, there are two prominent organizations that regularly compare health systems globally and often come to different assessments, the Commonwealth Fund, based in New York, and the Foundations for Research on Equal Opportunity, based in Houston.

1. Commonwealth Fund

The Commonwealth Fund (CMWF) has conducted for many years a survey of health systems major European nations, with the goal of deriving lessons for US health care reform. Philosophically it places great weight on coverage (universal access) and affordability (low spending per capita). Strangely, it does not consider each nation's R&D investment and success at innovation. CMWF compares 11 national health systems, with the US always ranking at the bottom due to its high costs and patchy insurance coverage. Italy is not one of the 11 nations included by CMWF in its comparisons but has been studied by the Fund separately. The Fund's most recent report describes the structure of the Italian system, as described below, and gives it high marks on access and affordability but less credit on quality of care.

https://www.commonwealthfund.org/international-health-policy-center/countries/italy

2. The Foundation for Research on Equal Opportunity

The Foundation for Research on Equal Opportunity (FREOPP) has developed an index of health system performance for 31 nations, including the US, large European nations, the Asian tigers, Israel, and the

UAE. Its philosophical emphasis is on promoting consumer choice and technological innovation. The US ranks poorly in the FREOPP index on fiscal sustainability (health spending as a fraction of GDP) but high on choice and innovation, and is placed just below northern European nations such as Switzerland and Germany. Italy ranks near the bottom on FREOPP index, however, due to what FREOPP interprets as limited consumer choice, modest quality of services, and a weak innovation ecosystem. While it features low spending per capita, Italy also has low income per capita, and so spending as a percent of GDP (sustainability) is weak.

https://freopp.org/italy-health-system-profile-29-in-the-world-index-of-healthcare-innovation-134a8fc399f3

Overall Rank	Country	Overall Tier	Overall Score	Quality	Choice	Science & Technology	Fiscal Sustainability
1	**Switzerland**	Excellent	59.56	73.35	46.53	47.28	71.06
2	**Germany**	Excellent	59.28	60.99	47.95	46.90	81.28
3	**Netherlands**	Excellent	59.14	65.70	50.42	49.97	70.46
4	**United States**	Excellent	54.96	59.71	57.65	75.14	27.33
5	**Ireland**	Excellent	54.48	67.07	41.77	40.71	68.39
6	**Israel**	Good	51.14	63.89	43.20	38.79	58.69
7	**Singapore**	Good	50.37	55.77	46.84	47.98	50.89
8	**Czech Republic**	Good	49.80	52.22	40.80	27.39	78.78
9	**Belgium**	Good	49.65	56.55	39.23	44.89	57.95
10	**Taiwan**	Good	49.19	57.15	46.42	25.28	67.90
11	**Australia**	Good	48.38	69.51	45.38	26.67	51.97
12	**Norway**	Good	48.26	64.16	32.06	43.74	53.11
13	**United Kingdom**	Good	47.78	58.76	42.01	49.39	40.97
14	**Denmark**	Good	47.59	57.53	34.15	52.63	46.03
15	**Sweden**	Good	47.40	61.73	38.18	49.72	39.98
16	**Hong Kong**	Good	47.35	48.36	37.13	28.29	75.61
17	**Canada**	Good	47.05	61.55	38.72	34.43	53.48
18	**Austria**	Good	46.59	58.57	43.36	40.90	43.52
19	**South Korea**	Good	46.47	61.39	44.92	18.83	60.75
20	**New Zealand**	Good	45.97	64.66	35.69	30.32	53.22
21	**Portugal**	Moderate	44.82	69.22	40.18	27.01	42.87
22	**United Arab Emirates**	Moderate	44.68	50.62	32.71	22.77	72.61
23	**Finland**	Moderate	43.65	52.60	27.20	46.78	48.04
24	**Spain**	Moderate	43.31	49.06	38.58	35.10	50.50
25	**Hungary**	Moderate	41.47	43.61	32.97	31.15	58.16
26	**Slovakia**	Moderate	41.36	43.70	34.47	27.46	59.80
27	**Greece**	Moderate	40.12	44.13	42.88	32.60	40.86
28	**France**	Moderate	40.08	55.98	35.13	39.17	30.03
29	**Italy**	Poor	37.29	50.57	30.42	30.39	37.81

