Report of Civil Society Consultation on UHC in Italy
Civil Society Engagement Mechanism for UHC2030 (CSEM)
August 2022

Presentation

The civil society consultation on UHC in Italy has been conducted by Villa Maraini Foundation, National Agency for Addictions of the Italian Red Cross and Training and Research Centre on addictions of the International Federation of Red Cross and Red Crescent Societies (IFRC).
Villa Maraini has been working in the field of substance abuse since more than 46 years, becoming one of the leading centres in drug addiction treatment and care. It provides various healthcare services for vulnerable and marginalized people, serving as a safe centre for those in need, working to mitigate the stigma and potential public health consequences of the spread of transmissible diseases as well as offering drug rehabilitation programmes.
As member of the CSEM for UHC2030, Villa Maraini has been asked to coordinate the national consultation on the State of Commitment to Universal Health Coverage in Italy, involving civil society leaders, community health providers, representatives of marginalized populations.

The following consultations have been conducted:

- 3 focus groups with people who use drugs (PWUDs) currently in treatment in the Villa Maraini services
- 1 focus group with health workers of Villa Maraini
- 7 interviews with community leaders and health providers

This document summarizes the main points and contributions collected with the above consultations. The full report of focus groups and interviews is included in the annexes 1-2.

Introduction

The Italian state runs a universal public healthcare system since 1978. The national health service (Servizio Sanitario Nazionale) provides residents with free or low-cost healthcare that includes access to general practitioners (GPs), treatment at public hospitals, subsidised medicines, lab services, ambulance services and certain specialist care.
Although the right to health is guaranteed by the legal framework, its access is very heterogeneous throughout the national territory, because the national health service is managed by regional administrations on a provincial level, with the result that the standard of treatment

isn't uniform throughout the country. For instance, public hospitals in Italy's northern and central regions are known to offer higher standards of care than those in the south. As a result, those who have the possibility prefer to be treated in a major city in North Italy.
The private healthcare sector has been developing a lot in the last years; there are high-quality specialist facilities in large urban centres, while university hospitals are also highly reputable.
Private healthcare services allows to avoid waiting lists, queues and complications of the public system. It also enables provisions for more comforts and personal choice when it comes to doctors and facilities. For these reasons, although public healthcare in Italy is free, most people still opt to utilise private healthcare if they can afford to.

Civil Society Perspectives on Achieving Universal Health Coverage

CATEGORY 1: ENSURING POLITICAL LEADERSHIP BEYOND HEALTH

The government institutions in charge of planning and implementing health policies are the Ministry of Health and the National Institute of Health (Istituto Superiore di Sanità), which is the main centre for research, control and technical-scientific advice on public health in Italy.
These institutions are divided in several departments and regional offices, but there isn't a specific department responsible for ensuring UHC, because the Italian healthcare system is based on the principle of universality. However, the fragmentation of the system and the regional decentralization make it difficult to ensure uniform and equitable access throughout the territory.
All citizens are guaranteed access to public health centres through the National Health Service (Servizio Sanitario Nazionale), but there are some groups of population who don't have the requirements or competences to make use of it (for ex. migrants, marginalized people, ecc.).
The representatives of PWUDs made reference to the so-called SERD (Servizi per le Dipendenze), which are the public centres for substance abuse treatment; access to these centres is free of charge for any individual with substance abuse disorders, but there are several factors which make access difficult, such as long waiting list, burocracy, mandatory referral to the centre located in the place of residence.

CATEGORY 2: LEAVE NO ONE BEHIND

As stated above, the Italian public healthcare system is universal and free of charge and includes medication, clinical and surgical care and hospitalization, but respect of this right is not equitable.
The groups experiencing more difficulty in access to health services are migrants, in particular 'irregular' ones, elderly persons, people with mental health problems, PWUDs.
For migrants, the main barrier is the limitation of medical services they can access through the national health service (some diagnostic tests or specific treatment cannot be provided with a temporary medical card). Elderly and poor persons can lack of competences and digital skills now required to schedule appointments or accessing some services. People with mental health problems and/or substance abuse disorders suffer from lack of adequate services, long waiting list, stigma and discrimination that surround the topics of mental health and substance abuse.
Moreover, for PWUDs it's mandatory to refer to the drug addiction service located in the place of residence, it's not possible to choose another treatment service. This represents a violation of the

universal right to health stated in the Italian Constitution, as well as of the national law on substance abuse, which states the right of people with substance abuse disorders to freely choose the place to be treated among all the public and private services available in the country.

