U.S. vs. Italy's Single-Payer Health System: Enlarging the Perspective

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In recent times in the United States (US) debate over the merits of single payer types of health care systems and universal coverage (which have the government in control of health care services and payments) has increased (Scheinker et al., 2021; Oberlander, 2019). There are wide discrepancies in the public's understanding and the health care providers perspective on these topics. The term "Medicare for All" has grown in popularity, often being mistaken for free universal health care. This can lead to unintended consequences for new policies (Kaiser Family Foundation, 2019).

The US Health System, ranked 37th by the World Health Organization (2000), has often been criticized for its high cost yet unresolved issues relating to universal access and poor health outcomes relative to other OECD (Organisation for Economic Co-operation and Development, n.d.) nations. Comparisons of the US health care system are often made to the single payer Canadian Health System (ranked 30th) and the National Health Service (NHS) in the United Kingdom (ranked 18th). However, fewer comparisons have been published with the world's second ranked Italian Health System, which is a single-payer system modeled after the NHS. A closer look at the US and the world's highest ranked single payer health system in Italy in areas relating to cost and coverage, services and resources, and health outcomes may advance the debate on options for the American healthcare system.

The Italian Health System

The current Italian Health System, known as the Servizio Sanitario Nazionale (SSN), was established in 1978 under the guiding principles of universal coverage, human dignity, and health needs (The Commonwealth Fund, 2020). Services are provided to all citizens and foreigners. Italy spends about 9 percent of GDP and about $3,400 per capita on health care services. Approximately 75 percent is publicly funded through a value-added tax, plus a corporate tax, and more than 20 percent is funded out-of-pocket by consumers. The central government determines annual SSN funding and controls the allocation of resources to each of the 19 regions and two autonomous provinces that provide required services known as the Essential Levels of Assistance (LEA) including pharmaceuticals, inpatient hospital care, outpatient specialists, prevention, home care, primary, and hospice (The Commonwealth Fund, 2020). The 19 regions and two provinces can provide more services but

must pay for them through taxation and patient co-payments. Not covered are services such as cosmetic care, orthodontics, and laser eye surgery. Pharmaceuticals are grouped into three tiers corresponding for life-saving or chronic care, in-hospital treatments, and all other treatments. Primary care is provided by physicians that enroll a list of clients up to a maximum number of 1,500 for general practitioners and 800 clients for pediatricians. Physicians receive a capitated fee or an amount per patient that is based on the number of patients on their list (The Commonwealth Fund, 2020). Specialists are often reimbursed on a fee-for-service basis. Many physicians work in both the public and private system. Private insurance accounts for about one percent of spending and covers about 6 million residents (approximately 10% of the population). Private insurance usually provides higher levels of comfort (such as private rooms) when receiving care and services not otherwise covered. In addition, a system of private hospitals exists that are accessible to those whose private insurance covers the costs or can pay out-of-pocket (The Commonwealth Fund, 2020). One characteristic of the Italian health care system is the extensive waiting time to see a physician, particularly a specialist for elective procedures, which in some cases can approach or exceed one year.

The US Health System

A frequent topic of debate at the federal and state levels; discussion of the US Health System often involves issues of high cost, lack of universal coverage, and fragmentation of services (The Commonwealth Fund, 2020). The US health spending is over $3.8 trillion or $11,582 per capita (American Medical Association, 2021). Total public spending accounts for about half of health care spending, private insurance provides about 40 percent, and the remaining 10 percent is out-of-pocket spending from consumers (American Medical Association, 2019). The Federal government operates Medicare (mainly for citizens 65 years and older) and works in partnership with the States to administer Medicaid (mainly for lower-income citizens) and the Children Health Insurance Plan (CHIP) (mainly for the children of low-income citizens). While Medicare is standardized across the country, Medicaid and CHIP vary by state. In 2015, more than 60 percent of US residents were covered by private health insurance, most commonly received through their place of

employment. Medicare covers about 17 percent of the population and Medicaid about 20 percent (Kaiser Family Foundation, 2022). In 2019, about 27 million Americans or approximately 9 percent, were uninsured. The passage of the Affordable Care Act (ACA) is often credited with reducing the number of uninsured from over 40 million to its current levels – although it does not cover undocumented residents (Kaiser Family Foundation, 2019). The ACA requires 10 essential services be provided that includes ambulatory care, emergency department, hospitalization, maternal/newborn, mental health/substance abuse, prescription drugs, rehabilitation, laboratory, prevention, chronic care, pediatrics (Healthcare.gov, 2022). The ACA allows the individual states to determine the level of these services provided.