The structure of the Italian health care system

Italy has historically been fragmented regionally, with unification only coming in 1870s. There continues to be tension between efforts at national integration and standardization, on the one hand, and regional autonomy and diversity, on the other. The Italian National Health Service (SSN) was established on the British model as part of the efforts at standardization but operates on a very regionalized basis. It features centralized tax funding, a national budget, hospital payment rates, and drug price negotiations. But the 21 Italian provinces administer their own budgets, which gives them considerable authority and discretion in the choice and structure of the services they provide. In their turn, local provider organizations (mostly public and nonprofit hospital-based systems) receive budgets from the regions. The main features of the delivery system include:

- Primary care physicians. PCPs mostly own their own small practices and are paid on a capitation basis by the regions. They do not face fee-for-service (FFS) incentives for over-utilization but also do not face incentives to promote patient access to care, leading to continual complaints.
- Specialty care physicians. Many SCPs are employed by hospitals and paid on a salaried basis. They also lack FFS incentives for over-treatment but face complaints of long waiting times for appointments and procedures.
- Hospitals. They are paid on a per-admission basis, but subject to annual. The quality and range of services varies substantially. There is substantial travel (mostly from hospitals in the south to those in Rome and the north) by patients seeking specialized treatment, a source of considerable resentment. During the Covid pandemic, the hospital-centered structure of delivery in regions such as Lombardy was criticized due to the barriers it created to care for infectious and chronic

conditions. Italy now is decentralizing ambulatory services from hospital outpatient clinics to community based centers that combine primary care, behavioral care, and social work.

- Drugs. Prices are negotiated with manufacturers by the national pharmaceutical agency AIFA. Regions and hospitals are delegated authority over formulary design and use tender contracts to extract further discounts from manufacturers. AIFA has been innovative in negotiating outcomes-based drug price models, in which the manufacturer's net price (after rebates) depends on whether the drug had its intended effect.

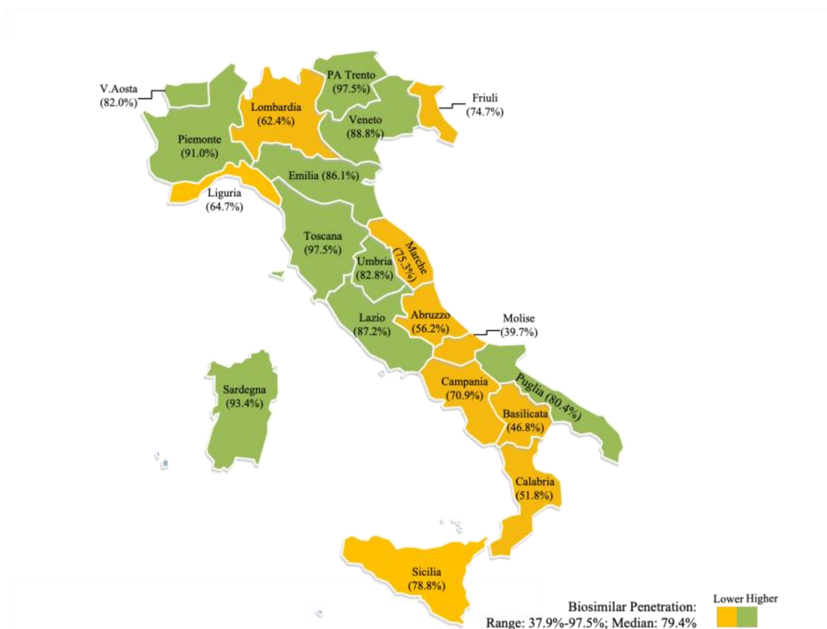
Site Visits to Two Prominent Hospitals in Rome

