



The Italian NHS in Lombardy and Veneto: near but far

Livio Garattini¹ · Marco Badinella Martini¹ · Alessandro Nobili¹

Received: 15 April 2021 / Accepted: 24 April 2021 / Published online: 2 May 2021
© Società Italiana di Medicina Interna (SIMI) 2021

Abbreviations

AGENAS	AGEnzia NAzionale per i Servizi sanitari regionali
L.R.	Legge Regionale
Veneto	Lombardy
AO	Azienda Ospedaliera
ACSS	Agenzia di Controllo del Sistema Socio-sanitario
AULSS	Azienda Unità Locale Socio-Sanitaria
AREU	Agenzia Regionale Emergenza Urgenza
ARIA	Azienda Regionale per Innovazione e Acquisti
ASST	Azienda Socio-Sanitaria Territoriale
ATS	Agenzia Tutela Salute

Dear Editor,

Italy is a large European country of around 60 million inhabitants, and its territory is divided into 20 regions, all governed by elected politicians [1].

Since 1976, Italy has adopted a National Health Service (NHS), which provides universal coverage funded by general taxation and services free of charge at the point of delivery [2]. Starting from 1992, the Italian NHS has been increasingly decentralized, with many powers devolved to regions. This has gradually transformed the Italian NHS into several uneven regional health services (RHSs) [1].

Italy was the first European country dramatically hit by the COVID-19 pandemic in early 2020, especially in the North. In particular, the number of victims was dramatically high in Lombardy (capital Milan), whilst much lower in Veneto (capital Venice), the two neighboring regions first hit by the pandemic [1].

Veneto is a large region (18,345 square kilometers) of around 5 million inhabitants located in the north-east of Italy. It has been always governed in the last decades by centre-right political coalitions.

The RHS is divided into nine local health authorities (AULSS), headed by general managers appointed at the regional level. AULSSs manage all the healthcare services delivered within their territory. The only exceptions are three autonomous hospital trusts (AO), of which two include the biggest hospitals in the region and the third one is specialized in oncology. The territory of each AULSS is subdivided in 26 districts, operational units that should organize the existing primary care services delivered in the community through public or private accredited facilities. The vast majority of central bodies have been merged in a single agency (*Azienda Zero*), which is responsible for AULSSs' funding, planning, accounting, auditing and job posting.

Starting from 2016, acute hospital facilities are systematically classified into a 'hub and spoke' conceptual network [3]. This has been the last step of a long and still ongoing process aimed at resetting the number of smaller acute hospitals that do not adequately meet safety and quality standards [4]. At present, there are 8 hubs (included the three AOs), 20 spokes (of which two private accredited hospitals), and 8 nodes (of which one private accredited hospital). All these hospitals have an Accident and Emergency service (AEs).

Lombardy (23,863 square kilometers) lies in the centre of Northern Italy and is the most populated region of the country, with approximately 10 million inhabitants (3.5 million of them resident in the metropolitan area of Milan). Although traditionally characterized by a quite uneven political situation at the county level, Lombardy has been mainly governed by centre-right political coalitions in the last decades.

Lombardy is the Italian region that has thrust more for a complete purchaser-provider split in its RHS, to foster market competition [2], particularly between public and private hospitals. A regional law issued in 2015 has drastically reformed the RHS local tier by separating the health services' planning, purchasing and control from their provision on the regional territory. The first tasks have been devolved

✉ Livio Garattini
livio.garattini@marionegri.it

¹ Institute for Pharmacological Research Mario Negri IRCCS, Milan, Italy

to 8 health protection agencies (*ATSs*), whereas public healthcare provision to 27 health territorial authorities (*ASSTs*). *ATSs* manage all contracts, accredit private health providers (e.g. hospitals and all general practices), and allocate the regional funds to them and *ASSTs*. *ASSTs* organize the supply of all public healthcare services delivered on their territory by dividing them in two poles: community (general practices excluded) and hospital services. *ATSs* and *ASSTs* are all headed by general managers appointed at the regional level. The territories of districts coincide with those of the 27 *ASSTs*, but *ATSs* can decide to subdivide them into district areas (currently 92 in total). Although districts are operational units aimed at delivering community services, their planning depends on *ATSs*. To complete the picture, there are many central agencies, of which are worth quoting for the relevance of their manpower the three for auditing (*ACSS*), tendering (*ARIA*) and emergency (*AREU*).

The number of acute hospitals working on behalf of the RHS is very high and, lacking a formal classification of each facility, it is hard to accurately quantify them. By adopting the presence of an AEs as a pre-requisite for selection, we found 68 public hospitals managed by the *ASSTs* and 29 private hospitals accredited by the *ATSs*, overall 97 acute hospitals (of which 16 located in the Milan municipality).

