HEALTH CARE: PUBLIC, PRIVATE OR NONPROFIT?

Comparative Survey on the Role of the Third Sector in Western Health Systems and Health Care in Veneto

Edited by Paolo Sommaggio and Claudio Di Gregorio

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We know only too well that what we are doing
is nothing more than a drop in the ocean.
But if the drop were not there,
the ocean would be missing something.
Mother Teresa of Calcutta

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ABBREVIATIONS

ACA (Affordable Care Act, also known as Patient Protection and Affordable Care Act – PPACA)
ADI (Integrated home care assistance)
AMI (Acute Myocardial Infarction)
AOU (University Hospital)
APS (Association for Social Promotion)
ATECO (Classification of economic activities)
BPCO (obstructive pulmonary disease)
BUR (Official Journal of the Veneto Region – Italy)
CG (Clinical Governance)
CTS (Code of Third Sector)
CSV (Service Centre for Volunteering)
DOC (Functional Department of Medical Oncology)
DGR (Resolution of the Veneto)
DRG (Diagnosis Related Group)
D03C (Standardized adult hospitalization rate for diabetes, BPCO and heart failure: proxy indicator of the reduced accessibility and functionality of the services of territorial medicine, responsible for the treatment of the diseases indicated, both in terms of prevention and treatment, according to the NSG System)
D14C (Composite indicator for age groups that measures the consumption of sentinel/tracer drugs for 1,000 inhabitants. Antibiotics, according to the NSG System)
D27C (Proxy indicator of the effectiveness of territorial management of patients with psychiatric diseases, according to the NSG System: percentage of re-admissions between 8 and 30 days in psychiatry).
D09Z (Indicator that measures the response times of mobile units in emergency response, according to the NSG System)
D10Z (Indicator I for the share of benefits delivered within the maximum time allowed in relation to priority class B: "short")
D22Z (Composite indicator that provides guidance on the provision of integrated home care service for patients treated with different levels of care intensity, according to the NSG System)
D30Z (Indicator for measuring the supply of home palliative care services for the management and care of terminal cancer patients)

D33Z (Indicator of the supply of residential/semi-residential structures by number of elderly people not self-sufficient in residential/semi-residential socio-sanitary treatment in relation to the resident population, by type of treatment – intensity of care – according to the NSG System)
ENI (European citizen not registered in the National Health Service)
ETS (Third Sector Entity or Nonprofit Organization)
EURICSE (/European Research Institute on Cooperative and Social Enterprises)
FSNS (National Standard Health Requirements)
GDP (Gross Domestic Product)
GSA (Centralized Health Management: Centre of responsibility that directly manages a share of the financing of the Regional Health Service)
HTA (Health Technology Assessment)
H01Z (Standardized Hospitalization Rate (ordinary and daytime) in relation to resident population: it expresses the demand for hospital care by residents)
H02Z (Share of breast cancer interventions performed in wards with activity volume above 150 (10% tolerance) annual interventions: it provides information on the proportion of interventions for malignant breast cancer performed in Departments whose activity volume is predictive of greater effectiveness and safety of surgical procedures)
H04Z (Indicator of inappropriate use of the hospital setting; direction: decreasing)
H50Z (Indicator that measures the performance of the hospital in relation to the share of interventions whose post-operative stay is considered appropriate; direction: decreasing)
H13C (Percentage of patients aged 65+ diagnosed with femoral neck fracture operated within 2 days on ordinary regimen)
H17C (Percentage of Cesarean deliveries in maternity of I level or otherwise with <1.000 deliveries)
H18C (Percentage of Cesarean deliveries in maternity of II level or otherwise with >=1.000 deliveries)
ICNPO (International Classification of Non-Profit Organization – United Nations Statistics Division)
IRCCS (Institute of Hospitalization and Scientific Care)
ISS (National Institute of Health)
ISTAT (National Institute of Statistics)
LEA (Essential level of care)
LEP (Essential levels of benefits)
L.R. (Regional Law)
MPR (Measles, mumps and rubella)
NADEF (Update to the Economic and Financial Document)
NHS (National Health Service – Britain)
NSG (New Guarantee System for essential levels of care, according to D.M. Health 12 March 2019)
OECD/OCSE (Organization of Economic Cooperation and Development)
ODV (Voluntary Organization)
PIL (Gross Domestic Product)
P01C (Basic vaccination coverage in children up to 24 months, according to the NSG system)

P02C (Vaccination coverage in children to 24 months for 1 dose of vaccine against measles, mumps, rubella MPR, according to the NSG System)
P10Z (Coverage of the main activities related to the control of animal records and their feeding, according to the NSG System)
P12Z (Coverage of the main control activities for food contamination, according to the NSG System)
P14C (Composite indicator on lifestyles)
P15C (Composite indicator to measure the activities of organized cancer screening programs and the effective participation of citizens)
PTDA (Indicators for the monitoring and evaluation of therapeutic diagnostic pathways)
RUNTS (Third Sector National Unique Register)
SDG (Sustainable Development Goals)
SNLG (Sistema Nazionale Linee Guida)
STP (Foreigner Temporarily Present in the Territory)
SSN (National Health Service in Italy)
SSP (Strategic Social Purchasing)
SSR (Regional Health System – also mentioned with the acronym RHS)
T.U. (Consolidated Act; e.g.: "T.U. sull'immigrazione", meaning "Immigration Consolidated Act"
ULSS (Local Social Health Unit)
UHC (Universal Health Coverage)
UOC (Complex Operative Unit)
WHO/OMS (World health Organization)

CONTENTS

INTRODUCTION

Around fifteen years ago, eminent British researchers (Heins et al, 2010)[1] conducted a comprehensive review of the global literature on the quality of the performance offered by the public health service, as well as by the private and by Nonprofits.

The afore mentioned studies suggested a better quality of services offered by non-profit institutions than those provided by the private sector (for-profit), while the value-driven studies pointed out that the services provided by the Nonprofit institutions more effectively corresponded to the needs of the target community, compared with ones offered by the private sector. Anyway, both the private sector and the Third Sector's performance in the healthcare field had been overcome by those of the public sector, both in terms of the extent of services provided and in terms of transparency of the organizational apparatus and the intervention strategies adopted.

A more recent and equally authoritative study (Rahal et al, 2024) still conducted in the United Kingdom, in the aftermath of the two reforms of the National Health Service (NHS)[2], shows that Third Sector is increasingly involved in the provision of health services, although the number of contracts with the NHS remains rather low.

Finally, it is worth mentioning the public/private initiative, cited as a virtuous example even by the World Health Organization (WHO – Regional Office for Europe, 2019), whose beneficiary is the Hospital of Treviso, in the Veneto Region, Italy.

The concerned partnership contract covers a period of 21 years, worth 250 million euro co-financed by the European Investment Bank (EIB), aimed at

[1] For a more detailed analysis, see Table 1 in the Appendix.

[2] The two "Health and Care Acts" are referred to the 2012 and 2022 Act, which introduce an integrated health system renewing the unified UK-wide medical care system established by the National Health Service Act 1946, effective on 5 July 1948.

providing 1000 new beds. All through the establishment of an "ad hoc" body – the "Ospedal Grando Impact Investing", a private company – whose scope is precisely dealing with financial operations with a strong social impact.

Our survey starts from here. Given the progressive entry of non-profit organizations into the world of health, with an operability closely linked to the rules of market and free competition, the question is whether an integrated "public – private – nonprofit" model can produce a high-quality health service, economically sustainable and closer to the stakeholders' needs.

It is also a question of verifying if such a model retains its validity regardless of the country's legal-institutional and economic-financial framework (National Health Service essentially public, centralized or decentralized, or essentially private Health Service in which the State plays a mere regulator role), as well as of the local organizational apparatus and regulation or ownership and assets' control (Heins et al, 2010; Horwitz, Nichols, 2022; Rahl, Mohan, 2024)[3].

The available data show that the concise expression "*health interventions and services*"[4] actually opens up a very complex and diverse universe of institutions, situations, organizational and operational dynamics that are substantially comparable in different health settings, whether operating at national, regional or local level, even when the survey is limited to hospital/outpatient services and to interventions and services closely connected with them.

In the context of the Veneto Region, whose Health Service – as it will be seen – represents an excellence at national level, there are four Institutes of Hospitalization and Scientific Care (IRCCS), including one private, and two nonprofits, dozens of outpatient units, also run by nonprofit organizations, hospitality services for the family members of patients, voluntary and solidarity organizations, accredited rescue services and/or ambulance transport under "*accreditation*" regime, to mention just those of greatest importance[5].

The survey, whose results are illustrated in the following pages, aims to verify whether the Veneto health care model, defined by several authors "tripar-

[3] According to the study edited by Heins E. et al, *A Review of the Evidence of Third Sector Performance…* cited above, p. 521, the ownership of assets of nonprofit entities is completely irrelevant, while according to Rahl C., Mohan J., Rahl C., Mohan J., *The Role of the Third Sector in Public Health Service Provision…*cit., p. 26 and Horwitz J.R., Nichols A., *Hospital Service Offerings Still Differ Substantially By Ownership Type,* Health Affairs (Millwood), 2022 Mar; 41(3): pp. 332-333, e p. 9, Table E and the related Appendix in *https://doi.org.10.1377/hlthaff.2021.01115*, ownership is an essential element in the analysis of the typology of entities operating in the health care services and in the monitoring of their performance.

[4] See art. 5, para. 1, lett. b) of the Legislative Decree 3 July 2017, n. 117 (Code of the Third Sector) and art. 2, para. 1, lett. b) of the Legislative Decree 3 July 2017, n. 112 (Decree of the Reform of Social Enterprises).

[5] See Table 13, in the Appendix.

tite" or "quadripartite" (Biancheri, 2023; Cusinato – Rigoli, 2023; Pisani – De Corte, 2023)[6] is, so to speak, replicable in other institutional contexts, under what conditions, and above all which role may the Nonprofits play and under which perspectives.

The comparative analysis of data concerning the role of the Third sector in the main western health systems is therefore functional to better understanding the data concerning the context of the Veneto region, of the health needs expressed by citizens and patients and to assess the effectiveness of the solutions offered by the Regional Health Service.

[6] See Biancheri G., *Il privato in sanità. La vera posta in gioco*, in Quotidiano Sanità, 16 gennaio 2023, p. 2 *https://www.quotidianosanita.it/studi-e-analisi/articolo.php?articolo_id=110245*. The author defines the Italian Health system as a "four-party", distinguishing between the different actors in public, private, "accredited" private and Third Sector entities; Cusinato A., Rigoli G., *Indagine conoscitiva sugli ambulatori medici del Veneto gestiti da Enti del Terzo Settore 2022*, Castelfranco Veneto, 2023, who highlight, within the structures managed by third sector entities, the clinics attributable to the Catholic Church (e.g. Cucine Economiche Popolari CEP of Padua, attributable to the diocesan Caritas), those attributable to forms of "lay" volunteering (e.g. CESAIM of Verona, an association whose purpose is to provide health care for immigrants so-called "irregular"), and finally those that constitute "branches" of International Organizations (e.g. "Emergency" clinic in Marghera (Venice), a branch of the NGO Emergency, engaged in the rescue to war victims, the first Italian NGO to sit in the special Forum established by the Economic and Social Council of the United Nations). The publication is also available in *https://cesaim.wixsite.com/cesaimverona;* Pisani G., De Corte j., *L'integrazione socio-sanitaria come asse di un nuovo modello di assistenza. Il possibile ruolo del Terzo Settore*, Euricse, 2023, Working Paper n. 128/23, ISSN 2281-8235 in *https://papers.ssrn.com/sol3/papers.cfm?abstract_id=4518875*.

1.
THE THIRD SECTOR IN HEALTH CARE: A REVIEW OF THE INTERNATIONAL EXPERIENCE

1.1. *Methodological premise*

In the study of a social phenomenon, such as the entry and operability of nonprofit organizations in the field of health, it is first essential to have objective and reliable data that attest to its existence, quantifying its scope and duration, researching its causes, its distribution and its possible growth or decline until extinction.

It is also essential to have data which allow the phenomenon under study to be measured and compared with other similar phenomena, but which have occurred in different legal, economic and social contexts.

The acquisition of such data is extremely complex because all the actors involved have only a part of the databases that researchers need and often these databases do not communicate with each other.

Let us take an example: if we want to know how much the Third Sector[1] in Veneto's health care is worth, we should be able to have access, in real time, to the budgets of the audience of nonprofit entities working in the field of health care, by legal form, turnover, public subsidies, special subsidies (in Italy the so called "five per thousand")[2], and so on.

[1] It should be noted that the term "*Third Sector*" used in the Italian Code of the Third Sector (CTS) has a broader scope than that of the documents approved by the United Nations, primarily by "Satellite Account on Non-profit and Related Institutions and Volunteer Work, New York, 2018, p. 16, which uses the expression Non-profit or Third Sector to designate the so-called "social economy", including "pure" non-profit, i.e. (a) entities not controlled by the Government, central or local; (b) some related institutions including social cooperatives, mutual societies, mutual aid companies and social enterprises, which also have limited possibilities of profit distribution, and the whole world of volunteering, which, at least in principle, operates completely free of charge. Not all the Third Sector is "non-profit" and, moreover, both expressions do not include the whole range of "socially responsible bodies". The expressions, therefore, especially in the comparative survey conducted on Western Health Systems should not be understood in a "strict sense", limiting it to the Italian CTS or the D. Lgs. 112/2017 (Decree on social Enterprises) or to laws related to them in some way , but contextualized with respect to the audience of "entities" referred to from time to time.

[2] The so called "five per thousand", introduced in Italy with art. 1, para. 337 – 340 of the Law 23 December 2005,

One could begin by examining the social balance sheet of these entities, but apart from their number (12,578 in 2020 in Veneto, of which only 8,560 are enrolled in RUNTS)[3], it should be noted that only the entities of the Third Sector with a total of "*revenues, annuities, income or other revenue in any way"* are *"required to publish the social balance sheet on their website*"[4].

One could turn to the Italian Revenue Agency and request the total data of these entities, based on the predominant activity declared for the purposes of assigning the VAT number and/or ATECO code[5]. However, apart from the fact that the delivery of such data, even for research purposes, does not fall within the ordinary functions of the Agency and it must still be taken into account the restrictions inherent to the GDPR[6], applicable to entities not classified as companies or legal persons (e.g.: unrecognized associations), the data obtained would also not tell us which part of the revenue included in the budget of an institution is attributable to "public contributions" and therefore has influence (and how much) on the total health expenditure.

In addition, the financial figure of a nonprofit organization could be determined by legislative reforms, as it happened in the different health systems that we will illustrate, or by exceptional events, as it occurred at a global level, during the Covid-19 pandemic, in the years 2020 and 2021.

The example we gave concerns only one of the 21 Regions and Autonomous Provinces of Italy – Veneto – with about 4.9 million inhabitants (given 2019) on the 58.94 million Italian population (given 2022), but it highlights the difficulties which we have mentioned in this premise and which naturally multiply when trying to compare necessarily partial data with as many partial data often referring to different years on a global scale, and therefore not homogeneous (Heins et al, 2010).

To overcome these difficulties, in this survey we have used data from official

No. 266, 2006 Finance Act) is a share of IRPEF (Personal Income Tax) that the State, based of citizens-taxpayers' suggestion at the time of their tax return, shares for nonprofit organizations listed on the Italian Revenue Agency.

[3] See the Press Release No. 1700 dated 3 October 2023 of the Veneto Region *"Resources for over 2 million euros to the Third Sector. Councillor Lanzarin: "We support fragility with social projects. volunteering supports institutions with excellent results*". For the meaning of the abbreviation RUNTS, please, see the ABBREVIATIONS list at the beginning of this survey.

[4] This is expressed in art. 14 of the Legislative Decree 3 July 2017, No. 117 (Third Sector Code).

[5] ATECO is the classification of economic activities adopted by ISTAT for statistical purposes, i.e. for the production and dissemination of official statistical data. The management of the classification is entrusted to ISTAT in the different updating phases to which it is subject both at national and international level. At national level, the classification is also used for other administrative purposes (e.g. tax). The meaning of ATECO and ISTAT is reported in the ABBREVIATIONS list at the beginning of this survey.

[6] (EU) Regulation No. 2016/679 of the European Parliament and of the Council of 27 April 2016, on the protection of individuals related to the processing of personal data.

sources, mostly quoted from other official sources, always reported in the text or in the footnotes. The data are detailed in the tables and graphs in the Appendix.

1.2. *Data on Global Health Expenditure*

The latest data on the state of health at global level are reported in two documents, published by the OECD (OECD, 2023) and the WHO (WHO, 2024) respectively.

Consistent with its institutional mission, the OECD document aims at illustrating the dynamics of health expenditure in 48 countries from five continents (including "key partners" and "candidates for accession")[7] with a focus on their health systems, while the WHO document is intended to monitor the strategies of the 95 countries participating in the "*Thirtheenth Global Programme of Work*" (GPW13) aimed at ensuring the "*Universal Health Coverage*" (UHC) by 2030.

The acronym and purpose include access to basic medicines and vaccines.

Among the data presented by the OECD document, the "*Dashboard on Health status in OECD countries, 2021 (unless indicated)*" of the participating countries is highlighted, in relation to four parameters: "life expectancy", "avoidable mortality", "chronic conditions", "Self-rated health"[8].

The study shows, as to "life expectancy", an OECD average fixed at 80 years and 3 months, in correspondence of which almost all advanced economies are found, including Italy (82.7). Above the average, in order, Japan (84.5), Switzerland (83.9), South Korea (83.6).

The "avoidable mortality" reports an OECD average of 237 people per 100,000 population, and even in this case the advanced economies are in the average, some of them – among which Italy with 146 people per 100,000 population[9] – even considerably below the OECD average; the figure for "chronic conditions" (diabetes prevalence) shows an OECD average of 7.0. Here too, the advanced economies, including Italy, are mostly in the middle, as is the case with data relating to self-assessment processes of health. The USA is a notable exception to the OECD parameters, being below the OECD average for all

[7] At present, there are 39 OECD member countries, while the so called "key partners" and "accession candidates" are 10: Argentina, Brazil, Bulgaria, China, Croatia, India, Indonesia, Peru, Romania, South Africa.

[8] See Table 2, in the Appendix.

[9] The data is however referred to the period 2016/2017, that is before the pandemic of Covid-19.

parameters examined except the last one ("self-rated health"), which registers better figures.

Dashboard on access to care is of particular interest[10].

Here too, the advanced economies, including Italy, are in line with the OECD average (97.9%), but there are some exceptions in the access to the essential health services.

Among them the USA, which has an average below that of the OECD (91.3%) and three EU countries, namely Hungary (95.0%), the Slovak Republic (95%) and Poland (94.0%).

As to the degree of satisfaction with the availability and quality of care ("*Population satisfied with availability of quality health care*": OECD average 66.8%), all advanced economies, including Italy, have a level of satisfaction in line with the OECD average, with the exception – in the European Union – of Greece, Lithuania, Hungary and Poland.

As to the "*Financial protection*" (Expenditure covered by compulsory prepayment – % of total expenditure: OECD average 75.9%), in the European Union only Greece and Portugal have a worse situation, while the other countries are all in line with the OECD average, and some of them (Northern Europe) have significantly better conditions.

Finally, as to the "*Service coverage*" (unmet needs for medical care % population) the OECD average is 1.8%. Italy is in line once again, while within the European Union, the worst situation seems to be accentuated for countries such as Estonia (8.1%), Greece (6.4%), Slovenia (4.7%), Finland (4.3%) and significantly better the Northern European countries, with Germany in the lead (0.1%).

Regarding the "*quality of care*" the OECD report examines four parameters: antibiotics prescribed; effective primary care (general practitioners, avoidable hospital admissions); effective preventive care (e.g.: mammography screening within the past two years); effective secondary care (mortality in the 30 days following discharge from hospital, for acute myocardial infarction or stroke per 100 admissions aged 45 and over)[11].

As to the first parameter (OECD average defined daily antibiotic dose per 1000 people: 13.1) in which Italy is in line, there is a certain excess in some of the advanced economies (France: 19.3), while data for the UK and the USA are not available.

With regards to the effective primary care/avoidable hospital admissions

[10] See Table 3, in the Appendix.

[11] See Table 4, in the Appendix.

(OECD average: 463 per 100,000 people), several advanced economies exceed the threshold: United States of America (725), Germany (728), Australia (654), Belgium (2019 data: 633).

For example, the USA and Germany, which respectively show an insufficient data in the effective primary care (725 and 728 against 463 OECD average), have a better performance in this parameter, compared to the OECD average (US of 4.3 vs 7.8 of the OECD and 6.6 Germany, in line with the OECD average). Italy reports the same data as Germany, but the data is related to the 2014/2015 biennium.

Let us come now to the core of the document: the health spending per capita (USD based on purchasing power parities) and the extent of its financial coverage.

As to the first question, the OECD shows an average per capita expenditure (based on purchasing power parities) of 4,986 dollars, a figure expressed in percentage terms equivalent to 9.2% of GDP, with a trend to increase in 2021. Above this average, both in absolute terms and as a percentage, are the OECD advanced economies (U.S.A. $12,555; 16.6%; Germany $8,011; 12.7%; France $6,630; 12.1%). Italy is in the OECD average (4,291 $; 9%); within the European Union, Luxembourg (5.5%) and Ireland (6.1%) are below.

What seems to be relevant is the year to which the data refer (2021), immediately after the pandemic peak from Covid-19[12].

Then, the OECD gives the average number per population (1000) of general practitioners (3.7), nurses (9.2) and beds in hospitals (4.3), indicating that Italy (4.1, 6.2 and 3.1 respectively) is in line with the OECD average, while in the rest of EU, Greece (6.3) and Portugal (6) are above the number of general practitioners, Finland is significantly above the number of nurses (18.9 given 2020), Germany (7.8), Austria (6.9) and Hungary (6.8) are above in number of beds. The US is below average for general practitioners (2.7) and the UK is below average for beds (2.7).

The data on the financial coverage by the National Health Service of healthcare spending incurred by patients is of greater interest[13].

The OECD average in percentage terms is 76% for general services, 90% for hospital admissions, 79% for outpatient services, 32% for dental care and 56% for pharmaceuticals. The figure for the USA, which is missing from the Table 6, is given in the Appendix, in Figures 1 and 4 where it appears at the top of the

[12] See first two columns of Table 5, in Appendix.
[13] See Table 6, in the Appendix.

OECD ranking. For Italy, the figure for "dental care" is not known (N/A). Its amount is tax-deductible by 19%, except for a deductible of 129.11 euros.

In the EU Member States, where the National Health Services provide general care for medical treatment, there is a level of health coverage above or in line with the OECD average (first column of the Table)[14] . However, the coverage of outpatient care is significantly below the OECD average in 10 out of 27 member countries[15]. The gap between health expenditure borne by the various NHS and the financial additional burden of the citizens-taxpayers is more visible in the figures accompanying the OECD document under review[16].

The per capita health expenditure actually incurred by the various SSN of the OECD countries, in 2022, is shown in the Appendix[17]. Comparing figures 4, 5 and 14, we see that the gap between public expenditure and total private expenditure per capita of population is gradually increasing in different countries. This gap in the financial coverage of healthcare services by the public sector seems to be one of the main reasons for the progressive citizens-taxpayers-patients' shift to the private sector as well as to the nonprofit sector, as to meeting adequate or supplementary responses to their health needs[18].

Finally, the OECD document shows the trend of healthcare spending in the long run (2006 – 2022) showing a constant growth, with an evident peak in the period February 2020 – February 2021, due to the pandemic emergency from Covid-19. On the other hand, the healthcare spending shows a significant decline in 2022, with the only exception of South Korea[19].

As already mentioned, the document of the World Health Organization has a more oriented approach to the examination of the progress achieved by the

[14] See Table 6, in the Appendix. Exception is represented by Poland (72%), Hungary (72%), Latvia (69%, Lithuania (69%), Bulgaria (65%), Portugal (63%) and Greece (62%). In Portugal (80%) and Greece (66%), the coverage gap is also confirmed as regards the financial extent of hospital admissions, which is 90% on average in the OECD.

[15] In alphabetical order: Belgium (69%), Bulgaria (61%), Greece (65%), Italy (61%), Latvia (72%), Lithuania (69%), Poland (71%), Portugal (59%), Spain (73%), Hungary (66%).

[16] See Figures 1 and 3, in the Appendix that, when reporting the data of healthcare expenditure per capita in 2022, highlight in a lighter color, in relation to income per capita, both in absolute value and percentage, the additional part borne by citizens-taxpayers besides taxes (indicated by the expression "*Voluntary/Out-of-pocket*", as opposed to that indicated by "*Government/Compulsory*"). In this sense, see also Biancheri G., *Il privato in sanità. La vera posta in gioco (The private sector in health care. The real stake.*), in Quotidiano Sanità, 16 gennaio 2023, in Quotidiano Sanità, 16 January 2023, *https://www.quotidianosanita.it/studi-e-analisi/articolo.php?articolo_id=110245.*

[17] The elaboration is carried out by Biancheri G., *Il privato in sanità*…, cited above. p. 3.

[18] The OECD document highlights as one of the causes of the shift of users to the private/non-profit sector also the lack of public intervention in some areas of assistance (e.g.: dental care), or the presence of medical facilities in certain territories (distance between home and public hospital or clinic, compared to private one), or finally outpatient services not delivered to non-residents (due to the lack of regulatory/administrative requirements).

[19] See Figure 5, in the Appendix.

health systems of its member countries, in view of the "*Universal Health Coverage*" (UHC) by 2030, the UN's sustainable development goal (SDG)[20].

The focus is therefore on the inequalities found between advanced economies and developing countries and within the same groups of countries (G7, EU, BRICS), and the relative trend of healthcare spending in the last twenty years[21] .

The reported differences in the pursuit of the objective of "*Universal Health Coverage*" (UHC) are of particular interest because they highlight a certain lack of homogeneity between groups of countries. For example, while all G7 countries provide coverage of essential services (access to basic medicines and vaccines) in a range from 80% to 100%, in the other OECD and non – EU countries, only Australia and Chile reach the maximum target set by the WHO. In the European Union, the difference between Western and Eastern countries is evident: the latter have a range of 60-79% in reaching the target.

Similar differences are found in the BRICS countries: only China and Brazil reach the highest range, while India, Russia and South Africa rank in a lower level.

As regards the trend of health expenditure, in low-and middle-income countries, healthcare spending appears to be insensitive to financial crises and even to pandemic emergencies, remaining rather constant over time (see Figure 7, in the Appendix).

These differences are due to various factors, ranging from the legal-institutional context, the organizational and distributive system of healthcare services, the available financial resources and, of course, to the experience gained over time.

Thus, the time is come to deepen this experience.

1.3. *The British experience*

The British National Health Service (NHS), established by the "National Health Service Act" of 6 November 1946, which came into force on 5 July 1948, is the most extensive example of universal health care. Several countries out of the world (including Italy) have inspired to its arrangements their own health system[22].

[20] See WHO/OMS, *World health statistics 2024: Monitoring health for the SDGs, Sustainable Development Goals*, Geneva, 2024, 43 – 51, in *https://iris.who.int/bitstream/handle/10665/376869/9789240094703-eng.pdf?sequence=1.*

[21] See Figures 6 and 7, in the Appendix.

[22] We refer to the L. 23 December 1978, n. 833, bearing "*Institution of the National Health Service*". See Maci-

The system was originally based on the principles of universal health coverage, both in terms of access and comprehensiveness of benefits, and public budget health expenditure, financed through general taxation. It was characterized by:

- public ownership of health facilities and centralized organization of service management;
- vertical integration of preventive and primary health care structures delivery with public hospitals;
- cost-free benefits.

The NHS was distributed over local organizational structures – the "*District Health Authorities*", one per 100-200 thousand inhabitants – with functions of managing hospital and general medical services[23], financed by the Government which appointed its individual boards.

The model was first amended by the "*National Health Service and Community Care Act*" of 29 June 1990[24], which marked the start of an internal market in the NHS, through a clear division between the purchasing functions of health services, assigned to 28 "*Health Authorities*", and those providing the services themselves, entrusted to NHS Trusts, endowed with complete managerial autonomy, including the privatization of the employment relationships. The rationale of the change was to create a competition between producers entirely within the NHS, (hence the name of "*internal market*" assigned to the new formula)[25]. The same Act establishes the practice of "fund-holding"[26] for general practitioners (GPs) whose purpose is to reduce the number of prescriptions, leaving the "*Health Board*" to fix upstream, for each financial year, the "*indicative amounts*" of drugs, medicines and health equipment that are reasonably expected from each of them.

occo G., *The 70 years of the NHS*, in Sanità Internazionale (International Health), 28 May 2018, p. 4, who says: "*The Beveridge model (chairman of the Commission which devised the model, EN) was adopted over time by many countries, first by the nations that joined the Commonwealth such as Canada, Australia and New Zealand, and then by the Scandinavian and Southern European countries such as Italy, Spain and Portugal (...). Those who conceived the NHS drew heavily on the tried and tested model of the British NHS, which was rightly considered a sort of big brother*".

[23] These services are provided by the "general practitioners" who correspond to our general practitioners (in the common language "family doctors" or "basic doctors"), where general practitioners (GPs) treat in the first place all medical conditions, referring patients to hospitals and other medical services for urgent and/or specialist treatments.

[24] The full text of the Act is available at *https://www.legislation.gov.uk/ukpga/1990/19/contents/enacted*.

[25] See., more in depth, The Health Foundation, *National Health Service and Community Care Act 1990*, 29 June 1990, in *https://navigator.health.org.uk/theme/national-health-service-and-community-care-act-1990* and Maciocco G., *The 70 years of the NHS*..., cited above, p. 5.

[26] See artt. 34 e 35 del "*NHS and Community Care*", cited above.

But it is with the two "*Health and Care Acts*" of 2012 and 2022 that it was intended to pursue the definitive transformation of the public model of health, the flagship of the British welfare, in a public – private – nonprofit model of a national health system, regulated by the market, against which authoritative studies are placed (Heins et al, 2010; Rahal – Mohan, 2024; Goodair – Reeves, 2024).

The 2012 reform first abolishes the "*Strategic Health Authorities*" and the "*Primary Care Trusts*" – which performed comparable functions, respectively, with those carried out by the Regional Health Systems (SSR) and the local Companies/Health Units (USL) in Italy – replacing them with a single public agency called "*NHS England*" (formerly called "*NHS Commissioning Board Authority*").

This agency is responsible for monitoring and funding the activities of over 200 consortia of general practitioners, called "Clinical Commissioning Groups" (CCGs). General medicine has therefore become the real fulcrum of a system that has completely wiped out public territorial planning, giving "*General Practioners*" (GPs) a wide autonomy, but its limits are indicated in terms of greater efficiency of the health budget which continues to be financed by general taxation.

Secondly, the 2012 reform transforms hospital facilities into "*NHS Foundation Trust*" (151 in 2019)[27], which provide general, specialist, mental health, community care, and ambulance services and are supported by a trust fund. The transformation process involves rigorous financial, governance and quality care assessments with frequent audits during each fiscal year.

The structure of the Foundation Trust is composed of three elements: the "Membership Community" comprising staff, patients and caregivers and members of the local community, the "Council of Governors" with 28 councilors, including the Chairman of the Trust and public councilors and finally the "Board of Directors", which includes the officers (executive and non-executive) and the Secretary of the Trust.

At the time of introduction, they were described as "*a sort of halfway house between the public and private sectors*" (Maciocco, 2018).

The latest reform is given – as mentioned – by the "*Health and Care Act*" of 2022, which establishes an integrated system of healthcare, entrusting its planning and organization powers to the NHS England, which manages the "*Integrated Care Systems*" (ICSs). The latest, in turn, operate through dedicated

[27] See Health and Care Act 2012, Part 4, "NHS foundation trusts & NHS trusts".

structures called "*Integrated Care Board*" (currently 42), each of which develops a type of integrated public – private – non-profit healthcare[28].

These are partnerships of organizations (districts, voluntary sector and other local partners) which have the task of improving health and care services, focusing on preventing and reducing inequalities in health[29].

This system currently comprises 229 trusts, of which 154 are Foundation trusts, 50 are mental health services trusts, 10 are ambulance services trusts, 124 are acute care and acute illness trusts (Acute Trusts), 220 are hospitals offering classical hospital services, 49 specialist hospitals, 246 community hospitals, 826 community providers and 6,925 general practitioners, who can work with each other in partnership.

The implementation of the reforms is monitored by the Commission for the Evaluation of the Quality of Health Services ("*Care Quality Commission*", CQC).

It is uneasy to attempt a comprehensive assessment of the new health model in force in Britain for just over a couple of years. Compared to the 1948 model, this is a significant change with the view to make the NHS more efficient and effective, in terms of overall service delivery and economically sustainable, according to market rules. The fundamental question remains the access to care and related services (Santuari, Sage, 2021; Dutton et al, 2023).

[28] See Health and Care Act, 2022, Part 1, Health service in England: integration, collaboration and other changes – para. 21. The Integrated Care Board is responsible for providing the following services: (a) hospital accommodation, (b) other accommodation for the purpose of any service provided under the a.m. Act, (c) medical services other than primary medical services (for primary medical services, see Part 4), (d) dental services other than primary dental services (for primary dental services, see Part 5), (e) ophthalmic services other than primary ophthalmic services (for primary ophthalmic services, see Part 6), (f) nursing and ambulance services, (g)such other services or facilities for the care of pregnant women, women who are breastfeeding and young children as the board considers are appropriate as part of the health service, (h) such other services or facilities for palliative care as the board considers are appropriate as part of the health service, (i) such other services or facilities for the prevention of illness, the care of persons suffering from illness and the after-care of persons who have suffered from illness as the board considers are appropriate as part of the health service, and (j) such other services or facilities as are required for the diagnosis and treatment of illness.

[29] See *NHS England. What are integrated care systems?* in *https://www.england.nhs.uk/integratedcare/what-is-integrated-care/*

1.4. *Other European experiences*

1.4.1. *Monitoring health expenditure per capita in some EU countries*

Before we go into the health experience of the main advanced economies in the European Union, it seems appropriate to dwell further on the available data on corresponding per capita expenditure.

The cue comes from studies conducted by the OECD European Observatory on Health Systems and Policy in 2023 on the data for 2022, that is to say, following the pandemic crisis caused by Covid-19 that, on one hand, necessarily increased the level of health expenditure in the procurement of vaccines, protective equipment and in the organization of dedicated hospital facilities, on the other hand, it has seen a slowdown in the public provision of hospitalization and care services and outpatient services for other diseases, including chronic ones, which has led users to turn to other health actors, both private and nonprofit organizations to ensure access to care.

These circumstances have increased the share of health expenditure per capita borne by patients, even in systems where it is traditionally provided by the public health service and financed by general taxation[30].

In Italy, per capita health expenditure is around 2.6% higher in 2022 than in 2019. This is due to a significant reduction in direct expenditure (-6%) and a more moderate decrease in public health spending (-3.5%), linked to the lower incidence, compared to 2021, of expenses related to the pandemic crisis from Covid-19 (OECD Italy, 2023). The OECD data also show a density of general practitioners (GPs) comparable to the OECD average, but significantly varying between regions, while the number of nurses is one quarter lower than the EU average. This is aggravated by the fact that these professionals are concentrated in older age groups[31].

As a result, the national level of hospital, outpatient, residential and semi-residential care services is (in some sectors even significantly) below the OECD average.

[30] See Figure 8 – 11, in the Appendix, referring to the ratio of total per capita health expenditure and the one to individual expenditure at purchasing power parity (PPP). The lighter colour in the histograms shown in the various figures indicates the proportion of expenditure entirely borne by the patients (Voluntary schemes and Households out-of-pocket). The corresponding data are taken from OECD European Observatory on Health Systems and Policies, State of Health in the EU, Country Health Profile 2023, respectively "Italy", "France", "Germany", "Finland", 2023, OECD Publishing, Paris/European Observatory on Health Systems and Policies, Brussels.

[31] See OECD European Observatory on Health Systems and Policies, State of Health in the EU..., cited above, p. 12, Figures 11 and 12, which shows that this density is lower in Liguria, Lombardy, Veneto and Trentino-Alto Adige, and significantly higher in the Adriatic belt of the territory and in Sicily.

In France, too, the rate of increase in per capita health expenditure reached a level of 2% in 2022, down sharply from the previous year (8.9%), still marked by the pandemic crisis caused by Covid-19 (OECD France, 2023). In absolute terms and at the same purchasing power parity terms (PPP), the level of French spending is above the EU average, with only a little less than that in prevention care (OECD France, 2023).

The density of doctors per population has also shown changes, down 8% for general practitioners (GPs) in 2020-2021, increasing in the specialist medical group (but the OECD does not tell us how much) and this density varies from Department to Department, creating a certain "medical desert" in rural areas. And yet – again according to the OECD – the level of unmet healthcare needs is lower than the EU average, even in 2022.

Germany has the highest level of health expenditure in the EU, both overall and per capita, above average in all areas of healthcare, with the highest density of doctors and nurses per population (OECD Germany, 2023). This expenditure is covered by the health system at 85.5% (EU average 81.1%) and coverage is concentrated in hospital (26%) and outpatient care (25%).

The last in order of discussion between EU countries of this brief review are the data concerning Finland that present a health expenditure per capita below the EU average, but also to that of the area to which the country belongs (Nordic countries: in addition to Finland, Sweden, Denmark, Iceland and Norway), although it increased by 4% after the Covid-19 pandemic (OECD Finland, 2023).

The National Health Service covers 79.8% of this expenditure in Finland, which is above the OECD average. Forty per cent of the coverage is for hospital care, 22% for outpatient care and 18% for long-term care. The density of general practitioners per population is higher than the EU average, while the density of nurses is lower. The level of unmet healthcare needs (6.5%) in Finland is three times higher than the EU average (2.2%) in 2022 and represents the highest level in the group of Nordic countries.

1.4.2. *The French experience*

The French health system, inspired by the principles of universality and comprehensiveness of the Beveridge model (NHS in Britain, 1948), is based on a compulsory health insurance ("*Couverture Maladie Universelle*" – CMU) which covers 71% of healthcare expenditure, State contribution, which covers 6%, a supplementary health insurance ("*Assurance Maladie Complémentaire*" – AMC) which covers 14% of HCE, while the remaining 9% is directly

borne by patients (OOP: out-of-pocket). In 2019, around 96% of the French population had taken out supplementary insurance. In the same year, there were 3008 hospitals in France, of which: 45% public, 33% private for-profit and 22% nonprofit.

Under the reform Act of 24 July 2019, the health system is distributed over 18 territorial "*Agence Régionale de Santé*", which aim "*at ensuring unified health management in the region, meet the needs of the population and increase the efficiency of the system*"[32].

The French health system links public funders with service providers, mostly private (private clinics, non-profit hospitals, etc.). The most medical and outpatient activities take place in free professional clinics: where the main financing of healthcare spending is public, the practice of the health professions is mostly private and ruled by contract of private law between professionals and public administration.

The recent pandemic has increased attention to mental health and the role of psychologists, but their services are not covered by the CMU[33].

In this context, from the 1983 decentralization law[34], new organizational and management functions have been partially outsourced to nonprofit organizations which already existed locally in the 1960s. These entities operate new services financed by grants or contracts with the regional government, departments (like to counties) and municipalities (Archambault, 2017).

These are public services, mainly dealing with the areas of Education, Health and Social Services[35].

With special reference to Health and limiting the survey to workers, employees or self-employed (excluding, therefore, volunteers), it is noted that nonprofit workers represent 12% of the total workforce occupied in this area, in France.

An important part of the services provided by private for-profit organizations (23% of the total workforce) consists of workers (doctors, nurses and paramedics) who operate essentially in a free market.

[32] See la *Loi No. 2009-879 du 21 juillet 2009 portant réforme de l'hôpital et relative aux patients, à la santé et aux territoires*, as amended by the Loi No. 2019-774 on July 24, 2019 bearing "*à l'organisation et à la transformation du système de santé*".

[33] The "*Code de la santé publique*" recognizes three main categories of health professionals: (1) medical professions (doctors, dentists and midwives), (2) pharmacists [Livre II, Titre IV] (3) auxiliaries [Livre III, Titres I – VII (nurses, physiotherapists)]. Neither of these categories includes psychologists, social workers, osteopaths and chiropractors. Many of these professional figures have an Order of membership and, from 2023, they must pass an examination every 6 years to certify the level of their professional ability.

[34] See Loi No. 83-8 du 7 janvier 1983 "*relative à la répartition de compétences entre les communes, les départements, les régions et l'Etat*".

[35] See Table 7, in the Appendix.

But the added value of the Third Sector in the three mentioned areas is given by the number of volunteers operating there, about 3,000,000 out of 16 million volunteers across the country.

The French National Institute of Statistics and Economic Studies (INSEE) estimates that 680,000 of these volunteers (around 23%) are involved in healthcare (Archambult, 2017).

1.4.3. *The German experience*

The German health system, whose model, introduced in 1883 by Chancellor Otto von Bismark was based on the principles of subsidiarity, solidarity and corporatism[36], is still today the antagonist of the Beveridge model (Driva et al, 2017).

Compared with the original concept, which based health care on the existence of social insurances financed by contributions from workers who covered treatment at health institutions, it now provides for a compulsory public health insurance ("*Gesetzliche Krankenversicherung*" – *GKV*), in which about 90% of the users participate, or alternatively a private voluntary insurance ("*Private Krankenversicherung*" – *PKV*), to which middle-income users are addressed.

Compulsory insurance covers approximately 89% of healthcare costs, and for this reason 13% of the population also have a voluntary supplementary insurance ("*Freiwillige Zusatzkrankenversicherung*" – *FVK*).

The health care system in Germany is highly decentralized, with the management of services being entrusted by law to individual Läender.

Hospitals (about 1700 in the whole country), which can only be accessed with a prescription, except for emergencies, are divided into three categories: public (41%), private (28%) and nonprofit (31%), mostly run by religious institutions or dedicated organizations, such as the Red Cross (Flennert et al, 2019).

Hospital services are financed by the number of benefits provided, based on a fixed "*per diem*" figure, irrespective of the type of care needed or the length of stay. All healthcare institutions pay the same daily amount.

However, this system is being revised, by virtue of the "*Krankenhausreform*" (hospital reform) which has just been adopted by the federal Government and is under discussion in the Bundestag. Its key features are: (1) quality of care, (2) comprehensive medical care for patients, (3) reduction of red tape[37].

[36] Each economic and labor sector had its own mutual fund.

[37] See, for further details, Bundesministerium fur Gesundheit, *Krankenhausreform*, in *https://www.bundesgesundheitsministerium.de/themen/krankenhaus/krankenhausreform.*

This is the context in which an evaluation of the role of the Third Sector and, particularly, of voluntary organizations in the management of German healthcare is being carried out.

Studies conducted on this subject (Flennert et al, 2019) have found, for example, that in healthcare for the elderly, volunteering, mainly performed by older adults towards peers registered encouraging findings. The volunteers have encouraged a greater use of specialist visits, which has significantly reduced the use of hospital admission by general practitioners, a field in which – as already seen – Germany is in a significantly worse situation than the OECD average as well as if compared to EU countries, not only those so called advanced economies[38]. The same studies also found that, in the treatment of depression, voluntary services offered by religious institutions performed significantly better than those offered by secular nonprofit organizations, thus providing feedback to the finding obtained, respectively, 15 years earlier, by other authors (Musick – Wilson, 2003) in the USA, and 10 years earlier in Great Britain (Heins et al, 2010). In the latter case, it was shown that the services provided by the nonprofit sector corresponded more effectively to the needs of the target community, than those offered by the private sector.

During the same surveys, it was also reported the importance of volunteers in the approach with people who belong to the same ethnic – religious communities, in which the human component seems to prevail over the professional. The quality of care is clearly reflected in this Flennert et al, 2019).

The studies mentioned above help to explain the progressive inclusion of the Third sector in a field – that of healthcare – which seems instead rigidly entrusted to a system of compulsory/voluntary insurance predetermined, where the public sector is given a monopoly in managing health.

1.4.4. *Other significant experiences: Finland*

In 2023, the reform of the health system entered into force in Finland, with the aim of revising the previous organizational and administrative structure, which was largely decentralized but also particularly fragmented, based on over 300 healthcare districts that managed both primary and secondary care, with the result already described above: a total and per capita health expenditure higher than the OECD average, with unmet health needs three times higher than the EU average.

[38] See column 2 in Table 4, in the Appendix. The figure shows the quality of care from the "effective primary care" perspective.

The new system is based on 22 territorial service units (Well-being Service Counties – WBSC) including the Helsinki Capital City, plus the Helsinki and Uusima Hospital District (Tynkkynen et al, 2023). In practice, the central Government, which finances health expenditure, is responsible for preparing guidelines for the management of services, the organization of which is entrusted to territorial units. The latter are responsible for the provision and distribution of primary and secondary health-care in the territory assigned to them.