CATEGORY 3: REGULATE AND LEGISLATE

There are no clear mechanisms for monitoring the right implementation of public health policies and the legislation. The fact that the national health system is administered at regional level creates differences and disparity in the quality, availability and efficacy of health services among regions. This decentralization of the health system has a negative impact also on the monitoring of health policy, because data are collected on a regional basis and consequently, are not homogeneous.

Moreover, there isn't a national mechanism for including data collected by the private sector and civil society organizations into the national surveillance system; therefore, a huge quantity of information about the access to health services of marginalized populations is missing in the official statistics. An example of this is the data about access to testing, treatment and care for HIV, Viral Hepatitis and other Sexually Transmitted Infections of most vulnerable and hard-to-reach groups (PWUDs, sex workers, LGBTs, migrants, homeless); many civil society organizations offer such services at community-based level, but data collected through these services are not included in the national surveillance system and therefore, cannot be used to assess the state of implementation of UHC and adapt health policies to the need of marginalized communities.

CATEGORY 4: UPHOLD QUALITY OF CARE

In general, the quality of care as well as the competence and professionalism of health workers are perceived as good. The problems are the inadequacy of many health facilities and medical equipment (too old), the long waiting lists for several diagnostics and tests, the lack of an adequate number of health providers, the difference of quality and efficiency among regions and in some cases between public and private sector.

In particular, local and national policies of recent years have discouraged young people from choosing medical studies or practising the medical profession in Italy, preferring to emigrate to other countries where salaries are much higher.

The most affected services are those for mental health and pathological addiction, because these services are under-prioritized and there is a lack of psychologists, psychiatrics, drug abuse treatment specialists.

Moreover, there is still a lack of community-based health services that could offer various typology of screening, testing, diagnostics, medical and psychological care, thus relieving the burden of hospitals and other public health facilities.

CATEGORY 5: INVEST MORE, INVEST BETTER

The general perception of the participants at the consultation is that the government is not spending enough for health, and the resources allocated in the last years have been decreasing or not spent in the right way, fostering the increasing of the private sector.

In order to facilitate UHC, more investments should be dedicated to the following priorities:

- Increase the number of health personnel;

- Ensure continuous training of health professionals, in accordance with new emerging needs of the population;
- Promote the development of community-based health services, closer to citizens and able to provide a quick access to primary care and first aid;
- Increase the number and quality of information and prevention services;
- Promote integrated healthcare and social services, able to offer a comprehensive support to people with multiple disorders and needs;
- Improve home care services, particularly for elderly people;
- Invest more in digital health, in order to reduce gaps and inequalities due to lack of digital skills in some groups of population;
- Reduce the cost of medicines and/or find alternatives to their purchasing (for ex. selling medicines in smaller packs or in single units);
- Increase access to health services for PWUDs.

CATEGORY 6: MOVE TOGETHER

At national and local level there are several associations and civil society organizations that work in the field of health or represent a specific group of patients. Some of them collaborate with government agencies through participation in round tables, working groups, joint projects, but there is not a systematic mechanism of civil society engagement in planning, monitoring and evaluating national health policies. Community planning and participatory budgeting processes are almost inexistent, and in any case the contributions of civil society are not binding.

There is still a need to advocate for a better collaboration between public health services and civil society organizations, despite the evidence of the effectiveness of such collaboration showed by the COVID-19 pandemic.

Civil society organizations can play an important role in the implementation of public health programmes and achievement of UHC, through the offering of different kind of community-based services. Moreover, CSOs have more experience and capacity in the organization of public awareness campaigns and community mobilization, such as fundraising events or prevention and information activities.