The Educational Summit was invited to tour two prominent teaching hospitals in Rome, Policlinico Gemelli and Fondazione Policlinico BioMedico, both affiliated with the Catholic Church. In both facilities participants were given overviews of the hospitals' operations, from both senior management and lead physicians, and then tours of selected wards. Participants were impressed by the dedication and enthusiasm of the physician staff but noted that the facilities and equipment were not as advanced as one might see in US teaching hospitals. The strong sense of mission, partly due to the religious affiliation, was evident throughout both facilities and with their physician and nursing staffs.

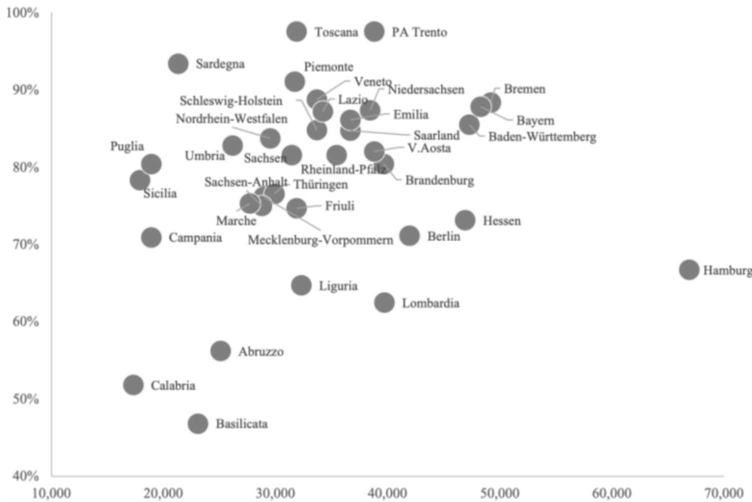
Regionalization: the example of biosimilars

Policymakers conceptualize the adoption of biosimilars, therapeutically effective but lower-cost versions of biologic medications, as a tool to moderate health care spending. It is expected that they will be adopted faster in low-income regions (such as the south of Italy) than in wealthier regions (e.g., northern provinces) due to the greater need for savings there. However, adoption also is dependent on trust on

the part of patients and doctors in the national government and professional societies, since the savings accrue to the health care system while the perceived risk accrues to the patient. The effect of social and political trust (which is lower in southern than in northern Italy) overwhelms the impact of need for budgetary savings (which is higher in the south than the north). Similar effects were found when comparing rates of biosimilar adoption between western and eastern regions in Germany.



There is a positive relationship between income per capita and the market penetration of biosimilars when looking across provinces, a counter-intuitive finding that highlights the countervailing effect of social and political trust.



Balancing pharmaceutical innovation and affordability

.

Both the US and Italy traditionally have viewed drugs as a budgetary challenge to be managed. The US has sought to meet the challenge through 'value-based payment' for providers and cost sharing for consumers. Italy (and most European nations) have relied principally on centralized budgetary control. In recent years a new focus has emerged in Italy as well as the US, one that views the life sciences sector as a strength rather than merely a burden. This has resulted from several intertwined factors. The Covid pandemic highlighted the imperative for innovation; the rise of China raises fears for loss of technological and military advantage; de-industrialization and loss of high-wage jobs has created a worrying rise in populism and nativism.

In the US and Italy there is now a debate: how can we balance innovation with affordability for drugs and new medical technology? In the US, we see some limited bipartisan cooperation on industrial policy (though the devil is always in the details), with the CHIPS and Science Act for semiconductors and ARPA-H for health care. In Italy, we see an active discussion on restructuring the governmental

pharmaceutical agency and creating incentives that support domestic pharmaceutical R&D, manufacturing, and supply chain. It is unclear how this discussion will align with the traditional Italian focus on controlling spending, especially through price regulation.