The activity of the WBSC is coordinated by five "*collaborative areas*", territorially organized around the main hospital centers in the country.

The private and nonprofit institutions play an important role in the provision of health services, with particular emphasis on outpatient care, mental health, orthopedic surgery, cardiology, gynecology – obstetrics and cancer treatment, also in dedicated hospitals. This role has been growing due to the costs and waiting times of services provided by the public sector, which – as already seen – are the main critical point of the Finnish health system: the "*unmet health needs*" (Tuurnas et al, 2023).

However, they complained about some regulatory uncertainties in the definition of respective competences and responsibilities between local authorities and the new WBSCs since the organization of services by nonprofit organizations has to do with both prevention medicine and services socio-health, involving not only patients but also their families: think of mental health. In this field, the Third Sector has so far filled a gap, both economically and by providing a personal *("human-to-human")* relationship with patients and their families which, in case of the adoption of too strict formulas even if aimed at a greater efficiency of health spending, may gradually fail.

1.5. *The Canadian experience*

Canada's health performance has already been seen by examining the data provided by the OECD and the WHO respectively, which place the North American State at the top both in terms of volume of health expenditure and as a percentage of GDP, and finally to achieve the targets set by the United Nations for access to basic care and vaccinations[39].

[39] See Tables 2 – 6, and Fig. 4 in the Appendix, excerpt, respectively, by the OECD report *Health at a Glance 2023. OECD Indicators*, OECD Publishing, Paris, *https:///doi.org/10.1787/7a7afb35-en*, and by WHO/OMS, *World health statistics 2024: Monitoring health for the SDGs, Sustainable Development Goals*, Geneva, 2024, *https://iris.who.int/bitstream/handle/10665/376869/9789240094703-eng.pdf?sequence=1.*

The Canadian health system is largely based on public intervention, which ensures universal coverage for essential health services, regardless of the actual patients' ability to pay[40].

The provision of health services is governed by the "*Canada Health Act*" (1984), which forms an interconnected set of ten provincial and three territorial health systems. Known by Canadians as "*Medicare*" or "*Assurance-maladie*", it provides access to a wide range of health services, financed through general taxation, covering 73% of per capita health expenditure (3% less than the OECD average)[41].

The 1995 "*Canada Health and Social Transfer*" completes the framework, consolidating federal cash transfers and fiscal measures in support of healthcare into a single funding mechanism (CHST), which administers the funds and distributes them to provinces and territories.

In short, the federal Government defines national principles that should inspire provincial and territorial health insurance plans, while provincial and territorial governments have primary jurisdiction over the actual administration and delivery of healthcare, including priority setting, budget administration and resource management.

The key principles are a) universal care[42], b) public management of insurance plans[43], c) completeness[44], d) portability[45], e) accessibility[46].

These principles are also accompanied by two conditions concerning access

[40] See Government of Canada, Canada's Health Care System, at https://www.canada.ca/en/health-canada/services/health-care-system/reports-publications/health-care-system/canada.html. Table 6 in the Appendix shows that the System covers 73% of total health expenditure, slightly below the OECD average (76%), but well above the average for hospital and outpatient care, while still well below the average for dental care and pharmaceutical spending.

[41] See again Table 6 and Figure 1 in the Appendix, where in the histogram for Canada, the clearest part represents the share of health expenditure borne directly by taxpayers (Voluntary/out-of-pocket).

[42] It establishes the right of all insured residents, regardless of their province or territory of residence, to access the same conditions to insured healthcare services provided by the provincial or territorial health insurance plan.

[43] The principle implies that provincial and territorial health insurance plans must be managed by a public authority. This does not, however, prevent the possibility of requiring external intervention for certain services necessary for administration, such as processing payments to doctors. Private facilities can also provide insured healthcare services, under condition that there is no charge for the person assisted.

[44] The health insurance plans of Provinces and Territories must cover all insured healthcare services.

[45] The principle avoids a health coverage gap when a change of residence occurs. Patients moving must continue to be covered for healthcare services insured by the jurisdiction of origin for the duration of any waiting period (up to three months) imposed by the Province or Territory of new residence, before the coverage is established in the new jurisdiction.

[46] Access to care must be provided in each province or territory on uniform terms and conditions, not barred or prevented by charges and extra billing to the user or other causes (e.g. age, health status, financial condition).

to public transfers by provincial and territorial administrations: those of 1) information[47] ; 2) recognition[48].

In the first instance, healthcare is provided, as in Italy, by the family doctor (General Practitioner – GP) who "dissects" patients at the upper level (hospital care, specialists, etc.).

OECD data does not tell us if there are "*unmet needs for medical care*"[49].

In this framework, the private sector and the Third Sector provide about 30% of health services. This figure has been constant for the last 20 years[50] .

The role of the Third Sector in Canada in relation to health needs depends on many factors.

First, beyond the formal health coverage, the distribution of primary and secondary healthcare services is not uniform: this circumstance causes some inequalities in per capita health expenditure within Provinces and Territories. For example, in the Northwest Territories it reaches 21,750 CAD, in British Columbia it is 9,182 CAD, in Ontario 8,245 CAD and in Quebec 8,785 CAD (CIHI, 2023)[51].

As to the primary care, a first explanation of the phenomenon lies in the progressive shortage of general practitioners at national level (Glazier, 2023).

Secondly, the interprofessional teams of healthcare are beginning to constitute an alternative method of care for families also in the field of primary care.

The characteristics and purposes of this type of team-based care may explain the growing preference of patients, corresponding to the reduction in the workload of GPs, improving for them the balance between professional and private life, and the quality of care itself. It also helps to fill gaps in care (especially in the field of mental health and chronic disease management), meets the needs of patients and the community and makes the workplace attractive to a variety of health professionals and associated personnel.

In 2021, the Private sector (for-profit and not-for-profit) hospital care

[47] The condition of information is that provincial and territorial administrations must inform the Minister of Health, who in turn submits a report to Parliament, about the material destination of federal funds for healthcare transferred to them.

[48] The recognition consists in the obligation of the provincial and territorial administrations to recognize as "*federal*" financial contributions made by the central government for health care services in all public documents or advertising or promotional material relating to health services insured in the province.

[49] See Table 3, last column, in the Appendix, which shows – with reference to Canada – the abbreviation N/A (data not available).

[50] See, in this sense, Government of Canada, Canada's Health Care System, cited above, in *https://www.canada.ca/en/health-canada/services/health-care-system/reports-publications/health-care-system/canada.html.*

[51] See Figure 12 in the Appendix for details.

amounted to CAD 6.455 billion, while the "*Households – out-of-pocket*" in the same compartment had a total of 971,700 million dollars[52].

In this respect, the most promising initiatives seem to be those of integrated public health care – nonprofit programmes, tested in the province of Alberta, Western Canada, and presented at the 23rd International Conference on Integrated Health Care in Antwerp, Belgium, from 22 to 24 May 2023 (Lewanczuk, 2023).

With a single health system divided into five administrative areas, the approach was to distribute functions and responsibilities at progressively smaller levels, in relation to resources and concrete possibilities of intervention, involving jointly the Third sector actors and their counterparts in the public health system. Joint committees have been set up, with responsibility for members only, to foster a common vision and coordinate their activities. Community-oriented approach based on existing assets, identifying services already in place at various levels, the critical issues involved in their delivery, wishes and needs, both at the individual level and in communities that are increasingly small and difficult to reach, and how best to support those communities in responding to the health needs expressed by civil society. From an infrastructure point of view, the health system, provincial government and leaders of Nonprofit organizations have created mechanisms to facilitate cooperation.

This approach has created formal links between the public health system and Third sector bodies, which are extremely useful in understanding community needs and factors affecting health.

The creation of joint committees responsible to members, rather than a hierarchy, has been particularly effective in improving procurement procedures for goods and services and meeting community needs.

With regards to the subject of hospital care or initiatives that involve Nonprofit organizations, the recent study conducted by the University of Toronto (Nelson et al, 2024) is worth-mentioning. It concerns the family and social reintegration programmes for older patients discharged from hospitals ("*Hospital-to-Home Transitions*").

The post-hospital period is a vulnerable condition for elderly people, placing them in a high risk category of adverse health effects. In 30% of the cases there is deconditioning[53] or "*hospital-associated disability*"[54], while 16% require a

[52] See, Tables H 1 and H2 of the Canadian Institute of Health Information – CIHI Report, *National Health Expenditure Trends, 2023, available in https://www.cihi.ca/en/national-health-expenditure-trends.*

[53] It consists in the process of loss of physical strength, as if one were still in the state of illness, or had been injured, and otherwise inactive. Usually, it is a consequence of physical inactivity or long bed rest.

[54] The expression refers to patients with completely new disabilities in performing daily actions. See, for a more in

rehospitalization within 30 days; this results in an increasing rate of hospitalization with increased mortality rate.

Finally, the study suggests that the results of recovery programs run by qualified volunteers, preferably at the same age or not too young, provide patients with a "*safety net*" and promote a gradual return to the pre-hospital period (Nelson et al, 2024).

1.6. *The U.S. experience*

1.6.1. *Legal Framework*

In the USA, universal health coverage principle applies differently from other health systems examined so far, both in terms of access and comprehensiveness of services provided to patients, independently on their economic or social situation, as well as in terms of financial charges borne by public expenditure.

In principle, health is considered a private matter, which is entrusted to the individual who provides it autonomously or, if employed, benefits from insurance plans set up by the employer, through the subscription of individual or collective insurance policies, benefiting in this respect from tax credits granted by law.

Admittedly, this does not mean that there has been no effort to bring about public intervention in the health sector. Indeed, limiting the review to the last century, we can start by mentioning the project of Health Policy Reform – part of the electoral platform of the new Progressive Party of Theodore Roosevelt, in 1912 – adopted by the American Association for Labor Legislation, which, in 1915, elaborated a bill in this direction, but the advent of the World War I dropped the initiative (Smith, 2023).

We will therefore limit ourselves to listing the regulatory interventions that have most significantly affected the current legal framework, at federal level.

The first noteworthy is the "*Social Security Amendments*" of 30 June 1965, also known as the "*Medicare and Medicaid Act*", strongly wanted by President Lyndon B. Johnson, who introduced, precisely, the so called "*Medicare*", a federal insurance plan that covers both hospital care (Part A) and the remainder (Part B) of an elderly health insurance policy. The same law also introduced the so called "Medicaid", which allowed the federal government to partially fund a

depth, Covinsky K.E., Pierluissi E., Johnston C.B., *Hospitalization-Associated Disability "She Was Probably Able to Ambulate, but I'm Not Sure"*, in Journal of American Medical Association, 2011, Vol. 306, n° 16, 1782 – 1794.

healthcare plan for the poor, through a program managed and co-financed by the individual States and that is still in force nowadays[55].

To achieve significant results in this area, it will be necessary to wait for the 1997 "*Balance Budget Act*", which, in addition to several amendments and additions to the various Medicare titles (parts A and B) and the healthcare service fee (FFS), added Part C, called "*State Children's Health Insurance Program*" – SCHIP. This is a joint federal – state program of health insurance for children, dedicated to the ones born in families that are below the federal poverty line (Carey et al, 2009).

In 2010, the "*Patient Protection and Affordable Care Act*", also called PPACA or "*Affordable Care Act*" – ACA better known as "*Obamacare*" was approved, containing the following provisions:

- gradual introduction of a comprehensive system of mandated health insurance reforms to eliminate "*some of the worst practices of insurance companies*" – screening of pre-existing conditions and premium loadings, policy cancellations on technicalities when illness seems imminent, annual and lifetime coverage caps;
- expanded "Medicaid" to cover uninsured adults of working-age adults (18-65) who earn less than 138% of the federal poverty line (and therefore are not eligible for subsidies on the health insurance marketplace), along with some whose existing insurance plans were too expensive based to their income. The ACA has extended eligibility to Medicaid in all 50 States and the District of Columbia. In this regard, the US Supreme Court, in the case "*NFIB vs Sebelius*" (28 June 2012)[56] ruled that individual States could choose whether or not to extend coverage. Currently 41 States (including Washington, D.C.) have extended coverage[57];
- introduction of a market-based health insurance system based on three standard levels (Parts A, B, C of *Medicare*) of insurance coverage, to enable consumers to compare similar policies and exchange insurance plans, also via the Internet, through price comparisons and purchase plans, directly by consumers;
- introduction of the mandate for insurers to fully cover certain preventative medicine services;

[55] See *Medicare and Medicaid Act* (1965), National Archives – Milestone Documents in *https://www.archives.gov/milestone-documents/medicare-and-medicaid-act*.

[56] See National Federation of Independent Business, et al vs Kathleen Sebelius, Secretary of Health and Human Services, et al, Case No. 11 – 393, 28 June 2012 in *https://www.supremecourt.gov/oral_arguments/argument_transcripts/2011/11-393.pdf*, also available in *https://www.oyez.org/cases/2011/11-393*.

[57] See Figure 13, in the Appendix.

- creation of "*high-risk*" pools for uninsured;
- grant of tax credits to businesses providing insurance policies to their employees;
- creation an insurance company rate review program;
- allowing dependents of the policy holder to benefit from their own insurance plan for 26 years;
- setting a minimum medical loss ratio between direct health spending and income-based insurance premiums, creating price competition;
- creation of the "*Patient-Centered Outcomes Research Institute*" to study the comparative effectiveness of insurance plans, financed through a share of life insurance premiums[58].

In 2017, with Executive Order No. 13813, President Donald Trump allowed insurance companies to sell short-term and low-cost plans with lower coverage, allowing even small businesses to buy "*collectively*" the health plans of the associations and expanding the health savings accounts[59].

With the "*Inflation Reduction Act*" – IRA on 16 August 2022, President Joe Biden allows the "*Medicare*" system to negotiate certain prices of medicines, limits the costs of the "D" part for the elderly at $2,000 per month and provides $64 billion for "Affordable Care Act" grants until 2025, originally expanded with the 2021 "*American Rescue Plan Act*" (Shah et al, 2024).

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In the light of the above regulatory framework, the management of health care in its various fields is entrusted partly to the public sector, partly to the private sector and partly to nonprofit organizations – "Charitable Nonprofit Organizations" – which are something different and wider than all the entities we have dealt with so far (Horwitz, 2020).

More precisely, the notion of "*Charity*" accepted in the US system is that

[58] See Figures 14 and 15 in the Appendix which show a significant decline in the number of US citizens without health insurance after the law came into force, and more in depth Obama B., *United States Health Care Reform. Progress to Date and Next Steps, in Journal of American Medical Association*, 2016, 316 (5), 525 – 532, at *https://jamanetwork.com/journals/jama/fullarticle/2533698, doi:10.1001/jama.2016.9797.*

[59] See Executive Order 13813 – *Promoting Healthcare Choice and Competition Across the United States* in *https://www.govinfo.gov/content/pkg/DCPD-201700742/pdf/DCPD-201700742.pdf.*

derived from §1.01 of the "*Restatement of the Law. Charitable Nonprofit Organizations*", adopted and promulgated by the American Law Institute in 2021, which states[60]:

(a) "*A charity is a legal entity with exclusively charitable purposes, established for the benefit of indefinite beneficiaries, and prohibited from providing impermissible private benefit.*

(b) *Charitable purposes include: (1) the relief of poverty; (2) the advancement of knowledge or education; (3) the advancement of religion; (4) the promotion of health; (5) governmental or municipal purposes; and (6) other purposes that are beneficial to the community*;

(c) *A purpose is not charitable if it is unlawful, its performance requires the commission of criminal or tortious activity, or it is otherwise contrary to fundamental public policy*".

The charitable purposes mentioned above are considered worthy of tax exemption (in particular corporate income tax), pursuant to Title 26, Section 501(c)(3) of the US Internal Revenue Code, according to which the following organizations are tax exempt: "*Corporations, and any community chest, fund, or foundation, organized and operated exclusively for religious, charitable, scientific, testing for public safety, literary, or educational purposes, or to foster national or international amateur sports competition (but only if no part of its activities involve the provision of athletic facilities or equipment), or for the prevention of cruelty to children or animals, no part of the net earnings of which inures to the benefit of any private shareholder or individual, no substantial part of the activities of which is carrying on propaganda, or otherwise attempting, to influence legislation (except as otherwise provided in subsection (h)), and which does not participate in, or intervene in (including the publishing or distributing of statements), any political campaign on behalf of (or in opposition to) any candidate for public office*" (Herring et al)[61].

[60] The American Law Institute is a closed-ended organization that brings together the best professionals of US law – professors, judges and lawyers – as well as a very small number of foreign experts, including an Italian scholar. Founded in 1923, based in Philadelphia – Pennsylvania, the American Law Institute aims to analyze and improve US Law, with a view to its modernization and simplification. The Institute is, among other things, co-author of the "*Uniform Commercial Code*" in force in all American states and author of the famous *'Restatements of the Law'*, collections of rules relating to various areas of law and which are recognized as having the highest authoritative value. The latest edition of "*Restatement of the Law, Charitable Nonprofit Organizations*" was edited by a group of about 40 experts in non-profit law, led by Professor Jill R. Horwitz of the U.C.L.A. – School of Law.

[61] See Herring B., Gaskin D., Zare H., Anderson G., *Comparing the Value of Nonprofit Hospitals' Tax Exemption to Their Community Benefits*, in Inquiry, The Journal of Health Care Organization, Provision, and Financing, Volume 55, 1 – 11, 2018, Jan. Dec., also available in *https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5813653/*, Tab. 2, p. 5, enumerate tax exemption granted to the nonprofit organizations dealing with health in the United States

More precisely, Section 501, (r) (6) requires entities that deal with health care and wish to benefit from tax exemptions to fulfil the following four requirements:

1. conduct a community health needs assessment (CHNA) and present an implementation strategy every three years;
2. meet the standards required for community health service delivery;
3. develop and make available to patients an affordable financial assistance programme;
4. limit extraordinary fundraising campaigns (IRS; Herring et al, 2018; Rapfogel, Gee, 2021).

The combined provisions of the above-mentioned rules imply that in the United States of America, Nonprofit institutions operating in health care enjoy extensive tax benefits, which partly explains their progressive expansion in this field, but also the criticism they sometimes receive, on the ratio "costs (tax exemption) / benefits (quality of rendered services)"[62].

1.6.2. *Nonprofits and Healthcare: the "Status of Art"*

A first representation of the impact of nonprofit organizations in the field of health care in the United States is provided by Tables 9 and 10 in Appendix and covers the period 2000 – 2013 (Horwitz, 2020).

In the field of health services ("*Health*") these entities reach a peak in 2009, with 44,130 units, then falling to 37,732 units in 2013, with a percentage ranging from 14.40% (2000) to 12.90% (2013) on the total of "*public charities*"[63].

In the field of "*hospital and primary care facilities*" in 2013, the number is 7,062 units, just 2.40% of the total, with revenues of about 864 billion US dollars out of a total of 1.623 billion US dollars achieved by the entire audience of "public charities", almost the half[64]. The "*assets*" of this category in the same year reach the share of 1.133 billion US dollars, about a third of the total held by the "*public charities*", which is 3.225 billion US dollars.

More recently, with regards to the ownership of acute care hospital facilities

of America: Federal corporate income tax, State corporate income tax, State sales tax; Local property tax; Tax bond's lower rates.

[62] See Table 8 in the Appendix, in this regard.

[63] Data are excerpt from Urban Institute and from National Center for Charitable Statistics. The ones covering 2013 are excerpt from McKeever L. et al, *Demystifying the Search Button: A Comprehensive PubMed Search Strategy for Performing an Exhaustive Literature Review*, in JPEN J Parenter Enteral Nutr. 2015 Aug;39(6):622-35. doi: *10.1177/0148607115593791. Epub 2015 Jun 30. PMID: 26129895; PMCID: PMC4513072*, Table 2.

[64] The data reflects the information contained in the templates (Form 990) submitted to the IRS by "*public charities*" and concerns their gross revenues.

and intensive care wards in the USA (2004 – 2019), it has been noted (Horwitz, Nichols; 2022) that non-profit organizations have a percentage ranging from 65.3% (2009) to 69.79% (2019), compared with public bodies having a percentage ranging from 12.91% (2008) to 10.85% (2019) and private entities (for-profit) whose percentage varies from 22.65% (2011) to 19.36% (2019). The data remain continuous throughout the assessed period. Facing these assets, there is a significantly higher number of admissions to care at hospitals by nonprofit institutions (74.3% in 2004; 74.26% in 2019) than those in the public sector (12.53% in 2007; 11.3% in 2019) and those of the private sector (15.39% in 2016; 14.44% in 2019).

The data now reported seems to overcome the reservation of those (Herring et al, 2018) who consider that the marginal benefit to the community of the tax exemption granted to nonprofit institutions working in health care is very small, and where it is more extensive and real "*added value*", this is rather dependent on the market structure. These same data also lead (Horwitz, 2020-2024; Horwitz, Nichols, 2022, Horwitz, 2024) to treat non-profit health organizations as "*health care entities*" rather than as one of the many categories of "*Nonprofit organizations*", placing the emphasis not so much on the entrepreneurial activity in place, but rather on the nature of their purpose and ownership of the assets they bear. This approach fully includes the nonprofit "*health care entities*" among the "*public charities*" of which they represent, as already seen, the most substantial part, distinguishing them – as does the Internal Revenue Code of federal tax law, in Section 501, (3) (c) – from "*Private Foundations*".

In fact, they, like the other "*charities*", are private law entities, nor can this nature be considered compromised by the enjoyment of particular tax benefits or contributions from public bodies that certainly do not make them public bodies. In addition, unlike the "*Private Foundations*", they do not belong to any private entity, even their founders and beyond the beneficial purposes indicated in §1.01, lett. b) of the "*Restatement of the Law. Charitable Nonprofit Organizations*", must fulfill the specific requirements already mentioned, set by the Internal Revenue Code.

The fact that they use market rules in the performance of these tasks is due to their nature as private law entities, the type of sector in which they operate and the services they intend to provide: health care, including hospital care, outpatient networks, and nonprofit insurance companies (Horwitz, 2020).

This approach is relevant in the dispute, already emerged after the entry into force of the "*Medicare and Medicaid Act*" of 1965 and, even more, after the launch of the "*Obamacare*" system in 2010.

Some scholars and policy makers (Herring et al, 2018, Bai et al, 2021 – 2023) contest the qualification of non-profit hospitals as "*charitable*" and therefore the merit of tax exemptions provided by the federal Tax Code, in the absence of free care, being affirmed by others (Horwitz, 2024; Schizer, 2023), also on the basis of an impressive mass of data (Zare et al, 2021; Owsley et al, 2022) and strict legal arguments, on the one hand, that the question is ill-posed and, on the other hand, that the ownership structure of hospitals run by Nonprofit health organizations (in the vast majority in the United States of America) is crucial to keep tax benefits for them.

In fact, while it seems unquestionable, on the legal level, that the nonprofit health care entities fully fall into the notion of "*charities*" offered by §1.01 of the "*Restatement*" – which expressly includes among its purposes the "*promotion of health*" – (Horwitz, 2020), the ownership of assets (economic profile) is directly linked to the statute and mission of any nonprofit organization (Schizer, 2023). The latter indicate the priorities and areas in which the health care institution is active, e.g.: mental health, provision of services which are less remunerative but correspond to the unmet needs of the elderly, not sufficiently met by public hospitals due to lack of resources; and by private (for-profit) entities for low remuneration.

Similar considerations may be made with regards to the other health services and benefits listed in Appendix – Tables 8 and 9.

1.7. *Some concluding remarks*

What is striking in the review of international data and foreign experience in health is the importance of the Third sector, regardless of the general principles which have historically governed the different health systems, entrusting the public sector to finance health care and manage care and facilities, or, on the contrary, leaving it to individual initiative (United States of America) the search for the best forms of health care (public, private, nonprofit) through access to the different insurance plans available on the market.

On either side of the ocean, hospitals, outpatient networks and nonprofit health workers account for a large share of the market, regardless of total expenditure/GDP or per capita health expenditure/income ratio.

In the UK, the latest "*Health and Care Act*" (2022) has formally established an integrated system of public – private – nonprofit healthcare; in France workers (doctors, nurses, administrative staff) of the nonprofit health sector

accounts for 12% of all workers, while volunteers account for 23% of the total; in Germany, nonprofit hospitals represent 31% of the total; in Canada, private and nonprofit organizations cover about 30% of hospital and outpatient facilities and in the United States of America nonprofit organizations ("*Charitable Nonprofits*") own about 70% of hospital facilities.

The Third Sector seems to be dedicated to fill-in the gap in fields of health care not reached by the public sector and considered as low-paying by the private sector (chronic diseases, treatment of depression and mental health in general in France, Germany and Finland), or dealing with the provisions particular services for specific categories of patients (e.g., those covered by the "*Hospital-to-Home Transitions*" programme), or finally, addressed to geographical areas which are difficult to reach (Canada).

In all the experiences reported, a particular characteristic of the nonprofit approach has been seen, consisting in the valorization of the "*human-to-human*" relationship, rather than the number of services rendered and/or waiting times for access to medical care.

This approach, which has certainly helped to bring the population closer to nonprofit health institutions, has led government authorities to develop and finance integrated health care programmes, granting them tax exemptions, broad enough and, finally, to regulate the terms and conditions of a real financial support.

All these initiatives have several similarities with the discipline and experience of the Third Sector in Italy and particularly in the Veneto Region, where – as it will be seen – the health service is variously structured, adhering to the principles of autonomy, administrative decentralization and subsidiarity, set forth in our Constitution (art. 5 and 118, co. 4, Cost. it.).

2.
LEGAL FRAMEWORK

2.1. *Constitutional rules on Health Protection and the Different Levels of Governance*

The legal framework governing the health care system in Italy is made up of various provisions, both constitutional and non-constitutional. While on the one hand they regulate the principles and areas of protection of "Health", on the other hand define the "levels of governance" of health care services affecting citizens.

Among the first, in addition to the fundamental art. 32 on health protection (Morana, 2021; Grandi, 2021; Piciocchi, 2022; Positano, 2022), to art. 5 on local autonomies and administrative decentralization (Staiano, 2017; 2021), are worth mentioning those reformed by the Constitutional Law n. 3 of 2001 (116, co. 3, 117, co. 3, 118, co. 4, 119, co. 1 and 2, 120) on the legislative concurrent power of the Regions, on financial autonomy of income and expenditure, on the equalization fund, the principle of subsidiarity (Magnani, 2006; Santuari, 2019), on the protection of essential levels of benefits, among which are fully included the essential levels of health care (Biancheri, 2023).

Among the ordinary laws, the Law of 23 December 1978, n. 833, establishing the National Health Service and the Law of 5 June 2003, n. 131 which, in implementation of the above-mentioned constitutional reform (art. 116, co. 3; art. 117, co. 1 – 3 and art. 120 Cost it.), establishes the so called "*Conference State – Regions*"[1].

In the above mentioned regulatory framework, health protection has become a matter of concurrent legislation between the State and the Regions:

– the exclusive legislation of the State being responsible for the determination of essential levels of benefits (LEP), which in health care are embodied in the determination of essential levels of care (LEA) to be guaranteed throughout

[1] Reference is made to the Constitutional Law of 18 October 2001, n. 3, "Amendments to Title V of the Second Part of the Constitution".

the national territory, in a manner consistent with the constraints of public finances, allocating the necessary resources to their financing, under conditions of efficiency and appropriateness;
- the Regions being responsible to the territorial organization of their regional health services – SSR (Mef – Ragioneria Generale dello Stato, 2023).

Focusing now on the concept of health and the areas of protection, it is appropriate to recall the notion offered by the World Health Organization (Ottawa Constitution of 1948) for which "*Health*" is "*a state of complete physical, social and mental well-being, and not merely the absence of disease or infirmity*" (WHO, 2021). Health is considered by the WHO as a fundamental human right. As a result, all people should have access to basic health resources. In the context of promotion, health is a resource that enables individuals to lead socially and economically productive lives. It is a positive concept that emphasizes the physical capabilities and social resources of the human person.

Art. 32 of the Italian Constitution, in stating that "*The Republic protects health as a fundamental right of the individual and the interest of the community, and guarantees free care to the needy*" retakes the concept and, placing it within the framework of the fundamental rights of the individual and the mandatory duties of solidarity affirmed by art. 2, qualifies the extension of its exercise also as "*claim by the individual to obtain health services that, from time to time, are necessary for the protection of their own health: claim that, for the subjects "needy", qualifies further as a right to free of charge the same services*" and that makes concrete, in the matter under consideration, the duty of economic and social solidarity required by art. 2 (Morana, 2021).

Alongside individual rights, art. 32 declares health protection to be a "*public interest*". This is an objective profile that, on the one hand, can legitimize the legislator to introduce restrictions also with respect to other constitutional freedoms, as we have had the opportunity to experience in the context of the Covid-19 pandemic (Morana, 2021; Grandi, 2021)[2] and, on the other hand, fully legitimates the inclusion of "*health interventions and services*" among the "*activities of general interest*" that are the object of the mission of health care nonprofit organizations[3].

[2] In jurisprudence, see for all Constitutional Court, May 26, 2022, n. 127, concerning urgent measures to deal with the epidemiological emergency from COVID-19 as referred to in Decree-Law 16 May 2020, n. 33 and, more widely, Const. Court. – Studies Service, *The management of the COVID-19 pandemic in constitutional jurisprudence*, Rome, 2023, in *https://www.cortecostituzionale.it/documenti/convegni_seminari/stu_331_20230320134520.pdf*

[3] See art. 5, co. 1, letter b) of the Legislative Decree 3 July 2017, n. 117 (Code of the Third Sector) and art. 2, co. 1, lett. b) of the Legislative Decree 3 July 2017, n. 112 (Revision of the Social Enterprise Legal Framework).

Art. 5 of the Constitution which, in recognizing and promoting "*local autonomy*", implements in the services that depend on the State the "*widest administrative decentralization*" and "*adapts the principles and methods of its legislation to the needs of autonomy and decentralization*" is the pillar on which the whole of the State – Regions relationship is based, being the subject of the wide constitutional reform of 2001. The reform itself involves a thorough analysis of the functions to be divided between Centre and periphery, answering the questions: "*what to transfer, why to transfer, what differentiates in the transfer between territories?*" In the health field, the incorrect allocation of functions, which leads to an excessive emphasis on the autonomy of the regional or local authority (Local Health Units – ULSS), would lead to inefficiencies and even to the failure of the system (Staiano, 2021).

The reform of Title V, which aims to implement the principles of autonomy and administrative decentralization is precisely focused on agreements between the State and the regions (art. 116, c. 3). The latter, in the exercise of concurrent legislative power, which – as already seen – includes health protection and regulatory power within the territory of competence (art. 117, co. 1 and 3), provided that this last is not reserved to the State.

In exercising these powers and administrative functions, the Regions inform themselves (art. 118, para. 1 and 4) of the principle of "*subsidiarity*", which concerns "*the quality of relations between the State and its constituent elements, individuals and communities, defining a method for limiting public power in relation to spheres of competence of civil society, entrusting them with general interest functions (subsidiarity in a horizontal sense). Subsidiarity is also a criterion for identifying, within public power, which level of government of that power, central or regional or local, should be responsible for the various public functions, giving preference to the levels closest to citizens, unless the goals to be achieved require action at higher levels of government (subsidiarity in a vertical sense)*" (Magnani, 2006).

It is precisely to this principle that art. 55 of Code of the Third Sector in providing that "*the Administrations ensure the active involvement of the nonprofit entities, through forms of co-programming and co-design and accreditation*", so much to induce some authors to consider the Italian health system is a "*four-party*" system: public, private, private "accredited" and nonprofit, either accredited or not (Biancheri, 2023).

In this institutional framework, the aspect that takes importance is the ability of local authorities to assume virtuous behaviors, aimed at pursuing recoveries of efficiency and effectiveness in the provision of essential levels of care – LEA (Mef – Ragioneria Generale dello Stato, 2023)

2.2. *The National Health Service: fundamental and organizational principles*

The L. 23 December 1978, n. 833 establishing the National Health Service, as "*a set of functions, structures, services and activities intended for the promotion, maintenance and recovery of health*" intends to implement the above mentioned institutional framework, setting, in turn, fundamental (art. 1 – 4) and organizational (art. 5 – 7) principles (Antonelli, 2010; Ricciardi – Tarricone, 2021).

Among the first:

- the equality of citizens who benefit from the service, which includes the forms of their participation in it (art. 1);
- the fairness (art. 3), understood as a guarantee of quality, efficiency, appropriateness and transparency of the service and particularly of the health services, as well as correct information by the doctors, nurses or other health care providers about the health care required by the citizen and appropriate to his/her level of education and understanding (informed consent, taking charge);
- the universality (art. 4), since the SSN is intended for the whole national community.

As to the organizational profile, the law provides that health protection is a public responsibility, and attributes:

- to the State, when approving the National Health Plan (three-year duration), the establishment of essential levels of health care – LEP/LEA
- to the Regions the health programming and management, ensuring the coordination and the collaboration between the different levels of governance (art. 3).

The same law gave general powers to the provinces and municipalities, but these were abolished by the subsequent Legislative Decree 30 December, 1992, n. 502 (Antonelli, 2010).

Law 833/1978 is also characterized by:

- the provision (art. 63) of compulsory health insurance for all citizens, who are provided with a health card (now electronic health record – FSE)[4] which contains personal health data (art. 27);
- the provision of local health units – USSL (art. 14 and 61) whose constitution, comprising groups of users ranging from 50,000 to 200,000 people, is allocated to the regions;

[4] See Electronic Health Record established by art. 12 of the Law Decree 18 October 2012, n. 179, last modified by the L. 28 March 2022 and defined, in its characteristics, by the Minister of Health Decree 7 September 2023.

– the definition of care services, which include (art. 25) general medical care, specialist care, nursing, hospital and pharmaceuticals. General, paediatric, specialist and nursing services are provided both in outpatients and at home. Medical and paediatric care is provided by the staff employed or contracted by the National Health Service operating in local health units or in the municipality of residence of the citizen, who chooses the family doctor from among the health care providers referred to in the preceding paragraph;
– the recognition of a specific role to Voluntary Associations (art. 1 and 45), whose relations with local health units are regulated by special conventions, within the framework of the procedures for health planning of the Regions (art. 55 of the Code of the Third Sector). Voluntary Associations are assigned, in particular (art. 71), the emergency rescue and the transport of the sick and injured with their own direct services and even by coordinating and disciplining those carried out by other local associations[5].

2.3. *The State – Regions Understandings and the Determination of Essential Levels of Care (LEA)*

The constitutional reform of 2001, which assigns to the regions certain legislative powers in health matters, redefines its system of governance through a mechanism of agreement between State and Regions, institutionalized with the entry into force of art. 8, para. 6 of the Law 5 June 2003, n. 131, concerning "*Implementation of art. 120 of the Constitution on the subsidiary power*".

The provision gives Central Government the power to "*promote the conclusion of agreements at the State-Regions Conference or Unified Conference, aimed at promoting the harmonization of their respective legislations or the achievement of uniform positions or the attainment of common objectives*".

In these agreements, usually three-year agreements, the State and the Regions agree on the level of financing for the SSN for the duration of the agree-

[5] The rule is coordinated with that of art. 2, lett. b) of the Decree of the Provisional Head of State of 13 November 1947, n. 1256 which originally assigned this task to the Italian Red Cross. This provision currently applies to all Volunteer Organizations that, pursuant to art. 57 of the Code of the Third Sector "*may be, in priority, subject to entrustment by convention to voluntary organizations, registered for at least six months in the National Register of the Third Sector, members of an association network referred to in article 41, paragraph 2, and accredited under the relevant regional legislation, where such exists, in cases where, by virtue of the specific nature of the service, direct entrustment guarantees the performance of the service of general interest, in a system of effective contribution to social objectives and the pursuit of solidarity objectives, under conditions of economic efficiency and appropriateness, as well as respecting the principles of transparency and non-discrimination*".

ment, to identify the financial resources necessary for medium-term programming.

The agreements also define the rules of the sector's government and the procedures for verifying the compliance with the obligations incumbent on the regions.

For example, the Health Pact 2019-2021 signed on 18 December 2019, confirming the increases in the level of funding indicated by the Budget Law for the year 2019, provided for changes to the monitoring system in the delivery of essential levels of care (LEA), from 2020 onwards, the introduction of additional flexibility in identifying the regional expenditure ceiling, specific actions to contain the phenomenon of "*interregional health mobility*" (GIMBE, 2024), spending on pharmaceuticals and medical devices, the revision of the system of sharing health care expenses by the beneficiaries, investments, health research, prevention, and the receivership in the course of return plans (Mef – Ragioneria Generale dello Stato, 2023)[6].

It is in the same institutional framework that, with the Agreement of 8 August 2001, was introduced the so-called "*Reward system*" in health, which consists of making the disbursement to each region of a part of the financing of the SSN – called, precisely, "*Reward share*", the amount of which is fixed by law – to the fulfilment of certain requirements verified annually, first and foremost the fulfilment concerning the budgetary balance of each Regional Health Service (SSR), including by providing additional resources to cover any regional deficit.

The Agreement of 8 August 2001, transposed by the Decree of the President of Council of Ministers on 29 November 2001, defined the essential levels of care – LEA. The contents of the services to be provided by each SRG, the rules for sharing social and health care services were thus disclosed and shared, as well as highlighted the services "*totally excluded*" from the LEAs or those "*included for particular subjects and under particular conditions*". The last update of the LEA was carried out with the Decree of President of the Council of Ministers (DPCM) on 23 June 2023[7].

The Essential Levels of Care (LEA) are the services and benefits that the National Health Service (SSN) is required to provide to all citizens, free of charge or against payment of a participation fee (ticket), with public resources collected through general taxation.

[6] Inter-regional health mobility is the phenomenon involving many people who use health services in facilities outside their region of residence.

[7] The complete picture of the LEA is from All. 1 to Mister of Health Decree 23 June 2023 mentioned in the text.

The DPCM 29 November 2001 identified three main levels of assistance:

- Collective prevention and public health, which includes all preventive activities aimed at the community and individuals; in particular:
  - surveillance, prevention and control of infectious and parasitic diseases, including vaccination programs;
  - protection of the health and safety of open and confined environments;
  - monitoring, prevention and protection of health and safety at the workplace;
  - animal health and urban veterinary hygiene;
  - food safety – consumer health protection;
  - monitoring and prevention of chronic diseases, including the promotion of healthy lifestyles and organized screening programs; surveillance and nutritional prevention;
  - forensic activities for public purposes.
- District health care, i.e. the activities and health and social services spread on the territory, as follows:
  - basic health care;
  - territorial health emergency;
  - pharmaceutical service;
  - complementary assistance;
  - specialist outpatient care;
  - prosthetic assistance;
  - thermal care;
  - home, territorial health and social care;
  - residential and semi-residential social health and social care.
- Inpatient care, which includes the following activities:
  - first aid;
  - ordinary acute hospital;
  - day surgery;
  - day hospital;
  - rehabilitation and long-term care after acute;
  - blood transfusion activities;
  - Cell, organ and tissue transplantation activities;
  - Poison Centres (CAV).

To this end, the so called "*Pacts for health*" have provided specific repayment plans[8], which are a key tool of the NHS governance aimed at resolving issues

[8] The repayment plans are instruments that, through the implementation of specific measures, aim at the recov-

related to efficiency and effectiveness in the use of resources made available in relation to the event, in some regions, high and unsustainable structural deficits and the presence of serious deficiencies in the proper delivery of LEA.

The system thus devised revealed three groups of autonomous regions and/or provinces:

- the first group, that of the "*virtuous regions*" (Piedmont, Lombardy, Veneto, Liguria, Emilia Romagna, Tuscany, Umbria, Marche, Basilicata) not subject to repayment plans, because they have health budgets in balance or with deficits contained in the ordinary regional capacity, which has therefore ensured over the years, along with other expected compliance, the passing of the annual premium review;
- the second group, that of "*regions with high deficits*" (Lazio, Abruzzo, Molise, Campania, Puglia, Calabria, Sicilia) and subject to repayment plans because they have had significant deficits in health budgets over time, the amount of which is not covered by the normal measures available from regional budgets. Along with this unsustainable budgetary imbalance, these regions showed major shortcomings in the delivery of LEA, characterized by an excess of hospital supply over the parameters set by the national programming, highlighting high rates of hospitalization and particularly marked indicators of inappropriateness in hospitals. At the same time, these regions were characterized by a high level of pharmaceutical expenditure, well above the parameters set by existing legislation. Both components, hospital and pharmaceutical, were taking resources from the delivery of the remaining levels of assistance and contributed to the formation of significant economic-financial imbalances (Mef – Ragioneria Generale dello Stato, 2023);
- the third group, that of "*special autonomies*" (Valle d'Aosta, Friuli – Venezia Giulia, Sardinia and the autonomous provinces of Trento and Bolzano) concerning local authorities not subject to repayment plans, as they provide direct funding for health care on their territory[9].

ery of situations of economic and financial imbalance and/or shortage in the provision of LEA. Their main purpose is to identify areas of significant delay or inefficiency in a SSR to plan and implement appropriate corrective measures. In this perspective, they selectively address the causes that generate economic and financial imbalances and disbursement shortages to avoid the occurrence of structural deficits as well as the provision of healthcare with poor performance from a disbursing point of view.

[9] It should be noted that the Valle d'Aosta, Friuli – Venezia Giulia, Sardinia and the Autonomous Provinces of Trento and Bolzano are not subject to any procedure for repayment as they enjoy the regime of "*special autonomy*" established by the Constitution. Sicily is not included in the "*special autonomy*", either because it is under a repayment plan or because it does not provide full funding for its own SSR.

The situation of health expenditure in the regions is shown in Table No. 14 and Figure 17 in the Appendix.

The complex annual procedure for checking the balance of regional health accounts is summarized in Figures 18 and 19 in the Appendix.

In the case of the regions subject to the repayment plan (first group, Fig. 18 – Step 1) that are in position of "*surplus*" the verification has a positive result. In this case, the region concerned may reduce the IRAP[10] rate or the regional IRPEF[11] supplement in proportion to the surplus.

Even in the case of "*balance*" the result is positive, but no follow-up measures are planned by the region concerned.

In the case of a "*deficit*", non-compulsory health expenditure is prohibited and, if a deficit still remains unmet, the Region may request an additional manoeuvre on current year's expenditure compared to what is planned in the repayment plan.

The procedure is slightly more complex for regions not subject to the repayment plan. In the event of a surplus or balanced budget, the review shall be concluded with a positive result and no action shall be taken. In the case of a deficit, it is necessary to assess its impact on the financing of health expenditure with real own resources. If the coverage is suitable and adequate, the review will be successful. If not, the Prime Minister shall send to the concerned region a "*warning to comply*" by 30 April each year. In the latter case (Fig. 19 – Step 2), the Region must find suitable coverage among its own resources. If the action is successful, the review will be successfully completed. Otherwise, the President of the Region, or a "*ad acta*" Commissioner appointed during the month of May, provides for adjustments to the budget aimed at finding suitable and adequate resources. Otherwise, the concerned Region will have to suspend all non-compulsory expenditure and draw new resources from maximizing the rates of the IRAP and the additional IRPEF.

[10] The regional tax on productive activities, better known by the acronym IRAP, is a tax established in Italy with Legislative Decree 15 December 1997, n. 446 and currently in force, affects the value of net production of enterprises, that is, in general terms, the income produced including personnel costs and financial expenses and revenues, with a rate varying from 3,90% to 8.50%. The determination of the rate between a minimum and a maximum is assigned to the Regions. Applies also to nonprofit entities, but the taxable amount is equal to the total compensation for employee, assimilated or occasional self-employed person calculated on a per capita basis. It is the only tax payable by companies that is proportional to turnover and not applied to operating profit. The Decree provides that 90% of the revenue obtained is allocated to the regions, to finance the National Health Fund, as a part of public expenditure.

[11] IRPEF is the acronym for personal income tax. The regional addition to IRPEF, introduced by art. 50 of the Legislative Decree 15 December 1997 n. 446 and, since 1998 is a derived tax, that is a tax established and regulated by the law of the State, whose revenue is attributed to the Regions that must, therefore, exercise their tax autonomy within the limits established by State law.

2.4. *The Reward System in Health*

The above-mentioned Agreement of 8 August 2001 introduced the so-called "reward system" in health, which consists in making access to each region conditional on a part of the SSN's funding, known as the "reward share".

This bonus is calculated on the total amount of government funding for SSN in regions that take measures to ensure balanced budgets, including the establishment of a Regional Center aimed at purchasing and tendering procedures for the supply of goods and services for predetermined volumes established by decree (Viceconte, 2012; Fantozzi, Gabriele, 2023; Scinetti et al, 2024).

Its concrete amount results from the monitoring of health expenditure fixed by law (Legislative Decree No. 68/2011) and compliance with certain requirements annually verified: at first, the fulfilment concerning the budget balance of each regional health service (SSR), including by providing additional resources to cover any eventual regional deficit.