CATEGORY 7: GENDER EQUALITY

There are no gender differences in the access to health services, but in some groups of population women may encounter more difficulties due to cultural habits (in case of migrants) or lifestyle behaviours (in case of women who use drugs, sex workers, etc.). These women may perceive discrimination or shame, and this may prevent them from accessing healthcare services.

The presence of children may represent an additional barrier, due to the fear of losing the custody of children in case of mental health problems or substance abuse disorders.

In general, the services most challenging for women are the ones related to gynaecology and pediatrics, because in the public sector these services are not always of good quality or there are long waiting list for tests and diagnostics; therefore, during pregnancy the majority of women have to refer to private services which are very expensive and not accessible to poor or marginalized women.

In addition, the greatest form of gender discrimination concerns the implementation of the right to abortion hindered by the large number of doctors in the country who refuse to do it.

CATEGORY 8: EMERGENCY PREPAREDNESS

The COVID-19 pandemic has strongly affected the access to care, since priority was given to emergency care and COVID-19 response. Scheduled health services for both clinical and surgical care were interrupted, and many consultations were conducted only by video calls.

According to the participants, those most affected were people from marginalized communities and people with chronic diseases, who experienced difficulties in receiving their regular treatment. It's the case of people in treatment for substance abuse disorders, since almost all the centres providing opioid substitution therapy and other pharmacological treatment were closed. The fact that Villa Maraini remained open and ensured the regular provision of services was highly valuated by most of the participants at the consultation. Moreover, this allowed us to notice that despite the common prejudices against PWUDs, people under opioid substitution treatment with methadone are less exposed to COVID-19 consequences, because the anti-inflammatory effect of methadone prevents the evolution from COVID infection to COVID disease.

The suggestions to be better prepared for other eventual pandemics are:

- invest more in health personnel and facilities;
- increase community-based healthcare services;
- improve prevention and information campaigns;
- invest more in digital health, equipping health services with technological tools and educating citizens on how to use them.

CATEGORY 9: LOOKING TO 2023

One element considered as fundamental in order to achieve UHC is the fight against stigma and discrimination toward marginalized communities, which is present in many health providers. People who use drugs, migrants, sex workers, LGBTs experience very often inequalities in treatment and care due to prejudices of health workers on their lifestyle behaviours, and this form of discrimination represent a barrier in the access to care for many people.

In light of this, looking ahead to 2023 these are the main requests of participants at the consultation both at national and international level:

National level:

- improve community-based health services for poor and marginalized populations;
- reduce inequalities between the public and private health sector, making the access to quality health services available to all citizens;
- reduce burocracy and long waiting lists for several diagnostics tests and consultations;
- increase the number of health personnel through higher salaries and more opportunities for young graduates

International level:

- invest more in public health, because 'more people are healthy, more communities are healthy';

- pay more attention to the needs of vulnerable people and make it easier for them to access health services;
- promote collaboration and common health strategies among countries, because 'in a globalized world, healthcare also should be globalized';
- reduce social and economic inequalities among different part of the world, ensuring an equal distribution of resources and medical tools.

Conclusions

The protection of public health represents in our country a constitutional dictate, a bi-partisan political commitment and a declared economic and social priority. The Italian public health system is considered one of the most progressive in the world, because it claims to offer Universal Health Coverage to all citizens, as stated in the article 32 of our Constitution.
However, in the last years the decreasing of investments, the increasing of private health services, the scarce job opportunities for health workers have undermined an ideally optimal system. Moreover, the decentralization of the public healthcare system to regions has created huge territorial differences in the quality and efficiency of health services.

In order to achieve UHC, the following points must be recognized as priorities by the government:

- ensure equal access to care for all citizens, including marginalized communities. In particular, it should be in the interest of each government to reach out all the PWUDs, since if they are dangerous for themselves and others, they could be more if ignored and marginalized;
- increase investments in public health, particularly in community-based health services able to respond to the primary and new emerging needs of the population;
- encourage access to the medical professions, also through adequate remuneration of health workers;
- involve all relevant stakeholders, including civil society organizations, both in the planning of policies and strategy that in the monitoring phase.