Approximately one-third of physicians work in primary care in private practice or a hospital system and can be reimbursed in several ways, including fee-for-service and capitation (The Commonwealth Fund, 2022). The remaining two-thirds of physicians are specialists that work in either private practice, group practice, or a hospital system (Association of American Medical Colleges, 2022). After-hours care is often provided in hospital emergency departments. Of the country's more than 5000 hospitals, 70% are private not-for-profit, 15% are for-profit businesses, and 15% are public or government operated (American Hospital Association, 2022).

Methodology

Descriptive analysis based on secondary data that are publicly available was conducted comparing selected indicators of the US and Italian health care systems. Data from 2019 were utilized when available to enable the comparison of health system performance prior to the impact of the COVID-19 pandemic. Data reviewed were in three domains. 1) Health care spending included percent of GDP (gross domestic product) spending, per capita health care cost in US dollars, out-of-pocket spending in US dollar, and percent of the population with health insurance (Table 1). 2) Selected health care resources included hospital beds per 1,000 population, physicians per 1,000 population, physician visits per year, nurses per 1,000 population and hospital nurses per bed (Table 2). 3) Selected population and health indicators are provided to provide insight on the

characteristics of the people of the two countries and included total population, percent of the population 65 years and older, life expectancy, infant mortality rate, obesity percentage, and diabetes percentage (Table 3).

Analysis

The analysis will provide a comparison of the US and Italian health care systems in three areas: health care spending, selected health care resources, and selected population and health indicators.

Health Care Spending

Health care spending in the United States is considerably higher than in Italy (see Table 1). As a percentage of Gross Domestic Product (GDP), the US spends about twice the amount as Italy. This amount is approaching one-fifth of the US economy, while in Italy spending is restricted to about nine percent of GDP. The US also spends substantially more per capita on health care ($11,582 versus $3,482). Although citizens of both countries have out-of-pocket expenditures not covered by insurance, the amount in the US is higher ($1,122 versus $791). The percent of the population with health insurance in Italy is higher with every resident covered compared to the US that has 91.4% of the population covered.

Table 1
Health Care Spending

Category	US	Italy
Percent GDP	17.7	9.0
Per Capita Health Care Cost (USD)	$11,582	$3,428
Out-of-pocket spending (USD)	$1,122	$791
Percent with health insurance	91.4	100

Source: OECD

Selected Health Care Resources

Italy has more health care resources in terms of hospitals and physicians while the US has more nurses (Table 2). Italy has about 15 percent more hospital beds per 1,000 population than in the US (3.2 versus 2.8). Italy also has approximately 50 percent more physicians per 1,000 population (4.0 versus 2.6) and the average Italian resident goes to the physicians about 70% more per year (6.8 physician visits per year) than in the US (4.0 visits per year). The supply of nurses is much greater in the US, having nearly three times the number of

nurses in Italy per 1,000 population. Also, the US has more nurses working in hospitals with the average number of nurses per hospital bed in the US are twice that of Italy.