The above-mentioned agreement introduced the current system of monitoring health accounts, which is fundamental for verifying the economic equilibrium of individual SSR.

The State-Regions Agreement of 23 March 2005, confirming previous compliance which is subject to annual review for accessing to the award share of the SSN funding, has ordered the establishment of two monitoring tables, currently operating in the health sector within the framework of the award system: the Table for the verification of regional compliance, established at the Ministry of Economy and Finance, coordinated by a representative of the Department of General Accounting of the State (RGS), and the Standing Committee for the Provision of LEA, established at the Ministry of Health.

Both Monitoring Tables see the participation of the two levels of governance in the health sector, the State and the Regions, as well as the participation and support of the Health Agencies: the National Agency for Regional Health Services (AGENAS) and the Italian Agency for Pharmaceuticals (AIFA).

As of 2012, pursuant to art. 15, para. 23, of the Law Decree No. 95/2012 about spending review procedure (Law No. 135/2012) the percentage of the award share for the regions defined for accessing has been fixed at 0,25% of the ordinary resources provided for by current legislation to finance the standard requirements of the SNA (FNFS), while, for 2021 only, this percentage was raised to 0,32 % pursuant to art. 35, paragraph 2 of DL. 73/2021 on urgent measures related to the COVID-19 emergency (Law No. 106/2021).

The 2023 budget law (Law No.197/2022), art. 1, para. 544, has provided for the further increase to 0,40% of the award share for 2022 only.

The National Standard Health Requirements (FSNS) is composed of different parts: the "indistinct" needs are the preponderant part (123,8 billion euros in 2023); to this is added a plurality of "fixed shares" (2,5 billion euros) for a multitude of objectives (prevention and treatment of cystic fibrosis, penitentiary medicine, innovative drugs, etc.); there is finally the "award share" (644 million euros), which is a set-aside amount distributed on the basis of agreements within the Conference of Regions and Autonomous Provinces, also to compensate for events that have disadvantaged some Regions, including, where appropriate, the allocation mechanisms adopted for the distribution of other resources and representing 2% for the regions performing in the last three years and 3% for others (Law No. 191/2009), respectively brought to 0,5 and 1% for 2019 and 2020, in order to provide liquidity to healthcare institutions during the Covid-19 pandemic, pursuant to the Law Decree No. 34/2020 (Donatini, 2020, Scinetti et al, 2023; Fantozzi, Gabriele, 2024)[12].

2.5. *The "Differentiated Autonomy"*

In the regulatory framework described above, the Law 26 June 2024, No. 86, bearing, "Provisions for the implementation of differentiated autonomy of regions with ordinary status pursuant to article 116, para. 3, of the Constitution", constitutes, if not the last act – that related to the material determination of essential levels of performance (LEA for health) – certainly the prodromic one.

Recalling (art. 1) all the constitutional principles outlined above, starting with that of autonomy and administrative decentralization (art. 5 Constitution), the principles of subsidiarity, differentiation and appropriateness (art.

[12] The authors highlight how the distribution criterion of the FSNS share called "indistinct" , according to the State – Regions Agreement of 21 December 2022, both for 98.5% that of the resident population and the frequency of health consumption by age groups, for 0.75% of available resources, based on the mortality rate of the population under 75 years, and for the remaining 0.75% based on indicators used to define particular territorial situations impacting health needs such as: in particular, the incidence of relative individual poverty, the incidence of low schooling in the population aged 15 and over and, finally, the unemployment rate. The allocation resulting from the allotment formula is compared, for each region, with the availability of regional revenues (IRAP and additional regional IRPEF already mentioned). In fact, the State budget feeds an equalization fund which allows resources to be redistributed from the richest regions to those with the lowest fiscal capacity. The State – Regions Agreement has established that, from 2023, the mortality rate of the population under 75 years old and indicators relating to territorial situations considered useful for defining the health needs of the Regions must also to be taken into account, as parameters to reflect socio-economic conditions.

118) combined with the duties of solidarity (art. 2), the regulatory system is concerned to define the principles for the attribution of additional forms and special conditions of autonomy to the Regions with ordinary status in implementation of article 116, co. 3.

In detail, art. 3 of the Law, provides for the delegation to the Government for the adoption, within twenty-four months, of specific legislative decrees aimed at identifying the essential levels of benefits concerning civil and social rights that must be guaranteed throughout the national territory. Among them, paragraph 3, lett. f), the "*protection of health*".

The acts of the initiatives for the attribution of specific forms and conditions of autonomy are the responsibility of the Region, which sends them to the Presidency of the Council of Ministers and to the Minister for the Regions (art. 2 of the Law).

The preliminary agreement negotiated between the State and the Region, accompanied by a technical report prepared in accordance with art. 116, co. 3 Cost., is approved by the Council of Ministers on a proposal from the Minister for regional affairs and autonomy.

It shall be forwarded immediately to the Unified Conference, for the expression of an opinion, which shall be given within sixty days from the date of transmission and, after the rendering of the opinion, to the Parliament. The approval of the autonomy bill by Parliament does not preclude the exercise of the power of the Government, pursuant to art. 120 Constitution already referred to (art. 3, co. 5, L. 86/2024), where the monitoring carried out by the appropriate Joint Commission[13] notes that the region concerned does not give sufficient guarantees of appropriateness and efficiency in the use of resources allocated to them for the provision of services (LEP/ LEA) according to criteria of congruence. The State – Region agreement has a duration of no more than ten years (art. 7).

With more specific reference to the decrees defining the LEP/LEA, art. 7 of the above – mentioned Law provides that they are adopted "*only after or at the same time as the entry into force of legislative measures allocating the necessary financial resources*".

[13] The Joint Committee, pursuant to art. 8 of L. 86/2024, also ensures annually the recognition of the alignment between the needs already defined and the development of the revenue from the shared taxes to finance the same functions. If the above-mentioned survey shows a deviation due to the variation of requirements or the trend of the revenue from the same taxes, also in light of changes in the economic cycle, the Minister for Economy and Finance, in agreement with the Minister for regional affairs and autonomy, after agreement within the Unified Conference, shall adopt, on a proposal from the Joint Committee, the necessary variations of the rates of participation defined in the agreements pursuant to Article 5, para. 2, while ensuring budgetary balance and within the limits of available resources.

Art. 4, co. 1, reiterates the concept, clarifying that "*the transfer of functions may only be carried out after the entry into force of the legislative measures allocating financial resources to ensure the same essential levels of performance throughout the national territory, including the Regions which have not signed the agreements, in order to avoid unequal treatment between Regions*". Thus, in the absence of funds, no decrees on LEP/LEA can be issued, and functions and resources cannot be transferred.

Anyway, art. 9 states that differentiated autonomy does not entail new burdens on public finances but, above all, it guarantees "*financial invariance*" for the Regions which are not parties to the agreements (i.e. the system of differentiated autonomy).

Art. 10, para. 1, sub-para a) of the Law, in recalling art. 119 of the Constitution, assigns to the State the tasks of promoting cohesion, social solidarity, insularity and the removal of economic and social imbalances, whereas the State and Regions are assigned the task of ensuring the effective exercise of civil and social rights and the performance of functions relating to essential levels of performance (LEP/LEA). At sub-para. b) the rule provides for the unification of current part resources and the simplification of related administrative procedures.

These, in summary, the guidelines of the so-called "*differentiated autonomy*", which – as seen – is likely to affect deeply on the levels of governance of the health sector, on the effectiveness of health protection and, above all, in terms of uniformity in the delivery of essential levels of benefits, on whose definition the Commission is working to fulfil its task over a period of 24 months (June 2026).

Numerous comments and observations on the legislative text that we attempted to synthesize have emerged from its first drafts by eminent scholars, either presidents of the Constitutional Court or constitutional judges (Amato et al, 2023; Gallo, 2024, Cassese, 2024).

As correctly observed (Arcano et al, 2024) the "key rule" of the Law on differentiated autonomy, with regards to LEP (LEA in health care) is that of art. 4, para. 1, which states that if the establishment of LEP results in additional costs for public finance, the transfer of functions to the regions which have requested them may be carried out "*only after the entry into force of the legislative measures allocating financial resources...*". The conditions for transfer of duties are therefore strictly provided.

In this process the LEA are essential because they are historically linked to so-called "*standard costs*" referred to by state transfers, especially for health expenditure towards Southern Italy. And the corresponding per capita data

(Banca d'Italia, 2020)[14] seem to confirm this impression (see Table 15, in the Appendix). They highlight the so-called "*per-capita fiscal balance*", that is the balance between each region's total expenditure on the provision of goods and services to each resident in its territory and what it receives from tax revenues. Where this balance is positive, the corresponding amount must be covered by the central Government through transfers of resources; where it is negative, resources "balance" in favor of those areas of the Nation that seem to show a less efficient management of their budget. In other words, where the fiscal balance is negative, the region which has recorded it contributes positively to the national budget balance and pro-rata to the transfers to other regions. The table shows that the South and the islands develop a positive fiscal balance of 3,178 euros per capita (deficit) equal to almost 70 billion euros, or 75.81% of the total resources, which the Centre – Northern Italy, through the central Government, transfers to that part of the country (Arcano et al, 2024).

But there is more: consulting the Table in more detail it is noted that the regions which have a negative per capita fiscal balance (tax revenue is higher than expenditure) are, in order, Lombardy (– 5,662); Emilia – Romagna (– 2,786); Lazio (– 2,702); Veneto (– 2.342). Apart from Lazio, the other three regions belong to the group of those which, since the adoption of the State – Regions Agreements (2001), are considered "*virtuous*". And they are also the same ones that have urged, at the time, the implementation of the constitutional reform of 2001 and therefore of the system of "*differentiated autonomy*".

A first observation on the content of the Law just described is that it does not operate a clear choice between responsible autonomy (better known as "*fiscal federalism*") and centralization of resources in the hands of the State (Arcano et al, 2024). Thus, even assuming that resources are initially distributed on some basis of equity at national level, over time the regions which grow the most or make a more efficient use of resources are increasingly reluctant to transfer the excess of their own resources to the central Government, or worse, tend to break even. On the other hand, the centralization of resources in the hands of the State could mean a reduction in the share of "*virtuous*" regions (as it is already the case for health) and vice versa, reducing the incentives for efficient and effective resource management.

Again on the issue of the correct determination of LEA, a procedure that constitutes the heart of the whole system of differentiated autonomy, it is ob-

[14] See Banca d'Italia, *L'economia delle regioni italiane,* n. 22, Roma, novembre 2020.

served (Amato et al, 2023)[15] that the approach followed by the Government in the Law overturns the constitutional dictates (art. 117 and 119 of the Constitution), outlining a procedure for agreement between State and the requesting Region, without prior determination of these levels, necessary for a correct quantification of the financial resources to be guaranteed to all the administrations, called in various ways to guarantee the provision of services relating to civil and social rights in all areas within their competence.

The determination of LEA made in this way runs – according to this interpretation – two risks:

- that an increase in regional autonomy leads to a lowering of the levels of protection of certain rights and services currently provided in territories not affected by the agreements;
- that, in a somewhat opposite way, the attribution to some Regions of particular forms and conditions of autonomy, with the corresponding resources, prejudice the possibility of attributing to other Regions (but also to local authorities and State administrations) the resources needed to ensure uniform delivery of LEA.

In this same vein, the critique of those (Gallo, 2024)[16] who highlight that Law 86/2024 has the defect of pursuing the objective of identifying LEA, not intending them as instruments of equalization of substantial services to be guaranteed by general character, but as mere participation share in the revenue of tax revenue earned in the national territory (IRAP, additional IRPEF, VAT). On the contrary, to ensure that the resources necessary to provide institutions in territories with a lower per-capita tax capacity for the full financing of their public functions are set aside in the equalization fund (art. 119 Cost.), more than "*standard*" costing and requirements are needed in a limited number of areas. The new Law seems to forget that art. 119 of the Constitution requires as a priority that equalization be implemented with reference to all the regions and that the budgetary autonomy which concerns them must be fully guaranteed within the more general balances of the State budget. In this context, LEA should be built in close connection with the protection of civil and social rights and not conceived as the new law does, only as long-term objectives of

[15] It is worth mentioning that Giuliano Amato, professor of Constitutional Law at the University of Rome "La Sapienza", has been twice President of the Council and Minister for Institutional Reforms, and is President emeritus of the Constitutional Court.

[16] It is worth mentioning that Franco Gallo, eminent Professor of Tax Law, Minister of Economy and Finance is President emeritus of the Constitutional Court.

regional public policies established by the State, in agreement with the regions concerned with "*differentiated autonomy*".

It is also noted that LEA should be identified and evaluated in a comprehensive manner by the Parliament and not exclusively transferred to its technical headquarters under the control of the Minister for regional affairs, as provided for by Law No. 86/2024. It seems, in short, that the latter, in its approach, contributes to the progressive departure from "*cooperative regionalism*" which is inspired by Title V of the Constitution and goes instead towards a "*competitive regionalism*", having an uncertain financial discipline, all to be rewritten and, above all, likely to produce new inequalities.

The same promoter of the Law on differentiated autonomy (Calderoli, 2024)[17] responds to these critiques, stating that:

- the prioritization (first the implementation of fiscal federalism and then the differentiated autonomy) has no reason to exist either from a constitutional point of view or from a financial point of view. Art. 116, para. 3, of the Constitution, in fact, requires for the implementation of differentiated autonomy the respect of the principles of another constitutional provision, that of art. 119 on fiscal federalism, and does not place an order of priority. The implementing Law does not in any way undermine these principles but guarantees the financial balance between regional functions and revenues (L. 42/2009) as well as financial neutrality for regions which do not wish to have access to differentiated autonomy;
- the Law n. 86/2024 initiates (after the first provisions of the budgetary law for 2023) an organic determination of LEA with the full involvement of the Houses of Parliament, identifying the subjects and areas of subjects to which they are related. The LEA are not merely long-term objectives, but must be built around benefits. They must be matched with standard costs and requirements, because the right to certain benefits cannot become a pretext for local authorities or the State to bear unlimited expenditure;
- the interpretation that Parliament would play a subordinate role in the process of implementing differentiated autonomy is wrong: the Parliament will be involved in the delegation exercise process, with the possibility of influencing the contents – sometimes particularly technical – of texts prepared by the Government. The latter will be required to follow up the acts of direc-

[17] It is worth mentioning that Roberto Calderoli, Minister for regional affairs and autonomy, was also the promoter of the Law 5 May 2009, n. 42, bearing "*Delegation to the Government in matters of fiscal federalism, implementing article 119 of the Constitution*".

tion approved by the Parliament, which, in turn, by express constitutional provision, will be called upon to deliberate on the State – Region agreement, with an absolute majority of its members;
– finally, as regards the relationship between regional spending power and the accountability of administrators, Law n. 86/2024 provides the Government with powerful monitoring tools both on the effective implementation of LEAs (art. 3, paragraph 4) and on the implementation of agreements (art. 8).

Finally, it seems worth-mentioning the considerations of the person (Cassese, 2024)[18] who was appointed to chair the Committee for the Identification of Essential Levels of Benefits (CLEP).

He recalls, preliminarily, that with the constitutional reform of 2001 three major changes occur: the fall of the word "*Mezzogiorno*" (Southern Italy) from the Constitutional Chart, the promise of differentiated autonomy and the provision that the State will set essential levels of benefits (LEP/LEA). At the end of 2022, the last two elements of the Constitutional reform were put together, establishing by law that the first can only be carried out after having fixed the second.

Today's debate – according to this interpretation – hides two real problems:
(a) assess the regional experience, by ascertaining the aspects (and places) where it has taken root and where it has not had similar luck, so as to prepare the means to strengthen it;
(b) the determination of historical costs and needs, i.e. the expenditure necessary to sustain essential levels of benefits (i.e., in health care – LEA) so as to determine how long a differentiation can be made, after ensuring the essential levels of civil and social rights for all citizens, while respecting budgetary constraints.

The above-mentioned debate was suspended by the decision of the Constitutional Court, not yet filed, on the questions of Constitutional legitimacy raised by the Regions of Puglia, Tuscany, Sardinia and Campania on the whole system of the recalled Law 86/2024 and the acts of constitution in court of the Presidency of the Council of Ministers, and with interventions of opposite sign regarding the regions of Lombardy, Piedmont and Veneto.

With a short press release, issued by the Office of Communication and Press of the Constitutional Court on 14 November 2024, pending the filing of the judgment itself, the judges have announced that they considered "unfounded"

[18] Also in this case, it is worth-mentioning that Sabino Cassese, Professor emeritus of Public Law of Economics and Administrative Law at the University "La Sapienza" of Rome, is Judge emeritus of the Constitutional Court.

the issue of constitutionality of the entire law on the "*differentiated autonomy of ordinary regions*" considering instead illegitimate only some specific provisions of the same legislative text.

According to the judges, art. 116, co. 3, of the Constitution (which regulates the attribution to ordinary regions of special forms and conditions of autonomy) must be interpreted in the context of the Italian state form. It recognizes, together with the fundamental role of the regions and the possibility for them to obtain dedicated forms of autonomy, the principles of unity of the Republic, solidarity between the regions, equality and guarantee of citizens' rights, as well as the balance of the budget.

The Judges consider that the distribution of legislative and administrative functions between the different territorial levels of government, in implementation of art. 116, para. 3, should not correspond to the need for a distribution of power between the different segments of the political system, but should be carried out in accordance with the common good of society and the protection of the rights guaranteed by Italian Constitution. To this end, the constitutional principle of subsidiarity governs the distribution of functions between the State and the Regions.

In this context, differentiated autonomy must be used to improve the efficiency of public services, ensure greater political accountability and better respond to citizens' expectations and needs.

The Court, in examining the appeals, the Attorney of the Prime Minister and the acts of intervention "*ad opponendum*", found the following aspects of the law to be unconstitutional:

- the possibility that the agreement between the State and the region and the subsequent law of differentiation transfer matters or areas of matters, where the Court considers that devolution must concern specific legislative and administrative functions and must be justified, in relation to the individual region, in the light of the principle of subsidiarity (art. 2, co. 2, L. 86/2024);
- the conferral of a legislative delegation for the determination of essential levels of benefits concerning civil and social rights (LEP) without appropriate guiding criteria, with the consequence that the substantive decision is put back in the hands of the Government, limiting the constitutional role of Parliament (art. 2, co. 4);
- the provision that a decree of the President of the Council of Ministers (DPCM) determines the updating of the LEP/LEA (art. 3, c. 7);
- the use of the procedure provided for by Law n. 197 of 2022 (budget law for 2023) for the determination of LEP with DPCM, until the entry into force of

the legislative decrees provided for by the same law to define the LEP (art. 3, co. 4);
- the possibility of modifying, by Inter-ministerial Decree, the rates of the share of revenue from State taxes, intended to finance the functions transferred, in case of a discrepancy between the expenditure needs and the trend of the same revenue; according to this forecast, the inefficient regions could be rewarded, which – after having obtained from the State the resources for the exercise of the functions transferred – are not able to ensure with these resources the accomplishment of the same functions (art. 5, co. 2);
- the optional, rather than the mandatory, contribution to the objectives of public finances for the regions receiving devolution, with the consequent weakening of the bonds of solidarity and unity of the Republic (art. 4, co. 2);
- the extension of Law No. 86 of 2024, and therefore of art. 116, third paragraph, Cost. Regions with special status, which can use the procedures provided for in their special statutes to obtain greater forms of autonomy (art. 11).

Moreover, the Court has interpreted other provisions of the law in a "constitutional manner":
- the legislative initiative concerning the differentiation law should not be understood as reserved solely to the Government (art. 3, co. 2);
- the law of differentiation is not merely an approval of the agreement ("*take or leave*") but implies the power of amendment of the Chambers; in this case, the agreement may be renegotiated (art. 3, co. 2);
- the limitation of the need to pre-determine LEP's to certain subjects (distinction between "LEP's subjects" and "NO LEP's subjects"") should be understood as meaning that, if the Legislator qualifies a subject as "NO-LEP's", the transfers concerned may not relate to functions relating to services concerning civil and social rights (art. 4);
- the identification of resources for transferred functions through revenue sharing should not be based on "*historical expenditure*" but rather on "*standard costs*" and requirements and efficiency criteria, by freeing up resources to be kept at the State's expense for covering expenses which, despite devolution, remain nevertheless at the State's expense;
- the financial invariance clause requires – in addition to what has been stated in the previous point – that, when concluding the agreement and identifying the resources involved, account is taken of the general framework of public finances and trends in the economic cycle, compliance with European Union obligations (art. 9).

The Court remains competent to examine the constitutionality of individual laws of differentiation, if they are censured by way of appeal in the main or in the incidental way from other regions.

It is the duty of Parliament, in exercising its discretion, to fill the gaps arising from the acceptance of some of the issues raised by the applicants, in compliance with constitutional principles, so as to ensure the full functionality of the law.

In summary: differentiated autonomy is in line with the constitutional dictates, but the mechanism for implementing the objectives set by the law needs significant corrections, to be able to remove the doubts of reported unconstitutionality (Trovati, 2024).

To do so, Law No. 86/2024 must return to Parliament, since the censures made by the Court make it lapse, from the time of publication of the judgment, the overall system, for the regulatory vacuum that comes to occur, on the norms declared to be totally incompatible with the Constitutional Charter, and on those whose interpretation must be "*constitutionally oriented*" (Trovati, 2024).

The publication of the substantial Judgment (Constitutional Court , 3 December 2024, No. 192) clarifies the general orientation of the Consulta that – it must be admitted – without declaring the overall illegitimacy of the regulatory provisions has strongly depowered its system. It is based on art. 116, para. 3, of the Constitutional Charter, for which "*the transfer of powers must relate to specific functions, whether legislative and/or administrative in nature, and be based on reasonable justification, expression of an appropriate investigation, as provided for by the principle of subsidiarity. The division of functions must correspond to the best way of implementing constitutional principles. The appropriateness of the allocation of the function to a given territorial level of government must be assessed with regard to the criteria of effectiveness and efficiency, fairness and responsibility of the public authority*".

The contested provisions (art. 1, para. 2, art. 2, para. 1, third sentence, and art. 3, para. 3, paragraph 2, art. 4, para. 1, first sentence, of the Law No. 86/2024, in the part where it mentions «subjects or areas of subjects referable to the LEP (LEA)» instead of «specific functions referable to the LEP (LEA)» are therefore "*unconstitutional where they allude to a transfer of all the functions (administrative and/or legislative) that are part of a subject, without prescribing that requests for agreement are justified in relation to the situation of the requesting region*".

We are pretty sure that the SSN, which someone (Biancheri, 2023) has defined as "*four-party*", to highlight the presence of at least four actors – public,

private-private, private "*accredited*" and non-profit – is different from what the founding fathers and those who conceived it in 1978 had perhaps imagined in defining health protection as "*a fundamental right and interest of the community*", which prefigures an equal level and quality of services for all citizens. But it is also true that the long and complex evolution of the corresponding legal framework, which have tried to describe so far, has helped to promote, if not to determine, the coming up of actors who, over time, have tried to fill the gaps left by the political decision-makers in matching the demand for health from civil society.

These actors and their role in the Italian health care will be talked about in the following pages.

2.6. *Health and Nonprofits, after the Third Sector Reform, in Italy*

As already mentioned, the Code of the Third Sector and the Decree on social enterprises have included health protection, more precisely "*health interventions and services*", respectively among the "activities of general interest" (art. 5, co. 1, lett. b) CTS) or among the "*general interest activities carried out by social enterprises – SGEI*" (art. 2, co. 1, lett. b) DIS), when performed by Third Sector Entities in accordance with the rules governing their operations.

The "*health interventions and services*" thus includes a very varied complex of activities, from inpatient care to outpatient networks, hospitality services, till to the whole wide sphere of volunteering[19] , as well as emergency services and/or ambulance transport, under the accreditation regime[20].

According to the latest census carried out by ISTAT[21], out of the 363,499 Nonprofit organizations existing in Italy, 12,578 operate in the health sector (2020 data). In terms of number, they rank eighth, representing 3.5% of the total, but employ 103,215 employees, equal to 11.9% of the total (870,183), ranking

[19] For example, the Italian Red Cross, a Volunteer Organization with 160 of history of health and social care, counts, in Veneto alone, about 9,000 volunteers, distributed in 27 territorial committees.

[20] Pursuant to art. 57, para. 1, of the CTS, "*Emergency and urgent health transport services may be, in priority, entrusted by convention to voluntary organizations, registered for at least six months in the National Register of the Third Sector – RUNTS, members of an association network referred to in article 41, para. 2, and accredited under the pertinent regional legislation, where applicable, in cases where, due to the specific nature of the service, direct entrustment guarantees the performance of the general interest service, in a system of effective contribution to social objectives and the pursuit of solidarity objectives, under conditions of economic efficiency and appropriateness, as well as respecting the principles of transparency and non-discrimination*".

[21] See Tables No. 16 and 17 in the Appendix.

third for employment on a national scale, after the "*Social assistance and civil protection*" and "*Education and research*" sectors.

The number of volunteers in the same sector is estimated at 19,630, with a total of worked hours exceeding 1 million (Faggiano, 2023)[22].

In the Veneto region, the number of Nonprofit organizations duly registered by the competent offices of the Veneto Region is 588, but this figure is probably an imperfect approximation as it has explained in the Table 18 (Azienda Zero, 2024).

The Nonprofit health workers who make up the SSR "providers" are divided into two categories of care: "*Health Care*" (SA – 588: hospital and similar; outpatient, SPA care establishments, mental health, "*intermediate*" facilities, transfusion centers, emergency services and medical transport) and "*Health and Social Care*" (SS – 1.016: RSA, addictions disabilities, minors), which in the classification of activities of "*general interest*" provided by art. 5 of the CTS belongs to another category[23].

These services and benefits will be discussed in detail on the following pages.

[22] See Faggiano I., *Associazioni pazienti: un milione di ore di volontariato, oltre 58mila persone assistite e 70mila visite gratuite*, in Sanità Informazione, 13 July 2023, *https://www.sanitainformazione.it/salute/associazioni-pazienti-un-milione-di-ore-di-volontariato-e-oltre-58mila-persone-assistite/*

[23] Extrapolating the data from the list of subjects registered in the Registry of Non-profit and Social Utility Organizations – Onlus, as of 22 November 2021, under "*Health Care*", there are 24 Volunteer Organizations, distributed by province: Belluno 2; Treviso 1; Verona 7; Vicenza 1; Padova 7; Rovigo 1. From the same list, No. 736 Odv are found in the Veneto Region, dealing with "*Health and Social Care*" on the same date. The extreme variety of legal forms admitted by the CTS to become a Nonprofit Organization (ETS) in Italy leads us to believe that these lists are still incomplete.

3.
ECONOMIC – FINANCIAL FRAMEWORK

3.1. *Monitoring National Health Spending*

Consolidated data for the last twenty years (OECD, 2023; Mef, 2023)[1] show a rather constant trend in health care spending, with a peak in 2020, driven by the pandemic crisis of COVID-19, immediately corrected from the following year. The trend is consistent with the OECD average, less pronounced than other G7 countries (United Kingdom and Germany) even during the pandemic (Fig. 2, in the Appendix).

The current expenditure data produced by the Ministry of Economy and Finance in the 2023 NADEF (Tables 12 and 13, in the Appendix) show an increase in absolute values, which holds account of the corresponding increase in the rate of inflation, in percentage terms as a share of GDP. There is an effective reduction from 6.7% (2022) to 6.1% (2026), with net indebtedness that, in the period 2023 – 26, shows a negative balance in 2023 alone, due to the need for a reduction in the expenditure ceiling for medical devices (1,085 billion euros) and to the increase in the hourly rate of additional services and to the advance payment in emergency services (88 million euros).

On the other hand, for the year 2024, the forecast of the same Ministry sees an upward adjustment (from 132.946 billion to 138.776 billion euros), with a percentage of 6,4% compared to GDP (instead of the planned 6,2%), but with a rate of change of 5,8% from the previous year. In the following years until 2027, a rate of change from 2,2% in 2025 to 1,8% in 2027 is expected, also in function of the progressive reduction of the deficit/GDP ratio required by the new Stability Pact for the Eurogroup countries.

In short, this means a progressive reduction of the health expenditure borne by public finances, which corresponds to a progressive increase of the share

[1] See Tables 12 – 13 and Fig. 2 in the Appendix.

borne by patients (out-of-pocket) already examined on the previous pages (Figures 8 and 17, in the Appendix) This is reflected in the "*repayment plans*" of the Regions.

This situation is also reflected on the essential levels of care (LEA) materially available, on their waiting times for users, on the unmet needs by the SSN and, consistently, on the freedom of care of the users, who are led to turn to the private or nonprofit sector (Toth, 2022).

3.2. *"Differentiated Autonomy" and "Essential Care Levels". Related measures*

As to the figures relating to the overrun of the medical device expenditure ceiling (1,085 billion euros) in 2023, the Ministry of Economy and Finance inform that the corresponding measures are related to differentiated autonomy and the determination of essential levels of benefits (actually, LEA) which – as mentioned in the previous pages – include "*District care*" and, particularly, Pharmaceuticals.

In these areas, the Law 29 December 2022, No. 197, art. 1, paragraphs 791 to 801 (Budgetary Law 2023) have established a Control Room composed of the competent Ministers "*ratione materiae*".

It shall be entrusted with:

- the recognition of state legislation and the functions exercised by the State and the Regions with ordinary status, in each of the matters referred to in Article 116, para. 3, of the Constitution;
- the recognition of historical expenditure of a permanent nature in the same subjects and functions;
- technical assumptions made by the Technical Committee for standard requirements;
- the determination, within the budget appropriations under existing legislation, of LEA, based on the technical assumptions made by the Technical Commission for standard requirements.

In this respect, the Ministry of Health has implemented, in deference to Legislative Decree No. 56/2000 ("*fiscal federalism*"), the New Guarantee System (NSG), aimed at ensuring that all Italian citizens receive essential levels of care (LEA) in conditions of quality, appropriateness and uniformity. One of its relevant aspects is the conceptual scheme underlying the system of indicators which associates each key level of assistance with the relevant attributes of the delivery processes such as efficiency, effectiveness, organizational and clinical appropriateness, safety of care.

The indicators are currently 88, distributed in the following macro areas: a) Collective prevention and public health (P), b) district care (D), c) hospital care (H), d) context indicators for estimating health needs (C), e) social equity indicators (E), f) indicators for monitoring and evaluation of care therapeutic diagnostic pathways (PDTA).

The indicators (see "ABBREVIATIONS" part for their corresponding meaning) are essential to the monitoring carried out by the Regional Compliance Verification Table, established at the Ministry of Economy and Finance, and by the Permanent Committee for the Provision of LEA, set up at the Ministry of Health.

For the Region to be compliant, the score of each service area must be within the range of 60 – 100. An assessment score of less than 60, even in one area, results in a negative outcome.

The results for the two-year period 2020 – 2021 (Ministry of Health, 2023), with reference to the Veneto Region, are reported in the Appendix (Fig. 22 and 23).

In the year 2020, in the District Area, Veneto has reached the highest score (100) in 6 out of 8 indicators (Standardized adult hospitalization rate for diabetes, response times of mobile units in emergency, share of services delivered in maximum time in relation to priority class B – short, consumption of antibiotics per 1000 inhabitants, offering of integrated home care service for patients treated at different levels of care intensity, offering of home palliative care services for the management and care of end-of-life cancer patients).

In the last of the above mentioned indicators (palliative care) the Veneto Region reached, in 2022, the national record. In this field, in addition to the services provided by the public structures of the various territorial ULSS, there are 7 ETS: 1 ETS Foundation and 6 ODVs, located in the provinces of Belluno (1), Venice (1) and Padua (4)[2].

In 2021, in the Hospital Area the Veneto Region recorded a further increase in score (+6) compared to the previous year; in addition, it confirmed the highest score in the District Area (5 indicators out of 8, as it is shown in the Fig. 23).

[2] See Press Release Com. n. 376 (AVN) dated 5 March 2024 of the Veneto Region.

3.3. *The Veneto Region Health Spending*

The health expenditure of the Veneto Region in the three-year period 2023 – 26 (Mission 13: Health protection) relates to the financing and management of expenses in the various areas provided for by the Guarantee System (NSG) and their distribution by Programme. Their trends are summarized in Figures 20 and 21, in the Appendix.

As it can be seen, the amount of expenditure for 2023 (on accrual basis: 10.357,85 MM euros; on cash basis: 11.514,50 MM euros) is almost entirely allocated to Programme 01 "*SSR – Ordinary funding for LEA guarantee*": 10,066.44 MM euros; for the remaining 159,84 MM euros to Programme 05 "*SSR – Health Investments*", to the compensation of deficits arising from past years "*Program 04*" and 450,000 euros to the "*SSR – Unitary regional policy for health protection*".

The distribution plan is validated by the MEF (RGS, 2023) which attests to its economic balance and records a surplus of 7,099 MM euros.

Looking at the expenditure forecasts for the following years, up to 2026, it is confirmed that the amounts are almost exclusively allocated to Programme 01 "*SSR – Ordinary funding for LEA guarantee*", and that the trend is of slight adjustment of current expenditure to inflation, but also that, for the year 2024, the resources for the Program 05 "*SSR – Health Investments*" have more than doubled, rising to 339,18 MM euros (Fig. 21).

The total number of hospital admissions amounts to 614.831 (of which 123,995 are carried out by the private sector – non-profit), the total number of outpatient services is 68.071.012 (of which 9.541.917 are provided by the private sector – non-profit). The value of hospitalization is about 2,6 billion euros (of which about 593 million euros for private and nonprofit organizations) and that of outpatient services of about 1,3 billion euros (of which 351 million euros made by private or nonprofit organizations).

The consolidated data of hospital admissions and specialist treatments carried out in the entire three-year period 2021 – 2023, including the so-called "ticket" (i.e. the share of expenses borne by the patient), show a progressive increase both in the number of admissions, and in the number of specialist treatments (see Figure 25, in the Appendix).

Total hospital admissions rose from 588.603 in 2021, of which 123.325 were absorbed by private or non-profit facilities (about 20.95%) to 638.755 in 2023, of which 125.723 were absorbed by private or non-profit facilities (19,68%), while the total number of specialist treatments rose from 67.192.422, of which

330.555.171 were provided by private or nonprofit entities (14,15% – data 2021) to 70.101.911, of which 9.267.031 were provided by private or nonprofit entities (13,21% – consolidated data 2023).

It should be noted that both hospitalization and specialist treatments fall within the intervention areas concerning essential levels of care (LEA) for which both private and nonprofit entities operate in the framework of a convention regime with the SSR, Mission 13 – Programme 01, mentioned above.

4.
HEALTH CARE IN VENETO: THE REGIONAL SYSTEM

4.1. *The Regional Health System: instruments, programming methods and financing mechanisms*

According to the most widespread opinion (Fuolega, 2012; Toniolo et al, 2012; Cignacco, Rizzato, 2018) the birth of the Regional Health Service (SSN) of the Veneto Region goes back to art. 4, paragraph 11, of the Law 22 May 1971, n. 340, which approved the Statute of the Region. In that paragraph "*health protection*" is expressly included among the social services that the Region intends to guarantee "to all citizens".

The concrete organization of the SSR follows, however, the entry into force of the National Health Service (SSN: Law 833/1978) which, as seen above, dictated the guidelines of the territorial organization (art. 10: establishment of local health units – USL; art. 11: regional competences). The first Units (31, actually) were established with the Regional Law n. 78 on 25 October 1979, bearing "*Rules for the establishment and operation of local health units*"[1].

With the subsequent regional laws of 14 September 1994, Nos. 55 and 56 respectively, the instruments and modalities of programming, mechanisms and sources of financing of "Public Health Authorities", their accounting, management and control arrangements were defined. The organizational structure of the Regional Health System was also outlined and reorganized trough 22 USL, along with the Hospitals of Padua and Verona, separating their management and operability from the USLs that previously administered them.

This reorganization was again modified with the L.R. 19/2016 that reduced the Units, renamed "Health and Social Care Units" (ULSS), from 22 to 9 (see Table 19, in the Appendix), to which are added the already mentioned Hospi-

[1] See BUR No. 53 of 26 October 1978. The Law was later repealed by the subsequent L.R. 14 September 1994, n. 56, except art. 40, concerning the management of the social functions of municipalities.

tals of Padua and Verona and the Veneto Oncology Institute (IOV) – IRCCS, created in 2005.

The final steps in this organizational process are:

- the L.R. 25 October 2016, n. 19, which identified a single body of governance of the Regional Health Service – Azienda Zero;
- the D.G.R. October 10, 2023 n. 1227, which establishes the Permanent Assembly of Citizens' and Patients' Organizations, committed on health and social health issues and a Control Room.

Both will be discussed more widely in Chapter 11.

4.2. *The Organizational Structure*

The Statute of the Veneto Region affirms the guiding principles of the Regional Health System, namely universality, equity, humanization of care and social integration in healthcare, which inevitably recall the principles of the SNN.

The main actors of the Veneto Regional Health System are: the Region, the Health and Social Area[2], the "Azienda Zero" and the ULSS, to which are added, from 2023, the Permanent Assembly of citizens' and patients' organizations and the Control Room.

The regional health care system is modulated by intensity of care, with hospitals developed according to a "*Hub and Spoke*" model (Cusani, De Corte, 2023), intermediate care facilities such as community hospitals and Territorial Rehabilitation Units (URT); hospice, outpatient rehabilitation facilities (ex art.26 L. 833/1978), sheltered therapeutic rehabilitation communities and other health facilities characterized by the temporary permanence; social health and semi-residential structures that are articulated in service centers for the elderly, disabled, addictions, developmental age, mental health, which has already been mentioned about the regional operability of nonprofit health care entities, after the reform of the Third Sector (see Table 18).

Although the system may appear to be conceived according to a "*top – down*" model, it is evident that there is an intense integration between public, private and nonprofit structures, as it can be drawn from the birth of several

[2] The Health and Social Area is, in turn, subdivided into a Department for Food Safety Prevention, a Pharmaceutical, prosthetic, medical devices Department, a Health Programming Department, a Social Services Department, a SSR Planning and Control Department which includes the "Azienda Zero", a Hospital Building Department for community purposes, a SSR – HR Department.

associations, even of excellence, aimed at corresponding to the specific territorial needs[3].

The "*Community Hospitals*" also enhance the regional offer. These are short-term hospitalization facilities for patients requiring medium/low clinical intensity and short-term stay.

As regards home care (ADI), the Region has for years been promoting a planned and homogeneous development of home care throughout the regional territory. This is the context of the reorganization initiated in 2017 with D.G.R. n.1075/2017.

The new organization includes:

(a) hourly attendance of nursing staff (7 days a week, in the time slot between 07:00 and 21:00);
(b) availability of nursing staff (reception, by nursing staff, of the requests for care of patients already in charge of the service itself and possible activation of nurses in the area of responsibility, 7 days a week, from 07:00 to 21:00, at each ULSS, by identifying a unique telephone number);
(c) access scheduling (developed over the course of the internal week, i.e. 7 days a week), consistently with the clinical-care complexity of patients).
(d) outsourcing of blood and biological samples, which also includes the storage and transport of samples to laboratories identified by Health Companies. This service is intended exclusively for non-ambulant patients in charge of the home care service of the Health Company or, in special cases, to other users expressly authorized by the Company.
(e) integration with the General Medical Doctors (GPs) and the Continuity Care Doctors.

The organization of home nursing activities should be planned in consistence with the needs for patients belonging to a single association form of general medicine (whether it is network, group or integrated group medicine) having as their reference a single ADI team.

To ensure the continuity of care, the Doctors of Continuity Assistance receive, in accordance with the provisions on protection of privacy, the updated list and relevant information on patients in their area of responsibility who are already in charge of the ADI service[4].

[3] It is the case, for instance, of the Association "L'Acero di Daphne" based in the province of Verona, founded in 2012 to spread the culture of palliative care among health personnel and to promote its practice, in line with the mandate of the Ministry of Health, or the case of the Polyclinic "Emergency" Odv in Venezia Marghera, that was founded in 2010 by the NGO of the same name, which offers free basic medical care, including dental and psychological support, aimed at facilitating access to the health system for those who are not able to benefit from the SSR.
[4] ADI: see the Part "ABBREVIATIONS". With the integrated home care: home care services are provided by health and social professionals who are integrated into each other (general practitioners, nurses, physiotherapists,

The ULSS are the primary tool for the management of social health and care services and with the aim of creating a more integrated care path in the territory, where primary care, home care, residential and intermediate care are linked and ensure an adequate response to the needs of people, between hospital and territory.

The approach that seems to guide the organizational system of health in the Veneto Region is precisely that of the search for the health needs of the resident population and unmet needs, especially on the infrastructural point of view (Sacco, 2023).

One of the specificities of SSN is the presence of a multiprofessional integration in managing complex care pathways, with a combination of managerial and clinical professionals for the design, implementation and effective management of such pathways or networks (Ghiotto et al, 2017). An example is the oncology care network (Rete Oncologica Veneto – ROV), often referred to as a reference model in Italy. Most hospitals are public hospitals, with a total of about 14% of the beds in private or nonprofit hospitals.

However, at each ULSS headquarters of a complex Operational Unit of Medical Oncology, a Functional Department of Clinical Oncology (DOC) is activated, which constitutes the first node of the Oncology Network. The DOC is usually coordinated by the Director of the Complex Operational Unit (UOC) of Medical Oncology. The Director of the Department is responsible for the oncology patient care path, implemented in application of the pre-defined guidelines and shared PDTAs for rapid management and best PDTA[5] for the cancer patient. The Department is responsible for all the structures/services in the relevant area (public, private, nonprofit) involved in the process of care, assistance and rehabilitation, from primary and secondary prevention services, to general practitioners, to the Centers of Palliative Care/Territorial hospice.

Another example is the telemedicine tools, first of all the so-called "Electronic health record – FSE", which according to data provided by the SSR Veneto (2020)[6], is consulted by 58% of residents, by 90% of general practitioners, from 98% of ULSS for the verification and entry of patient health information.

Specialized outpatient care, including visits, diagnosis, laboratory services and other care not requiring hospitalization are provided directly through Dis-

social workers, specialist doctors etc.), according to a personalized intervention defined by the Health and Social Care Unit. See D.G.R. No. 1075 of 13 July 2017.

[5] As highlighted in the "ABBREVIATIONS" part of this survey, the acronym "PTDA" refers to indicators for monitoring and evaluation of care therapeutic diagnostic pathways.

[6] See *https://www.fascicolosanitario.gov.it/fse-veneto.*

trict health centers and hospitals, laboratories and suppliers, owned by public, and accredited private and nonprofit organizations.

Long waiting times, a common phenomenon in Italy, do not seem to constitute an element of criticality in Veneto, where the regional plan for managing waiting times (DGR 1164/2019) for the period 2019 – 2023 has respected the maximum fixed by the National Health Plan (Sacco, 2023).

5.
REGIONAL HEALTH SYSTEM VENETO: FROM HEALTH UNITS TO LOCAL HEALTH AND SOCIAL CARE UNITS

5.1. *The territorial reorganization of health facilities (1979-2016)*

The territorial organization of the SSR Veneto has developed in several stages, all oriented to ensure, according to the statutory requirements, identical benefits and health protection for all citizens resident in Veneto and this, above all, regardless of the territorial criticalities that could be represented by mountain areas and the obstacles related to communication routes.

The organizational structure resulting from L.R. 78/1979, which identified 31 local health units in the seven Venetian provinces, was precisely intended to pursue the goal of covering the territory as widely as possible.

This structure remained more or less stable until 1994, even if there were no lack of regulatory measures aimed at redetermining the territories under the jurisdiction of one or the other USL (Cuttaia, 2017)[1].

The most important novelty of L.R. 56/1994, also mentioned above, is not so much the passage from 31 to 22 of the USLs, but rather the creation of two Hospitaller Authorities in Padua and Verona, intended to constitute real national hubs and therefore made administratively and operationally autonomous from the territorial reference USL.

The definitive reorganization is due to L.R. 19/2016 that brings definitively to 9 the territorial units, calling them "Health and Social Care Units" (ULSS) to witness the integration between the two areas of assistance, which adds the three hospital wards of Padua, Verona (Integrated University Hospital) and the Veneto Oncology Institute (IOV) – IRCSS, founded in 2005, putting the health governance at the head of the newly formed "Azienda Zero" (Zero Health Care) and the identified "Area Sanità e Sociale" (Health and Social Area) of the Region.

[1] In this connection, reference is made to L.R. 32/1981, 2/1984 and 30/1989.

All this in the declared intention of rationalization, strengthening the district model and coordination of structures, entities and actors that support the social health system (art. 11 para. 4, lett. a) and b) and of "*development of the regional health service founded on participatory methods based on paths marked by maximum transparency, responsible sharing, respecting the principle of efficiency, effectiveness, rationality and economy in the use of resources in order to continue to guarantee fair access to services, while safeguarding territorial specificities*" (art. 1, para. 1, L. 19/2016).