Lombardy and Veneto are two wealthy neighboring regions, also not so different from a physical geography perspective. Although the territory of Lombardy is about one fourth larger, the proportions between plain and mountain areas are rather similar. Moreover, although the population is approximately half lower in Veneto, this difference is mainly due to the metropolitan area of Milan. Last but not least for the scope of our comparison, even the political contexts of these two regions have been similar in the last decades.

Despite all these similarities, the organizational frameworks of the two RHSs have become increasingly different, with scanty justification related to the peculiarity of the Milan area. Nowadays there are 13 important authorities and agencies in Veneto, whereas at least 38 are in Lombardy altogether, many of them somehow intertwined and overlapping. This roughly three times higher number of bodies inevitably makes much more complex the clinical governance of the RHS in Lombardy.

The density of acute hospitals in Veneto is almost one-third less by population and half less by surface compared to Lombardy, with very unevenly scattered facilities on the two territories, even after taking account of the Milan metropolis. In addition to the traditionally much higher number of private hospitals, even that of small-sized acute hospitals (< 150 beds) is now disproportionately higher in Lombardy (44% of total hospitals vs 27% in Veneto), and the gap between the distribution of the two hospital networks is likely to have increased during the last decades. While the strategy planned in Veneto to increase efficiency

within the acute hospital network has constrained small facilities in the long run, the ‘quasi market’ strategy aimed at thrusting competition between hospitals has not achieved similar results in Lombardy.

The very heterogeneous frameworks of the two RHSs analyzed confirm that the organization and management of healthcare services delivered within the universal tax-funded Italian NHS have been shaped very differently [2], even in geographically, economically and politically similar regions. In particular, the organizational consistency of the Italian NHS is undermined by regional autonomy, which makes it very prone to influence from local policies and economies [1].

Once agreed that the public sector is potentially the best ‘insurer’ to grant universal coverage and thus fund a national health system, the choices to provide healthcare services are less obvious [5]. However, in a typical ‘market failure’ context such as the healthcare market, competition among providers is not justified by the economic theory and requires strong ideological support. Free prices cannot be competitive, by definition, and setting them through regulation (e.g. tariffs for hospital services) is necessarily an arbitrary exercise.

On the other hand, it is fair to recognize that traditional public sector bureaucracy and political influence at all the NHSs tiers have fueled the myth of market competition as an alternative strategy. For instance, most efforts to plan rational public hospital networks by closing small acute hospitals in Italy failed mainly because of trade unions and political resistance, eventually leading to arguable reorganizations. Trades and shops around little hospitals have likely been the ‘best allies’ against their closure, in a country where around 90% of 7903 municipalities have less than 15,000 inhabitants. Last but not least, the appointments of general managers often based on political affiliations rather than professional skills have contributed to achieve these disappointing results.

Nevertheless, once ruled out competing and pricing as a suitable strategy for managing public healthcare services, planning and budgeting are the only solution, possibly in a climate of collaboration and integration among health professionals. Ideally, there is no doubt that an organizational culture rooted in collaborative teamwork fits healthcare services much better than a competitive one. In practice, the big challenge of the future is to develop the best incentives for limiting political influence and administrative bureaucracy, the real ‘devils in disguise’ of the public sector.

Funding No sources of funding were used to conduct this study or prepare this manuscript.

Declarations

Conflict of interest Livio Garattini, Marco Badinella Martini and Alessandro Nobili have no conflicts of interest directly relevant to this article.

Human and animal rights statement This article does not contain any studies with human participants or animals performed by any of the authors.

Informed consent None.

References

1. Garattini L, Zanetti M, Freemantle N (2020) The Italian NHS: What lessons to draw from COVID-19? *Appl Health Econ Health Policy* 18(4):463–466
2. Ferre F, de Belvis AG, Valerio L, Longhi S, Lazzari A, Fattore G, Ricciardi W, Maresso A (2014) Italy: health system review. *Health Syst Transit* 16(4):1–168
3. Rechel B, Džakula A, Duran A, Fattore G, Edwards N, Grignon M, Haas M, Habicht T, Marchildon GP, Moreno A, Ricciardi W, Vaughan L, Smith TA (2016) Hospitals in rural or remote areas: an exploratory review of policies in 8 high-income countries. *Health Policy* 120(7):758–769
4. Toniolo F, Mantoan D, Maresso A (2012) Veneto region, Italy. Health system review. *Health Syst Transit* 14(1):1–138
5. Garattini L, Padula A (2019) Competition in health markets: Is something rotten? *J R Soc Med* 112(1):6–10

Publisher's Note Springer Nature remains neutral with regard to jurisdictional claims in published maps and institutional affiliations.