Table 2
Selected Health Care Resources

Health Resource	US	Italy
Hospital Beds per 1,000 population	2.8	3.2
Physicians per 1,000 population	2.6	4.0
Physicians Visits per year	4.0	6.8
Nurses per 1,000 population	15.7	5.9
Hospital nurses per bed	2.84	1.4

Sources: Kaiser Family Foundation and Statista

Selected Population and Health Indicators

Selected population and health indictors for the two countries are provided in Table 3. Italy and the US are in different parts of the world with different cultures that may impact the health of the population. The US population greatly exceeds that of Italy by more than six-fold. Italy has a much greater proportion of its population 65 years and older when compared to the US (23.3% versus 16.0%). Life expectancy is greater in Italy with the average Italian living more than four years longer than the average US resident. The infant mortality rate in Italy is less than one-half of the US rate (2.7 versus 5.6). The obesity percentage of the population (Body Mass Index greater than 30) in the US is four times the Italian percentage (40.0% versus 10.8%). Also, the percentage of diabetes in the US is more than twice the rate in Italy (10.8% versus 5.0%).

Table 3
Selected Population and Health Indicators

Indicator	US	Italy
Total Population (millions)	329.5	59.5
Percent population 65+	16.0	23.3
Life Expectancy	78.8	83.2
Infant Mortality Rate	5.6	2.7
Obesity Percentage (BMI >30)	40.0	10.8
Diabetes Percentage	10.8	5.0

Sources: US Bureau of Census, Statista, CDC, The Commonwealth Fund

Discussion/Conclusion

A review of the Italian health care system provides some valuable insight to the benefits of a single payer health care system. Lessons learned from Italy include that all residents can have insurance coverage, that health care costs can be lower than in the US, and that the population can enjoy a relatively higher level of health. The Italians accomplish this with a much higher proportion of the population over the age of 65, who are known to have higher health care costs. The Italians also have more hospital beds per capita, more physicians per capita, and their residents have more physician visits per year than in the US. The higher number of physicians and the willingness of the population to seek care more often may lead to early detection reducing health care costs and enhancing health. Culture, lifestyle, and diet may account for at least some of the four plus years of life expectancy the Italians experience over the US residents.

Some modifications would be needed to the US system to achieve the level of health care resources in Italy. The hospital bed supply would need to be expanded by nearly 15% from the current level of 2.8 beds per 1,000 population to equal the 3.2 beds per 1,000 population in Italy. Even more challenging would be increasing the supply of physicians from the US level of 2.6 per 1,000 population to equal Italy's 4.0 physicians per 1,000 population, an increase of more than 50%, or approximately a half of a million physicians. In addition, the number of patient visits to physicians would need to increase by 70% to have the current US rate of 4 physician visits per year to equal the Italian rate of 6.8 visits per year.

It seems highly unlikely that the US could adopt an Italian style single health care system. Significant investment to address increasing the physician supply and number of hospital beds would be required. Although it is common for Italian residents to wait an extended period of time for health care services, it also seems unlikely that US residents will be willing to wait similar extended periods of time for health care services. The US may benefit more in the intermediate time frame by focusing on policies that improve the health of the population, particularly for disadvantaged and vulnerable groups.

About the Author

Dr. Stephen J. Notaro is a Doctoral Faculty Instructor in the ACCESS program at the University of Phoenix. He earned a Doctorate in healthcare policy and administration, a Master's degree in public administration, and a Bachelor's degree in health administration. He has over 25 years of experience as a professor having designed and established a Master of Science in Health Administration program, teaching courses in medical ethics, strategic planning, health policy, health finance, and led multiple study abroad courses to Italy to study the Italian Health System.

Currently Dr. Notaro is teaching doctoral courses in research design, leadership theory, and serves on dissertation committees. He has taught undergraduate courses in health care delivery in the U.S. and public and community health. Dr. Notaro's research agenda includes identifying area wide needs, assessments of existing services using statistical and financial analysis, the development of strategic plans, and the development of health care services and programs to address those needs, as well as recently published studies on doctor-patient communication in cancer prognosis. Dr. Notaro has won multiple awards for teaching excellence, with a philosophy of employing any resource and sparing no effort to help all students succeed in academia and beyond.

In addition, Dr. Notaro has 11 years of professional experience in health planning and health care consulting and 20 years of management experience in non-for-profit organizations. He has served as a consultant to not-for-profit organizations and has been a featured speaker at conferences and seminars on management, fund-raising, ethics, and leadership.

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