5.2. *The Veneto Region Hospital Network (D.G.R. 614/2019)*

The hospital organization follows D.G.R. n. 614 of 14 May 2019 and its annexes, which set the levels and equipment of individual public facilities and the minimum requirements of accredited private facilities. The result is 69 hospitals, of which 42 public (60.87%) and 27 private accredited structures (39.13%), 3 of which are run by ETS (4.34%). The detail is shown in Table 20 and Figure 26, in the Appendix[2].

The last of the above categories should be extended to include 7 other "accredited" structures, which are among the 27 private ones. The latter, belonging to religious institutions and already present as "Onlus"[3] in the searcher held by the Agenzia delle Entrate (Italian Revenue Agency), are not yet registered in the National Register of the Third Sector – RUNTS, due to art. 101, paragraphs 2 and 10, of the CTS, which states: "*Until the National Register of the Third Sector becomes operational, the previous rules shall continue to apply for the purposes and effects of registering entities in the Registers of Onlus, Voluntary Organizations, Associations for social promotion...*" the provisions concerning the transfer to this register being subject "*to authorization by the European Commission, requested by the Ministry of Labor and Social Policies, pursuant to Article 108, paragraph 3, of the Treaty on the Functioning of the European Union*", not yet acted upon.

On this point, the T.A.R. Lombardia (Administrative Regional Court of Lombardy), Sect. II, with ruling n. 2533 of 1 October 2024, has established the absence of a precise obligation for non-profit organizations to be registered in

[2] See Annex A to the D.G.R. n. 614 on 14 May 2019.

[3] Onlus is the abbreviation for Organizzazioni non lucrative di utilità sociale (Organizations Not-for-profit and Social Utility).

the RUNTS, applying for them the transitional regime referred to in the afore mentioned art. 101 of the CTS.

It follows, therefore, that the accredited hospitals belonging to and managed by non-profit organizations are 10 (14,34% of the total).

To this figure must be added that concerning the "Intermediate structures", 2,013 in the entire territory of Veneto region[4] , 797 of which are "accredited private structures", i.e. belonging to for-profit or non-profit organizations (about 40%).

The comparison of the data presented so far and summarized in Table 20 with those from Figures 24 and 25 shows a model of health care which is clearly integrated among the public, private and nonprofit structures aimed at identifying and then finding the health needs expressed by users of the Veneto Region, through an organization of services rooted in the territory.

This model, which just after the promulgation of the afore mentioned D.G.R. offered a population of around 4,9 million people 17.000 beds in hospitals for "acute", 3.000 beds in intermediate structures, 30.000 beds in residential structures (75% high-intensity care; 25% medium-intensity care), and able to produce a home care offer for 120.000 people, was cited as an example of adequate health care provision to citizens-patients from the most important Health Organization (WHO, 2016).

5.3. *Health Care for Foreigners*

To complete this brief review on the regulatory and organizational evolution of health in Veneto, it is worth deepening the approach to "non-citizens", which involves not only the deepening of epidemiological-therapeutic aspects, but also of regulatory, logistic – organizational, social and cultural aspects.

The process, which we call, by convention, "*hosting foreigners*", crossed two phases (Cusinato – Rigoli, 2023):

– that started with the L.R. of 30 January 1990 n. 9, on "*Interventions in the field of immigration*", preceding both the Single Text on immigration on the status of foreigners (Legislative Decree No. 25 July 1998, n. 286)[5] and

[4] See the Annex C to D.G.R. 614/2019. They are "*Community Hospitals*", "*Rehabilitation Centers*", and "*Hospice*".

[5] For the sake of completeness of information, the text of art. 34 of the Legislative Decree July 25, 1998, n. 286 is given, bearing "*The Consolidated Act of the provisions concerning immigration and rules on the status of foreigner*", as amended by art. 14, para. 1, of L. 7 April 2017, n. 47 and art. 1, paragraph 1, let. o) of the Law Decree 4 October 2018, n. 113, converted with modifications by L. 1° December 2018, n. 132: "1. *The following are required to register*

the Regulation on immigration and the conditions of foreigners (D.P.R. 31 August 1999, No. 394)[6];
– that started with D.G.R. July 26, 2021, No. 1030, bearing "*Combating health poverty*".

with the national health service and have equal treatment and full equality of rights and duties compared to Italian citizens as regards their contribution obligation, the care provided in Italy by the national health service and its time validity:
a) legally resident aliens who are in the regular course of employment or self-employment or are registered on the job list;
b) aliens who are lawfully resident or have applied for the renewal of their residence permit, for employment, self-employment, family reasons, asylum, subsidiary protection, special cases, special protection, medical treatment [omissis], for asylum request, for pending adoption, for custody, for acquisition of citizenship;
b-bis) unaccompanied foreign minors, even in the absence of a residence permit, following legal alerts after their discovery on national territory.
2. *Health care shall also be provided to dependent family members residing regularly. Until they are registered with the SSN (NHS), children of foreigners registered with the SSN shall be treated as minors registered with the SSN from birth.*
3.*The alien legally residing, not falling within the categories indicated in paragraphs 1 and 2 is required to insure against the risk of illness, accident and maternity by concluding a special insurance policy with an Italian or foreign insurance institution, valid on the national territory, or by registration with the SSN (NHS) also valid for dependents. For the registration to the national health service, an annual contribution of a percentage equal to that provided for Italian citizens must be paid in terms of participation in the expenses, on the total income earned in Italy and abroad during the previous year. The amount of the contribution is determined by decree of the Minister of Health, in agreement with the Minister of the Treasury, Budget and Economic Planning and may not be less than 2.000 euros annually*".

[6] The relevant articles from D.P.R. 31 August 1999, n. 394, concerning "*Rules for implementing the single text of the provisions on immigration and rules on the status of aliens*" are reproduced here: Art. 42. Assistance for foreigners registered with the National Health Service – SSN _
The foreigner holding a residence permit for one of the reasons mentioned in article 34, para. 1, of the Consolidated Act, and for whom the conditions provided therein are fulfilled, is required to apply for registration with the National Health Service and is registered, together with the dependents, in the lists of eligible persons of the local health unit, henceforth indicated by the acronym U.S.L. in whose territory he has his residence or, in the absence thereof, in whose territory he actually resides, on a par with the Italian citizen. The registration is also due, on equal terms with the Italian citizen in the same circumstances, to the alien legally resident registered in the employment lists. Rehabilitation and prosthetic care are also provided on the same basis.
In the absence of a registered address, the place of actual residence is the one indicated on the residence permit. Registration with the U.S.L. is valid for the duration of the residence permit.
For the seasonal foreign worker, registration is made, for the duration of the work activity, at the U.S.L. of the municipality indicated for the purpose of issuing the residence permit.
Art. 43 – Health care for foreigners not registered with the SSN (NHS) _*1. Emergency health care is provided to foreign nationals who are legally resident but not registered with the National Health Service. Foreigners who are not registered with the National Health Service can also ask the hospital or the local health unit (USL) to receive, against payment of the relevant fees, medical services of choice.*
2. To foreign nationals present in the territory of the State, not in compliance with the rules on entry and residence, the health care referred to above shall in any case be provided under the same conditions in accredited public and private health structures.
3. The prescription and registration of care for foreigners without a residence permit are carried out, within the limits indicated above, using a regional code with the acronym STP (Straniero Temporaneamente Presente – Temporarily Alien Present). This acronym must also be used for reporting the care provided by public and private structures accredited for the reimbursement and prescription, on a regional prescription book, of drugs that can be dispensed on equal terms of participation in the expenditure with Italian citizens, by the pharmacies affiliated.

The cited L.R. 9/1990, art. 4, para. 1, established the full equality of treatment between foreigners residing in the Veneto Region and Italian citizens: "*In order to ensure the protection of public health, the Region ensures that immigrants and their families, who reside in the regional territory, receive health care at hospitals and local services, public or contracted, on prescription-proposal of a doctor employed by the regional structures of the National Health Service, under the same conditions and within the limits provided for the Italian citizen*".

And to this end the regional law approved a three-year plan of interventions in favor of immigrants, which favored (art. 3, co. 3, let. g) "*the contribution and support of the activity carried out by institutions and associations, cooperatives and organizations working for immigrants*".

These provisions antedate almost ten years those then issued by the national Parliament and that provided for the universality of the right to health and the duty to pursue it, as a guarantee of protection of the entire community, as precisely enshrined in art. 32 of the Constitution.

There had already been significant initiatives of nonprofit organizations, mostly affiliated to religious institutions, started since the eighties of the last century (Cusinato – Rigoli, 2023)[7], which were followed in the nineties, always before the entry into force of the T.U. (Consolidated Act) on immigration, those of the so-called "lay" type[8] which developed from the first decade of this century[9].

However, it is after the enactment of the Code of the Third Sector and the approval of D.G.R. 26 July 2021, No. 1030 "*Combating poverty*", that the system is completely reorganized, establishing that "*in consideration of the new needs and the need to reach as many people as possible, identify the Third Sector Entities as suitable subjects, considering their fundamental role of intercepting the real needs of the territory and their ability to network*" (art. 1 of All. A to DGR 1030/2021), that should be established in this regard "*District clinics of proximity*" and "Mobile clinics" (art. 2, All. A, cited) and finally that these initiatives should benefit "elderly people and single people, people with disabilities and special pathologies, pregnant women, lone parents, parents with minor chil-

[7] The authors recall the establishment of a Health Care Service at the "Cucine Economiche Popolari – CEP" in Padua, belonging to the local diocesan "Caritas", even if this service was not originally directed only to immigrants, but to all people who, for various reasons, did not turn to public health facilities.

[8] We refer, for example, to the establishment in 1993 of the Centro Salute Immigrati – CESAIM, Verona, an association whose purpose is to provide health care for immigrants so-called "irregulars". Starting with 122 medical visits in that year, the service recorded peaks of more than 10.000 annual visits at the beginning of 2000, to settle on the approximately 7.000 visits until 2019.

[9] Among these the already mentioned establishment of the "Emergency" Polyclinic in Venice Marghera, in 2010.

dren, migrants, Foreign nationals legally resident in the region registered with the National Health Service (NHS) regardless of their nationality, Community citizens without a T.E.A.M (European Health Insurance Card), persons not in compliance with the rules on entry and residence with STP code, citizens without a place of residence or without a place of residence, citizens transiting to other nations" (art. 3 of A), that is people in "conditions of socio-economic vulnerability", which inevitably reflect on their epidemiological situation (Table 21, in the Appendix).

However, it is after the enactment of the Code of the Third Sector and the approval of D.G.R. 26 July 2021, No. 1030 "*Combating poverty*", that the system is completely reorganized, establishing that "*in consideration of the new needs and the need to reach as many people as possible, identify the Third Sector Entities as suitable entities, considering their fundamental role of intercepting the real needs of the territory and their ability to network*" (art. 1 of Annex A to DGR 1030/2021), that:

- should be established in this regard "*District Proximity Outpatients*" and "*Mobile Outpatients*" (art. 2, Annex A, cited above);
- these initiatives should benefit "*elderly people and single people, people with disabilities and special pathologies, pregnant women, lone parents, parents with minor children, migrants, foreign nationals legally resident in the region registered with the SSN (NHS) regardless of their nationality, EU citizens without a T.E.A.M (European Health Insurance Card), persons not in compliance with the rules on entry and residence with STP code, citizens without a place of residence or without a place of residence, citizens transiting to other nations*" (art. 3 of Annex A); that is people in "*conditions of socio-economic vulnerability*", which inevitably reflect on their epidemiological situation (see Table 21, in the Appendix).

As can be seen from the Annex A to the DGR, the reorganization of Health Care facilities in favor of immigrants and people who are in particular conditions of economic and social disadvantage ("*combating poverty*"), has as its object the organization of a network of outpatient clinics, which pair with the "*Community Hospitals*" already mentioned above.

The approach is to reach the areas less served by the ordinary hospital network, precisely in order to guarantee all residents, even temporary on the territory of Veneto, equal conditions of health care.

The resulting network of outpatient clinics and the role played by nonprofit organizations will be widely discussed in Chapter 7.

6.
THE SCIENTIFIC INSTITUTES FOR RESEARCH, HOSPITALIZATION AND HEALTHCARE (IRCCS) OPERATING IN VENETO

6.1. *The Public IRCCS (SIRHH)*

The Scientific Institutes for Hospitalization and Healthcare (IRCCS) are hospitals of excellence that pursue research objectives, mainly clinical and translational (Hutton, 2012), in the biomedical field and in that of the organization and management of health services, and who perform high-quality hospital and care services or carry out other activities with the characteristics of excellence.

The research is oriented to the public interest with a spillover effect on patient care, also as technical and operational support to other organs of the SSN (NHS) for the exercise of care functions, to pursue the objectives of the National Health Plan in terms of health research and training of staff (Ministry of Health, 7 August 2024).

The reorganization of the related discipline is due, in Italy, to the Legislative Decree October 16, 2003, No. 288, which provides, as a priority, the sharing between the Ministry of Health and the Regions the transformation of public institutes in foundations and the definition of their management bodies.

The recognition of the excellence character of these institutes is subject to the possession of specific requirements, among which the valid title of the research activity carried out in the last three years regarding the specific discipline assigned (art. 13, para. 3, let. d) of Lgs. D. No. 288/2003).

The above mentioned framework has been subject to further reform, following the entry into force of Legislative Decree 23 December 2022, n.200.

The key points of the reform are:

1. the enhancement of the role of IRCCs as "Research and Care Institutes" of excellence, national and international relevance;
2. strengthening the evaluation system in order to ensure transparency and greater consistency with the international framework for biomedical re-

search, and revising the criteria for the recognition procedure; To revoke or confirm the scientific character of institutions;
3. the procedure for the recognition of IRCCS is more objective and anchored to the needs of different territories, including with reference to the minimum reference basin for each thematic area of research;
4. ensuring equal access to care provided by IRCCs for all citizens regardless of their place of residence, according to the principles of appropriateness and optimization of health care;
5. ensuring that the overall funding of health research under the National Health Fund (FSN) remains adequate and effective, even in case of recognition of new IRCCS.

There are currently 53 IRCCS in Italy: 23 public and 30 private institutes. Four of these (1 public and 3 private) are placed in Veneto (Ministry of Health – Health Research, 2024)[1].

The only public IRCCS is the Venetian Oncology Institute – IOV, established by the Regional Law (L.R.) 22 December 2005, No. 26, specifically dedicated to cancer research and prevention, diagnosis and treatment of cancers.

Over time, it has established itself as a national and international center for health research and a highly specialized hospital. It is recognized by the Organization of European Cancer Institutes (OECI) as "Comprehensive Cancer Centre" and by the European Network for Rare Adult Cancers EURACAN[2]; it is the Regional Reference Center for Surgery of Diseases of the Esophagus (neoplasms of the esophagus and gastric-esophageal junction) for skin melanoma and soft tissue sarcoma. In 2024, IOV ranked 109th in the World's Centers of Excellence for Oncology (World's Best Specialized Hospitals)[3].

As already seen (Table 20, in the Appendix), IOV is a hub of regional coordination of clinical oncology departments and multidisciplinary oncology groups (GOM) also operating at the Hospital-University Authority of Padova, at the Integrated University Hospital Authority of Verona and, of course, in the framework of the ULSS.

Its headquarters is in Padova, within the "Busonera" Hospital. In Padova are also operating its Radiotherapy Centers and Laboratories. Other operational

[1] See *https://www.salute.gov.it/portale/ricercaSanitaria/dettaglioContenutiRicercaSanitaria.jsp?lingua=italiano&id=794&area=Ricerca%20sanitaria&menu=ssn&tab=2.*

[2] EURACAN (European network for rare adult solid cancer) is one of the 24 European reference networks (ERN), collaborative virtual realities of highly specialized and high-quality clinical and research centers, created for the sharing of knowledge and coordination of healthcare between EU Member States, especially in relation to complex and rare diseases, as well as for the development of joint research projects.

[3] See *https://www.newsweek.com/rankings/worlds-best-specialized-hospitals-2025/oncology.*

centers are at the San Giacomo Hospital in Castelfranco Veneto (Treviso), and in Monselice (Padova), and at the Hospitals of South-Padova.

In 2023, IOV registered over 9.200 admissions; from 2021 to 2023 it carried out 44.987 to 57.242 chemotherapy treatments (+11.91%), 36.063 to 42.678 treatments related to project "Screening" research papillomavirus (HPV) (+16%) and 304 to 517 robotic surgery interventions (+12.15%), collecting over 1000 scientific publications in the three-year period (IOV, 2024).

In 2022, it had obtained a total of 19,324 MM euros for research, of which 7,3 MM from private individuals, 0.426 MM from the Region and other entities, 5,033 MM for final projects, 2,8 MM from the "five per thousand" system, 3,7 MM from the Ministry of Health (IOV, 2024)[4].

6.2. *The Private IRCCS (SIRHH)*

As already seen, the majority of IRCCS in Italy belong to the private sector. In terms of beds, this means that about 18,3% of the total beds are held by private IRCCS, and in the field of hospital rehabilitation the percentage of beds held by private IRCCS rises to 23.4% (CERGAS – Bocconi, 2023). Most of these structures belong to religious institutions (Borzi, 2020).

Veneto also falls into this statistic, considering that 3 out of 4 IRCCS are private and that, beyond the legal forms taken by the institutes which will be illustrated below, they all belong to religious institutions.

6.2.1. *IRCCS San Camillo S.r.l. (LLC)*

The first of the private IRCCS (the second on the portal of the Veneto Region dedicated to IRCCS)[5] is the San Camillo Hospital in the Lido di Venezia, inaugurated in 1928 by the then Cardinal of Venice, Pietro La Fontaine, under the name "Istituto Eliomarino dei Padri Camilliani", recognized as IRCSS, on 18 March 2005.

With Health Ministerial Decrees on 15 July 15, 2020 and September 23, 2023 respectively, the establishment as a business and limited liability company "San Camillo IRCCS S.r.l" (LLC within the "Fondazione Opera San Camillo" (Reliogious Institution) and the transfer of their respective shares to the "Con-

[4] See *https://www.ioveneto.it/ricerca/scientific-report/risorse-per-la-ricerca/.*

[5] See *https://salute.regione.veneto.it/info/informazioni/irccs.*

gregazione delle Suore Mantellate Serve di Maria di Pistoia" (Religious Institution), as well as the afferent to the only thematic area "rehabilitation".

It has 109 beds, 47 researchers and 12 units of "*support staff*" and a District Health Residence (RSD), intended for people, especially elderly not self-sufficient, who needed healthcare that could not be provided as a home care service and for people discharged from hospital wards for whom an interim period of admission was provided within an intermediate post-acute care facility. (Social Budget, 2022).

The main research areas are biomedicine, neuroscience, motor and cognitive rehabilitation, with 53 scientific publications in 2022.

The clinical care activity is provided by three complex operating units (UOC) which constitute the only neurorehabilitation department: spinal cord damage and multiple sclerosis; cerebrovascular diseases; severe brain lesions acquired.

The number of admissions has fallen from 600 in 2020 to 423 in 2022. The percentage of patients from locations outside the Veneto region is 6%.

Outpatient services have risen from 17.770 in 2020 to 19.679 in 2022.

The turnover achieved in 2023 is around 14,6 MM euros (Ufficio Camerale di Venezia, 2024).

6.2.2. *IRCCS E. Medea – La nostra Famiglia*

IRCCS Eugenio Medea of the Association "La Nostra Famiglia" (Our Family: religious institution, legally recognized), received Ministerial Recognition in 1985, for the discipline "medicine of rehabilitation". It has its main headquarters in Bosisio Parini (Province of Lecco – Lombardy) – and other scientific sites and poles in Apulia and Friuli – Venezia Giulia [6].

In the Veneto region, the IRCCS operates in Conegliano and Pieve di Soligo, both sites located in the province of Treviso.

Its scientific activity is divided into four lines of research: 1) *Clinical neuroscience of the evolutionary age in neurorehabilitation* (Neuropathology, Neurophysiopathology and Rehabilitation); 2) *Developmental psychopathology, Psychopathology of the socio-environmental context and educational processes with*

[6] The "E. Medea" Institute of the Association "La Nostra Famiglia", bore from the foundation in Ponte Lambro (province of Lecco), in 1946, of the community of the "Little Apostles of Charity", by Father Luigi Monza and the afore mentioned Association. The community was established as a Diocesan Secular Institute on 18 January 1950.The Meeting between the prelate and the Prof. Eugenio Medea, psychiatrist, neurologist, co-founder of the Italian League of Mental Health, in that circumstance, gave the life to the establishment of a real regional Center for children in difficulty, in those years still confined to psychiatric hospitals or non-specialized institutions. The last Ministerial Decree confirming the IRCCS status was issued in 2021.

rehabilitative relapses; 3) *Neurobiology, Computational Biology and Pharmacology*; 4) *Applied technologies* (Neuroimaging, Bioengineering, Robotics).

With special reference to the two research poles of Veneto – Conegliano and Pieve di Soligo, both constituting Units of III level – the research activity is focused on the area "Severe Disability of Developmental Age" and "Severe Disability of Developmental Age", producing – in the three years 2018 – 2020, n. 2.046 rehabilitation projects and 6.027 functional profiles ICF[7].

The research activity, conducted by a total of 60 researchers out of 77, produced 405 publications over the three-year period under review.

The Institute has signed MOU with the Children's Hospital Medical Center in Cincinnati, Yale University (U.S.A.), King's College in London and the University of Reading (U.K.)

For these activities, the Institute received contributions for a total of 4,255 MM euros in 2020 (Ministry of Health, Minutes of the Evaluation Committee, 24 March 2022).

As to the health care, the two poles have a total of 35 beds and in 2020 received contributions for a total of 5,3 MM euros, of which 5,1 million from SSN (NHS)[8].

The 2020 Profit and Loss Statement shows a turnover of 26,9 MM euros, of which 19,8 MM euros for "Revenue from Services" (Ministry of Health, Minutes of the Evaluation Committee, 24 March 2022).

6.2.3. *IRCCS Ospedale Sacro Cuore Don Calabria*

The IRCCS "Hospital Sacro Cuore – Don Calabria" of the Congregation of the Poor Servants of Divine Providence – Casa Buoni Fanciulli, based in Negrar di Valpolicella (Province of Verona), founded in 1922, has been recognized as an IRCCS for the discipline "Infectious and tropical diseases" with Decree of the Minister of Health on 23 May 2018 and confirmed with further D.M. on 27 July 2021.

The hospital is located inside the "Citadel of charity", a kind of "Health Care Center" where a health care area and a health and social care area, for a total of 968 beds (549 dedicated to the health area), can be found.

The healthcare sector recorded a total of 30,650 admissions in 2022, including 1,404 for the discipline "tropical infectious diseases" and 29,900 admissions

[7] ICF: International classification of functioning, disability and health. Source: WHO, *ICF short version: international classification of functioning, disability and health, 2008.*

[8] No data about the ordinary hospitalizations and "day hospital" type of the two Veneto poles are available.

in 2020, with 22,450 surgical procedures, while outpatient services amounted to 1,318,401 in 2022 and 1,340,914 in 2023 (data provided directly by the Institute in a note of 20 November 2024).

Research activity has grown over the years; in particular, in the field of recognition, research has developed along two main lines: a) Global Health: communicable diseases and human mobility, which aims at the acquisition of clinical and epidemiological data on infectious diseases, the refinement of diagnostic and treatment tools, the study of their pathophysiology and impact on human health, and the immunological response, both spontaneous and vaccine-induced; b) Neglected Infectious and Tropical Diseases on diseases that are often endemic in many of the world's poorest countries and also affect migrants and international travellers. The most explored research areas are epidemiological aspects, diagnostics and clinical approach. In 2023, the Impact Factor normalized according to the criteria of the Ministry of Health (Triennial Programming 2022-2024 Scientific Institutions for Care and Hospitalization (IRCCS)) was 509, an increase compared to previous years.

In addition, the IRCCS has developed important professionals in the oncology path who, supported by the best technologies, carry out clinical and research activities with a particular inclination to multidisciplinary (GOM) in the management of patients diagnosed with cancer. The initiative "*From hospital to home: taking care of a person with spinal cord injury*", by the Spinal Unit of the Institute (12 October 2024), seems to be particularly interesting.

The initiative concerns diagnostic and therapeutic pathways for patients returning home after treatment at highly specialized facilities for the care of such lesions. After discharge from the hospital, these patients start a new daily routine, which presents motor deficits and more or less consistent sensibility, depending on the neurological level and the completeness of the spinal cord injury (quadriplegia, paraplegia, etc.). The complications that may arise require adequate management by the territory, namely, in the first place, by the outpatient networks and general practitioners.

In Chapter 1, para. 1.5., we had mentioned a similar initiative led by the University of Toronto (*see infra*), called "*Hospital-to-Home Transitions*" and concerning the reintegration programmes in the family and social context of older patients discharged from hospital facilities (Nelson et al, 2024).

This seems to confirm what we said in those pages, i.e. what affects here and beyond the oceans, the differences in regulations, the linguistic and cultural factors is that the Third Sector seems to be committed in fields of health care not yet reached by the public sector and/or considered as low-paying by the pri-

vate sector (chronic diseases, treatment of depression and mental health in general in France, Germany and Finland). Nonprofit health care entities seem also devoted to special services for specific categories of patients (e.g. those covered by the "*Hospital-to-Home Transitions*" programme), or, finally, to geographical areas which are difficult to reach (Canada).

In all the afore mentioned experiences, a particular characteristic of the nonprofit approach may be seized, consisting in the valorization of the "*human-to-human*" relationship, rather than the number of services rendered and/or waiting times for access to medical care.

Anyway, the ICRSS Sacro Cuore Don Calabria recorded a total turnover of 201.790.055,60 euros (of which 169.942.627,24 euros borne by the S.S.N. (NHS) and 7.825.751,08 by private individuals) in 2019, ending the financial year with an active balance (estimated) of about 2,9 million euros (Ministry of Health, Minutes of the Evaluation Commission DD. 2020)[9].

[9] Although repeatedly requested, the Institute has not provided the financial data referred to the period 2020 – 2023.

7.
THE NETWORK OF NONPROFIT OUTPATIENTS

7.1. *Geographical Distribution*

In the previous Chapters we have illustrated the guidelines of the SSR Veneto structure and functioning of, highlighting how it is based on a complex balance between health sector operators (public, private, private accredited, nonprofits) hospital networks (General Hospitals, Community hospitals and Outpatient clinics) and, as well as in the rest of Italy, the general practitioners.

We have already seen the role of nonprofit organizations in hospital networks, including Scientific Institutes for Research, Hospitalization and Healthcare (IRCCS), and there we also mentioned some examples of Outpatient clinics entrusted to Nonprofits. It is time to talk about these structures in a more widespread and detailed way.

We have already seen the role of non-profit organizations in hospital networks, including the Scientific Institutes for Research, Hospitalization and Healthcare, and there we also cited some examples of Outpatient clinics whose management has been entrusted to Nonprofits. It is time to talk about these latter structures in a more comprehensive and detailed way.

Their distribution in the Veneto region is summarized in Table 22 and Figure 27.

They represent, probably, the last link of that path of health and social care integration advocated by the Region since its L.R. 78/1979, then amended by L.R. n. 56/1994 (art. 8, para. 2 and 11), and implemented by DGR 614/2019 and 1030/2021.

The latter, in particular, has formally authorized "*the ULSS to activate forms of collaboration with Third Sector entities, having specific experience, in order to facilitate access to care for people in conditions of health poverty, by concluding annual agreements, possibly renewable*"; and entrusted the Regional Health Planning Directorate to take care of the acts following the "*confirmation of*

the validity of the Memorandum of Understanding between Region Veneto and Emergency NGO Onlus[1]" (Cusinato – Rigoli, 2023; Pisani – De Corte, 2023).

Of the 13 structures mentioned in the table, the first two – the Outpatient clinics of Castelfranco Veneto and Montebelluna – ULSS 2, Province of Treviso – are both born from a co-planning initiative of the CSV (Volunteer Service Center of Belluno and Treviso (ETS born in 1997, reconstituted in 2020 and operational since 2021) and the ULSS 2 Marca Trevigiana, for the promotion, orientation, territorial animation, and to give visibility to the values of volunteering and the social impact of voluntary action in the community. They are located, respectively, at the Castelfranco Veneto Hospital and at the former Inam[2] Palace of Montebelluna and have played a major role in the reception phase of the Ukrainian citizens after 22 February 2022.

The "Ambulatorio Castelfranco Veneto" (Outpatient Clinic) offers general medicine services and small nursing services to people, Italian and foreigners not related to a general practitioner. The Outpatient provides essential drugs. Doctors have a regional prescription book and can prescribe drugs, specialist visits, diagnostic examinations for essential or continuing care. Its volunteers instruct the procedures for obtaining the STP/ENI card (Foreign Temporarily present on the territory/ European citizen not registered in the National Health Service).

The "Ambulatorio Montebelluna" (Outpatient Clinic) is also under agreement with ULSS 2 since 2022 and performs the same services as that of Castelfranco Veneto.

The Poliambulatorio "Emergency" (Outpatient clinic), was founded in 2010 in Venezia Marghera by the NGO with the same name for the implementation of the Organization's "Italy Programme", launched in 2006 in Palermo, a programme that currently covers several fixed and mobile outpatient clinics in 6 Italian regions.

It is the second partner of SSR Veneto (USSL 3 – Serenissima), after the one of "Caritas" in Padua, which has been operating since 1998.

Within the "Emergency" Outpatient the following services are offered:

- general medical care;
- pediatrics, with support for the entire socio-health of the child (vaccinations, health assessment, food education, oral hygiene education);

[1] Onlus is the abbreviation for "Nonprofit and social organization".

[2] Inam is the abbreviation for the National Institute for Health Insurance, now merged into INPS, National Institute for Social Security.

- nursing services, including events dedicated to the prevention of sexually transmitted diseases, nutrition, hygiene, management of chronic diseases, for individual patients or groups;
- dentistry, including conservative-endodontic treatments, surgery, extractive, tartar ablation and oral hygiene education for individuals and groups;
- supply of ophthalmic lenses;
- socio-health orientation, including language mediation;
- psychological listening;
- health education and training.

The staff includes 2 doctors, 1 nurse, 4 cultural mediators, 1 dental chair assistant, 1 cleaning person.

The volunteer staff consists of 22 doctors (internists, pediatricians, dentists), 2 psychologists, 7 nurses and 13 non-health volunteers.

All services are provided free of charge.

Within the ULSS 3 Serenissima operates also the "Ambulatorio Solidale A. Monterosso" in Venezia (Venice) Mestre, created in 2016 and managed by the "Circolo Auser diritti del malato" Odv, the fourth in Table 22.

Moving in the district of ULSS 5 Polesana (Province of Rovigo) we find the "Ambulatorio di Medicina di base Sant'Andrea" (Basic Medicine Outpatient Clinic) in Rovigo, which enjoys an agreement with the afore mentioned ULSS 5, pursuant to DGR 1030/2021. In the structure, created by the diocesan Caritas of Adria-Rovigo, and managed by "Il Manto di Martino" ETS, which is its operational arm, 4 volunteer doctors are in charge, one day a week, along with the "shower service". It provides general medical care to people (especially foreigners without a residence permit and/or holding STP/ENI code) who do not have a primary health care provider.

In the Province of Padua (ULSS 6 Euganea) we find the Health Service of the "Cucine Economiche Popolari", a pious work of the Catholic Church of Padua, which carries out social and health activities for people living with a situation of social, economic and health distress.

Thanks to the signing of a specific Protocol of understanding with USSL 6 in October 2019, the Service provides healthcare to Italian and foreign indigent people, with the aim of promoting public health. The Protocol, in addition to recognizing and regularizing the service, provides for the supply of some drugs of group A (others are donated thanks to the collaboration with "Fondazione Banco Farmaceutico" Onlus) and the possibility of sending people to the Office "Listening Desk for Foreigners" for pharmaceutical prescriptions and their taking charge.

Since 1 January 2019, the CEP are managed by the Fondazione Nervo Pasini, which has been registered with RUNTS since September 2022.

Within the area of ULSS 6 Euganea (Province of Padua) we find, in addition, the aforementioned "Caritas" Polyclinic, born from a collaboration between the Municipal Administration and the diocesan Caritas of Padua, managed by the Association Adam – Onlus (registered in the Registry of Nonprofit and Social Organizations in 2008) since 2014. In December 2022, the Adam Association signed an agreement with ULSS 6 Euganea. In December 2022, the Adam Association signed an agreement with ULSS 6 Euganea. The premises, which has 8 dental doctors, 1 ophthalmologist, 2 chair assistants, 1 x-ray technician and 1 repair technician, provides dental and eye services. Two dental laboratories also provide free mobile prostheses and use free spectacle frames and lenses from various local optical centers.

The users are mostly foreign citizens residing illegally, or with STP/ ENI card, or citizens without fixed residence, both Italian and foreigners, minors in poverty reported by the social services of the municipality of Padova.

Last, but not least, it is worth mentioning the association "Medici in strada" (Doctors in the street) established in 2017 in Padua as Odv and registered at RUNTS, which manages the "Mobile Camper", which is generally parked in the most crowded neighborhoods of the city. Doctors perform initial checks to approach people who would otherwise not turn to the health providers. Healthcare services are totally free of charge.

In the Province of Vicenza (ULSS 8 Berica) we find the "Ambulatorio popolare Caracol Olol Jackson" born as a non-profit organization in 2018, based in Vicenza, which since March 2021 is authorized to carry out health care activities, under a special agreement with ULLS 8.

It has a general medical office with six doctors providing services in dentistry, pediatrics, otorhinolaryngology, gynecology, ophthalmology, pain therapy, diabetology, infectious medicine and psychotherapy, as well as a reception desk, providing psycho-sociological and healthcare information.

In the district of ULSS 8 Berica is also located the "Ambulatorio della Croce Rossa Italiana" (Italian Red Cross) of Bassano del Grappa, which is under the local Committee of the Red Cross. Created in 1984, it also runs a STP center (temporarily present foreigners), since 2007. After the Covid-19 experience, the clinic has been reorganized as "Outpatient Proximity Clinic" (Annex A to DGR 28 July 2021 No. 1030) able to provide a medical-nursing service free and free of charge, that the Committee makes available the territory with the objective of meeting the basic and first level needs, from a health and social care point of view, mainly addressed to the vulnerable population.

The health care services provided are:
- basic medical nursing activities, such as vital signs measurement, capillary blood glucose detection, simple and advanced dressings, suture removal, hygiene specialist medical advice and preventive medicine, general surgery, cardiology (with electrocardiogram), orthopedics, hematology, internal and general medicine, dermatology and pediatrics;
- health and social care for people with STP card, in agreement with the company ULSS 7 Pedemontana, with "medical-advocacy" advice, administrative and bureaucratic assistance to the needy, and cultural mediation;
- Social Service Desk: contact point for information and guidance to the local services for individuals and community in general. The clinic works in collaboration with the social services of the municipalities.

The clinic has 30 volunteers, including 11 doctors (including a pediatrician, cardiologist, surgeon, orthopedist, internist, hematologist, dermatologist) and 8 nurses.

In USSL9 Scaligera (Province of Verona) we find the "Centro Salute Immigrati – CESAIM" OdV established in 1993 in Verona, at the initiative of the Municipal Council of Women's Associations and a group of volunteering doctors and nurses of the city of Scaligera, registered with RUNTS. Since 2001, the CESAIM OdV in USSL9 Scaligera (Province of Verona) we find the "Centro Salute Immigrati – CESAIM" OdV established in 1993 in Verona, at the initiative of the Municipal Council of Women's Associations and a group of volunteering doctors and nurses of the city, and it is nowadays registered with RUNTS. Since 2001, The CESAIM OdV has been working in the framework of an agreement with the USSL Scaligera (now USSL 9) that provides the Centre with the necessary spaces for the performance of outpatient activities.

It employs 76 volunteers: 52 doctors (including 36 specialists), 14 nurses and 10 secretarial volunteers, carrying out:
- general medical activities with direct access;
- specialist care (pediatrics, cardiology and echocardiography, hematology, endocrinology, hepatology, gynecology, infectious medicine, nephrology, neurology, orthopedics, otorhinolaryngology, psychiatry and addiction, psychology, urology);
- nursing services;
- ultrasound scan;
- distribution of medicines (the clinic has an internal pharmacy).

The users are mostly Italian citizens who do not have a regular SSN registration, whether or not they hold a STP/ ENI card.

In the ULSS 9 territorial district we also find the "Sportello medico" (Medical Desk) divided into two spaces, opened respectively in the two convents of Barana and San Bernardino (Province of Verona) by the Voluntary Organization "Medici per la pace", created in 2022 in Verona, where it is based and registered with RUNTS.

It has 22 doctors (including 12 specialists) and 4 nurses, provides outpatient I level services to homeless in difficult social and economic conditions.

The run healthcare activities are:

- basic medical examinations with anamnestic and health documentation in a computerized file, to ensure proper management of health information and continuity of care;
- triage, consisting of the evaluation of medical history, signs and symptoms, to identify potentially dangerous situations and/or that require the sending to the NHS, sometimes with urgency;
- basic therapeutic services (for example, wound dressing, removal of sutures, provision of drugs such as antibiotics, painkillers, antipyretics for a cure cycle, etc.);
- social and health counselling: approach and guidance of users, where necessary, to specialized services for multiprofessional management (e.g. Alcohology Unit, Addiction Service, Mental Health Centre, Anti-Diabetic Centre, etc.);
- implementation of tuberculosis screening programs (chest x-ray) and vaccination campaigns (Covid-19, influenza, anti-pneumococcal);
- administrative advice aimed at obtaining the documents necessary for access to the SSN.

The above mentioned structures must be supplemented by:

- the very recent Caritas Outpatient Clinic "Senza Confini" (Without borders) in Venice Mestre, which started its free activity on January 10, 2023, offering services of general medicine, specialist visits (Surgery, Cardiology, Dermatology, Diabetology, Endocrinology, Gastroenterology, Neurology and Ophthalmology) and nursing care, under an agreement signed with the ULSS 3 Serenissima, pursuant to DGR 1030/2021;
- "Ambulatorio CRI Vicenza", the two "Salute solidale" Ambulatori (Outpatient clinics of Vicenza and Valdagno (9 September 2022, the last two in the province of Vicenza, managed by the homonymous Odv, created in 2014 (Cusinato – Rigoli, 2023) and made with the contribution of the Rotary Club Valle dell'Agno and about 70 volunteer doctors.

Thus, the Veneto Region avails itself of 17 structures in total between "Am-

bulatori di prossimità" (Outpatient Proximity Clinics), "Ambulatori mobili" (Mobile Outpatients) and "Servizi" (Service Centers), managed by Nonprofits: religious institutions, volunteer organizations, mostly connected to the Catholic Church, or secular.

Figure 27 in the Appendix shows how the ETS outpatient network integrates more than appropriately the hospital network (public, private accredited, private "*tout court*" and non-profit) highlighted in Figure 26, which mainly concerns the provinces of Venice, Padua, Verona, where there are also Academic hospitals or Scientific Institutes of Hospitalization and Healthcare of excellence (IRCCS).

In contrast, the overlap of the two figures 26 and 27 highlights the critical issues pertaining to USSL 1 Dolomiti (province of Belluno), where the only existing structures are made up of the four "Presidi ospedalieri in zona disagiata" (Hospital Wards in a disadvantaged areas) of Agordo, Pieve di Cadore, Asiago and Cortina (Annex A DGR 614 on 14 May 2019), all public. At the moment, in the indicated area no "*proximity*" or "*mobile*" outpatient clinic, either public or private (for profit or non-profit), seems to be available.

7.2. *Users*

Table 22 in the Appendix provides the list of existing Nonprofit outpatient clinics in the Veneto Region, operating according to the "accreditation" or "conventions" regimes (art. 55, co. 4, and 56 CTS), the latter reserved for voluntary organizations and associations of social promotion, which have been registering for at least six months in the National Register of the Third Sector (RUNTS). These are instruments designed to provide social services or activities of general interest to third parties, when more favorable with respect to the market.

Only Nonprofit entities operating since the end of 2022 (4 out of 17) are missing from the list.

Table also shows the number of users: Italian and foreign citizens who, for various reasons, do not access the usual registration tools provided by the SSN (NHS). They are 40.122 people, if the survey starts from 1998 (Poliambulatorio "Caritas" di Padova), or just under 35.000 if the survey started from 2010 (Poliambulatorio "Emergency" di Venezia Marghera), with an estimated historical average of users equal to 5.575 people per year on the entire territory of Veneto, 6.582 in 2022.

The origin of the foreign nationals who use the services is shown in Figure 28 in the Appendix.

According to the survey already carried out on a percentage basis (Cusinato – Rigoli, 2023) the majority of users come from the African continent (44.63%); in second place is Europe (excluding Italy) which has a percentage of 27,69%, then Asia for 17, 44%, then Italy for 7,52%, then the Americas, for 2,71% and finally Oceania for 0,1%, given that the latter is irrelevant and therefore not reported in the pie, but only in the Legend.

Some clarifications are necessary. First, what strikes a little is the figure for European users (almost one third), who are "*EU citizens not subject to a residence permit, often employed in seasonal work and domestic workers living together*"(Cusinato – Rigoli, 2023), or extra – EU (mostly from Albania and the Eastern European countries) and do not meet the requirements for registration in the categories of temporarily present foreigners (STP), or European citizens who, although they are regularly present on the territory, they are not registered with the National Health Service (ENI), because the categories mentioned above are reserved only for "*irregular immigrants*". The figure for Italian citizens is also striking – 3.174, or 7,52% – mainly living in the provinces of Venice, Verona and Rovigo, but not formally residents there and therefore not holding a health card.

The largest number of foreigners from the African continent come from Morocco (16,07%), followed by Nigeria (15,14%) and Tunisia (4,47%)[3].

For foreigners from Asia the largest communities are those of Bangladesh (5,86%) and Pakistan (5,82%)[4].

Comparing the above mentioned Table 21 with Table 23, which shows the percentage composition of pathologies detected in users of ETS clinics in Veneto and in foreign patients discharged from hospitals in Italy (years 2021 – 2022), a pathological picture of patients in Nonprofit Outpatient Clinics in 2022 is significantly different from that of homogeneous patients discharged the year before from hospitals throughout the country. The latter are generally characterized by a lower severity of pathologies and/ or the possibility of performing home care.

The differences are highlighted in yellow in the last column of the table.

The comparison not only results doubled the boxes (in yellow) of "sensitive"

[3] The reported data represents the percentage of users in the various Nonprofit Outpatient Clinics belonging to a given community on the total number of users.

[4] Again, the figures refer to the percentage of users belonging to a community in relation to the total number of users.

pathologies, but also detected pathologies that had not aroused interest in the other detection (data 2021).

Among the notable situations, "Musculoskeletal and connective tissue disorders" (+7,65%), "Other external causes of morbidity and mortality", "Dermatopathies" (Diseases of the skin and subcutaneous tissue: +6,32%), "Endocrine, nutritional and metabolic diseases" (+4,59%), not detected before.

The conclusion to be drawn is that the Nonprofit outpatient network has not only allowed coverage of population groups which would otherwise not be reached by the SSN or SSR, but also to contribute to the monitoring of the actual state of health of the population insistent on the territory.

And this is undoubtedly another added value of the health and social care integration model of the Veneto Region.

8.
HOSPITALITY SERVICES

8.1. *The organizational and planning structure of social services in Veneto Region*

At national level, the structure of "*social interventions and services*" is regulated by the L. 8 November 2000, No. 328, bearing "*Framework Law for the implementation of the integrated system of social interventions and services*" which, in art. 1, paragraphs 4 and 5, respectively states:

– "*The local authorities, the regions and the State shall, within their respective spheres of competence, recognize and facilitate the role of nonprofit and social utility bodies (Onlus), cooperation bodies, associations and social promotion bodies, the foundations and employers' organizations, volunteer organizations, recognized bodies of religious denominations with which the State has concluded agreements or arrangements in the field of planning, organizing and managing integrated system of social interventions and services*";
– "*The management and provision of services are provided by public bodies and, as actors in the design and concerted implementation of interventions, to nonprofit and social utility bodies (Onlus), cooperation bodies, voluntary organizations, associations and social promotion bodies, foundations, employers' organizations and other private entities. The integrated system of social interventions and services also aims to promote social solidarity, with the exploitation of initiatives by individuals, families, forms of self-help and reciprocity and organized solidarity*".

The following art. 8, para. 3, let. b) and h) (Function of the regions), states, inter alia, that the Regions "*are responsible in particular for the following functions: [...] b) definition of integrated policies on social interventions,* [omissis] *health"; h) Definition of quality requirements for services management and delivery*".

Finally, as far as we are concerned here – the hospitality services – art. 22 of the aforementioned "Framework Law", in defining the integrated system of so-

cial interventions and services, includes the provision of the following benefits (paragraph 4, let. c), d) and e): "*c) home care; d) residential and semi-residential facilities for people with social vulnerabilities; e) community-based residential or day centers*" (Balboni et al, 2003; Coen L., 2020; Franca, 2020).

We take the liberty to recall the Framework Law with regards to hospitality services, firstly because these last, although not strictly falling within the scope of "*health interventions and care*" that the CTS, art. 5, let. b) considers "*activities of general interest*" to be carried out by Nonprofit entities (ETS), possibly using the procedures referred to in articles 55 and 56 of the Code (co-programming, co-design, accreditation and agreements) are closely related to them[1], are closely related to them.

Let's consider, for example, the housing needs of family members of patients forced to move between regions in order to benefit from health interventions and services not available in their region of residence, which may result in long-term stay away from their home, or to households in particularly vulnerable social conditions. An integrated system of social interventions and services, including healthcare, not only does not neglect these aspects but also provides for them to be the organization, promoting the participation of those who today belong to the wide audience of Third Sector entities.

Secondly, the regulatory review is due to the very recent Regional Law (L.R.) 4 April 2024, n. 9, of Veneto, which in defining the "Organizational and planning structure of social interventions and services", recalls the aforementioned Framework Law 328/2000 promoting (art. 1, paragraphs 2 and 3) "*the contribution of public institutions, social formations, individuals, families and third sector entities, hereinafter ETS" [...] in the "building participatory processes and integration with health, social and health services* [omissis] *and in any case with all matters related to welfare policies to ensure planning and programming more responsive to the territorial context, in compliance with the Essential Levels of Social Benefits, hereinafter LEPS".*

To this end, the regional law establishes (art. 9) the social territorial areas (ATS), which are normally constituted by the municipalities included in a certain ULSS, and (art. 14) the regional network for associated management and social inclusion, as a regional ATS participation and comparison body, where "*three representatives identified by the representative organizations of the ETS*" are invited to participate.

[1] The agreement procedure, ex art. 56 CTS – "Conventions", is reserved for Volunteer organizations and Associations of social promotion.

With specific regards to the organization of hospitality services, the issues that are highlighted are related to the economic actors involved and the ways in which they participate in the organization of the services just identified.

This is because the expression "Third sector entities" includes "*cooperation bodies, associations and social promotion associations, foundations, voluntary organizations, recognized bodies of religious denominations*" mentioned in art. 1 of the Framework Law to which they must be added, pursuant to D. Lgs. 112/2017 (Legislative Decree on Social Enterprises), no less than private entities, i.e. entities that correspond to different ways of dealing with public bodies, either regional or municipal.

The actual regulation of the afore mentioned services is left to the regional legislator and, as we have already seen, to the local decision-maker who can rely on private parties and, in comparison with them, choose between launching a tender procedure using the Code of public contracts (D. Lgs. 36/2023). Or the public authority may use the co-programming, co-design and accreditation procedures, as provided for by the Code of the Third Sector (D. Lgs. 117/2017), or conclude agreements, as provided by this last Code, but in this case only to the "*voluntary organizations*" and "*social promotion associations*", with modalities that do not refer to the respective performance fees, but to reimbursable expenses (Franca, 2020; Santuari, 2023), with not insignificant effects on competition aa well as on the quality of services covered by the relevant procedures.

The national administrative case law (CdS 2052/2018)[2] and the Constitutional case law (131/2020 of 26 June 2020)[3] expressed their views on the issues

[2] See the opinion of the Council of State – Special Commission, 20 August 2018, No. 2052, at the request of the National Anti-Corruption Authority (ANAC), on the regulations applicable to the entrustment of social services, in light of the combined provisions of the then-current Procurement Code (D. Lgs. 50/2016) and of the CTS (D. Lgs. 117/2017). According to that opinion "*the procedure for entrusting social services governed by national law is not subject to the regulation of euro-unitary origin, subject to certain conditions. This is the case when: – the procedure governed by national law is not selective; – it does not lead, even prospectively, to the award of a social service; – the procedure governed by national law aims at entrusting a private body with a social service that, however, the entrusted entity will perform on a completely free*" […] "*In the case of co-design and partnership, therefore, only the proven occurrence of the element of gratuity excludes the subsumption of the procedure within the Euro-unitary framework*". As regards the procedure of the convention, art. 56 CTS, the Council of State notes that "*the process of selecting a volunteer organization or social promotion association for the purpose of concluding an agreement to carry out social activities or services of general interest in favor of third parties is not influenced by the principle of competitiveness, but only from the principle of equal treatment*". In this case, the CdS suggests "*to define the concept of 'reimbursement of expenses'*".

[3] See judgment cited in G.U. 1 July 2020, No. 27, President Cartabia, Rapporteur Antonini. In this case, the Constitutional Court recalling the jurisprudence of the European Union summarized in the following footnote, has highlighted how the "*conflicting dichotomy between the values of competition and those of solidarity tends to dampen*" [...] "*in relation to activities with a marked social value*", for which the public authorities are given the opportunity to prepare "*an organizational model inspired not by the principle of competition but by that of soli-*

set out above, expressly recalling the European case law (case C-50/14, 28 January 2016, case C-113/13 of 11 December 2014)[4], each of which is based on two concepts: competition and solidarity.

Based on the cited interpretative framework, the most recent administrative case law (Tar of Tuscany – Section I, 1 June 2020, No. 666) has taken up the subject of the conventions, ex art. 56 CTS, reiterating – further to what was expressed two years earlier by the Council of State – that the requirement of "free" work provided by voluntary organizations (Odv) must be understood "not as '*absence of consideration*' but as "'*non-economic substance' of the relation between two entities, or inability to cover the value of factors of production and, in particular, of labor, whose performance is not supported by an economic interest (as it normally is) but by a pure purpose of social solidarity (which connotes the phenomenon of volunteers)*". *This implies that the agreement cannot give rise to any form of direct or indirect remuneration by the public entity, whatever its formal name is, to the volunteer or salaried and managerial staff of the entrusted entity. In the present case, this condition cannot be said to have been fulfilled, being that* – notes the First Instance Court – "*the vast majority of teachers attending language courses offered by the other party of the proceeding received and receive a* 'remuneration', *although in the form of reimbursement of* 'living expenses'. *Therefore, that 'total absence of economicality' which clearly and unequivocally places reliance outside the logic of the market does not exist*". Based on these arguments, the Administrative Court (Tar of Tuscany)) upheld the appeal of the interested party by annulling the convention procedure managed by a municipality that had invited, pursuant to art. 56 CTS, OdV and APS to submit proposals for the organization and management of foreign language courses.

darity (provided that nonprofit organizations contribute, under equal conditions of treatment, in an effective and transparent way to the pursuit of social objectives)".

[4] See C 106/04 Official Journal of the European Union of 21 March 2016 and C 46/3 of 9 February 2015 Official Journal of the European Union. See also C 106/04 Official Journal of the European Union of 21 March 2016 and C 46/3 of 9 February 2015. In the Case C-50/14, the Court (Fifth Chamber) held that: 1) Articles 49 TFEU and 56 TFEU must be interpreted as not precluding national legislation such as that at issue in the main proceedings, which allows local authorities to award the provision of health transport services by direct entrustment, without any form of publicity, to voluntary organizations, provided that the regulatory and contractual framework in which the organizations operate actually contributes to a social objective and to the pursuit of the objectives of solidarity and budgetary efficiency; 2) Where a Member State allows public authorities to use voluntary organizations directly for the performance of certain tasks, a public authority intending to enter into conventions with such organizations shall not be required to do, under Union law, a prior comparison of proposals from various associations; 3) Where a Member State, which allows public authorities to use voluntary organizations directly for the performance of certain tasks, authorizes such organizations to carry out certain commercial activities, it is for that Member State to fix the limits within which such activities may be carried out. However, these limits must ensure that the commercial activities mentioned are marginal in relation to the overall activities of such organizations and support their pursuit of voluntary activity.

The judgment, now quoted in the essential points of its explanatory part, has aroused not a few doubts in doctrine (Franca, 2020; Pellizzari, 2020; Santuari, 2020), which pointed out, first, how the economic importance of the service entrusted is not decisive in determining the applicable legal regime, nor is the provision in the agreement (convention) for the reimbursement of certain expenses. On the contrary, it is relevant – according to the doctrine referred to – the assessment made upstream in order to the organizational and financing terms of the service, as well as the greater convenience of using the convention, compared to the market rules.

In the same vein, another doctrine (Bombardelli, 2019) considers that the use of the system of "*social welfare*" inspired by the principle of solidarity is entirely legitimate, since it allows the territorial authority to ensure the protection of users, "*seeking the highest quality of service through competitive comparison between potential suppliers*".

Further supporter of this interpretation is who (Santuari, 2020) notes that art. 56 of the CTS, dealing with conventions, is limited to identifying the path (comparative evaluation), the modalities (precisely the conventions) and the contents of the same. The action of local authorities is therefore positively anchored in the Reform of the Third Sector, which gives the Public Administration – as a result of a tried and tested comparison – the power to identify the association with which, also following a proposal by the same or other associations (art. 55, para. 3, CTS, which refers expressly to Law n. 241/1990 on the transparency of administration), the agreement is defined.

The relevance of the above mentioned debate in the review of the organizational and planning structure of social services in Veneto is due to the L.R. Veneto 4 April 2024, No. 9, bearing the same subject, of which we have outlined the essential features and stressed how it intends to promote not only the contribution of Nonprofits in the organization of services in question, but also in "*the construction of participatory processes and integration with health interventions and services, health and social care,* [omissis] *in compliance with the Essential Levels of Social Benefits*" that in the field of health, as already seen in previous chapters, correspond to the Essential Levels of Care (LEAs).

The new regional law entrusts the promotion of the integrated system of social services and assistance (art. 7) to the Territorial Social Spheres (ATS) and the municipalities (art. 8) with the associated exercise of the social – welfare function, with the participation of public, private (including, according to art. 7, "benefit corporations" and "for-profit enterprises") and Nonprofit organizations.

One wonders then (Santuari, 2023) whether the normative dictation does not

constitute an opportunity to extend the operational space to forms of business that, although characterized by authentic social vocation and entrepreneurial responsibility, do not belong to the audience, or to the notion of nonprofit.

It seems clear that where public administrations intend to involve at the same time private, accredited and nonprofit entities in the processes of organizing and providing social services of the type mentioned above (hospitality services) they will not be able to waive the procedures established by the CTS.

Such an eventuality seems to be also allowed by art. 6 of the Public Contracts Code, which states "*In implementing the principles of social solidarity and horizontal subsidiarity, public administration may develop, in relation to activities with a marked social value, organizational models of shared administration, without synallagmatic relations, based on the sharing of administrative functions with entities of the Third Sector referred to in the Code of the Third Sector referred to in the Legislative Decree 3 July 2017, n. 117, provided that they contribute to the pursuit of social objectives under conditions of equal treatment, in an effective and transparent manner and on the basis of the principle of result*".

The regional law 9/2024 could therefore represent the legal – operational framework through which many municipalities and local health authorities can regulate their economic relations with nonprofit organizations, adequately integrating the existing discipline to find concrete ways in which for-profit but socially oriented enterprises can participate in these processes.

The following pages highlight, moreover, how in the territory of Veneto hospitality services are still organized and managed, so to speak, to "*leopard spots*", sometimes with a direct "organizational and planning" commitment of the public body, involving private operators (through the usual service procurement procedures), volunteer organizations and social promotion associations (through the conclusion of agreements), or resulted from spontaneous initiatives of bodies, often "*spurious*" (think of the civil-law religious bodies, but not transformed into ETS), and however able to meet the demand from civil society.

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8.2. *Territorial Distribution*

The L.R. 9/2024 illustrated above fits in (and coordinates with) regulatory initiatives of a specific character aimed at the financial support of so called "*family caregivers*", i.e. of those who take care of the spouse or other part of civil unions, the cohabiting, a family member or related person within the second degree who is unable to take care of himself.

The ICD CG (Prescription of Home Care – Caregiver) is part of the larger and structured system that intervenes in support of the role of care, regulated by DGR 295/2021 of the Veneto Region. The aid is given in the form of a monthly financial contribution granted to family caregivers who assist people with severe disabilities, pursuant to Law 104/92, particularly dedicated to persons who:

- need life-saving assistance and depend on medical equipment (such as respirators);
- adults and elderly people with dementia accompanied by severe behavioral disorders;
- are adults (aged 18-64) with severe physical and motor disabilities who also have accompanying allowance;
- or are in the age group 3-64 years, with a severe mental and intellectual disability.

For the latter two categories (physically or mentally disabled) there is no ISEE-based access threshold (Equivalent Economic Status Indicator)[5].

The interventions of relief and support to the family caregiver can be combined with the services provided by the demanding home care, after a specific assessment of the need by the Multidisciplinary Evaluation Unit (UVM).

There are three categories of intervention:

- Intervention A.1. Intended for caregivers who assist people with severe disabilities, taking also into account the phenomena of early onset;
- Intervention A.2. intended for caregivers of those who have not had access to residential facilities due to emergency regulatory provisions (e.g., during the Covid-19 pandemic);

[5] The ISEE is a document of interest to all families and, more generally, citizens who need to determine their income situation, with reference to the composition of the household, in order to benefit from certain services, support tools and bonuses, including the "*universal single cheque*". The presentation of the DSU – 'single self-statement' and the determination of the equivalent economic status indicator have undergone a number of changes and updates aimed at making the issuance ISEE document by the INPS (National Institute of Social Security) as simple and quick as possible.

– Intervention A.3 for caregivers under the accompanying programs to deinstitutionalization and reunification with the assisted person.

Apart from these interventions, the individual ULSS or care places issue indications concerning hospitality services for family members, often consisting in the preparation of agreements with local hotel facilities, for a discount on living expenses.

In the larger structures, and in particular at the University hospitals AOU) and at Scientific Institutes for Research, Hospitalization and Healthcare (IRCCS), special guides are provided to the "Hospitality Houses" (for example, at AOU Padova in collaboration with the Volunteer Service Center and IOV Padova, in the "Hospitality Card").

In other locations, hospitality services are provided by private or nonprofit organizations, largely attributable to religious institutions, not yet organized into a real integrated system, as provided for by the recalled L.R. 9/2024.

From the north to the south of the territory of Veneto, within the USSL 1 Bellunese, there are two structures, both called "Casa Tua" (Your House – Onlus), born respectively in 1996 (Casa Tua 1) and 2002 (Casa Tua 2), the first from an agreement between ULSS 1 and the Committee of Voluntary Organizations, based in the garden of the Hospital "San Martino", intended for family members of the sick who provide care to their loved ones and patients who undergo continuous therapy. Composed of ten bedrooms, four bathrooms, one of which is accessible to disabled people, a kitchen for common use, a laundry room and a large living room with an area of over 200 square meters, it can accommodate at least 14 people. The volunteers take care of the people they receive in both the reception and hospitality phases as well as in their moral and material needs. The hospitality is free and the revenues come mostly from donations of associations and individuals who periodically organize collections in favor of the Voluntary Organization (Odv), while the remaining revenues are made up of the eventual offers of the guests.

The "Casa Tua 2" structure was created by ULSS 1, in compliance with DGRV 2989/2000, on palliative care and pain therapy[6] , with the contribution of the Veneto Region, the Cariverona Foundation and the Voluntary Organizations (Association "Francesco Cucchini" Onlus, founded in 1989).

In the territorial area belonging to ULSS 2 Trevigiana, the only structure offering hospitality services is that provided by the "Italian Association against

[6] It is hardly necessary to recall (see above Cap. 3) that in the years 2022 and 2023 the Veneto Region has achieved the national primacy in the provision of palliative care services for terminal patients.

leukemia, lymphoma and myeloma – AIL ETS", near the Hospital "Ca' Foncello" of Treviso, which offers free hospitality, throughout the treatment period, to patients of Hematology of Treviso who come from outside the city and their family members or companions. The house consists of 2 double bedrooms with bathroom.

Moving on to the territorial area of ULSS 3 Serenissima (Venice), the local health unit used a model of conventions on three areas (Venice – Mestre, Mirano and Dolo) in order to support and assist also from the logistical point of view users and their families coming – especially but not exclusively – from outside the Region, to promote their hospitality, for the period necessary for the path of care. All patients and their family members are exempt from paying the tourist tax.

In the area of Mestre (Hospital "all'Angelo"), accommodation facilities consist of a residence and 5 hotels, all provided with restaurant and laundry service, with an average discount of 25% on the ordinary rate for accommodation and 10% on meals. In the area of Mirano, there are 7 reception facilities: 6 "*Bed & Breakfast*" and a hotel structure in convention, all with dedicated rates.

In the area of Dolo, the convention involves two hotel facilities and a "Bed & Breakfast". All hospitality services use the same discounts as described above.

In short, the parties concerned are all private for-profit.

In the ULSS 4 Veneto Orientale (San Donà – Portogruaro) there are no operating hospitality services. However, the local health unit on 7 November 2022 published a Notice of expression of interest aimed at identifying Third sector entities available for co-design and management, in partnership, of "*social services, disability and social marginality*", "*support for vulnerable people and prevention of institutionalization of elderly people who are not self-sufficient*", "*temporary housing and post stations*", financed by the European Union – Next Generation EU.

On the website of ULSS 5 Polesana (Province of Rovigo) there are no hospitality services of the type indicated so far for family members of patients in care at their public or private hospital structures.

In the territorial area of ULSS 6 Euganea (Province of Padova) we find several solutions related to hospitality services, especially linked to the two centers of excellence (University Hospital of Padovaa and IOV), which are also independent health structures.

As already mentioned, the University Hospital of Padova – AOU provides its guests with a real publication dedicated to hospitality services for patients and their families ('Hospitality Houses') with a total of 9 structures, 5 of which

are managed by Odv, 2 from ETS Foundations, 1 from a Social Enterprise and 1 from a religious institution.

The IOV adds to the 5 ODVs mentioned above, which share with the AOU of Padua, two other hospitality houses, managed respectively by 1 ODVs and 1 Foundation and a hotel structure, entirely private.

On the website of ULSS 7 Pedemontana (area Bassano del Grappa), there are several "Day centers" dedicated to elderly people, but no hospitality services of the type mentioned above.

For the territorial area of ULSS 8 Berica, the only known hospitality structure is managed by a religious institute ("Casa Religiosa di ospitalità San Domenico"), which also constitutes a "holiday home".

On the portal of USLL 9 Scaligera, in whose territorial area insist the Integrated University Hospital of Verona – AOUI (which is an autonomous health structure) and the IRCCS Sacro Cuore Hospital Don Calabria, no indications are found on hospitality services or homes for family members of patients who are subject to interregional mobility for reasons of hospitalization and care.

The AOUI in Verona presents instead a list of accommodation (10 Bed & Breakfast, 5 residences with apartments, 2 hotels, 4 guesthouses and two residential facilities managed by religious institutes) all agreed with the hospital.

The IRCCS Hospital Sacro Cuore Don Calabria has instead entered into an agreement with a hotel structure to facilitate the stay of patients and their non-resident families, which provides for a discount of 15% on average rates.

Thus, on the territory of Veneto there are 55 hotels and accommodation facilities in total, 38 of which are run by private for-profit partners (about 68%), 13 (about 24%) managed by ETS (Odv, Foundations and Social Enterprises) and 4 by religious institutions with civil-law status (8%).

The brief survey of hospitality services carried out here offers some food for thought.

First, the presence on the territory of different actors: private for-profit, non-profit organizations (ETS) and religious institutions with civil-law status, but not transformed into ETS. Private for-profit represent the largest part in terms of quantity, but the rest reach a third of the supplier audience.

The second point comes from the considerations made in the previous paragraph: private for-profit (hotels, bed and breakfasts, guesthouses, etc.) that the websites of the afore mentioned ULSS classify in non-technical usage "partners", are probably linked to the Health Units by typical business relations, falling under the discipline of the Code of public contracts rather than that dictated by the Code of the Third Sector, to which are probably related only the

remaining components of the audience, Voluntary organizations (ODV) and the Associations for social promotion (APS) and may be the religious institutes. But all these initiatives are aimed at meeting growing needs arising from the territory and therefore lacking an "integrated" perspective, which is precisely what L. 9/2024 proposes instead to promote, bringing into line – through the action of ATS – all possible public actors (municipalities, ULSS), private ones (for-profit companies, benefit corporations), ETS accredited and not, (including the ODVs and APs) for the exercise, in an associated form, of the social assistance function, that, as already seen, includes the field of health.

The lack of an integrated perspective has led to the "*leopard spot*" geographical distribution of the accommodation facilities that we had indicated above and that concentrates the offer of hospitality services around the centers of excellence (IRCCS and University Hospitals) leaving the other areas in a position of "*unmet needs*".

The role and function of the Third sector in this area is not only quantitatively relevant (almost a third of all entities active on the territory), but also proves strategic in fulfilling that function of horizontal subsidiarity that art. 118, para. 4, of the Constitution, reserves the "*autonomous initiative of citizens, individuals and fellows, for carrying out activities of general interest*".

9.
VOLUNTEERING AND SOLIDARITY

9.1. *Regulatory framework*

In describing the structure of the SSR Veneto we have referred several times to Voluntary organizations and volunteers as peculiar actors to the integrated system of interventions and social services, including health care, and promoters "*of social solidarity, with the valorization of the initiatives of individuals, families, forms of self-help and reciprocity*" (art. 1, para. 4, L. 388/2000).

We have also tried to point out the critical points that doctrine and jurisprudence have pointed out about the very notion of "*volunteering*" and "*volunteer*", and the effects that both notions produce in the organization of its own activities in the market system and on the partnership instruments with the public administration.

There is therefore a need to attempt a regulatory framework, albeit brief, for the "*volunteer*" and social structures (voluntary organizations, indeed) in which he carries out his work.

The first thing to clarify is that there is no one-size-fits-all definition of the term at global level, so much so that even the United Nations (Volunteers Report, 2011) limit themselves to indicating its main characteristics: "*There are three key defining characteristics of volunteering. First the activity should not be undertaken primarily for financial reward, although the reimbursement of expenses and some token payment may be allowed. Second, the activity should be undertaken voluntarily, according to an individual's own freewill, although there are grey areas here too, such as school community service schemes which encourage, and sometimes require, students to get involved in voluntary work and Food for Work programmes, where there is an explicit exchange between community involvement and food assistance. Third, the activity should be of benefit to someone other than the volunteer, or to society at large, although it is recognized that volunteering brings significant benefit to the volunteer as well.*"

The Council of Europe (Charter of Volunteering, 2012)[1] defines a volunteer as someone "*who carries out activities benefiting society, by free will. These activities are undertaken for a nonprofit cause, benefiting the personal development of the volunteer, who commits their time and energy for the general good without financial reward*".

The European Union, rather than providing the concept of volunteering activity, defines volunteering as "*a pathway to integration and employment and a key factor for improving social cohesion. Above all, volunteering translates the fundamental values of justice, solidarity, inclusion and citizenship* […] *Volunteers help shape European society, and volunteers who work outside of their home countries are actively helping to build a Citizens' Europe*" (COM (2011) 568 final on 29 September 2011) and in the same document, it acknowledges that "*each country has different notions, definitions and traditions*" in the field of volunteering.

The subsequent Regulation (EU) 2018/1475 of 2 October 2018, which establishes the legal framework for the European Solidarity Corps, defines "*volunteering*" as "*a solidarity activity that takes the form of a voluntary unpaid activity for a period of up to twelve months* [which] *provides young people with the opportunity to contribute to the daily work of organizations in solidarity activities to the ultimate benefit of the communities within which the activities are carried out. It takes place either in a country other than the country of residence of the participant (cross-border) or in the country of residence of the participant (in-country); that does not substitute traineeships or jobs and, therefore, is in no case equated with employment and is based on a written volunteering agreement*" (art. 1, para.1, n. 2).

Outside the European context, the U.S. "Volunteer Protection Act" of 1997, defines the volunteer as "*a person who provides services to a non-profit organization but does not receive compensation or anything of value exceeding $500.00 per year for his or her services. A person may receive reimbursement of his or her expenses and still be protected as a volunteer by the Act. For organizations that reimburse officers or volunteers for their expenses based on the submission of receipts or invoices, there should be no problem showing that these people are 'volunteers' under the Act*" (Freeman, 1997; Horwitz, Mead, 2008)[2].

[1] See *https://ec.europa.eu/citizenship/pdf/volunteering_charter_en.pdf.*

[2] According to Richard B. Feeman, economist and expert of labor market "*volunteering can be best understood as 'a conscience good'*" which he defines as "*public goods to which people give time or money because they recognize the moral case for doing so and for which they feel social pressure to undertake when asked, but whose provision they would just as soon let someone else do*".

Some common features can be seen from the examples given above:

(a) the gratuity of the work provided by the volunteer (United Nations, 2011; Council of Europe 2012), to which a reimbursement of expenses within a predetermined limit may be granted (U.S. Volunteers Protection Act, 1997);
(b) the voluntary nature of service offered (United Nations, 2011; Council of Europe, 2012);
(c) solidarity, integration and inclusion, to which volunteer's action must be inspired (European Union, 2011 and 2018).

All these characteristics are included in the notion of volunteer and volunteering offered by the Italian Code of the Third Sector, in art. 17, paragraphs 2 and 3: "2. *A volunteer is a person who, by his or her own free choice, carries out activities in favor of the community and the common good, including through a third sector entity, providing their time and skills to promote responses to the needs of the people and communities benefiting from his or her action, in a personal, spontaneous and free of charge, without profit either direct or indirect, and exclusively for solidarity purposes*". "3. *The activity of the volunteer may not be remunerated in any way even by the beneficiary. The volunteer may be reimbursed by the Third sector entity through which he carries out the activity only the expenses actually incurred and documented for the activity performed, within maximum limits and under conditions previously established by the same entity. Reimbursement of flat-rate expenses is in any case prohibited*"[3].

Art. 17, para. 1, CTS, establishes, for the protection of volunteers, that Third sector entities that use volunteers who provide their service in a "*not occasional*" way are required to "*register them in a special register*" and the subsequent art. 18 states that "*Third sector entities that employ volunteers must insure them against accidents and diseases related to the performance of the volunteer activity, as well as for liability towards third parties*"[4].

[3] Pursuant to para. 4 of art. 17 "the costs incurred by the volunteer may also be reimbursed on a self-certification basis [...] provided that they do not exceed the amount of 10 euros per day and 150 euros per month and the competent social body decides on the types of expenses and voluntary activities for which this method of reimbursement is permitted". Para. 5, finally, specifies that "*the status of volunteer is incompatible with any form of employment or self-employment and with any other paid employment relationship with the entity whose member or associate the volunteer is or through which he carries out his voluntary activity*".

[4] For the sake of completeness, it is worth recalling the judgment of the Court of Auditors, Section Autonomies, of 14 November 2017, no. 26, which clarified that "*the* 'ratio iuris' *underlying the discipline of voluntary activities contained in the Code of the Third Sector is also extendable to local authorities that intend to actively support the free participation of* '*individual volunteers*' *in operational activities of service to the person and protection of non-industrial or commercial common goods. The absence of legislation ensuring compliance with certain essential conditions to guarantee volunteers free and spontaneous participation, with the characteristics of occasional, complementary and totally free participation requires, however, the adoption of a regulation governing the modalities for access and conduct of business in accordance with the rules imposed on Third sector entities. To this end, provision*

These characteristics are reflected in the Voluntary Organizations, which (art. 32, co. 1 CTS) "*must avail in such a prevalent way of the activity of their volunteers or of the activity of persons belonging to the associated bodies*" and although they may employ employees or self-employed persons in the performance of their work, "*the number of workers employed in the activity may not exceed fifty percent of the number of volunteers*".

These characteristics and limitations of Voluntary organizations explain the different procedure for involving such entities in the allocation of social activities or services of general interest, compared not only to private entities, but also compared to the other bodies of the Third Sector: that of "*conventions*", which "*may only provide for reimbursement to Voluntary organizations of the expenses actually incurred and documented*", with attribution of services made "*respecting the principles of impartiality, publicity, transparency, participation and equal treatment by means of comparative procedures*" (Art. 56 CTS).

With particular reference to the concerned field – health – the Code of the Third Sector has provided a contribution in favor of voluntary organizations "*for the purchase by them of ambulances, medical vehicles and capital goods used directly and exclusively for activities of general interest, which, by their characteristics, are not susceptible to various uses without radical transformation, as well as for the donation of the goods indicated therein to public health care facilities by Voluntary Organizations*" (Art. 76, co. 1 CTS)[5].

This provision has provoked the reactions of other health professionals, who have raised objections of illegitimacy before the Constitutional Court in relation to articles 2 (solidarity), 4 (right of labor and promotion of it), 9 (protection of the environment and animals), 18 (liberty of association); 118, paragraph 4, (subsidiarity) of the Constitutional Charter.

By its judgment of 16 March 2022, n. 72[6], the Court rejected the objections, pointing out, first, that although "*Code of Third Sector* [has] *played a unifying function, aimed at ordering and bringing coherence to the ETS discipline, overcoming previous fragmentation and overlap, however this did not resolve itself in an indiscriminate homologation of all the ETS overcoming previous fragmenta-*

should be made for the establishment of a special register of volunteers whose results, if they comply with the criteria laid down for the maintenance of voluntary registers, shall be binding in respect of the identification of persons entitled to insurance coverage against accidents and diseases as well as for civil liability for damages caused to third parties as a result of the performance of the activity, with charges borne by the local authority as final beneficiary of the activities of individual volunteers from the same coordinates".

[5] Para. 2 of art. 76 CTS specifies that this contribution corresponds "*to the VAT rate of the total purchase price, by corresponding reduction of the same price practiced by the seller*".

[6] In G.U. (Official Gazette of the Republic) 16 March 2022, No. 11.

tion and overlap, but this has not ended in a seamless homologation of all ETS. Within the legal scope of this definition, in fact, specific and different characterizations of organizational models have remained alive, to the point that it is the entities in their autonomy to identify, by diversifying, if necessary, the one that best allows, according to the history and identity of each, the achievement of its own institutional purposes" (Ground, para. 4). And it is in this perspective that, according to art. 32 CTS, "*Voluntary Organizations* [carry out their activities] *making predominant use of the voluntary activity of its members or of persons belonging to associated entities*" and that, consistently, the following art. 33 "*expressly obliges the Odv to receive, for the general interest activity performed*, *only reimbursement of the expenses actually incurred and documented*" (Ground, para. 7).

"*This is not 'neutral' as, instead, argued by the transferor, because it prevents the Odv from obtaining positive margins from the performance of the activity of general interest to be used for the growth of the activity itself unlike the social enterprises, which may receive forms of consideration from the recipients of the services rendered*". (Ground, para. 7).

"*Volunteering is a fundamental way of civic participation and social capital formation of democratic institutions, to the point that it would be paradoxical to penalize precisely those entities which are structurally characterized by a predominance of volunteers, because of the limitation of mere reimbursement of expenses. It does not therefore appear unreasonable or discriminatory that the contribution covered by the contested provision should be accessible only to ETS which are characterized by a regulatory link with the prevalence of volunteers and the related principle of gratuitousness excluding other entities for which no such provision exists and which therefore can negotiate remuneration with which to independently finance the purchase or renewal of the assets considered in the contested regulation*" (Ground, para. 8).

For these reasons, the Constitutional Court is urged to hope that "*the legislator intervenes to revise in less rigid terms the selective filter provided for by the censored norm so as to allow access to the relevant resources also to all those ETS on whose action – by regulatory provision, as in the case of [Voluntary Organizations and] social promotion associations, or for the concrete organizational choice of the institution to use a significant number of volunteers compared to that of employees – more reflects the general scope of art. 17, paragraph 3, Cod. Third sector, whereby the volunteer may be reimbursed 'only the expenses actually incurred and documented for the activity performed*".

This clarifies the legal perspective, organizational peculiarities and social

purposes of Voluntary Organizations in the discipline of the Third Sector, all the characteristics necessary to understand the scope and role they play in the healthcare that they carry out in Veneto Region.

9.2. *Territorial Distribution*

The regulatory framework so far achieved still lacks a piece: that of the insertion of Voluntary organizations within health structures.

Art. 14, para. 7, of the Legislative Decree. No. 502/1992, as amended by art. 12 of the Legislative Decree 19 June 1999, No. 229, bearing "*Improvement of health regulations* ", provides for it, establishing: "*The presence and activity of Voluntary organizations and bodies for the protection of rights within health care structures is encouraged. To this end, local health units and hospitals shall conclude agreements or protocols with these bodies, free of charge for the Regional Health Fund, setting out the areas and methods of cooperation, without prejudice to the right to privacy, however guaranteed to the citizen and not interfering in the choices of health professionals; Healthcare Units, Voluntary organizations and Protection of rights bodies agree on common programs to foster the adjustment of health facilities and services to the needs of citizens. The relations between Healthcare Units and Voluntary organizations that perform free service and assistance functions within the structures are regulated on the basis of what is provided by the Law 11 August 1991, No. 266 ('Framework Law on Volunteering', repealed by art. 102 of the CTS), and by the regional implementing laws*"[7].

In other words, the Voluntary organizations are an inseparable element of the SSN (NHS), so much so that not only is their "*presence and activity within the health structures*" allowed, but it is even "*favored*", i.e. promoted, albeit "*without any charge to the Regional Health Fund*". To this end, the ULSS and hospitals "*conclude agreements or protocols that establish the areas and modalities of collaboration, to favor the adjustment of health structure and services to the needs of citizens*".

This is not only because – as established by art. 32 Constitution – "*health is a fundamental right of the individual*", but also because its protection constitutes "*the interest of the community*".

In fact, the most advanced hospital structures have long ago established, in

[7] The regulations on Volunteering contained in the Law 266/1991 have been merged into the Code of the Third Sector. Reference is made, particularly, to art. 17 – 19; 32 – 34; 45 – 46; 54 – 56 – 57; 61 – 68; 72 – 74; 76; 84; 101.

addition to the conventions mentioned above, special regulations on relations with Voluntary organizations, whereas, as stated by the recalled Constitutional Court in its judgment No. 72/2022 "*Volunteering is a fundamental modality of civic participation and social capital formation in democratic institutions*" (Petrangolini et al, 2021; Biancheri et al, 2023)[8].

The Voluntary organizations engaged in health in the Veneto region are 505, distributed geographically as shown by Table 24, in Appendix.

The largest number is found at the ULSS 8 Berica (province of Vicenza) which reports 101, followed by the University Hospital Unit of Padua, which records 99 and then by the ULSS 9 Scaligera (Province of Verona), which records 87.

Again, there is a "leopard-spot" distribution, in the sense that in some areas the Odv are just a few (ULSS1 Bellunese, Province of Belluno, and ULSS 5 Polesana, Province of Rovigo, both recording 25 presences).

Comparing the table 24 with figures 26 (Geographical distribution of major hospitals) and 27 (Geographical distribution of the ETS outpatient network), it is highlighted that the presence of Voluntary organizations in the territory is mirrored to the distribution of other health devices (public, private, accredited and not, and nonprofit) on the Veneto territory. This is probably the major critical element.

There is no reliable data on the number of volunteers working in the territory and at the health facilities.

9.3. *Type of Services*

Going on to list the types of services provided by the Odv at the hospitals and equivalent units in the territory of Veneto, it should be noted that of the 505 Voluntary organizations registered with the ULSS or Hospitals, 103 are local sections of Odv operating at national level (e.g. CRI, AIDO, AVIS, AVO, AUSER)[9].

[8] See, by way of example, but not exhaustive, the Regulation on relations between Istituto Oncologico Veneto (IOV) – IRCCS and the Voluntary organizations, approved with Resolution of the Director General n. 53 of 26 January 2023 in *https://www.ioveneto.it/wp-content/uploads/2023/01/DEF-Regolamento_Volontari-IOV-DDG-53_2023.pdf* and similar Regulations approved by the University Hospital Unit of Padua, updated on 23 September 2024, in *https://www.aopd.veneto.it/index.cfm?action=mys.apridoc&id=2545*.

[9] CRI – Croce Rossa Italiana (Red Cross Italy); AIDO – Associazione italiana per la Donazione di Organi, Tessuti e Cellule (Italian Association for the Donation of Organs, Tissues and Cells); AVIS – Associazione Volontari Italiani del Sangue (Association of Italian Volunteers of the Blood); AVO – Associazione Volontari Ospedalieri

They therefore carry out, at local level, the mission of their 'parent company', in relation to the agreement concluded with the ULSS or competent hospitals, in the assigned departments, in compliance with the Regulation governing the healthcare activities of individual structures, and on the basis of assistance and solidarity projects presented from time to time.

Although the Voluntary organizations include in their files medical and paramedical personnel, both conventions and regulations generally provide for the non-provision of health care services and the non-interference with the normal activities of the Hospital medical and paramedical personnel. In cases of emergency (such as the COVID-19 pandemic emergency), but always following special agreements with the Region, the University Hospitals and the competent ULSSs, certain Odvs have installed mobile centers, managed the provision of PPE and also the administration of vaccines at dedicated centers.

More generally, the ODV perform activities not replacing and complementing the ordinary health activity, attributable to the concept of "*solidarity*" highlighted above, in support of patients and their families: moral and social support; comfort and companionship; care; recreational activities, especially in pediatric wards and towards the elderly; listening desk, information, health promotion and first orientation.

In the Veneto experience these activities are carried out mainly in the pediatric, psychiatric and oncology departments of hospitals.

9.4. *Integration*

Solidarity is only one of the elements that characterize the activity of voluntary organizations in the health facilities listed above. The other element is "*integration*".

We had mentioned it (Cap. 8) commenting on the very recent L.R. 9/2024, about the "*integrated system of interventions and social services*".

Art. 1, para. 2 of that law states that "*the Region and the associated Municipalities in the Territorial Social Spheres [...] promote the integrated system of interventions and social services, with the participation of public institutions, social training, individuals, families and Third sector entities*" system that is realized "*through the construction of participatory processes and integration with health interventions and social services*" (art. 1, para. 3).

(Association of Hospital Volunteers); AUSER – Autogestione dei servizi, Associazione per l'invecchiamento attivo (Self-Management Services, Active Ageing Association).

We have also seen as art. 14, para. 7 of the Legislative Decree No. 502/1992 states that "*Healthcare Units and Voluntary organizations and rights protection bodies agree on common programs to facilitate the adjustment of health structures and services to the needs of citizens*".

It is precisely from the regulatory framework just indicated and the from subsequent Implementing Decision of the Council of the European Union n. 10160/21 of 6 July 2021 concerning the approval of the National Recovery and Resilience Plan (PNRR) and in particular the Mission 6 Health – Component 1 Proximity networks, facilities and telemedicine for territorial health care, that is born the Inter-Ministerial Decree Health – Economics 23 May 2022, n. 77, "defining models and standards for the development of territorial assistance in the National Health Service", to ensure essential levels of care (LEA) reducing inequalities, and simultaneously building a shared and homogeneous model of service provision on the national territory.

In the Annex 1, para. 2, the Decree states that "*this vision is pursued, in particular, through:*

- *the development of proximity structures, such as* 'Community Houses'*, as a reference point for responding to health and social-health needs relevant to the target population;*
- Integration *of health and social care and the development of multiprofessional teams that take care of the person in a holistic way, with particular attention to mental health and more fragile conditions;*
- *exploitation of co-design with users;*
- *the exploitation of all community resources in different forms and through the involvement of different local actors (Local Health Units, Municipalities and their aggregations, professionals, patients and their caregivers, associations/* organizations of the Third sector*, etc.*".

The Community Houses (Annex 1, para. 5, D. M. 77/2022 are defined as "*the physical and easily identifiable place to which citizens can access for health care, social and health-related needs and the organizational model of proximity care for the reference population. In the Community House, all professionals work in an integrated and multidisciplinary manner for the design and delivery of health care and social integration interventions*", *ensuring in a coordinated way* "*the activation of multidisciplinary care pathways, which provide for* integration *between health services, hospital and territorial, and between health and social services*" *[as well as]* "*the participation of the local community, citizens' associations, patients, caregivers*".

The Veneto region is currently second in Italy for number of active Commu-

nity Houses – 77 in 2021 out of a total of 99 foreseen by the PNRR – after the Emilia – Romagna region which has already activated 124 (40 more than those financed with funds from the PNRR)[10].

They are concentrated mainly in the territorial districts of ULSS 6 Euganea – Province of Padua and University Hospital: 20 – and ULSS 9 Scaligera – Province of Verona and Integrated University Hospital of Verona: 19 – but also in the USSL 2 Marca Trevigiana – Province of Treviso: 17 (Salvalaggio, 2023). These areas have the largest number of Voluntary organizations operating in the field of health: 104, 102 and 37 respectively.

Family caregivers and Voluntary organizations (both of patients and caregivers) play a key role in clinical support (AGENAS, 2022; Costa – De Luca, 2023), e.g. in the provision of information and promotion of prevention activities, as well as social support for patients and caregivers.

In the previous pages we had reported the case of the Association "*L'Acero di Daphne*", Odv based in the province of Verona, founded in 2012 to spread the culture of palliative care among health personnel and promote its practice, in line with the mandate of the Ministry of Health.

The "Integrated home care" provides home care services by integrated health and social professionals (general practitioners, nurses, physiotherapists, social workers, medical specialists, volunteers), according to a personalized intervention defined by the Local Health and Social Care Unit – ULSS (D.G.R. n. 1075/2017; Sacco, 2021).

These are only a few examples of the integration function performed by Voluntary organizations.

They base their work on people and their needs (human-to-human) – as we have seen about the Finnish experience (Ch. 1., par. 1.4.4) – rather than on the tasks assigned to individual volunteers: socialization services and recreation (e.g. shared activities, emotional support), personal assistance (e.g. accompanying patients to the doctor, changing with family members who provide care for a few hours), administrative services (e.g. support in administrative procedures, communication and public relations), catering services, information services (e.g. guidance at the hospital reception), group consultations or direct support to nursing staff (e.g. in the hospital ward), not less than cultural mediation, essential in emergency services (e.g. the Ukraine emergency, following the invasion of that territory, in February 2022).

Voluntary organizations provide additional services that positively affect

[10] Source: Chamber of Deputies, 2021.

patient satisfaction and which the structured health care providers cannot fulfil, due to staff shortages and financial constraints (Costa – De Luca, 2023). They also carry out monitoring and prevention activities, as noted about the ETS outpatient networks in Veneto in Chapter 7.

This function of integration between health and social services is the basis for that "integrated system of interventions and social services" which is, in turn, the foundation of the definition of essential levels of care (LEA) covering the entire national territory; in accordance with the constitutional requirements. Voluntary organizations are in the position to fulfill (and in fact do) due to their institutional mission. Solidarity and integration are, therefore, inseparable.

10.
EMERGENCY AND/OR AMBULANCE TRANSPORT SERVICES UNDER ACCREDITATION

10.1. *Legal framework, Numerical Consistency and Legal Form of the Accredited Entities*

The regional health transport system for emergency and rescue services in Veneto is regulated by L.R. 27 July 2012, n. 26. The Law gives health institutions, associations and other authorized and accredited bodies the possibility to contribute to the development of emergency transport and rescue activities, both intrinsically related to health.

This is in view of their territorial spread, rooted in the health and social fabric of Veneto, as well as of the values of efficiency and quality of service rendered, in the general interest and respecting the principles of universality, solidarity, economy and adequacy (art. 1).

The afore mentioned law (art. 2) defines "*medical transport of emergency and rescue, the activity carried out with means of relief by the personnel, sanitary and non-sanitary, assigned to such service, in the exercise of the functions of:*

(a) emergency and emergency transport services, carried out by means of rescue vehicles and operated by the Emergency and Medical Emergencies Coordination Centers (SUEM)[1]*;*

[1] The Emergency and Urgency Service (S.U.E.M.) is the health emergency and medical alert service outside the hospital in Italy, which answers to the medical emergency number "118" or, where there is a unique emergency number, "112".
It is born from the D.P.R. 27 March 1992 "*Act of guidance and coordination to regions for the determination of levels of emergency health care*" and the subsequent Guidelines 1/1996 "Emergency and Urgency System", approved by the Minister of Health with D.M. 17 May 1996, following the State – Regions agreements and published on the same date in the G.U. General Series n. 114. The emergency health system consists of: 1. a health alert system, with a short and universal telephone number ("118" or, if already activated "112") in connection with the operational centers; 2.a territorial rescue system; 3. a network of hospital services and wards, functionally differentiated and hierarchically organized. The emergency-urgency response procedures are divided into four operational levels: a) points of first aid; b) hospital first aid; c) emergency departments, emergency and acceptance of first level; d) emergency departments, second level urgency and acceptance.

(b) transport services provided in the Essential Levels of Assistance (LEAs), carried out by rescue vehicles;
(c) transport services in which the patient's medical condition requires only the use of a rescue vehicle and during the journey the need for assistance by health or other appropriately trained personnel, and the need to ensure continuity of care".

Art. 5, which regulates the arrangements for organizing emergency medical transport and rescue services, then states that: "*1. The activities of medical transport for rescue and emergency are carried out by ULSS companies, as well as by the entities listed in the regional list* [omissis]. 2. *The relations with the ULSS, as well as the ways in which the entities included in the regional list contribute to the rescue and emergency activities, are regulated by special conventions, concluded on the basis of a standard scheme approved by the regional board and made public in accordance with the provisions of current state and European legislation on public contracts*. 3. *The conventions referred to in paragraph 2 provide for a budget system defined according to criteria based on the application of standard costs identified by the regional board and updated every three years* [omissis]. 5. *If the activity of medical transport for rescue and emergency cannot be ensured by the entities registered on the regional list, the ULSS may entrust it, in return for payment, to entities identified through open competitive procedures, in compliance with the provisions of current State and European legislation on public contracts, meeting the appropriate requirements to ensure adequate levels of quality and enhance the social function of the service*".

The classification of services on-call is not uniform in national and EU legislation and is mostly dependent on the type of vehicles and ambulances used, their equipment and crews, matter regulated by the D.M. Transport 17 December 1987, n. 553, concerning "Technical and administrative regulations relating to motor ambulances".

The EU regulation distinguishes between:
- Type A ambulances, intended for non-emergency medical transport;
- Type B ambulances, first aid, equipped with advanced equipment, which are enabled to provide help even in the field. An emergency doctor is on board;
- Type C ambulances, for situations of maximum emergency on which not only the advanced equipment is placed, but also of the hospital type, such as intubation and assisted ventilation during transport. They can function as a mobile resuscitation center and always travel with one or more doctors on board[2].

[2] We refer to the European Committee for Standardization (CEN) regulation. The abbreviation EN 1789:2020

The Italian legislation provides for a more complex codification:

- Type A ambulance: with emergency doctor on board, is the car called in an emergency for a rapid transfer of the patient to a hospital facility or immediate field intervention;
- Type B ambulance: intended for the transport of patients, it can also be an auto medical or a medical taxi, is called in case of need, when one must transfer an infirm or a person who cannot move from or to a care center;
- Type C ambulance: although it does not appear explicitly in the DM Transport 553/1987, updated to 2009, it is the so-called "*mobile intensive care unit*". Often the type A ambulance, which takes care of patients in need of advanced treatment.

There are other acronyms:

- MSB, basic rescue vehicles: carry simple aids and personal rescuer;
- MSI, intermediate or nursing rescue vehicles: carry simple and/or advanced equipment, with the presence of a nurse on board;
- MSA, advanced rescue vehicles: carry advanced equipment, with the presence of a nurse and a doctor specialized in anesthesia and resuscitation.
- VLV: Fast light vehicle, such as the auto medical vehicle, which is a means of transport that activates in an emergency and can assist ambulance operations or, in some cases, replace it altogether. The term should not be confused with the so-called "*medical taxi*", which is intended for non-emergency situations.

All these types are included in the expression "*purchase of ambulances, vehicles for health activities and capital goods*", subject to State contribution in favor of Voluntary organizations, pursuant to art. 76 of the Code of the Third Sector (CTS), already commented on in Chapter 9.

In any case, with the D.G.R. 1095 of 18 August 2015, the Veneto Region has established or extended the list of entities accredited to the above transport services (Annex A), to establish the training and professional requirements for personnel involved in rescue and medical transport activities (Annex B), and to define the indicators for regional accreditation for the performance of rescue and medical transport activities.

The 2015 list in Annex A of the Resolution (D.G.R.) distinguishes the activ-

indicates a series of reference standards to give uniformity to the rescue service in the EU Member States. Yellow is the most visible color, even at night and immediately perceptible. The color code is RAL 1016, commonly called sulfur yellow. It should also alternate with checkered green, full-body coating or only a horizontal band on the sides, depending on the category of ambulance. The star of life, international symbol of the rescue (stylized with six points with the stick of Aesculapius in the center) is present on the ambulances of each country.

ity of "*rescue and medical transport*" (A1) from that of mere "*medical transport*" (A2), and counts a total of 93 entities (66 in type A1, 27 in type A2).

The legal form of Voluntary organizations is the prevailing one (31 units: 20 in category A1, 11 in category A2), followed by Social Promotion Associations – ASP (23 units: 19 in category A1, 4 in category A2) which share with the Odv the organizational structure and the possibility for public administrations to subscribe with them "*agreements for the provision of social services or activities of general interest to third parties, if more favorable than recourse to the market*".

Than we find Social cooperatives, now "*de jure*" "*Social Enterprises*" within the meaning of Legislative Decree No. 112/2017 (13 units: 7 in category A1, 6 in category A2), then the Foundations and Associations, i.e. the former Onlus not yet transited in the National Single Register of the Third Sector – RUNTS (10 units: 8 in category A1, 2 in category A2), and the remaining (15 units in total) are private entities, mostly in corporate form (general partnership, limited liability company, etc.).

According to the data of "Azienda Zero" Authority, updated on 28 June 2024 (Table 18), the total number of Nonprofits that currently provide rescue and transport services in the territory of Veneto amounts to 91 units, registering an increase of about 18% compared to 2015 (77 units in total in Annex A to DGR 1095/2015).

10.2. *Territorial Distribution*

The territorial distribution of the entities accredited in "*rescue and medical transport services*" (A1) that is taken from Annex A to the D.G.R. 1095/2015 sees in first place the province of Verona (15 entities), followed by that of Belluno (12 entities), that of Vicenza (9 entities), Padova, Treviso and Venice (8 entities each), Rovigo (3 entities). Two of the accredited bodies (1 social enterprise and 1 Onlus) are located outside the region: Bolzano (South Tyrol) and Ferrara (Emilia – Romagna).

As to the services of mere "*medical transport*" (A2), from Annex A to D.G.R. 1095/2015 are not found in the province of Padua.

Again, the highest concentration is in the province of Verona (8 entities), followed by that of Rovigo (7 entities), Venice (5 entities), Vicenza (3 entities), Treviso (2) and Belluno (1). Only one body, among those accredited, was located outside the region: Mantua (Lombardy).

It is not possible to compare the data of the accredited entities in 2015 with

those provided by "Azienda Zero" and updated on 28 because these last refer only to the "*Third sector entities*" – ETS accredited by the Veneto Region and do not include "*private for-profit*" entities.

10.3. *Case studies*

The overview of national legislation (CTS: artt. 56, 57 and 76; D.M. Trasporti 553/1987), EU Regulation (Directive 2014/24/EU; EN 1789:2020) and regional provisions (L.R. 26/2012; DGR 1095/2015) conducted in the previous pages on the subject "*emergency rescue and medical transport*" and ordinary "*medical transport*", particularly complex, helps to explain the occurrence of doubts and disputes about the correct procedure used by territorial and health administrations, in the allocation of medical transport services (emergency rescue and medical transport as well as ordinary medical transport), in the choice of partner, with the view of the respect for the general principles of competition, solidarity and good conduct.

And in fact, the matter has given rise to various cases, decided by national and Eu courts, also on issues raised by bodies established in the territory of the Veneto region, which we propose to summarize below.

The first "*Case study*" is that decided by the European Union Court of Justice – Ninth Chamber – with order C-11/19 of 6 February 2020[3], raised by the Council of State – Italy.

The facts: in 2017, ULSS n. 6 Euganea launched a call for tenders for the award of the contract for the medical transport service for patients in ambulances and hemodialysis according to the criterion of the "most economically advantageous tender", for a period of five years, with the option of an additional year. The annual value of this contract was estimated at 5.043.560 euros, equivalent to 25.217.800 euros for the five-year period.

The institution "Pia Opera Croce Verde" – IPAB[4] , regularly enrolled in the

[3] See Official Journal of the European Union, Volume 63, 21 September 2020 /C 313/05 Case C-11/19: Order of the Court (Ninth Chamber) of 6 February 2020 (request for a preliminary ruling from the Council of State— Italy) — ULSS No 6 Euganea vs Pia Opera Croce Verde Padova (Reference for a preliminary ruling — Article 99 of the Rules of Procedure of the Court of Justice — Public procurement — Directive 2014/24/EU — Article 10(h) — Article 12(4) — Specific exclusions for service contracts — Civil defense, civil protection, and danger prevention services — Non-profit organizations or associations — Ordinary and emergency medical transport services — Regional legislation requiring priority to be given to recourse to a partnership between contracting authorities — Freedom of the Member States to choose how services are provided — Limits — Obligation to State reasons.

[4] IPAB stands for Public Institution of Assistance and Charity. These bodies were established in 1890 by the Law No. 6790, which has undergone numerous revisions over time, most recently with the Legislative Decree 4 May

All. A (A1) of the above-mentioned DGR 1095/2015 challenged before the Regional Administrative Court of Veneto the decision of the ULSS n. 6 to opt for the award by tender instead of a partnership between public sector entities. In fact, once the conditions required for the conclusion of such a partnership were fulfilled, the regional law Veneto n. 26/2012 required to conclude with the accredited public body an agreement governed by article 12, paragraph 4 of the EU Directive 2014/24 and article 5, paragraph 6, of the then-current Public Contracts Code, without the need to award a public contract, or even a public contract subject to the simplified regime, as provided for in article 10, letter h) of the Directive and Article 17, paragraph 1, letter h), of the recalled Code.

In this respect, the Croce Verde (Green Cross) claimed to be not merely a private-law association carrying out voluntary activities but a non-economic public body, more precisely an IPAB, that would participate in this capacity for more than a century to the healthcare services aimed at citizens of the territory of Padua, mainly by ensuring the nonprofit transport of wounded and sick, without profit. It was also entrusted with the emergency rescue and medical transport service of ULSS n. 6 Euganea by agreement concluded on 22 December 2017, in application of the L.R. No. 26/2012. In addition, following a tender launched in 2010, extended twice and expired on 31 March 2018, it would also be awarded the service of the ordinary "*medical transport*"[5].

The Regional Administrative Court of Veneto has however observed that articles 10 and 74 of the EU Directive 2014/24, as well as art.17, para. 1, letter h), of the Code of Public Contracts then in force provided for the award of the contract of ordinary "*transport in ambulance*", by tender. However, since the Court upheld the first ground of challenge, alleging that ULSS No. 6 Euganea had not the power to organize the contested tender, ULSS 6 appealed against the judgment of the Regional Administrative Court Veneto on this point, before the Council of State, as referring Court.

The Council of State, which rejected the main appeal, had to rule on the appeal in which the "Croce Verde" had reintroduced the argument it had raised at first instance. In this connection, the Council considered that a distinction

2001, n. 7. The Decree provided for the possible transformation of the legal personality of public law entities into private law personalities that would confer on them a series of benefits, comparable to those provided for the Onlus (e.g. liberal grants) as well as all functional agreements to the pursuit of their institutional purposes and the fulfilment of the commitments made in the regional programming, including the establishment of companies or foundations to carry out activities instrumental to the institutional ones and to provide maintenance of their assets.

[5] In the 'A2' Section of the Annex A list. A (ordinary medical transport" to DGR 1095/2015, in truth the Pia Opera Croce Verde – IPAB of Padua, does not appear, while only the subsidiaries of Verona and Vicenza appear.

should be made between "*emergency rescue and medical transport service*" and ordinary "*transport service*" in ambulance.

The distinction is relevant because Article 10 of the afore mentioned Directive 2014/24, read in conjunction with its 28th recital, and Article 17, Co. 1, lett. h), of the Code of Public Contracts would exempt from the rule of public procurement the service of emergency rescue and medical transport, which consists, for Nonprofit organizations, in the transport of ambulances and in the primary care activity of patients in an urgency situation. The ambulance service, being devoid of the connotation of urgency, would instead be subject to the "*light*" regime introduced by articles 74 to 77 of the afore mentioned EU Directive 2014/24, if, as in the main proceedings, has a threshold amounting at least 750.000 euros.

Based on these considerations, the referring Court (Council of State – Italy) took the view that the mentioned service could be qualified as an "*ordinary transport service*" or a "*rescue and medical transport service*", and not as an "*emergency rescue and medical transport service*", as alleged by the appellant. Therefore, according to art. 5 of the cited L.R. n. 26/2012, the Council considered that the contracting authority could have opted for a call for tenders only if it had not been possible to award the contract directly "*by agreement*" (articles 56 and 57 CTS).

Conversely, the tendering procedure would have ensured compliance with the principles of EU law of impartiality, publicity, transparency, participation and equal treatment by comparing several tenders, in the light of the most economically advantageous tender criterion.

Thus, where EU law does not qualify different and concomitant general interests such as the exploitation of volunteering, the use of direct contracting by means of a "convention" could not be justified. This was the case in the present case, since the "Pia Opera Croce Verde" entity claimed to be the only body accredited in the Veneto region which already had the nature of a public body, a circumstance which would exclude any competition and comparison between the potential operators concerned in carrying out the service at issue in the main proceedings. Moreover, being included in the regional list referred to in article 4 of the regional law no. 26/2012, it would have had "*full title*" as an economic operator, to participate in the contested tender and would thus have had the opportunity to assert the value of his bid there.

For the reasons mentioned above, the Council of State decided to stay proceedings and refer the following preliminary questions to the Court of Justice of the European Union:

"1) *The Court shall determine whether, in the case where the parties (ULSS 6 Euganea and Pia Opera Croce Verde) are both public bodies, the Considering No. 28, art. 10 and art. 12, para. 4, of the Directive 2014/24 preclude the applicability of art. 5, in conjunction with articles 1, 2, 3 and 4 of the Regional Law n. 26/2012, based on the public-public partnership referred to in the afore mentioned art. 12, para. 4, and of art. 5, para. 6, of the Code of Public Contracts*;

2) *The Court shall also determine whether, in the case where both parties are public bodies, Considering No. 28, art. 10 and art. 12, para. 4, of the EU Directive 2014/24 prevent the applicability of the provisions of the Regional Law n. 26/2012, based on the public-public partnership referred to in the afore mentioned art. 12, para. 4, and to in art. 5, paragraph 6, of the Code of Public Contracts, in the limited sense of obliging the contracting station (ULSS 6) to externalize the reasons for choosing to entrust the service of 'medical transport' by tender, instead of by direct agreement ('convention')*".

In this regard, the European Union Court of Justice ruled as follows:

"*On the first question: art. 10, letter h), and art. 12, para. 4, of Directive 2014/24/EU of the European Parliament and of the Council of 26 February 2014, on public procurement must be interpreted* 'as not being in conflict' *with regional legislation which makes the award of a public contract conditional on the fact that a partnership between public sector bodies does not allow 'medical transport service' to be provided ordinary, provided that the choice made in favor of a particular mode of service provision, and carried out at a stage prior to the award of the public contract, respects the principles of equal treatment, non-discrimination and mutual recognition, proportionality and transparency*;

On the second question: art. 10, point h), and art. 12, paragraph 4, of the EU Directive 2014/24 must be interpreted 'as not precluding' *a regional rule requiring the contracting authority to justify its choice to award the ordinary 'medical transport' service by tendering out tender instead of entrusting it directly by a convention concluded with another contracting authority*".

The issue was re-proposed (second *Case study*) to the Constitutional Court with an appeal filed by the Presidency of the Council of Ministers on 18-22 November 2019 and filed on 27 November, referring to art. 117, second paragraph, letter e), of the Constitution and art. 3, para. 1, of the Constitutional Law 26 February 1948 (Special Statute for Sardinia), on a question of constitutional legitimacy of the law of the Autonomous Region of Sardinia 16 September 2019, n. 16, "*Second budget change. Health provisions*".

This provision provides that "*the Region is authorized to fund annually AREUS for activities performed by associations and social cooperatives agreed*

with the emergency-urgency service '118'. The expenditure is quantified in euro 5.000.000 for each of the years 2019, 2020 and 2021 (Mission 13 – Programme 02 – Title 1). From 2022, the financing of the same expenditure is provided for in accordance with article 38, paragraph 1, of the Legislative Decree 23 June 2011, No. 118 (Provisions on the harmonization of accounting systems and budget plans of the regions, local authorities and their bodies, pursuant to articles 1 and 2 of Law 5 May 2009, No. 42), and subsequent amendments and additions, within the limits of the annual budget allocated for the same purposes to Mission 13 – Programme 02 – Title 1 and the corresponding annual budgetary laws".

According to the State Attorney's Office, art. 1, paragraph 5, of the Sardinian Law no. 16 of 2019 would legitimize in a stable way the conventional instrument for the development of emergency-urgency service with respect to two types of entities of the Third sector specifically identified, or the nonprofit associations and social cooperatives. Furthermore, direct entrustment could only occur in cases where, by the specific nature of the service, it "*ensure the provision of services of general interest, in a system of effective contribution to a social objective and of pursuit of solidarity objectives, under conditions of economic efficiency and appropriateness, and in accordance with the principles of transparency and non-discrimination. Outside the conventional instrument, the public nature of the service contract would remain mandatory*".

By deed filed on 20 December 2019, the Autonomous Region of Sardinia has appeared in Court, claiming for the rejection of the appeal.

The Constitutional Court, with Judgment 26 November 2020, n. 255 rejected the appeal (and the raised question of constitutional illegitimacy of the recalled regional law, based on three orders of considerations:

""*the regional law at issue intervenes on the regulation of social and health services, in this case emergency and urgency services, with regards to which, as to the entrustment of the service, profiles concerning "the protection of competition" come up, especially when provisions in favor of Nonprofit organizations are introduced. Under Directive 2014/24/EU of the European Parliament and of the Council of 26 February 2014 on public procurement, it remains up to the Member States to decide whether or not they wish to take part in activities with a high social value, an organizational model inspired not by the* principle of competition*, but by that of* solidarity*, which may provide for entrustment through methods outside the public procurement regime or in any case through a lighter system of public evidence. Moreover, Considering No. 28 and art. 10, letter h) of the Directive exclude from its scope certain specific services provided by Nonprofit organizations and associations, including emergency-urgency medical transport;*

Among the alternative means for entrusting social services is certainly the convention (provided for by art. 1, paragraph 5 L.R. challenged). So already art. 7 of the Law 11 August 1991, n. 266 (Framework Law on volunteering) and art. 30 of the Law of 7 December 2000, n. 383 (Discipline of associations for social promotion), regulated the agreements with Voluntary organizations and Associations for social promotion. As regards the Social Cooperatives, the discipline is found in the Law of 8 November 1991, n. 381 (Discipline of social cooperatives). Art. 57 of the Code of the Third sector, instead, provides the option for the administrations to entrust the service of 'emergency and urgent medical transport'*, in priority and through direct agreements, to only Voluntary organizations. It is here relevant that, with reference to the Social Cooperatives, the Code of the Third sector provides that they remain governed by Law n. 381 of 1991 (art. 40), adding that the provisions of the CTS apply to Third sector institutions* 'only' *as compatible and not derogated from this framework (art. 3, paragraph 1);*

Regional legislation, in short, has intervened to regulate, within the above-outlined regulatory framework (State competence), the entrustment of the 'emergency and urgency service by convention' *to Third sector entities other than Voluntary organizations. In this sense, art. 1, paragraph 5, of the Regional Law Sardinia n. 16 of 2019 is not suitable to affect art. 57 Code of Third Sector, which if anything would have intervened on the aspects regulated by the pre-existing regional legislation*".

Finally, it is important to point out (third *Case Study*) the Judgment of the Council of State, Third Section, 16 November 2020, n. 7082, which resolved – taking into account the indications of the EU Court of Justice referred to above – the incidental question concerning the "*rescue and medical transport service*" and in particular the one concerning the entrustment of the service of medical transport of patients in ambulance and hemodialyzed on the appeal proposed by ULSS 6 Euganea and the University Hospital of Padua against the Pia Opera Croce Verde, also of Padua.

In the light of the above-mentioned European, national and regional legislation and the case law of the EU Court of Justice (C-11/19), the Council of State has noted the following:

"a) (point 10.6.1.) *art. 1 of the L.R. Veneto n. 26/2012 has given 'to health organizations and associations authorized and accredited the possibility to contribute to the performance of the activities of emergency transport and intrinsically health; art. 5, paragraph 1, of L.R. 26/2012 provides that 'The rescue and emergency transport activity is carried out by the companies ULSS, as well as by the entities listed in the regional list referred to in art. 4'; on its side, para. 5 of this*

provision states that: 'If the activity of medical transport for relief and emergency cannot be ensured by the persons registered in the regional list referred to in article 4, the ULSS companies may entrust it, in return for public recognition of the persons identified through public competition procedures, In compliance with the provisions of existing state and European legislation on public contracts, meeting the appropriate requirements to ensure adequate levels of quality and enhance the social function of the service'.

b) (point 10.6.2.) *Consequently, the ULSS has the power to directly manage the transport service in question, or to use the other public entities referred to in art. 4 of the same Act;* only *when the* 'rescue and emergency medical transport' cannot *be carried out by such entities, the ULSS authorities may entrust it to public tender procedures, as provided for in art. 5, paragraph 5, of L.R. 26/12, providing the reasons for this decision".*

In conclusion, for the reasons set out above, the Council of State has upheld the incidental appeal, in the residual part.

Possibly the subject of health transport, either "*ordinary*" or "*emergency*" – although already addressed and ruled in judicial proceedings at the highest level by administrative, constitutional and euro-unitary justice – will reserves new issues in the future, especially in terms of the corresponding management of health care expenditure, whether limited to "*reimbursement of expenses*" or extended to the strict evaluation of "*living costs*" and to the comparison of offers according to market rules, balancing the requirements of competition and solidarity, in order to identify the best administrative procedure to be adopted.

As already warned in Cap. 8, on the L.R. n. 9/2024 which requires the participation of all economic actors (public, private accredited, for-profit enterprises, benefit corporations and Third sector entities), in the organization of the "integrated system of interventions and social services" (art. 7), even in this area it seems desirable a greater harmony of rules, which ensures efficiency and quality of service provided, respecting the principles of universality, solidarity, economy, appropriateness and, above all, the general interest.

11.
THE "AZIENDA ZERO", THE "PERMANENT ASSEMBLY OF CITIZENS AND PATIENTS" AND THE "PARTICIPATORY HEALTH EXECUTIVE BOARD"

11.1. *Nature and functions of the "Azienda Zero"*

We have made already reference to the "Azienda Zero" Authority and to the regional law that established it (L.R. 25 October 2016, No. 19) in Chapter 5, about the reorganization of the organizational system of the SSR Veneto.

It is necessary to describe more in depth its role and responsibilities, also in the light of the integration processes of health and social services of the Veneto Region, which have seen an important acceleration in recent years.

"Azienda Zero" has the nature of a public body and – as established by art. 1 of its founding law – as mission the "*rationalization, integration and efficiency of healthcare services, social and technical-administrative services of the regional health service [based on the pursuit of the development of SSR] on participatory modalities based on paths marked by maximum transparency, responsible sharing, respecting the principle of efficiency, effectiveness, rationality and affordability in the use of resources in order to continue to ensure equitable access to services*".

The Authority is entrusted with the following tasks in order to carry out its mission:

(a) Centralized Health Management (GSA) according to the directives issued by the Regional Government;
(b) the management of cash flows relating to financing regional health needs;
(c) the keeping of GSA records;
(d) the preparation of the budget and balance sheet of the GSA and its annexes, on which the "Health and Social Security Area" appoints the visa of congruence;
(e) the preparation of the consolidated balance sheet and balance sheet of the Regional Health Service and its annexes, on which the Area of Health and Social Services affixes the visa of congruence;

(f) the accounting guidelines of ULSS and other regional health service bodies;
(g) the management of technical and specialist activities for the system and for the regional health service, including, by way of example without being exhaustive, centralized purchasing with due regard to quality, cost-effectiveness and clinical specificity, after evaluation by the Regional Commission for Investment in Technology and Construction (CRITE); technical support to management training and regional clinical risk; accreditation procedures ECM (Continuing Education in Medicine); information technology infrastructures, connectivity, information systems and data flows in a view of the homogenization and development of the ICT system; technical services for the assessment of health technology (HTA); the activation of the electronic health record – FSE;
(h) the direction and coordination of the Public Relations Offices in health and social care matters, at ULSS sites.

To this end, the Authority has 6 Complex Operating Units:

- UOC Autorizzazione all'Esercizio e Organismo Tecnicamente Accreditante (COU Operating Authorization and Technical Accreditation Body), whose mission is to ensure uniformity of evaluation throughout the regional territory, ensuring transparency in the management of activities, the third-party nature of the body itself in carrying out its functions and the unification of processes for improving the system of services offered to citizens, as a "*continuous*" instrument of government;
- UOC Formazione e Sviluppo delle Professioni Sanitarie – FSPS (COU) Training and Development of Health Professions), whose mission is to support and disseminate the culture of training and ECM, integrating it with the organizational and welfare models developed by the programming of the Regional Health System (SSR). It is responsible for the entire ECM accreditation process of public and private providers in the Veneto region, monitoring specific training activities and managing critical aspects, through the competent support of its professionals;
- UOC Governo Clinico (COU Clinical Governance), whose mission is to carry out clinical organizational coherence assessments of care activities, identifying organizational reference standards and proposing improvement objectives. It monitors the welfare network with particular reference to the adherence between the services provided and the role assigned to the structure by the regional programming;
- UOC Rischio clinico (COU Clinical Risk), whose mission is to operate in a logic of governance of all activities aimed at prevention, monitoring and

risk management related to the delivery of healthcare services as well as the appropriate use of structural, technological and organizational resources);
- UOC Screening (COU Screening), whose mission is to conduct oncological screening, hepatitis C (HCV) screening, health surveillance of the population exposed to PFAS ("*Per-and polyfluoroalkyl substances*"), enforcement of legislation on production, trade and use of plant protection products, enforcement of regulations on REACH ("*Registration, Evaluation, Authorization and Restriction of Chemicals*") and CLP ("*Classification, Labelling and Packaging*");
- UOC Servizio Epidemiologico Regionale (COU Regional Epidemiological Service) whose mission is to support regional health and social care planning, through the feeding and maintenance of the Regional Mortality Register and several Pathology Registers, and the production of indicators and technical reports on population health.

In essence, "Azienda Zero" is the technical-administrative support and the financial monitoring body of regional health policy, which highlights opportunities and criticalities, with a view to development and integration.

Tables 14 and 15, reflecting respectively the analyses of the Ministry of Economy and Finance (Local Authorities – Health Profit and Loss Account) and of the Bank of Italy (The Economy of the Italian Regions – State of the so-called "*fiscal balances*"), and Figures 20 and 21, which show the trend of regional health expenditure, both as a guarantee of the provision of LEAs and of the unity of health protection, are a proof of this process.

11.2. *The Permanent Assembly of Citizens and Patients*

To complete a path that includes the strengthening and exploitation of an informed participation of citizens' and patients' organizations in activities related to the planning and evaluation of health services at regional level[1], and

[1] Reference is made to the Health Pact 2019-2021 between the Government and the Regions, approved by a Memorandum of Understanding pursuant to art. 8, para. 6, of the Law of 5 June 2003, n. 131, which constitutes a financial and programmatic agreement, of three years duration, on the expenditure and programming of the Servizio Sanitario Nazionale – SSN (NHS). In this act, it was agreed, inter alia, that the "*to promote the development of projects on a regional and/or ULSS basis, with the objective of improving [...] citizen involvement through the implementation of inclusive participation practices on relevant subjects, results-oriented in terms of both* 'outputs' *and* 'outcomes', *which can be accountable to the citizens themselves*". On these premises, with the D.G.R. 31 July 2023, No. 925 was approved the scheme of collaboration agreement between the Region of Veneto, the Catholic University of the Sacred Heart (UCSC), in Rome, at which operates the University Training Laboratory called "Patient Advocacy Lab" (PAL), the School of Economics and Management of Health Systems (ALTEMS), and "Azienda

the corresponding development of managerial skills in patient advocacy and patient engagement for those working in the context of public institutions, the Veneto Region has considered necessary to define an organizational model that offers the operational instruments to make this participation effective.

In this context, with the D.G.R. 10 October 2023, n. 1227, the Veneto Region has established the "Permanent Assembly of citizens' and patients' organizations", assigning the function of investigative support, technical, methodological and organizational support to the Permanent Technical Group for project design of the "*Coordinated System for the evaluation and quality enhancement of the regional social health system (SSSR)*"[2], already established at Azienda Zero Authority with D.G.R. No. 49 of 2022 (point 2. of the Regional Government Resolution). The Assembly is the stable forum for comparison between the organizations themselves, that is the broadest expression of involvement of the stakeholders of the Regional Health System (SSR).

At the same time (point 5.), the "*Organizational model for the active participation of citizens' and patients' organizations in the planning and evaluation of the Regional Health Service*" was approved, as specified in Annex A to the D.G.R.

The above mentioned organizations participating in this programme have the following characteristics:

1. be registered in the National Single Register of the Third Sector (RUNTS);
2. be operational in the territory of the Veneto Region;
3. have a minimum of ten associates;
4. carry out the activities referred to in letter b ("health interventions and services") or letter c ("health and social care services") of art. 5, para. 1 of the D. Lgs. 117/2017 – Code of the Third Sector, as provided for by its statute and as stated in the application for registration to RUNTS as activities actually exercised;

Zero" Authority, where the Permanent Technical Group to support projects developed within the "Coordinated System for the quality of the Regional Social Health System (SSSR) is established.

[2] The Permanent Technical Group of support to projects developed within the "*Coordinated System for the Evaluation and Valorization of quality of the Regional Social Health System (SSSR)*" has functions of implementation of the projects, return of results, definition and development of instruments of support. In particular, the GTP instructs and manages the procedure for the accession, verification and maintenance of the requirements of the Third Sector Entities that join the Assembly; prepares the annual report of the activities of the Assembly and transmits it to the Executive Board; supports the Third Sector Entities in their active participation in the Assembly and its regular and continuous functioning; provides the necessary investigative, technical, methodological and informative support to the Assembly (See point 3. D.G.R. 25 January 2022, n. 49 and the Resolution of the General Director of Azienda Zero on 14 June 2024).

5. not to have, among the members of the management bodies, staff employed by units and entities of the SSR of the Veneto Region.

The Assembly shall have the following functions:

(a) elaboration of contributions on topics, measures, programmes or activities for which the Health Management Board of the Veneto Region considers it useful to obtain proposals, opinions and observations from the organizations themselves;
(b) Comparison and synthesis of instances, themes or activities aimed at improving the SSR that may emerge from individual organizations and that can be proposed to the attention of the Executive Board;
(c) election of their representatives who join the Executive Board;
(d) identification of the representatives called to be part of the Thematic Tables of the different Directorates of the Health and Social Area[3] .

With successive resolutions (DDG) of the General Director of Azienda Zero 14 June 2024, n. 340 and 16 June 2024, n. 389, 111 "citizens' and patients' organizations" were identified that are eligible to participate in the Executive Board.

Although the Assembly does not represent a "*unicum*" of institutions of this type in Italy[4], the model of "*Participatory Healthcare*" of the Veneto aims at promoting a "*continuous*" comparison between regional institutions and Third sector entities, ensuring a concrete contribution in the definition of "*Therapeutic Diagnostic Care Pathways*" (PTDA) and other health services (Petrangolini, 2024).

This approach, which is characterized by its pragmatism, is also evident from the D.G.R. 23 September 2024, n. 1108.

With it, the Veneto Region accepts the Agreement between the Government, the Regions and the Autonomous Provinces of Trento and Bolzano, approved at the Conference State-Regions, on the document "*The role of Voluntary associations, of patients and civic activism in cancer networks*" and identifies the CRAO (Regional Coordination for Oncology Networks) as a useful reference structure, both in order to identify ways of implementing the involvement of

[3] The Health and Social Area ensures coordination and development in the field of health and social care policies, according to the competences attributed to its General Director by art. 1, para. 4, of the L.R. n. 23/2012.

[4] By Resolution of 15 October 2019, No. 736, on "*Role and means of participation of citizens' organizations in the planning and evaluation of Regional Health Services. Act of direction*", the Lazio Region (B.U.R. Lazio 29 October 2019, n 27) has constituted the "*Assembly of Citizens' Organizations*", which represents the public mean of comparison with the organizations themselves, in the definition, monitoring and improvement of regional health policies through its convening at least once a year. With the Decree of the Regional Government of Campania 9 June 2021, No. 303 was approved similar Act of Direction bearing "*Role and means for participation of citizens' organizations in the planning and evaluation of regional health services*".

patient associations and civic activism in the oncology networks already in place, and to support the Executive Board of the Veneto Region "*Participatory Health Care*" on this specific topic.

11.3. *The Participatory Health Care Executive Board*

To complete the picture of the components of the model of "*Participatory Health Care*" of Veneto region, with the same resolution D.G.R. 10 October 2023, n. 1127 (point 4.) was established the "Executive Board" which, to use the same words of the measure, constitutes "*the institutional forum for comparison between public institutions active in the health and social care field and citizens' and patients' organizations, which guarantees the involvement and active participation of the latter in the construction and improvement of the Regional Health Service*".

The following are full members:

- the Health Assessor – Social Services – Social and Health Planning of the Veneto Region;
- the Director-General of the Health and Social Services Area;
- the Directors of the services responsible for regional assistance planning:
- the Director of the Directorate for Health Planning;
- the Director of the Directorate for Social Services;
- the Director of Dependencies, Third Sector, New Marginalities and Social Inclusion;
- the Health Director of "Azienda Zero" Authority;
- two Directors-General of health care Units (ULSS) representing the Units (or their delegates);
- ten Representatives of the Permanent Assembly of Citizens' and Patients' Organizations.

Other regional leaders and/or professionals with expertise in specific topics of discussion may also be invited to participate in the Executive Board.

The ten representatives of the Permanent Assembly of Citizens' and Patients' Organizations who join the Executive Board are elected on the following basis:

- a representative of ETS also articulated on a regional basis that carry out the activities referred to in letter b ("*health interventions and services*") of art. 5, para. 1, of the Code of Third Sector (CTS);
- a representative of ETS also articulated on a regional basis that carry out the activities referred to in letter c ("*health and social care services*") of art. 5, para. 1, of the Code of Third Sector (CTS);

- five representatives of ETS who carry out the activities referred to in letter b ("*health interventions and services*") of art. 5, para. 1, of the Code of the Third Sector, at least with provincial territorial representativeness;
- three representatives of ETS who carry out the activities referred to in letter c ("*health and social care services*") of art. 5, para. 1, of the Code of the Third Sector, with the same characteristics of representativeness as in the previous subparagraph.

The representation of organizations providing direct assistance to patients, both social and health care, must be guaranteed among all representatives of the organizations.

The representatives of the Assembly in the Executive Board remain in office for three years.

The Executive Board (point 5.) performs the following functions:

- consult the Assembly on matters, measures, programs or activities for which it considers appropriate to take a position by making proposals, opinions, comments or contributions;
- involves the Assembly in evaluation and monitoring of health and social health activities at regional level providing evidence of its results and promotes the involvement of citizens' and patients' organizations at company level (AOU, AOUI, ULSS, IOV);
- promotes the involvement of citizens and patients represented in the Assembly, taking into account the regulatory indications in specific areas, tables and working groups already established or to be established at regional and company level, In particular, in the area of planning services to the citizen and in the activities of clinical networks and regional coordination;
- involves the Assembly in co-designing interventions and acts in health and social health;
- acquires and evaluates the requests made by the Assembly, valuing them, where appropriate, in the planning acts and in the drafting and subsequent application of documents with a technical health content.

The involvement of the organizations is always expressed through representatives of the Permanent Assembly of citizens' and patients' organizations in the Executive Board.

The "U.O. Monitoraggio e controllo attuazione PNRR" (Operational Unit for Monitoring and control implementation PNRR) at the Health and Social Area of the Veneto Region, performs functions of Organizational Secretariat of the Executive Board.

Compared to the models offered by the regions of Lazio and Campania,

the Veneto model presents a "*corporate*" approach to the "*Participatory Health Care*", which seems to emulate the organizational structure prepared by art. 11 of the Decree on social enterprise (D. Lgs. 112/2017 – DIS), concerning the "*Involvement of workers, users and other interested parties in activities*", which requires these entities to provide "*in the company regulations or statutes appropriate forms of involvement of workers and users and other parties directly involved in their activities*" (para. 1), by regulating in particular:

"*a) the cases and modalities of participation by workers and users, including through their representatives, in the assembly of associates or members* (in the Veneto model, the Permanent Assembly of citizens' and patients' organizations);

b) *in the most important social enterprises* (*alternatively, having two of the following parameters: assets exceeding 5,5 million euros; revenues from sales or services 8,8 million euros; employees employed during the financial year: 50 units*), *the appointment by the employees and, where appropriate, the users of at least one member of both the administrative body and the supervisory body*".

The Permanent Assembly, then, is not just a "forum" gracefully granted to Third Sector entities to assist with their proposals and initiatives the innovation and development processes of SSR or to signal critical situations in order to protect the health of citizens and patients, but plays a driving role on issues, measures, programmes or activities concerning SSR, participating in the co-design of interventions and acts as well as – through the representatives of the Stakeholders – entering the "*button room*", i.e. in the Executive Board.

It could be observed that a system, so to speak "*complete*", would have provided for at least one representative of citizens and patients also in the Regional Control Unit (D.G.R. 30 December 2010, n. 3444, All. A, par. 5.1): a "*super partes*" supervisory body of the activities carried out and a guarantee of the proper functioning of the SSR, appointed by Decree of the Regional Secretary General for Health and chaired by an expert nominated by the region, which is composed of 10 members: five from public bodies and five proposed by the most representative associations of the private sector, all identified based on experience gained in the field of controls.

The NRC performs the following functions:

- to prepare and/or update operational guidelines on the monitoring and assessment of the appropriateness of health services, normally once a year, in accordance with regional health policy guidelines and in line with scientific and technological developments;
- to verify the adequacy and appropriateness of the Annual Internal and External Control Plans and proceed to their approval;

- to settle any outstanding disputes and conclude the examination in time for the establishment of the financial statements, provided that the obligations of safeguarding the treasury are respected, expressing a judgment without appeal, without prejudice to the obvious differences in coding with regards to specific regional directives;
- to acquire further information on specific situations arising from the analysis of data contained in the regional archive of hospitalization and outpatient specialist activities provided by public, private accredited establishments and equivalent providers, from the reports of the "UOC Ispezioni sanitarie e socio-sanitarie di Azienda Zero" (COU Health and Social Care Inspections of Azienda Zero Authority) or regional structures and autonomous considerations by the NRC itself;
- carry out comparative analyses on the results of the controls of individual ULSS, Hospitals, IRCCS, and private accredited companies.

Agreement on unresolved issues is reached by a simple majority of the present people.

The Regional Control Unit is also responsible for monitoring the application of the regional regulations on controls, including those relating to economic benefits, by communicating promptly with the competent regional structures, any problems/criticalities detected; this in order to allow the regional administration to make the health control system more clear, uniform and transparent[5].

It could be argued, on the contrary, that the afore mentioned body for monitoring and assessing the appropriateness of health care services has already a sufficient number of "*representatives proposed by the most representative associations in the private sector*" and that the formula does not exclude entities of the Third Sector which, pursuant to art. 4 of the CTS are, precisely "*private entities*", but an addition to the provision of the D.G.R. 3444/2010, would probably have given the plant of "*Participatory Health Care*" a greater incisiveness.

[5] See *https://salute.regione.veneto.it/web/controlliattivitasanitaria/funzioni-del-nucleo-regionale-di-controllo.*

12.
THE ROLE OF NONPROFITS IN THE HEALTH CARE SYSTEM OF VENETO REGION

12.1. *The Values and the Value of the Third Sector in Veneto Health Care*

What is the value of the Third Sector in the Veneto Health Care?

Available and up-to-date data are summarized in Tables 25 and 26, in the Appendix.

They concern the "values": accounting and tax collected and processed by Azienda Zero and the Regional Revenue Directorate – DRE Veneto, with different criteria, depending on the institutional mission to which the two bodies are assigned: the first, in charge of collating data on the activity flows of "health interventions and services" related to essential levels of care (LEA), also in function of monitoring regional health expenditure; the second, aimed at checking data relevant for tax collection purposes, but also to manage the "Search engine of the list of registered voluntary organizations" which, as recently stated by the Tar Lombardy, remains in charge until the European Commission has granted the authorization referred to in art. 101, para. 10, CTS[1] .

Regarding the interpretation of the data, we should recall the methodological premise made at the beginning of this survey (Chapter 1, para. 1.1), in which we pointed out that only the entities of the Third Sector with a total of "*revenues, rents, income or other revenues of any kind*" exceeding 1 million euros are "*required to publish on their website the social balance sheet*" (art. 14, co. 1, CTS). For all the others, the research is quite complex and precisely for this reason the reading of the results is not always univocal, also because the data have been collected for different purposes.

We tried to relate them to each other, to respond the initial question.

In this respect, Table 25, relating to the 2022 annuity only, takes into account the entities of the Third sector included in the list of suppliers of the SSR

[1] See Tar (Administrative Regional Court) Lombardy, Section II, 1 October 2024, No. 2533.

Veneto, resulting from electronic invoicing, which under the "*health interventions and services*" (art. 5, para. 1, lett. b) CTS) have lent their activity to the Veneto SSR in its various articulations (Hospitals, IRCCS, ULSS) limited to the achievement of "*essential levels of care*" – LEA.

It should be warned that in the list provided by Azienda Zero the entities accredited and registered with RUNTS, in 2022, constituted a small percentage. On the other hand, in the list of suppliers released by Azienda Zero were also included entities with no domicile for tax purposes in the Veneto Region and yet relevant for Azienda Zero: that's because also their services affected the overall health care expenditure[2].

It was nevertheless considered useful to acquire the aggregated data presented in Table 25 for two reasons:

- firstly, because the amounts of benefits shown in Figure 25 includes the entire private sector (for-profit, for-profit "*accredited*" and not-for-profit);
- secondly, because the amounts indicated only refer to the "*regional tax rate*" applied in reference to "*hospitalizations*" and "*specialized treatments*".

It is, in short, a partial data, both subjectively (it does not include all the Third sector engaged in Veneto Health, and not all the ETS that appear as "suppliers" are necessarily located in Veneto), either objectively (values also exclude contributions or donations received from public or private bodies, or credits resulting from participation in the "*5 per thousand*" system, and so on).

Table 25 includes the same entities – 588 – marked in red in Table 18 by Azienda Zero but, with the help of the Italian Revenue Agency, it shows the aggregated data related to accounting and tax values resulting from income tax and VAT returns (data not in the possession of Azienda Zero).

The resulting values are those reasonably expected: compared to the total of "regional tax rates" recorded in Figure 25 under "PRIVATE/NON PROFITS", totaling 935.646.550 euros, Table 25 shows a total Revenue (Revenues) of 2.125.869.676 euros, a turnover for VAT purposes of 2.125.615.419 euros and under "Income" a total of 67.158.245 euros. It should be noted that this last item does not include, under art. 79 CTS:

(a) funds received as a result of public collections made occasionally, including through offers of goods of modest value or services to financiers, in conjunction with celebrations, anniversaries or awareness campaigns;
(b) contributions and grants made by public authorities for the performance, whether under contract or accreditation, of scientific research activities of

[2] See Figures 20 e 21, Mission 13, Program 01 "SSR – Ordinary Funding for the LEA Guarantee".

particular social interest and sums derived from activities carried out free of charge[3]; or against payment of fees that do not exceed the actual costs, also taking into account the economic contributions of the entities referred to above and subject to any share in the expenditure provided for by the law.

The same entities have recorded "Tangible assets" [(1) land and buildings; 2) plant and machinery; 3) hospital facilities, outpatient and commercial equipment; 4) ambulances and other vehicles for medical transport; 5) other ongoing assets and advances] for 918.199.390 euros.

Table 26 was instead entirely made by the Italian Revenue Agency, on data pertaining to entities of the Third Sector which, independent of their registration with RUNTS:

(a) have their own "tax domicile" (registered office) in Veneto:
(b) carried out as an exclusive or predominant activity declared a "sanitary" activity, such as classified according to the "ATECO" Codes[4].

Table identifies 8 categories and it is necessary to warn that at least three of them, indicated by the double asterisk, operate within hospital or outpatient structures, as functional to the more general activity of "*health interventions and services*".

They are highlighted because the operators themselves have a VAT number.

The category marked with an asterisk ("*Hospitals and long-term care homes*") includes actual hospital structures and does not coincide with the known acronym "RSA" (Nursing homes) which, in Table 18, are designated by the term "ELDERLY" for a total of 502, compared with the total recorded in Table 26, which is only 9.

The total of ETS thus identified is 1.735, compared to 588 resulting from the findings on electronic invoicing relating to health care services as a guarantee of LEAs, released by Azienda Zero.

[3] These sums must be recorded in the VAT return if they are subject to tax and contribute to turnover. Even if they relate to services rendered by volunteers, they contribute in any case to the determination of the so-called "*imputed costs*", to which the social security and insurance coverage of the volunteers must be related. These "costs" are called "*imputed*" because the organization does not "*pay*" for the service provided; in front of these "costs", the revenues "imputed" themselves, must be recorded in the management report, because at the same time the volunteers offer their activity, although free of charge. The circumstance also explains the differences found between the values resulting in Tables 25 and 26 under the item "Revenues".

[4] The acronym "ATECO" derives from the initial letters "AT" of Activity and "ECO" of Economic. In other words, it represents the economic activities nomenclature (NACE) created by Eurostat. The ATECO codes are an alpha numeric combination, which identifies an economic activity. Letters and numbers have a different value: the letters identify the macroeconomic sector to which that specific activity belongs. The numbers represent categories and sub-categories of sectors. ATECO codes are a category approved by ISTAT (National Institute of Statistics) in 1991 and updated in 2007 in close collaboration with the Italian Revenue Agency, Chambers of Commerce and other bodies, ministries and business associations.

Having made these clarifications, we can examine the data related to the period 2021 – 2023, considered by this survey because immediately following the pandemic emergency from Covid-19.

The value of "Revenues" is decreased from 1,102 billion euros (2021) to 1,061 billion euros (2023), and that of "Costs" from 1,027 billion euros (2021) to 1,008 billion euros (2023). The total of "Assets" increases from 152,3 million euros (2021) to approximately 152,9 million euros (2023).

Whatever you want to interpret them, these data attest the accounting and tax "values" of the ETS that contribute to the "SSR – ordinary fund for LEAs guarantee", which cover a range from 10.5% (Table 26, year 2023) to approximately 19% (Table 25, year 2022) of regional health expenditure, as highlighted in Figure 20, "Mission 13, Program 01".

Continuing the survey on the "values" of the Third sector in "health" in Veneto Region, it has already been said that it holds only 4,3% of accredited hospital structures, but two out of four IRCCS belongs to Nonprofits (Table 20). Thet also manage 13 "*proximity*" outpatient or multi-patient structures, including one mobile unit (Table 22).

The Voluntary organizations (505 in all), which are an essential part of it are engaged in all the Venetian ULSS, in the University Hospitals and in an IRCCS (Table 24).

In the hospitality services (Chapter 8, para. 8.2.), Voluntary organizations, mostly affiliated to Religious Institutions, run all the existing shelters, providing free services to the relatives of patients or ensuring, by agreement with the municipalities concerned, exemption from paying the tourist tax.

In the emergency and medical transport, the total of Nonprofits amounted to 91 units, with a revenue of 19,868 million euros in 2023.

These, in brief, the "*values*", i.e. the figures of the Third sector in "Health Care" in Veneto.

But what is its overall "*value*", i.e. the social impact it produces on public institutions, donors and, above all, patients and their families, in a word on the audience of "*Stakeholders*"?

Starting with the two IRCCS managed by ETS – Medea and Don Calabria – which have a total of one hundred researchers in rehabilitation medicine – suffice to mention that only in the period 2018 – 2020, the first one produced no. 2.046 rehabilitation projects and 6.027 functional profiles ICF, 405 scientific publications and signed memorandum of Understanding with the Children's Hospital Medical Center of Cincinnati and with Yale University (U.S.A.), with King's College London and the University of Reading (UK) (Chapter 6, para. 6.2.2).

In terms of "*Health interventions and services*", the Hospital Don Calabria has recorded a total of 30.650 admissions in 2022, including 1.404 for the discipline "*tropical infectious diseases*" and 29.900 admissions in 2020, with 22.450 surgical procedures, while outpatient services amount to 1.318.401 in 2022 and 1.340.914 in 2023 (data provided directly by the Institute in a note of 20 November 2024).

The ETS outpatient networks (Table 22) treated more than 40.000 people free of charge from 1998 (oldest data) to 2022, with a historical average of 5.575 patients per year and a total of 6.582 actual patients in 2022.

These are people, Italians and foreigners who, for various reasons, could not have benefited from the SSR (see Chapter 7), although the regional legislation (L.R. n. 9/1990 and D.G.R. 26 July 2021, n. 1030 on combating poverty) ensure full equality of treatment in health care for all people concerned. It was also found that the provision of these services and the preparation of the related organizational apparatus have contributed to the monitoring of the actual state of health of the population living on the territory, what appears to be an undoubted element of evaluation of the social impact constituted by the Third sector in the health sector of the Veneto Region.

But the "*value*", i.e. the social impact of the action taken by the entities of the Third sector is given, as in the other countries whose experience we have reported above, most of all by the witnessed ability to grasp the "*unmet needs*" of the communities of citizens and patients to whom they are addressed.

It depends not on the professional deontology, ethical code, logic of profit or gift of the respective operators, but from the peculiarities that their mission, as written down in the respective statutes, manages to express and from the "*human-to-human*" approach which represents, at the same time, the cornerstone of their action and the essential element of an "*integrated*" and "*participatory*" health care system.

12.2. *NPOs and the cost/effectiveness for the SSR Veneto*

From the beginning of our survey we observed how the examined National Health Systems, however organized, are concerned with ensuring that all citizens-patients-taxpayers are protected in their health, understood as "*complete physical, social and mental well-being, not only the absence of disease or infirmity, but also as a resource that enables people to lead productive lives on an individual, social and economic level*" (WHO, 1948).

To achieve this objective, the States establish, in different ways, that a share of the health expenditure per capita is borne by the same affiliates, not only through general taxation, but through an additional burden for the use of a certain health care service or medical assistance (the so-called "*out-of-pocket*": see Fig. 3; 8 – 11).

In their action, however, the mentioned National Health Systems face three orders of problems:

- how to ensure that everyone has "*access to treatment*" at reasonable times and for a reasonable fee, regardless of where they are located throughout the country, which means first and foremost eliminating or at least drastically reducing "*waiting times*";
- how to monitor the actual "*degree of satisfaction*" of the needs for "*health interventions and services*" that citizens expect, and if this degree does not meet expectations, how to remove obstacles to their proper delivery (see Figure 16);
- how to combine the "*individual right to health*" with the "*public interest*" and therefore with the "*general interest*" in protecting the health of all the population administered, an interest which, by its nature, cannot ignore the protection of the health of foreigners and their inclusion in the provision of "*universal health coverage*" (WHO, 2024), i.e. access to essential services (basic medicines and vaccinations: see Figure 6, in the Appendix).

The effectiveness of an "integrated" model – public, private, nonprofit – such as that of SSR Veneto is measured by the response capacity it manages to provide to these orders of problems, especially when the responses must be sought at a global level (for example, in the case of a pandemic, such as Covid-19).

In such cases, the adoption of actions and the acquisition of resources agreed at supranational level is necessary, as happened with the launch of the "Next Generation EU" programme, intended for the Member States of the European Union, and, in accordance with the principle of subsidiarity, from them devolved to regional or local authorities: for example in Italy, through the "*National Recovery and Resilience Plan – PNRR*" and its "missions", aimed at removing obstacles to the achievement of the above mentioned objectives.

All this, in a context of the progressive aging of the global population, which highlights health needs not always "*met*" by the National Health Services, because considered less "*essential*" than others: chronic diseases, those related to dental care, almost never covered by the NHS, or mental health, various disabilities, etc.

This is reflected in the increasingly acute shortage of health personnel, es-

pecially in public hospitals and outpatient clinics, even in advanced economies (general practitioners or specialists, nurses, other health care workers: see Figure 29), and which affects some countries to a greater extent than others (OECD, 2024): among them Italy, immediately after Bulgaria, also for the retirement of entire generations of health care workers, because of age limits.

In addition, a recent investigation, conducted in Italy (Cort of Auditors, 2024) on the reduction of waiting lists related to health services not provided during the epidemiological emergency period from Covid-19 – problem whose solution was intended, among other things, a share of the "PNRR" funds – revealed that only 30% of those funds were spent by the SSRs and mostly used to close or reduce budget deficits rather than to reduce waiting lists.

Consider, for example the case of surgical admissions, shown in Table 27.

The blue box in the second column shows the total number of patients on the waiting list for surgery as of 1 January 2023. The pink box shows the interventions carried out during the same year (fifth column), the recovery rate compared to the programmed interventions (sixth column), but also the number of programmed interventions cancelled (seventh column).

The latter may mean three things: first, that the operations were not so urgent and patients preferred to postpone their execution; the second is that the interventions were actually not returnable but patients preferred to turn to private structures, accredited or not, or crowded the Emergency Departments hoping in hospital admission; the third and last possibility is that they have turned to the same public hospital structures, operating in the so-called "*free profession*" regime[5] to reduce waiting times, or to the nonprofit structures "*contracted*" with the NHS, where existing.

The eighth column shows the remaining patients on the waiting list as of 31 December 2023.

In this context, the Veneto region has fewer patients on the waiting list (9,441) than other regions with a similar number of residents and patients on the waiting list (10.667), although starting from a longer waiting list (45.673 vs 44.609) and having recorded a lower number of cancelled interventions (10.508) than those recorded by other regions with similar characteristics (15.913).

Table 28 refers to the "cancer screening" sector.

The status of waiting lists as of 1 January 2023 (blue box) is shown in col-

[5] The "*intramural free profession*" also called "*intramoenia*" refers to healthcare provided outside normal working hours by doctors of a public hospital ward, who use the outpatient and diagnostic spaces of the hospital itself, against a payment by the patient of a regional rate covering the entire cost.

umns 4 and 5 ("Invitations" to patients on waiting list and "Services" on list not yet provided at that date). In this box, the ordinary regions, including Veneto, which in the fifth column do not have patients on waiting lists are 10 out of 19.

The same regions did not register "Remainders" of patients on waiting lists for the whole year 2023 (pink box, third last column).

The evidences presented here are an example of the role – in terms of "*cost/effectiveness*" ratio – of the inclusion of Nonprofit organizations in the "*integrated*" and "*participatory*" health care model, operating in the Veneto region.

We have already reported the number of surgical interventions performed by nonprofit IRCCS in the period 2020 – 2022, to which is added the number of health care services also recalled.

But to these should also be added the number of patients – over 6.000 people a year, Italians and foreigners – in care at the network of ETS outpatient structures in Veneto, contracted with various ULSS or municipal administrations. These are entities that provide their healthcare services free of charge even in fields where public medicine often fails to reach, due to lack of personnel and means, and sometimes because of a lack of knowledge of the most disparate local realities: nursing services, including events on the prevention of sexually transmitted diseases, on nutrition, hygiene, management of chronic conditions, for individual patients or groups; dental care, including conservative-endodontic care, surgery, educational activities, oral hygiene ablation and education for individuals and groups; provision of ophthalmic lenses; health and social care guidance including language and cultural mediation, psychological listening desks; health education and training, "*transition-to-home*" after a long-term hospital stay[6].

Five hundred and fifty Voluntary organizations that regularly operate at the public hospitals, as registered by the various ULSS, following a convention or one of the various co-design, co-programming, and accreditation processes, which historically start from the health needs represented by the municipal administrations.

If to all this is added that the "Health Budget" of Veneto has been in surplus for more than a decade, it seems to be possible to conclude on the effectiveness of the model, according to the parameter "*cost/effectiveness*".

But there is even more: the model of "*integrated*" and "*participatory*" health care seems to have succeeded in involving the main beneficiaries of what every public health service should reach: the users.

[6] It is worth to represent that the Court of Auditors' investigation (table 31, p. 134) shows that the Veneto had 45.238 outpatient services on a waiting list, as at 1 January 2023, all performed during the year.

The Permanent Assembly of citizens and patients and the Executive Board of participatory health care mentioned above not only have the function of listening to the "*cahiers de doléances*" transmitted from the territory, but intend to make the "*stakeholders*", together with the managers and health professionals, the real protagonists of the system, with an instrument perhaps different but complementary to that of the democratic process, which manifests itself in the electoral vote: that of participation, an emblem of political, economic and social solidarity.

CONCLUSION

About 20 years ago, in her book "*Partners Not Rivals: Privatization and the Public Good*" Professor Martha Minow, eminent scholar of Nonprofit Organizations and Law at Harvard Law School, and Dean emeritus of the same School, asked herself provocatively if the overwhelming power that Charitable Nonprofits had acquired in the US economy – in the areas of education, justice, health and welfare programs, all historically attributed to the competence of the various levels of government and public administration enjoying various tax exemptions and benefits – were a threat rather than an advantage in the pursuit of the Public Good.

She also questioned herself whether, in the current situation, the public and private sectors should not be considered as competitors, since they are subject to different rules, both legal and economic, and whether Nonprofit Organizations should be regulated by rules different from those governing the formation of Government (electoral vote) and for-profit enterprises (the quest for profit, precisely, of which they are responsible to shareholders rather than voters).

Finally, she asked herself whether it would not be preferable to address the funds needed for the tax exemptions granted to the Third sector entities directly to Public Services.

It seems to be listening to the arguments that still fill the political and academic debate in Italy, especially on the Health Care subject, where there is a fear of a progressive race towards the privatization of sectors and rights to health established by internationally accepted principles (WHO Statute) as well as by our Constitutional Charter.

Professor Minow concluded in her book that public – private – Third sector partnership is far preferable, provided it results in effective collaboration, with clear rules and tasks and allow the participation of citizens – users to the choices that in concrete effect on their fundamental freedoms, access and quality of care.

Twenty years later, in his book "*How to Save the World in Six (Not So Easy) Steps. Bringing Out the Best in Nonprofit*", Professor David M. Schizer, an equally eminent scholar and lecturer, inter alia, of Nonprofit Organizations Law, at Columbia Law School in New York, of which he was the youngest and the longest-serving Dean, indirectly responding Professor Minow's question about the opportunity for Third Sector bodies to have a special discipline, highlighted that the true strength of Nonprofits is usually in their mission and goals, rather than in the budget they have, and finally in the ability to involve the Stakeholders, primarily the donors, in the activities they carry out.

He is echoed by Professor of Law and Medicine Jill R. Horwitz, Lecturer, inter alia, of Nonprofit Organizations Law at the U.C.L.A. – School of Law in Los Angeles that, in her article "*Threatening Nonprofit Hospital Tax Exemption. A Better Path Forward*" , published in the Journal of American Medical Association, on January 19, 2024, suggests that the solution is not to link tax exemption to free care by Hospitals run by Charitable Nonprofit entities, because this is not necessarily the best way for every Nonprofit hospital to promote health protection.

Rather, governments at different levels (State and local) can regulate the activity of nonprofit hospitals so as to avoid them being, even inadvertently, pushed to emulate their for-profit competitors or to transform themselves directly into for-profit hospitals, by reducing or eliminating non-remunerative services, or by increasing remunerative services, often unnecessary and costly. Giving local councils the opportunity to make informed decisions on how Nonprofit organizations can best promote their solidarity objectives is the best way to ensure that their hospitals behave in a manner consistent with their mission.

The above opinions are concretely confirmed by the survey carried out so far in the various National Health Systems examined and, in particular, in the Regional Health System of Veneto.

As we have seen, in the USA – where there is no public health protection system at Beveridge (UK) or Bismark (Germany) – the Third Sector controls 69.79% of hospitals and provides 74.26% of hospital admissions (Table 11 – 2019 data), but also in France, where there is a mainly public National Health System, the employees (employed or self-employed) of the private/non-profit sector employed in the Health sector represent 35% of the total (Table 7 – 2016 data).

In the UK, where the Beveridge system of public universal health coverage has been in place since 1948, two separate "*Health Care Acts*" (2012 and 2022)

have now introduced an integrated system of public – private – non-profit healthcare ("*Integrated Care Systems*" – ICSs) which in turn operate through dedicated structures called "*Integrated Care Board*s".

In Germany (Bismark model), the European country with the highest health expenditure, hospitals (about 1700 on the whole national territory), which are accessible only by prescription, except for emergencies, are divided into three categories: public (41%), private (28%) and non-profit (31%), mostly run by religious bodies or dedicated organizations such as the Red Cross (Flennert et al, 2019).

In other words: the private and Nonprofit sectors together own 59% of the existing hospital facilities in the national territory.

In Finland, which is the Nordic country with the greatest difficulties in providing health services, the private and nonprofit sectors play an important role, particularly in the field of outpatient care, mental health, orthopedic surgery, cardiology, gynecology – obstetrics and cancer care, including in dedicated hospital centers.

In Canada, the most promising initiatives seem to be those of "*integrated*" health care and public – nonprofit programs, tested in the province of Alberta, Western Canada, and presented at the 23rd International Conference on Integrated Health Care in Antwerp, Belgium, from 22 to 24 May 2023 (Lewanczuk, 2023). With a single health system divided into five administrative areas, the approach was to distribute functions and responsibilities at progressively smaller levels, in relation to resources and concrete possibilities of intervention, involving jointly the Third sector actors and their counterparts in the Public Health System. Joint committees, responsible only to members, have been set up to foster a common vision and coordinate their activities.

So, what about Italy? In Italy, as already noted (Chapter, para. 6.1.), of the 53 existing IRCCS – our hospitals of excellence for care and scientific research – 23 are public and 30 private. Of these, 4 (1 public and 3 private) are seated in Veneto (Ministry of Health – Health Research, 2024)[1].

It has also been seen as the progressive aging of the population, accompanied by the progressive shortage of medical and nursing personnel (either general practitioners or pediatricians of free choice, or employed in hospital and/ or outpatient structures) and the inefficiency in the organization of some regional

[1] *https://www.salute.gov.it/portale/ricercaSanitaria/dettaglioContenutiRicercaSanitaria.jsp?lingua=italiano&id=794&area=Ricerca%20sanitaria&menu=ssn&tab=2.*

health services has caused, over time, a progressive interregional mobility and not a few imbalances in the budgets of the regions with Ordinary Statutes.

In this context, it is to be commended that the SSR Veneto has tried to involve progressively all available resources, human and financial, in the production and delivery of health care, with initiatives cited, for example, even by the highest Health Organization (such the case of the Public Hospital of Treviso, beneficiary of a contribution of 250 million euros for the realization of 1000 beds in 21 years, co-financed by the European Investment Bank, through the "*ad hoc*" creation of a private entity: the "*Ospedal Grando Impact Investing*")[2].

All this by constantly keeping the health budget in surplus (Tables 14 and 15) and cancelling, or significantly reducing, the waiting lists (Tables 27 and 28).

The most important initiative, whose actual developments and results there will be a way to evaluate over time seems however to be that of the creation of an "*integrated and participatory Health Care system*", which has not only involved all possible economic and institutional actors in the planning, programming and delivery of health and social care, including Nonprofit organizations and private entities, starting with benefit corporations, but has also fostered the active participation of citizens and patients as a key factor.

And in this process, what is the role plaid by the Third Sector?

In the previous Chapters and in the Tables and Figures shown in the Appendix, taken from the data provided by the various components of the Health and Social Area of the Veneto Region and/or reworked by the Italian Revenue Agency, we have highlighted the numerical consistency in the services provided in hospital and outpatient structures, in hospitality services, in volunteering and solidarity, emergency and medical transport. The Third sector has allowed to cover areas not otherwise accessible by the Regional Health Service, providing its work, often free of charge, indistinctly to citizens and foreigners, thus contributing to their closeness to the Public Institutions.

The detractors will certainly have a way of saying that it is still a little thing, nothing more than a drop in the ocean. However – as Mother Teresa of Calcutta was used to say – if that drop was not there, in the ocean something would be missing.

[2] See WHO Regional Office for Europe, *Economic and social impacts and benefits of health systems. Report*, Copenhagen (DK), 2019, p. 21, in *https://iris.who.int/handle/10665/329683.*

REFERENCES

ARCHAMBAULT E., *The evolution of public service provision by the third sector in France*, in The Political Quarterly, Vol. 88 (3), 2017, pp.465-472, in *https://shs.hal.science/halshs-01598959*.

ADEBOWALE V. CBE, *The voluntary sector: a game-changer in integrated care systems*, in National Health Service Confederation Voices Blogs, 25 March 2022, disponibile in *https://www.nhsconfed.org/articles/voluntary-sector-game-changer-integrated-care-systems*.

AMATO G., BALBONI E., BASSANINI F., CAMMELLI M., CARLI M., *L'autonomia regionale "differenziata" e la sua attuazione: questioni di procedura e di metodo*, Astrid Paper n. 93, Aprile 2023, in *https://www.astrid-online.it/static/upload/fina/finale---autonomia-differenziata-pos-paper-17-aprilefinal.pdf*.

ANAAO – ASSOMED Veneto, *Osservazioni al Piano Socio Sanitario Regionale del Veneto 2019-2023*, settembre 2018.

ANTONELLI V., *Breve storia del Servizio sanitario nazionale*, in Amministrazione in cammino, 2010, n. 4, in *https://amministrazioneincammino.luiss.it/wp-content/uploads/2010/04/Antonelli.pdf*

BAI G, ZARE H, EISENBERG MD, POLSKY D, ANDERSON GF., *Analysis suggests government and nonprofit hospitals' charity care is not aligned with their favorable tax treatment*. in Health Affairs *(Millwood)*, 2021; 40 (4):629-636.

BIANCHERI G., *Il privato in sanità. La vera posta in gioco*, in Quotidiano Sanità, 16 gennaio 2023, *https://www.quotidianosanita.it/studi-e-analisi/articolo.php?articolo_id=110245*.

BIANCHERI G., FRANCESCHETTI L., VANNUCCI A., *La partecipazione dei pazienti e il ruolo delle comunità nella promozione della salute*, in Quotidiano Sanità – Studi e Analisi, 3 luglio 2023, in *https://www.quotidianosanita.it/studi-e-analisi/articolo.php?articolo_id=115166*.

BONIN M., CAMPOSTRINI S., MANTOAN D., *Riforma sanitaria in Veneto. Una strada per il Servizio Sanitario Nazionale?* in Scienza in rete, 13 ottobre 2017, disponibile anche in *https://www.scienzainrete.it/articolo/riforma-sanitaria-veneto-strada-servizio-sanitario-nazionale/mauro-bonin-stefano*.

BORZI N., *Sanità, il fronte caldo del Terzo Settore*, in "Valori, Notizie di finanza etica ed economia sostenibile", 28 aprile 2020, *https://valori.it/sanita-terzo-settore-non-profit/*.

CALABRESE E., *Veneto, così la governance della nuova Sanità*, in "Il Sole 24 Ore – Sanità", 31 ottobre 2016.

CAREY, D., HERRING B., LENAIN P., *Health Care Reform in the United States*, *OECD Economics Department Working Papers*, No. 665, OECD publishing, Paris Cedex, 2009.

CARRETTI M., BARASH A., CASTELLANA E., *Il Sistema Sanitario Francese*, in Salute internazionale, 22 maggio 2024, in *https://www.saluteinternazionale.info/2024/05/il-sistema-sanitario-francese/.*

CERATI F., *Dagli USA il modello sanitario non profit*, in "Il Sole 24 Ore – Salute", 17 luglio 2019.

CERGAS – Bocconi *Rapporto OASI 2023*, Osservatorio sulle Aziende e sul Sistema sanitario Italiano, Milano, novembre 2023.

CIGNACCO A., RIZZATO M., *Sistema sanitario: dal livello nazionale a quello regionale veneto*, 5 giugno 2018, in *https://www.altalex.com/documents/news/2018/05/31/sistema-sanitario-dal-livello-nazionale-a-quello-regionale-veneto.*

CONSIGLIO REGIONALE VENETO, *Piano Socio Sanitario Regionale 2019 – 2023*, settembre 2018.

COSTA G., DE LUCA F., *Il ruolo delle associazioni di volontariato nelle Case della Salute e nelle Case di Comunità: un approfondimento empirico, in* Autonomie locali e servizi sociali, 1/2023, pp. 101-118.

CUSINATO A., RIGOLI G., *Indagine conoscitiva sugli ambulatori medici del Veneto gestiti da Enti del Terzo Settore 2022*, Castelfranco Veneto, 2023.

CUTTAIA F.G., *La riorganizzazione della sanità in Veneto*, in "Federalismi.it", n. 14/2017, pp. 1-7.

DONATINI A., *International Health Care System Profiles – Italy,* 5 June 2020, in *https://www.commonwealthfund.org/international-health-policy-center/countries/italy.*

DUTTON B., HUMPHREY N., QUALTER P., *Getting the pieces to fit: NHS and third sector collaboration to enhance crisis mental health service provision for young people*, in BMC Health Services Research (2023), The University of Manchester (UK), *https://doi.org/10.1186/s12913-023-09198-w.*

ECCHER A., MARLETTA S., SBARAGLIA M., GUERRIERO A., ROSSI M., GAMBARO G., SCARPA A., DEI TOS P., *Digital pathology structure and deployment in Veneto: a proof-of-concept study*, in Virchows Archiv (2024) 485:453–460, *https://doi.org/10.1007/s00428-024-03823-7.*

ER. DI., *Spesa sanitaria: nel 2022 a carico degli italiani 40, 26 miliardi (+8,3%), la metà per visite e interventi*, in "Il Sole 24 Ore – Sanità 24", 21 dicembre 2023.

FAGGIANO I., *Assemblea permanente delle organizzazioni dei cittadini e dei pazienti, il Veneto si prepara a formare la sua 'squadra'*, intervista sul tema a Teresa Petrangolini, Direttore Patient Advocacy Lab di ALTEMS, Università Cattolica del Sacro Cuore – Roma, in Sanità Informazione – Advocacy e Associazioni, 15 febbraio 2024, *https://www.sanitainformazione.it/advocacy-e-associazioni/assemblea-permanente-delle-organizzazioni-dei-cittadini-e-dei-pazienti-il-veneto-si-prepara-a-formare-la-sua-squadra/*;

FANTOZZI R., GABRIELE S., *Il riparto del fabbisogno sanitario nazionale tra nuovi criteri e attuazioni incompiute*, in UPB, focus tematico n. 3, Roma 27 marzo 2024, pp. 1-32, *https://www.upbilancio.it/wp-content/uploads/2024/03/Focus_3_2024_Riparto-fabb_san.pdf*;

FATTORINI L., *Tempi di bilanci per la sanità britannica*, in Salute internazionale, n. 2/2024 in *https://www.saluteinternazionale.info/2024/02/tempi-di-bilanci-per-la-sanita-uk/.*

FLENNERT M., KÖNIG H. H., HAJEK A., *The association between voluntary work and health care use among older adults in Germany*, in BMC Health Services Research, 2019, in *https://doi.org/10.1186/s12913-019-3867-x*.

FRANCA S., *Le convenzioni con il Terzo settore tra gratuità del rapporto e regime dei rimborsi. Nota a Tar Toscana, 1° giugno 2020, n. 666*, in Impresa sociale, n. 4/2020, pp. 94-103;

FREEMAN R., *Working for Nothing: The Supply of Volunteer Labor*, 1997, 15 J. PUB. ECON. S140-S141.

FUOLEGA F., *Origini e storia del Sistema Socio Sanitario regionale*, maggio 2012, a cura della Segreteria Regionale per la Sanità Direzione Controlli e Governo SSR Veneto, in *https://www.regione.veneto.it/web/sanita/origini-e-storia*.

GHIOTTO M. C., RIZZOLO Y., GANDOLFO E., ZULIANI E., MANTOAN D., *Strengthening primary care: The Veneto Region's model of the Integrated Medical Group*, in "Health Policy", Volume 122, Issue 11, November 2018, Pages 1149-1154.

GIMBE, *Report Osservatorio GIMBE n. 1/2024. La mobilità sanitaria interregionale nel 2021*, Fondazione GIMBE, Bologna, 16 gennaio 2024, in *www.gimbe.org/mobilita2021.*

GLAZIER R. H., *Our role in making the Canadian health care system one of the world's best. How family medicine and primary care can transform-and bring the rest of the system with us*, in Can Fam Physician, 2023 Jan; Vol. 69 (1), pp. 11-16, *doi: 10.46747/cfp.690111*, also available in *https://pubmed.ncbi.nlm.nih.gov/36693751/.*

GOODAIR B., REEVES A., *The effect of health-care privatization on the quality of care*, in "The Lancet Public Health", March 2024, 9: e199–206, Department of Social Policy and Intervention, University of Oxford, Oxford, UK, in *https://doi.org/10.1016/S2468-2667(24)00003-3*.

HEINS E., PRICE D., POLLOCK A.M., MILLER E., MOHAN J., SHAOUL J., *A Review of the Evidence of Third Sector Performance and Its Relevance for a Universal Comprehensive Health System*, in "Social Policy & Society" 9:4, 515–526_Cambridge University Press, 2010, *doi:10.1017/S1474746410000230.*

HERRING B., GASKIN D., ZARE H., ANDERSON G., *Comparing the Value of Nonprofit Hospitals' Tax Exemption to Their Community Benefits*, in Inquiry, The Journal of Health Care Organization, Provision, and Financing, Volume 55, 1 – 11, 2018, Jan. Dec., also available in *https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5813653/.*

HINES J.R. Jr, HORWITZ J.R., NICHOLS A., *The Attack on Nonprofit Status:a Charitable Assessment*, in Michigan Law Review, 108, p. 1179 – 1220 (2010).

HORWITZ J.R., MEAD J., *Letting Good Deeds Go Unpunished: Volunteer Immunity Laws and Tort Deterrence*, 2008, Working Paper No. 08-009, pp. 1-42, in *https://michigan.law.umich.edu/*

HORWITZ J. R., NICHOLS A., *Hospital Service Offerings Still Differ Substantially By Ownership Type,* Health Affairs (Millwood), 2022 Mar; 41(3): pp. 331-340, *https://doi.org.10.1377/hlthaff.2021.01115.*

HORWITZ J. R., *Threatening Nonprofit Hospital Tax Exemption. A Better Path Forward*, in Journal of American Medical Association, 18 January 2024, doi:10.1001/jama.2023.28289.

HORWITZ J. R., *Charitable nonprofits and the business of health care,* in Powell W., Bromley P., eds. The Nonprofit Sector: A Research Handbook, 3rd ed. Stanford University Press; 2020, Chapter 17, 413-444.

HSCI, *Developing the Third Sector's Role in Health and Social Care Integration*, 2018 in *https://ctsi.org.uk/wp-content/uploads/2018/06/HSCI-Developing-Third-Sector-Role-Handbook-Final.pdf.*

HUTTON J., *Pediatric Biomedical Informatics: Computer Applications in Pediatric Research (Translational Bioinformatics Book*), Springer NYC, 2012.

ISS, *Governo clinico, SNLG e HTA*, Roma, 5 gennaio 2022.

ISS, *Le determinanti della spesa out-of-pocket*, Roma, 18 marzo 2021.

ISTAT, *Struttura e profili del Settore Non Profit*, Roma, 14 ottobre 2022.

ISTAT, *Il benessere equo e sostenibile dei territori, Veneto 2023*, Roma, 2023.

JONES M., JALLINOJA P., ILKKA P., *Representing the 'Voice' of Patients: How Third Sector Organizations Conceptualize and Communicate Experiential Knowledge in Health Service Development*, in ISTR Voluntas, 2021, 32:561–572, *https://doi.org/10.1007/s11266-020-00296-5*.

LEWANCZUK R., *Creating a system wide third sector – health system partnership*, excerpt from the 23rd International Conference on Integrated Care, Antwerp, Flanders, 22-24 May 2023 in International Journal of Integrated Care, *23(S1):012 DOI: doi.org/10.5334/ijic.ICIC23012*.

MINISTERO DELL'ECONOMIA E DELLE FINANZE, Ragioneria Generale dello Stato, *Il monitoraggio della spesa sanitaria, Rapporto n. 10*, Roma, dicembre 2023, pp. 179 – 202.

MINISTERO DELL'ECONOMIA E DELLE FINANZE *Documento di economia e finanza 2023. Nota di Aggiornamento*, Roma, 27 settembre 2023.

MINISTERO DELLA SALUTE, Direzione generale della programmazione sanitaria – Ufficio 6 *Monitoraggio dei LEA attraverso il Nuovo Sistema di Garanzia. Metodologia e risultati dell'anno 2020,* Roma, 6 marzo 2023.

MINISTERO DELLA SALUTE, Direzione generale della programmazione sanitaria – Ufficio 6 *Monitoraggio dei LEA attraverso il Nuovo Sistema di Garanzia. Metodologia e risultati dell'anno 2021,* Roma, maggio 2023.

NELSON M.L.A., SARAGOSA M., SINGH H., HI J., *Examining the Role of Third Sector Organization Volunteers in Facilitating Hospital-to-Home Transitions for Older Adults – a Collective Case Study*, in International Journal of Integrated Care, 2024; 24(1): 16, 1–13, *https://doi. org/10.5334/ijic.7670*.

OBAMA B., *United States Health Care Reform. Progress to Date and Next Steps*, in Journal of American Medical Association, 2016, 316 (5), 525 – 532, in *https://jamanetwork.com/journals/jama/fullarticle/2533698*, doi:10.1001/jama.2016.9797

OECD, *Data Explorer, Health expenditure and financing*, in *https://data-explorer.oecd.org*.

OECD, *Health at a Glance 2023. OECD Indicators*, OECD Publishing, Paris, *https://doi.org/10.1787/7a7afb35-en*.

OECD, *OECD (2023), Time for Better Care at the End of Life,* OECD Health Policy Studies, OECD Publishing, Paris, 2023 *https://doi.org/10.1787/722b927a-en*.

OECD, European Observatory on Health Systems and Policies, *Italia: Profilo della Sanità*, *2023*, OECD Publishing, Paris, in *https://doi.org/10.1787/1e266bea-it*.

OECD, European Observatory on Health Systems and Policies, *State of Health in the EU, France 2023: Country Health Profile*, OECD Publishing, 2023, Paris, in *https://doi.org/10.1787/07c48f9f-en*.

OECD, European Observatory on Health Systems and Policies, *State of Health in the EU, Germany 2023. Country Health Profile*, 2023, OECD Publishing, Paris, in *https://doi.org/10.1787/21dd4679-en*.

OECD, European Observatory on Health Systems and Policies, *Finland: Country Health Profile 2023*, State of Health in the EU, OECD Publishing, Paris, 2023, in *https://doi.org/10.1787/e7af1b4d-en*.

OECD, *Declaration on Building Better Policies for More Resilient Health Systems*, OECD Publishing, Paris, 2024, in *https://legalinstruments.oecd.org/Instruments/instruments/OECD-LEGAL-0500*.

OWSLEY K.M. LINDROOTH R.C., *Understanding the relationship between nonprofit hospital community benefit spending and system membership: an analysis of independent hospital acquisitions*, in J Health Econ. 2022 Dec; 86:102696, doi: 10.1016/j.jhealeco.2022.102696. Epub 2022 Oct 25. PMID: 36323185.

PELLIZZARI S., *Sentenza 131/2020: attuare con responsabilità l'art. 55 del Codice del Terzo settore*, in Impresa sociale, 9 luglio 2020, *https://www.rivistaimpresasociale.it/forum/articolo/attuare-con-responsabilita-l-art-55*.

PETRANGOLINI T., MORANDI F., DELLE MONACHE L., MORO M., DI BRINO E., CICCHETTI A., *La storia delle associazioni dei pazienti e dei cittadini impegnate in sanità in Italia: conquiste, ostacoli e trasformazioni*, Roma, aprile 2021, pp. 31-52.

PISANI G., DECORTE J., *L'integrazione socio-sanitaria come asse di un nuovo modello di assistenza. il possibile ruolo del Terzo settore*, Euricse, 2023, Working Paper n. 128/23, 1-73.

RAHAL C., MOHAN J., *The Role of the Third Sector in Public Health Service Provision: Evidence from 25,338 heterogeneous procurement datasets*, Leverhulme Centre for Demographic Science, University of Oxford and Third Sector Research Centre, University of Birmingham, February 19, 2024, *https://osf.io/preprints/socarxiv/t4x52*.

RAPFOGEL N., GEE E., *How Nonprofit Hospitals Can Support Communities and Advance Public Health*, in *https://www.americanprogress.org/article/nonprofit-hospitals-can-support-communities-advance-public-health/*.

RICCIARDI W, TARRICONE R., *The evolution of the Italian National Health Service*, Lancet. 2021 Dec 11; 398(10317):2193-2206. *doi: 10.1016/S0140-6736(21)01733-5. Epub 2021 Oct 22. PMID: 34695372*.

RUGGERI M., DRAGO C., CADEDDU C., ARMUZZI A., LEONE S., MARCHETTI M., *The Determinants of Out-of-Pocket Expenditure in IBD Italian Patients. Results from the AMICI Survey,* in International Journal of Environmental Research and Public Health, 2020, 17 (21). 8156.

SACCO Y., *Advice on unmet healthcare infrastructure needs – Region Veneto*, 30 April 2021, Scuola Superiore Sant'Anna (Pisa), *https://www.santannapisa.it/sites/default/files/veneto_regional_report_final_version.pdf*.

SANTUARI A., *Riforma degli ambiti territoriali sociali e coinvolgimento dei soggetti privati. Breve commento del ddl della Regione Veneto del 18 aprile 2023*, in Welforum.it – Osservatorio nazionale sulle politiche sociali, 16 giugno 2023, in *https://www.welforum.it/riforma-degli-ambiti-territoriali-sociali-e-coinvolgimento-dei-soggetti-privati/*.

SANTUARI A., *Il principio di sussidiarietà orizzontale quale paradigma per la definizione dei rapporti tra ETS e pubblica amministrazione nella riforma del Terzo settore, in* Terzo settore, non profit e cooperative – n. 2 – Aprile / Giugno 2019, pp. 68-78.

SANTUARI A., SAGE W., *Paradigms of Healthcare Systems, Law, and Regulation: A Transatlantic Conversation*, in The Oxford Handbook of Comparative Health Law, Edited by David Orentlicher and Tamara K. Hervey, Oxford University Press, 2021, Part I – Chapter 2, pp. 19.65.

SCHIZER D. M., *How to Save the World in Six (not so easy) Steps. Bringing Out the Best in Nonprofits., Post Hill Press, New York,* 2023, pp. 26; 112-140.

SCINETTI F., TURATI G., VIRGADAMO L. *Come viene finanziata la sanità tra le Regioni?* in Osservatorio sui conti pubblici italiani – OCPI, 31 maggio 2024, pp. 1-11, *https://osservatoriocpi.unicatt.it/ocpi-Come%20viene%20finanziata%20la%20sanita%20tra%20le%20Regioni.pdf.*

SHAH S., GOOCH J., MEYERS J., KIRBY M., VAN COUWENBERGHE, *The Inflation Reduction Act's Ripple Effects on the US Health Care Ecosystem*, 8 February 2024, in *https://www.bcg.com/publications/2024/inflation-reduction-acts-effects-on-us-health-care-ecosystem*.

SMITH K., *A (Brief) History of Health Policy in the United States*, in Delaware Journal of Public Health, 2023 Dec 31;9(5):6-10. *doi: 10.32481/djph.2023.12.003. PMID: 38283712; PMCID: PMC10810293.*

TOTH F., *The Public/Private Sector Mix in the Italian Healthcare System: Some Issues of Equity and Quality of Care,* in "The Public/Private Sector Mix in Healthcare Delivery: A Comparative Study", Chapter 8, New York, 2023; online edition, Oxford Academic, 17 Nov. 2022, pages 177 – 202 *https://doi.org/10.1093/oso/9780197571101.003.0008*.

TUURNAS S., KILKKU N., *The role and position of the third sector in social and health care system? Reflections from Finnish Reform*, in Nordic Journal of Wellbeing and Sustainable Welfare Development, Volume 2, nr. 2-2023, s. 1–5, *https://doi.org/10.18261/njwel.2.2.1.*

TYNKKYNNEN LK, KESKIMÄKI I, KARANIKOLOS M., LITVINOVA Y., *Finland: Health system summary*, 2023, Tampere.

VICECONTE N., *L'evoluzione del sistema di finanziamento del Servizio Sanitario Nazionale tra federalismo "promesso" ed esigenze di bilancio*, in Italian Papers on Federalism, Rivista giuridica on line ISSiRFA – CNR, nn. 1-2-3/2012, pp. 5 – 11, *https://www.ipof.it/1118/.*

WHO/OMS World Health Organization, Organizzazione Mondiale della Sanità *Global Health Expenditure Database, https://apps.who.int/nha/database/Select/Indicators/en.*

WHO/OMS, Regional Office for Europe, *Economic and social impacts and benefits of health systems. Report*, Copenhagen (DK), 2019, in *https://iris.who.int/handle/10665/329683.*

ZARE H, EISENBERG M, ANDERSON G., *Charity care and community benefit in nonprofit hospitals: definition and requirements*, in *Inquiry*. 2021; 58: 469580211028180.

RELEVANT WEBSITES AND PORTALS

- *https://www.archives.gov/milestone-documents/*
- *https://avvoverona.it*
- *https://www.azero.veneto.it*
- *https://www.aopd.veneto.it/Volontariato-e-Solidarieta*
- *https://www.aopd.veneto.it/Servizi-ospitalita*
- *https://www.aovr.veneto.it*
- *https://www.bcg.com/publications*
- *https://www.cihi.ca*
- *https://commission.europa.eu/about-european-commission/departments-and-executive-agencies/eurostat-european-statistics_en*
- *https://www.commonwealthfund.org/international-health-policy-center/countries/italy*
- *https://ctsi.org.uk*
- *https://euricse.eu/en*
- *www.gimbe.org*
- *https://www.healthaffairs.org/*
- *https://www.imperial.nhs.uk/*
- *https://iris.who.int*
- *https://www.istat.it*
- *https://jamanetwork.com/*
- *https://www.legislation.gov.uk/*
- *http://www.law.umich.edu/*
- *https://www.newsweek.com/rankings/worlds-best-specialized-hospitals-2025/*
- *https://www.nhsconfed.org*
- *https://www.oecd-ilibrary.org/docserver*
- *https://www.salute.gov.it*
- *https://www.iss.it*
- *https://www.regione.veneto.it/web/guest/area-sanita-e-sociale1*
- *https://www.regione.veneto.it/web/sociale/autorizzazione-e-accreditamento*
- *https://www.regione.veneto.it/direzione-programmazione-sanitaria*
- *https://salute.regione.veneto.it/*
- *https://www.regione.veneto.it/web/sanita/elenchi-strutture-sanitarie-private-accreditate*
- *https://www.sanita24.ilsole24ore.com*

– *https://www.sup.org*
– *https://www.supremecourt.gov/*
– *https://www.welforum.it*
– *https://www.who.int*

APPENDIX

Table 1. Measurement of the performance of public – private – non-profit health services

Performance measure	No. of studies	Tendency of findings
Efficiency	15	Ambiguous
Quality of care	43	In favour of non-profits (comparison with for-profits)
Innovation	4	No clear differences between sectors (non-profit versus public)
Trust	3	Non-profits considered more trustworthy than for-profits
Value-driven	27	Non-profits more community-oriented than for-profits, but outperformed by public sector

Source: Heins E., Price D., Pollock A. M., Miller E., Mohan J., Shaoul J., *A Review of the Evidence of Third Sector Performance and Its Relevance for a Universal Comprehensive Health System*, in Social Policy & Society, 9:4515-526_Cambridge University Press, 2010, p. 520, Table 3.

Note: the table sets out the number of studies carried out globally on the quality of the performance of health services provided by the private and non-profit public sector. The studies suggest, as to the quality of services provided, a better quality of services offered by the Nonprofit sector than those provided by the Private sector, while "*value-driven*" studies report that the performance of the Non-profit world is more community-oriented than that of the Private sector, but is outperformed by the Public Sector.

Table 2. Dashboard on Health status in OECD countries, 2021 (unless indicated)

	Life expectancy		Avoidable mortality		Chronic conditions		Self-rated health	
	Years of life at birth		Deaths per 100 000 population (age-standardised)		Diabetes prevalence (% adults, age-standardised)		Population in poor health (% population aged 15+)	
OECD	**80.3**	**+**	**237**	**+**	**7.0**	**-**	**7.9**	**+**
Australia	83.3	+	144	+	6.4	+	3.7[3]	+
Austria	81.3	+	198	+	4.6	+	7.4	+
Belgium	81.9	+	176[2]	+	3.6	+	8.0	+
Canada	81.6	+	171[2]	+	7.7	+	2.8	=
Chile	81.0	+	247[1]	-	10.8	-	6.8	-
Colombia	76.8	+	328[1]	-	8.3	+	1.3[2]	N/A
Costa Rica	80.8	+	237[1]	-	8.8	+	3.4[2]	N/A
Czech Republic	77.2	-	335	-	7.1	-	8.6	+
Denmark	81.5	+	174[1]	+	5.3	+	7.7	+
Estonia	77.2	+	363	+	6.5	+	12.1	+
Finland	81.9	+	186[1]	+	6.1	-	6.2	+
France	82.4	+	160[3]	+	5.3	+	8.9	-
Germany	80.8	+	195[1]	+	6.9	-	12.4	-
Greece	80.2	-	204[1]	-	6.4	-	6.5	+
Hungary	74.3	-	404[2]	+	7.0	-	8.2	+
Iceland	83.2	+	142	+	5.5	-	5.9[2]	+
Ireland	82.4	+	172[2]	+	3.0	+	5.2	-
Israel	82.6	+	141[1]	+	8.5	-	10.9	+
Italy	82.7	+	146[3]	+	6.4	-	8.1	+
Japan	84.5	+	134[1]	+	6.6	+	13.6[2]	+
Korea	83.6	+	142[1]	+	6.8	+	13.8[1]	+
Latvia	73.1	=	531	-	5.9	+	13.1	+
Lithuania	74.2	+	481	+	5.8	+	13.1	+
Luxembourg	82.7	+	147	+	5.9	-	5.9	+
Mexico	75.4	+	665[1]	-	16.9	-	N/A	N/A
Netherlands	81.4	+	161[1]	+	4.5	+	5.2	+
New Zealand	82.3	+	179[3]	+	6.2	+	2.1	+
Norway	83.2	+	156[3]	+	3.6	+	9.0[1]	-
Poland	75.5	-	344[1]	-	6.8	+	10.3	+
Portugal	81.5	+	180[2]	+	9.1	+	13.3	+
Slovak Republic	74.6	-	321[2]	+	5.8	-	13.2	+
Slovenia	80.7	+	221[1]	+	5.8	+	8.3	+
Spain	83.3	+	163	+	10.3	-	7.7	-
Sweden	83.1	+	150[2]	+	5.0	-	6.4	-
Switzerland	83.9	+	133[1]	+	4.6	+	3.9	-
Türkiye	78.6[2]	+	233[2]	+	14.5	-	8.4	+
United Kingdom	80.4[1]	=	222[1]	-	6.3	-	7.4[2]	-
United States	76.4	-	336[1]	-	10.7	-	3.1	=

Better than the OECD average.
Close to the OECD average.
Worse than the OECD average.
1. 2020 data.
2. 2018/19 data.
3. 2016/17 data.

Source: OECD report *Health at a Glance*, 2023. *OECD Indicators*, OECD Publishing, Paris, *https:// doi.org/10.1787/7a7afb35-en*, Table 1.2.

Note: the sign "+" in the various columns indicates an improvement in time, the sign "-" indicates a deterioration in time, the sign "=" represents the absence of significant changes. In the Table, Latvia, Lithuania and Mexico were excluded from the calculation of deviance for "*avoidable mortality*" (Second column), while Mexico and Turkey were excluded from the prevailing diabetic factors. As to the parameter "*avoidable mortality*", Italy has a better condition than the OECD average. In all other considered parameters Italy is close to the OECD average. The average life expectancy is around 82 years.

Table 3. Dashboard on access to care in OECD countries 2021 (unless indicated)

	Population coverage, eligibility		Population coverage, satisfaction (2022)		Financial protection		Service coverage	
	Population eligible for core services (% population)		Population satisfied with availability of quality health care (% population)		Expenditure covered by compulsory prepayment (% total expenditure)		Population reporting unmet needs for medical care (% population)	
OECD	**97.9**	-	**66.8**	-	**75.9**	+	**2.3**	+
Australia	100	=	71	-	71.9[1]	+	N/A	N/A
Austria	99.9	=	84	-	78.3	+	0.2	+
Belgium	98.6	-	90	+	77.6	+	1.7	+
Canada	100	=	56	-	72.9	+	N/A	N/A
Chile	94.3	+	39	+	62.7	+	N/A	N/A
Colombia	94.7[2]	-	41	-	78.4	+	N/A	N/A
Costa Rica	90.9	-	70	+	74.5	+	N/A	N/A
Czech Republic	100	=	77	+	86.4	+	0.3	+
Denmark	100	=	81	=	85.2	+	1.2	+
Estonia	95.9	+	63	+	76.2	+	8.1	+
Finland	100	=	70	+	79.8	+	4.3	+
France	99.9	=	71	-	84.8	+	2.8	+
Germany	99.9	+	85	-	85.5	+	0.1	+
Greece	100.0	=	44	+	62.1	-	6.4	+
Hungary	95.0	-	44	-	72.5	+	1.2	+
Iceland	100	=	68	-	83.7	+	3.4[2]	+
Ireland	100	=	67	+	77.4	+	2.0	+
Israel	100	=	69	=	68.2[1]	+	N/A	N/A
Italy	100	=	55	=	75.5	-	1.8	+
Japan	100[1]	=	76	+	84.9[1]	+	N/A	N/A
Korea	100	=	78	+	62.3	+	N/A	N/A
Latvia	100	=	57	+	69.5	+	4.0	N/A
Lithuania	98.8	+	51	=	68.6	-	2.4	N/A
Luxembourg	100	=	86	-	86.0	+	1.1	+
Mexico	72.4[1]	-	57	-	50.2	-	N/A	N/A
Netherlands	99.9	+	83	-	84.9	+	0.1	+
New Zealand	100	=	64	-	80.3	-	N/A	N/A
Norway	100	=	80	-	85.6	+	0.9	+
Poland	94.0	-	51	+	72.5	+	2.6	+
Portugal	100	=	63	+	63.2	-	2.3	-
Slovak Republic	95	-	54	-	79.7	+	2.9	+
Slovenia	100	=	68	-	73.7	+	4.7	-
Spain	100[1]	+	64	-	71.6	-	1.1	+
Sweden	100	=	74	-	85.9	+	1.2	+
Switzerland	100	=	94	=	67.7	+	0.5	+
Türkiye	98.8	+	53	-	78.8	-	2.4	N/A
United Kingdom	100	=	67	-	83.0	+	N/A	N/A
United States	91.3	+	75	+	83.6	+	N/A	N/A

Better than the OECD average.
Close to the OECD average.
Worse than the OECD average.
1. 2020 data.
2. 2018 data.

Source: OECD report *Health at a Glance*, 2023. *OECD Indicators*, OECD Publishing, Paris, *https:// doi.org/10.1787/7a7afb35-en*, Table 1.4.

Note: the sign "+" in the various columns indicates an improvement in time, the sign "-" indicates a deterioration in time, the sign "=" represents the absence of significant changes. The Table shows, against a Public Health Service formally guaranteed to the entire population, a general satisfaction on access to (and quality of) essential services (55%) close to the OECD average (66.8%). The "mismatch" between demand and supply of health services, equal to 1.8%, is close to and still lower than the average of OECD countries (2.3%). Column 3 shows the total expenditure covered by the "ticket" (75.5%), again in line with OECD data (75.9%). However, in the public coverage of health services Italy is at the 13th place among the countries of the European Union.

Table 4. Dashboard on quality of care in OECD countries 2021 (unless indicated

	Safe primary care		Effective primary care		Effective preventive care		Effective secondary care		
	Antibiotics prescribed (defined daily dose per 1 000 people)		Avoidable hospital admissions (per 100 000 people, age-sex standardised)		Mammography screening within the past 2 years (% women aged 50-69)		AMI	Stroke	
							30-day mortality following AMI or stroke (per 100 admissions aged 45 years and over, age-sex standardised)		
OECD	13.1	+	463	+	55.1	-	6.8	7.8	+
Australia	16.8	-	654	+	47.1	-	3.3[1]	4.8	+
Austria	7.2	+	483	+	40.1	N/A	5.8	6.6	+
Belgium	16.0	+	633[2]	-	56.1[1]	-	4.3	8.2	+
Canada	9.0	N/A	388	+	59.7[2]	+	4.7	7.7	+
Chile	N/A	N/A	220	+	35.8	+	7.2[2]	8.3	+
Colombia	N/A	N/A	N/A	N/A	N/A	N/A	5.6[2]	6.1	+
Costa Rica	N/A	N/A	278[3]	+	36	+	N/A	N/A	N/A
Czech Republic	11.5	N/A	577	+	58.3	+	6.2	9.4	=
Denmark	12.6	+	538	+	83.0	=	4.8	4.9	+
Estonia	8.7	+	354	+	58.7	+	11.3	9.0	-
Finland	9.4	+	490	+	82.2	-	7.3	9.1	+
France	19.3	+	601[4]	+	46.9	-	5.5[2]	7.3[4]	+
Germany	8.1	+	728	+	47.5	-	8.6	6.6	+
Greece	21.7	+	N/A	N/A	65.7[2]	+	N/A	N/A	N/A
Hungary	10.8	+	N/A	N/A	29.8	-	N/A	N/A	N/A
Iceland	15.7	+	308	+	54.0	-	1.7	3.1	+
Ireland	16.3	+	498	+	62.4	-	5.4	6.3	+
Israel	14.4	+	440	+	71.9	+	5.2	5.4	+
Italy	15.9	+	214	+	55.9	-	5.3[2]	6.6[4]	+
Japan	12.2[2]	+	N/A	N/A	44.6[2]	+	8.3[1]	2.9	+
Korea	16.0	+	375	+	69.9	+	8.4	3.3	+
Latvia	10.1	+	N/A	N/A	30.8	-	15.9	20.5	-
Lithuania	11.7	N/A	554	+	45.5	+	10.3	15.4	+
Luxembourg	14.6	+	502	-	53.8	-	9.9	6.0	+
Mexico	N/A	N/A	195	+	20.2[1]	+	23.7	17.2	+
Netherlands	7.6	+	318	+	72.7	-	2.9	4.9	+
New Zealand	N/A	N/A	N/A	N/A	63.3	-	4.1	5.9	+
Norway	12.8	+	477	+	65.5	-	2.6	3.1	+
Poland	18.8	-	663	+	33.2	N/A	5.2	11.8[3]	+
Portugal	13.7	+	266	N/A	80.2[2]	-	8.0	10.4	+
Slovak Republic	14.5	+	615	+	25.5	-	7.4	9.9	+
Slovenia	8.7	+	367	+	77.2	+	5.1	12.1	+
Spain	18.4	-	356	+	73.8[1]	-	6.5	9.4	+
Sweden	8.6	+	361	+	80.0	N/A	3.6	5.5	+
Switzerland	N/A	N/A	424	-	49[3]	+	5.1[4]	5.6[4]	+
Türkiye	11.3	+	827[3]	N/A	20.5	-	6.0	7.6	N/A
United Kingdom	N/A	N/A	403	+	64.2	-	6.7	9.0	+
United States	N/A	N/A	725	+	76.1	-	5.5[1]	4.3	-

Better than the OECD average.
Close to the OECD average.
Worse than the OECD average.

1. 2020 data.
2. 2019 data.
3. 2017/18 data.
4. 2014/15 data.

Notes: The symbol + indicates an improvement over time, – a deterioration, and = no change. Latvia and Mexico are excluded from the standard deviation calculation for AMI and stroke mortality. OECD averages shown here differ slightly from those in chapter 6 due to differences in country coverage. Avoidable hospital admissions cover asthma, chronic obstructive pulmonary disease, congestive heart failure and diabetes.

Source: OECD report *Health at a Glance*, 2023. *OECD Indicators*, OECD Publishing, Paris, *https:// doi.org/10.1787/7a7afb35-en*, Table 1.5.

Note: it is worth noting the figure that appears in the third column in correspondence of Italy, referred to "Effective primary care – Avoidable Hospital Admissions", per 100,000 inhabitants by reason of age and sex, which shows that Italy is above the OECD average in this field. The indicator shows that the health emergency has been remedied by the appropriateness of first aid and/or basic outpatient care or home care. The green color of the box highlights the position of excellence (in 2021 Italy ranks third in the ranking of OECD countries).

Table 5. Dashboard on health system capacity and resources in OECD countries, 2021 (unless indicated)

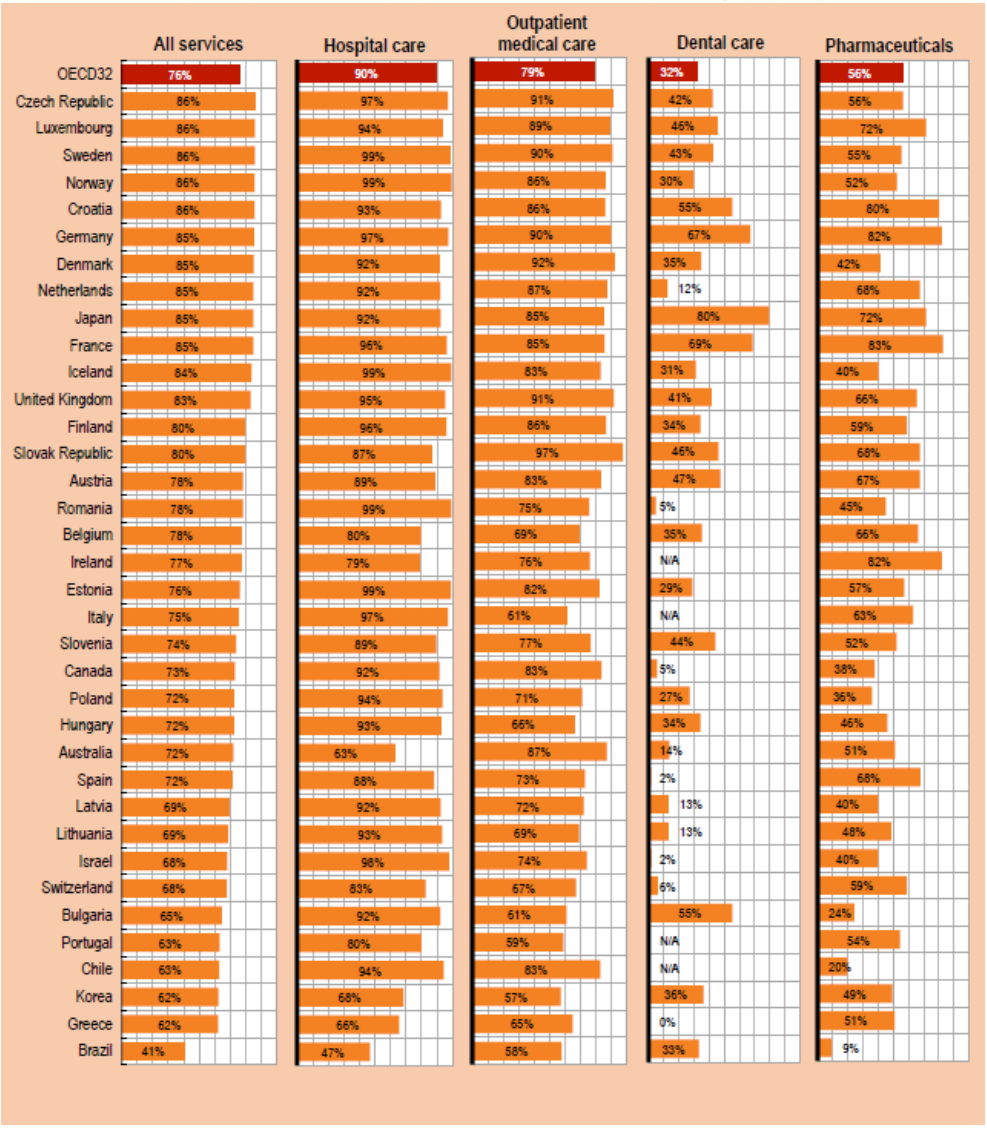
	Health Spending (2022)				Doctors		Nurses		Hospital beds	
	Per capita (USD based on purchasing power parities)		% GDP		Practising physicians (per 1 000 population)		Practising nurses (per 1 000 population)		Per 1 000 population	
OECD	**4 986**	**+**	**9.2**	**+**	**3.7**	**+**	**9.2**	**+**	**4.3**	**-**
Australia	6 372	+	9.6	+	4.0	+	12.8	+	3.8[3]	+
Austria	7 275	+	11.4	+	5.4	+	10.6	N/A	6.9	-
Belgium	6 600	+	10.9	+	3.3	+	11.1[2]	+	5.5	-
Canada	6 319	+	11.2	+	2.8	+	10.3	+	2.6	-
Chile	2 699	+	9.0	+	2.9	+	3.7	+	2.0	-
Colombia	1 640	+	8.1	+	2.5	+	1.6	+	1.7[1]	+
Costa Rica	1 658	+	7.2	-	N/A	N/A	N/A	N/A	1.2	-
Czech Republic	4 512	+	9.1	+	4.3	+	9.0	+	6.7	-
Denmark	6 280	+	9.5	-	4.4[1]	+	10.2[1]	+	2.5	-
Estonia	3 103	+	6.9	+	3.4	+	6.5	+	4.4	-
Finland	5 599	+	10.0	+	3.6[1]	+	18.9[1]	+	2.8	-
France	6 630	+	12.1	+	3.2	+	9.7	+	5.7	-
Germany	8 011	+	12.7	+	4.5	+	12.0	+	7.8	-
Greece	3 015	+	8.6	-	6.3	+	3.8	+	4.3	-
Hungary	2 840	+	6.7	-	3.3	+	5.3	N/A	6.8	-
Iceland	5 314	+	8.6	+	4.4	+	15.0	+	2.8[1]	-
Ireland	6 047	+	6.1	-	4.0	+	12.7	N/A	2.9	N/A
Israel	3 444	+	7.4	+	3.4	+	5.4	+	2.9	-
Italy	4 291	+	9.0	+	4.1	+	6.2	+	3.1	-
Japan	5 251	+	11.5	+	2.6[1]	+	12.1[1]	+	12.6	-
Korea	4 570	+	9.7	+	2.6	+	8.8	+	12.8	+
Latvia	3 445	+	8.8	+	3.4	+	4.2	-	5.2	-
Lithuania	3 587	+	7.5	+	4.5	+	7.9	+	6.1	-
Luxembourg	6 436	+	5.5	+	3.0[3]	+	11.7[3]	+	4.1	-
Mexico	1 181	+	5.5	-	2.5	+	2.9	+	1.0	-
Netherlands	6 729	+	10.2	-	3.9	+	11.4	+	3.0	-
New Zealand	6 061	+	11.2	+	3.5	+	10.9	+	2.7	-
Norway	7 771	+	7.9	-	5.2	+	18.3	+	3.4	-
Poland	2 973	+	6.7	+	3.4	N/A	5.7	+	6.3	-
Portugal	4 162	+	10.6	+	6	+	7.4	+	3.5	+
Slovak Republic	2 756	+	7.8	+	3.7	+	5.7	-	5.7	-
Slovenia	4 114	+	8.8	+	3.3	+	10.5	+	4.3	-
Spain	4 432	+	10.4	+	4.5	+	6.3	+	3.0	-
Sweden	6 438	+	10.7	-	4.3[1]	+	10.7[1]	-	2.0	-
Switzerland	8 049	+	11.3	+	4.4	+	18.4	+	4.4	-
Türkiye	1 827	+	4.3	-	2.2	+	2.8	+	3.0	+
United Kingdom	5 493	+	11.3	+	3.2	+	8.7	+	2.4	-
United States	12 555	+	16.6	+	2.7	+	12.0	+	2.8	-

Above the OECD average.
Close to the OECD average.
Below the OECD average.
1. 2020 data.
2. 2018 data.
3. 2016/17 data.

Source: OECD report *Health at a Glance 2023. OECD Indicators*, OECD Publishing, Paris, *https:// doi.org/10.1787/7a7afb35-en*, Table 1.6.

Note: the sign "+" in the various columns indicates an improvement in time, the sign "-" indicates a deterioration in time, the sign "=" represents the absence of significant changes. The different shades, from the brightest to the softest, represent, respectively, the performance of the country concerned compared to the OECD average: above the brightest, below the softest.
Italy is part of the OECD average for all indicators and in the European Union it is placed, respectively, at the 12th place for average health expenditure per capita, at the 11th place for health expenditure/GDP ratio, at the 8th place for number of doctors in relation to population, at the 17th place for nurses per inhabitant (6.2.) and, finally, at 15th place for the number of beds per 1000 inhabitants (3.1.)

Table 6. Extent of financial coverage in OECD countries, 2021 (or nearest year) (*Health spending and expenditure on compulsory insurance in proportion to total Health spending by type of care)*



Source: OECD report *Health at a Glance 2023. OECD Indicators*, OECD Publishing, Paris, *https:// doi.org/10.1787/7a7afb35-en*, Table 5.7.

Note: N/A means "Not available". For Italy, public expenditure covers health services for 75% (-1% compared to the OECD average, 11st position in the European Union), hospitalization for 97% (-7% OECD average); outpatient specialist services for 61% (-1% OECD average); public expenditure does not cover dental care (OECD average 32%), pharmaceutical expenditure for 63% (+ 7% compared to the OECD average).

Table 7. The breakdown of paid employment in public services across the public, private and non-profit sector in France – 2016

Area	Employment share by sector			Total
	Public	Private for-profit	Nonprofit	
Education	76%	5%	19%	100%
Health	65%	23%	12%	100%
Social Services	28%	10%	62%	100%
Share of total employment in France	25.5%	67%	7.5%	100%

Note: the table is a re-elaborated version of the data contained in Table 2 in ARCHAMBAULT E., *The evolution of public service provision by the third sector in France*, The Political Quarterly, Vol. 88 (3), 2017, p. 469, in *https://shs.hal.science/halshs-01598959* and in the document of the Direction de la recherche, des études, de l'évaluation et des statistiques – DREES, *Les dépenses de santé en 2016 – Résultats des comptes de la santé – édition 2017.*

Table 8. Characteristics of U.S. Hospitals with Community Benefits Exceeding the Tax Exclusion

	Total community benefits exceed tax exemption	Incremental community benefits exceed tax exemption	Total charity care exceed tax exemption	Incremental charity care exceed tax exemption
Baseline percent with CB > TE	74%	62%	25%	20%
Marginal effect of hospital characteristic				
Under 50 beds (reference)	n/a	n/a	n/a	n/a
50 to 199 beds	−3.3	−3.3	−1.2	−3.0
200 to 499 beds	2.8	−8.1**	−1.2	−5.1*
500 or more beds	7.2	−4.8	−5.6	−8.6*
Member of a system	−16.0***	−1.6	−1.7	5.3***
Church operated	2.0	−0.4	−3.9	−2.9
Teaching hospital	7.0**	3.9	1.5	−0.4
Percent Medicare patients	−0.6	22.6**	18.1*	3.8
Percent Medicaid patients	11.2	31.1***	12.0	15.3**
Has a trauma center	−1.5	3.2	−0.8	3.8**
Obstetrics provided	−1.3	−0.5	−4.5*	−4.2**
Case mix index	−7.3	−6.1	−16.1**	−7.5*
Marginal effect of market characteristic				
Rural area	−5.1	2.2	−4.7	−2.8
Percent nonwhite in county	−0.2**	0.0	0.0	0.0
Percent in poverty in county	0.8*	0.0	0.4	0.0
Percent uninsured in county	0.6	1.7***	1.0**	0.9***
County has public hospital	−5.1	−3.6	−2.8	−3.1
County has FQHC	3.3	2.6	3.0	2.8
Hospital HHI (000s)	0.0	−0.2	−0.1	−0.3
Insurance HHI (000s)	0.8	−2.3*	−0.9	0.9
State malpractice payments	1.0	3.6***	1.8**	3.2***
State indicators included	Yes	Yes	Yes	Yes

Note. Data are from 1648 nonprofit hospitals in 2012 with information in the Internal Revenue Service 990 Schedule H, Centers for Medicare and Medicaid Service Hospital Cost Reports, and American Hospital Annual Survey. CB = community benefit; TE = tax exemption; HHI = Herfindahl-Hirschman index.
*$P < .10$. **$P < .05$. ***$P < .01$.

Source: Herring B., Gaskin D., Zare H., Anderson G. (Johns Hopkins University Baltimore*) Comparing the Value of Nonprofit Hospitals' Tax Exemption to Their Community Inquiry Benefits*, in Journal, The Health Provision Organization, and Financing, Volume 55, 2018, p. 8, Tab. 4. It compares the data provided by the IRS for 1648 nonprofit hospitals dating back to 2012 by assessing the ratio of benefits received by the target community (CB = Community Benefit) to the federal and local tax exemptions they enjoy (TE: federal corporate income tax, the state corporate income tax, state sales tax, and local property taxes).

Note: The authors warn that the nature and level of hospital services provided include the size of beds, ownership of the hospital system, affiliation to a Church or other religious institution, the training model, the percentage of patients who enjoy "Medicare" and/or "Medicaid", the presence of a Trauma Center, the midwifery services provided and the index of cases in which the patient benefits from a mix of all the services listed above.
The result of the comparison suggests that the marginal benefits received by the community (understood as a correspondence between 1 unit of change in an independent variable and increase of the benefit for the community exceeding the tax exemption by x percentage points) depend on the characteristics of hospital services and the healthcare market rather than on the "CB – TE" ratio.

Table 9. Number and percentage of nonprofit health care organizations in the U.S.A. (selected years, 2013–2000)

Type of charity	*2013*	*2011*	*2010*	*2009*	*2007*	*2005*	*2004*	*2000*
				Number of charities				
Health	37,732	41,619	44,128	44,130	42,880	41,243	38,633	36,057
Hospitals and primary care facilities	7,062	7,308	7,657	7,526	7,360	5,045	3,139	6,929
Other health	30,670	34,111	36,471	36,604	35,520	36,198	35,494	29,128
All public charities	293,103	335,037	366,086	362,926	342,995	310,683	299,033	249,859
				Percentage of charities				
Health	12.90%	12.40%	12.10%	12.20%	12.50%	13.30%	12.90%	14.40%
Hospitals and primary care facilities	2.40%	2.20%	2.10%	2.10%	2.10%	1.60%	1.00%	2.80%
Other health charities	10.50%	10.20%	10.00%	10.10%	10.40%	11.70%	11.90%	11.70%
Other public charities	87.10%	87.60%	87.90%	87.80%	87.50%	86.70%	87.10%	85.60%

Source: Horwitz J. R., *Charitable* nonprofits and the business of health care, in Powell W., Bromley P., eds. The Nonprofit Sector: A Research Handbook, 3rd ed. Stanford University Press; 2020, Chapter 17, p. 417, Tab. 17.1.

Note: It should be noted that the expression "*public charity*" does not indicate a "public" institution in the sense of belonging to the Government or another sector of the public administration, but distinguishes, in the US system, this legal entity from the "Private Foundation". While "*public charities*" remain private law entities, they are entitled to prepare and implement extensive fundraising programs among the public, i.e.: communities as well as government agencies, private foundations, etc. For further information, see Baker. G., *Private Foundation vs. Public Charity: Definition, Differences, and Benefits Explained*, in *https://www.reninc.com/private-foundation-vs-public – charity/#:~:text=In%20 general%2C%20public%20charities%20have,or%20even%other%20public%2 0charities.*

Table 10. Revenues, expenses, and assets of health care charities and all public charities in U.S.A. (selected years, 2013–2000)

	2013	*2011*	*2010*	*2009*	*2007*	*2005*	*2004*	*2000*
				Revenue (in billions $)				
Health	1,025.30	942.4	907.7	842.7	788.7	672.131	616.449	459.4
Hospital and primary care	864	798.5	773.4	716	663.5	492.498	446.433	383.2
Other health	161.3	143.8	134.3	126.7	125.2	179.633	170.016	76.2
Total public charities	1734.1	1593.6	1514.2	1399.3	1399.7	1144.022	1050.134	836.9
				Expenses (in billions $)				
Health	975.8	895.3	missing	827.5	739.4	637.323	588.299	missing
Hospital and primary care	823.9	758.4		698.7	626.4	468	426.672	
Other health	151.9	136.9		128.8	113	169.323	161.627	
Total public charities	1623.8	1498.2		1399.9	1251.9	1053.487	981.271	
				Assets (in billions $)				
Health	1392.8	1202.6	1141.8	1046	1003.2	826.159	748.34	606.9
Hospital and primary care	1133.5	973.3	926.9	844	792.8	608.836	539.604	468.2
Other health	259.3	229.3	214.9	202	210.4	217.323	208.736	138.7
Total public charities	3225	2856	2708.9	2533.6	2576.8	1975.792	1819.32	1500.2

Source: Horwitz J. R., Charitable nonprofits and the business of health care, in Powell W., Bromley P., eds. The Nonprofit Sector: a Research Manual, 3rd ed. Stanford University Press; 2020, chapter 17, p. 417, tab. 17.2.

Note: The warnings already expressed in the previous table apply to the expression "public charities".

Table 11. Hospital Ownership among General Acute Care Hospitals in U.S.A. (2004-2019)

	% Hospitals			% Hospitals, Admission Weighted		
Year	Govt	Non-Profit	For-Profit	Govt	Non-Profit	For-Profit
2004	12.09	67.47	20.44	11.67	75.3	13.02
2005	12.13	67.62	20.25	11.74	75.37	12.89
2006	12.85	67.03	20.12	12.15	74.87	12.98
2007	12.77	65.91	21.33	12.53	74.47	13
2008	12.91	65.93	21.17	12.66	74.13	13.21
2009	12.56	65.3	22.14	12.39	74.1	13.51
2010	12.37	65.72	21.92	12.14	74.11	13.75
2011	11.86	65.49	22.65	12	73.7	14.3
2012	11.4	66.6	22	11.69	73.48	14.83
2013	10.84	67.39	21.77	11.41	73.88	14.7
2014	11.06	68.09	20.85	11.63	73.32	15.05
2015	10.91	67.83	21.26	11.49	73.28	15.22
2016	10.58	67.92	21.5	11.21	73.41	15.39
2017	10.75	68.53	20.72	11.34	73.96	14.7
2018	10.66	68.72	20.62	11.3	73.94	14.76
2019	10.85	69.79	19.36	11.3	74.26	14.44

Source: Horwitz J. R., Nichols A., *Hospital Service Offerings Still Differ Substantially by Ownership Type*, in Health Affairs (Millwood), March 2022; 41(3): pp. 331-340, *https://doi.org.10.1377/hlthaff.2021.01115, Appendix, p. 14, Table E.*

Table 12. Healthcare spending in Italy 2022 – 2026.

TOTAL CURRENT EXPENDITURE in mln euros (Health spending)					
Year	**2022**	**2023**	**2024**	**2025**	**2026**
	131.103	134.734	132.946	136.701	138.972
Percentage of GDP					
Year	**2022**	**2023**	**2024**	**2025**	**2026**
	6,7	6,6	6,2	6,2	6,1

Note: the Table elaborates the data resulting from MEF, *Economic and Finance Document 2023. Update note*, Rome, 27 September 2023, pp. 62 – 63, Tables III – 1A "Public Administration account under current legislation (in million euros)" and III – 1B "Public Administration account under current legislation (as a percentage of GDP)".

Table 13. Net debt for healthcare spending in Italy 2023-2026

NET EFFECTS OF THE MAIN PUBLIC FINANCE MEASURES, TAKEN IN 2023, ON THE NET DEBT OF THE PUBLIC ADMINISTRATION (value in mln euros)				
HEALTH				
Year	**2023**	**2024**	**2025**	**2026**
	- 1.173	**0**	**0**	**0**
Creation of the fund for the payment of the State contribution for the exceeding the expenditure ceiling of medical devices	- 1.085	**0**	**0**	**0**
Increase in the hourly rate of additional benefits and advance payment in the emergency/urgency services	- 88	**0**	**0**	**0**

Note: The Table elaborates the data resulting from MEF, *Economic and Finance Document 2023. Update note*, Rome, 27 September 2023, p. 102, Tables III – 11 "Account of the PA to current legislation (in million euros)".

Table 14. Health expenditure: operating results assessed by the Compliance Review Table by Region – Years 2013 – 2022

Regioni	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
Piemonte	-37,1	56,8	5,8	8,4	2,1	-8,5	-9,4	48,3	53,5	-27,9
Valle d'Aosta*	-53,1	-34,3	-25,6	-25,7	-21,8	-20,5	-22,7	-18,6	-20,7	-40,4
Lombardia	10,2	4,2	21,4	5,9	5,1	6,0	6,3	11,0	6,3	0,3
Provincia autonoma di Bolzano*	-190,1	-141,6	-204,5	-224,0	-267,5	-264,0	-237,7	-308,7	-324,6	-309,1
Provincia autonoma di Trento*	-223,5	-214,7	13,3	6,5	-196,4	-198,5	-194,8	-190,0	-181,3	-238,9
Veneto	4,4	15,7	3,5	13,7	51,9	13,1	13,3	2,2	8,5	7,1
Friuli Venezia Giulia*	-38,4	50,5	5,8	9,8	-52,0	-97,9	-135,0	-10,3	-132,8	-90,7
Liguria	-78,2	-63,7	-98,5	-63,7	-56,1	-51,6	-53,7	-0,0	-36,0	-65,1
Emilia Romagna	0,0	13,2	0,0	0,2	0,2	0,2	0,2	0,3	0,3	-99,9
Toscana	-25,1	7,4	-21,8	-42,0	-94,0	-18,0	-12,9	-93,2	-149,6	-76,2
Umbria	4,8	9,5	2,9	2,9	2,8	0,7	0,1	0,0	0,1	0,8
Marche	48,5	62,1	62,0	24,5	0,9	0,7	0,5	0,3	0,3	0,0
Lazio	-669,6	-355,1	-332,6	-136,5	-45,7	6,4	108,4	84,4	0,0	-222,3
Abruzzo	10,0	6,6	-5,8	-38,6	-42,1	0,1	-12,2	-15,3	13,9	-6,8
Molise	-99,4	-60,0	-44,7	-42,1	-35,1	-29,6	-95,3	-41,2	-60,0	-43,5
Campania	8,8	127,8	49,8	30,8	12,6	33,3	31,7	25,4	12,3	7,9
Puglia	-42,5	14,0	-54,1	-38,2	3,7	-53,8	-38,4	-24,2	-132,9	-148,8
Basilicata	0,0	1,5	-7,7	9,8	4,5	0,3	0,6	4,3	1,7	-9,9
Calabria	-33,9	-65,7	-58,5	-99,4	-101,5	-197,9	-225,4	-123,3	26,1	140,4
Sicilia	0,1	0,0	13,7	-0,0	-0,0	0,0	0,9	0,0	0,0	-39,4
Sardegna*	-380,4	-361,6	-328,4	-325,2	-240,2	-205,7	-168,7	-77,4	-182,2	-152,3
ITALIA	-1.784,7	-927,7	-1.003,9	-923,0	-1.068,6	-1.084,9	-1.044,0	-726,0	-1.097,1	-1.414,7

Source: Income Account of Local Health Authorities.

Note: the operating results in the table are consistent with the findings (for the regions with special status and autonomous provinces until 2021) of the activity of the "Compliance Review Table by Region", based on the criteria for evaluating the bookkeeping entries adopted by it. In this respect, they may differ from the operating results of the Regional Consolidated Income Statement model (999). The Regional Compliance Review Table was established by the Agreement of 23 March 2005 (art. 12) resulting from the State – Regions Conference. It includes, in addition to the representative of the Ministry of Economy and Finance, which coordinates it, representatives of the Department of Regional Affairs of the Presidency of the Council of Ministers; of he Ministry of Health; of the Regions in charge of the Health and Financial Affairs Areas, within the framework of the Conference of Presidents of the Autonomous Regions and Provinces; of an additional region indicated by the Conference of Presidents of the Autonomous Regions and Provinces; of the Agency for Regional Health Services; of the Secretariat of the Permanent Conference for relations between the State, the Regions and the Autonomous Provinces of Trento and Bolzano; of the Secretariat of the Conference of Presidents of the Regions and Autonomous Provinces.

Table 15. State of per-capita fiscal balance in the Regions of Italy – Year 2019. Primary Expenditure Revenue Fiscal balance

	Primary Expenditure	Revenue	Fiscal balance
Piemonte	13.959	14.744	-785
Valle d'Aosta	23.905	18.080	5.825
Lombardia	13.212	18.874	-5.662
Prov. aut. di Bolzano	21.044	17.689	3.355
Prov. aut. di Trento	21.700	20.902	798
Veneto	12.697	15.040	-2.342
Friuli-Venezia Giulia	14.957	15.678	-721
Liguria	15.132	14.554	578
Emilia-Romagna	14.078	16.864	-2.786
Toscana	13.865	14.420	-554
Umbria	14.332	12.508	1.824
Marche	13.702	12.918	784
Lazio	14.185	16.887	-2.702
Abruzzo	14.344	11.416	2.928
Molise	14.646	10.058	4.587
Campania	11.673	8.873	2.800
Puglia	12.262	9.062	3.200
Basilicata	15.405	10.224	5.181
Calabria	12.941	8.634	4.307
Sicilia	11.782	8.867	2.916
Sardegna	13.550	10.379	3.171
Nord	13.925	16.856	-2.931
Centro	14.035	15.296	-1.261
Sud e Isole	12.400	9.222	3.178

Source: Banca d'Italia. *L'economia delle regioni italiane,* n. 22, Roma, novembre 2020.

Note: the fiscal balance is the balance between expenditure and revenue. If it is positive, the region spends more on each citizen than the tax revenue generated in its own territory; thus, it receives transfers from the rest of the country through the State. If the balance is negative, the region spends less per citizen than the total tax revenue generated in its territory; thus, it positively contributes to the balance of the public budget and/or to the transfers to other regions.

Table 16. Distribution of Nonprofit entities in Italy by unit and number of employees (2020) Nonprofit institutions and employees by region/autonomous province and geographical breakdown. Absolute values, percentage changes and population incidence ratio

Regioni/Province autonome e Ripartizioni(a)	Istituzioni			Dipendenti		
	v.a.	Per 10 mila abitanti	Var. % 2020/2019	v.a.	Per 10 mila abitanti	Var. % 2020/2019
Piemonte	30.203	70,4	0,6	72.780	169,5	-2,5
Valle d'Aosta / Vallée D'Aoste	1.432	115,0	1,6	1.986	159,4	7,8
Lombardia	57.909	57,9	-0,4	192.726	192,6	-0,5
Liguria	11.136	73,2	-0,1	22.228	146,1	-0,8
Nord-Ovest	**100.680**	**63,1**	**0,0**	**289.720**	**181,7**	**-1,0**
Bolzano / Bozen	*5.861*	*109,8*	*1,8*	*10.212*	*191,3*	*3,0*
Trento	*6.510*	*119,7*	*0,3*	*14.263*	*262,1*	*3,4*
Trentino-Alto Adige / Südtirol	12.371	114,8	1,0	24.465	227,0	3,2
Veneto	30.793	63,2	-0,9	79.720	163,5	-0,4
Friuli Venezia Giulia	10.985	91,2	0,1	21.365	177,5	3,8
Emilia-Romagna	27.658	62,1	-0,9	82.291	184,9	-0,9
Nord-Est	**81.807**	**70,5**	**-0,5**	**207.841**	**179,1**	**0,2**
Toscana	28.002	75,8	-0,6	53.709	145,4	1,7
Umbria	7.217	83,2	1,2	12.124	139,7	1,6
Marche	11.503	76,4	-0,5	19.174	127,4	0,8
Lazio	33.958	59,1	0,4	113.898	198,3	3,6
Centro	**80.680**	**68,3**	**0,0**	**198.905**	**168,4**	**2,7**
Abruzzo	8.171	63,5	-1,7	11.496	89,3	1,1
Molise	2.054	69,1	-0,4	3.361	113,0	-0,5
Campania	22.453	39,6	4,5	35.614	62,8	3,3
Puglia	19.278	48,9	1,6	40.181	101,9	2,7
Basilicata	3.769	68,6	0,1	5.868	106,8	-1,4
Calabria	10.287	54,8	-0,4	11.148	59,4	0,4
Sud	**66.012**	**48,5**	**1,7**	**107.668**	**79,0**	**2,1**
Sicilia	22.799	47,0	0,6	42.555	87,7	8,4
Sardegna	11.521	72,0	0,7	23.494	146,8	-0,3
Isole	**34.320**	**53,2**	**0,6**	**66.049**	**102,3**	**5,1**
ITALIA	**363.499**	**61,2**	**0,2**	**870.183**	**146,4**	**1,0**

(a) La stima dello stato di attività delle istituzioni non profit è meno accurata nei domini di numerosità ridotta.

Source: ISTAT, *Structure and profiles of the Nonprofit sector*, Year 2020, Rome, 14 October 2022, Prospectus 2.

Note: In the year of greatest impact of COVID-19, the values in Veneto (The largest Region in North – Eastern Italy) are almost stable, both in terms of units and in terms of employees.

Table 17. Distribution of Nonprofit entities in Italy by main business sector (2020)

Settori di attività prevalente[a]	Istituzioni		Dipendenti[b]	
	v.a.	%	v.a.	%
Attività culturali e artistiche	57.615	15,9	20.038	2,3
Attività sportive	119.476	32,9	18.747	2,2
Attività ricreative e di socializzazione	51.954	14,3	10.827	1,2
Istruzione e ricerca	13.839	3,8	130.392	15,0
Sanità	12.578	3,5	103.215	11,9
Assistenza sociale e protezione civile	35.868	9,9	421.356	48,4
Ambiente	6.316	1,7	2.145	0,2
Sviluppo economico e coesione sociale	6.351	1,7	98.918	11,4
Tutela dei diritti e attività politica	6.684	1,8	3.350	0,4
Filantropia e promozione del volontariato	4.126	1,1	2.667	0,3
Cooperazione e solidarietà internazionale	4.635	1,3	3.868	0,4
Religione	17.249	4,7	9.396	1,1
Relazioni sindacali e rappresentanza interessi	24.610	6,8	40.686	4,7
Altre attività	2.198	0,6	4.578	0,5
TOTALE	363.499	100,0	870.183	100,0

(a) Per l'anno di riferimento 2020, al fine di allineare le classificazioni ATECO e ICNPO, alcune istituzioni sono state classificate differentemente rispetto ag anni precedenti. I settori maggiormente interessati dalla riclassificazione sono: sanità, assistenza sociale e protezione civile, sviluppo economico e coesion sociale, attività culturali e artistiche, attività ricreative e di socializzazione.

(b) Nel caso di istituzioni che svolgono più attività, la variazione dei dipendenti può riguardare il settore d'attività secondario e non quello prevalente.

Source: ISTAT, *Structure and profiles of the Nonprofit sector*, Year 2020, Rome, 14 October 2022, Prospectus 5.

Note: As it can be seen, the entities carrying out healthcare activities (Sanità = Health, sixth row) 12,578, represent just 3,5% of the total but employ a number of employees equal to 11.9% of the total (103,215 out of 870,183), ranking third for the number of employees on a national scale, after the sectors "Assistenza sociale e protezione civile" (seventh row) = Social assistance and civil protection and "Istruzione e ricerca" (fifth row) = Education and research, fifth row.

Table 18. Distribution of non-profit organizations in the Health Sector in Veneto Region – Italy (2024

Type of Care		Number
Health Care	SA	
OUTPATIENS		138
INPATIENTS		27
THERMAL CARE		84
HEALTH CARE		178
INTERMEDIATE STRUCTURES		67
TRANSFUSION CENTRES		3
TRANSPORT AND RESCUE		(Partial: 588) 91
Health and Social Care	SS	
ELDERLY		502
ADDICTIONS		83
DISABILITY		417
CHILDREN		(Partial: 1016) 14
		GRAND TOTAL: 1604

Source: Veneto Region – Azienda Zero (data updated on 28 June 2024).

Note: data refer to entities that have provided services related to LEA, under the accreditation regime. Therefore, the overall result is an approximation by default of the number of ETS in Veneto, actually operating, but not affecting the audience of Health care service suppliers of the SSR Veneto

Table 19. Local Social and Healthcare Units (ULSS) in Veneto Region, Italy, L.R. No. 19/2016

ULSS and Hospitals – Names of the Units	**Territorial Area**
ULSS No. 1 Dolomiti	Belluno Province
ULSS No. 2 Marca Trevigiana	Treviso Province
ULSS No. 3 Serenissima	Province of Venice (Eastern Veneto excluded)
ULSS No. 4 Veneto Orientale	Eastern Veneto
ULSS No. 5 Polesana	Rovigo Province
ULSS No. 6 Euganea	Padua Province
ULSS No. 7 Pedemontana	Bassanese County
ULSS No. 8 Berica	Vicenza Province (Bassanese excluded)
ULSS No. 9 Scaligera	Verona Province
City Hospital – University of Padua	National and Regional Hub
Integrated University Hospital City of Verona	National and Regional Hub
IRCCS Istituto Oncologico Veneto (IOV) - Padua	National and Regional Hub

Table 20. Hospital Network in the Veneto Region, Italy (D.G.R. 614/2019)

Typology/Name or number	Classification DM 70/2015 (Ministry of Health)	Classification of Hospital Cards	Public/Private/ Nonprofit
IRCCS			
Istituto Oncologico Veneto - Padova		National-Regional Hub	Public
"Medea" - Istituto "La Nostra Famiglia" – Conegliano (TV)	Single-specialist Structure	Rehabilitation Facility	Private accredited – Volunteer Organization (Nonprofit) ETS
"San Camillo" - Venezia	Single-specialist Structure	Rehabilitation Facility	Private - Foundation accredited
Ospedale Sacro Cuore-Don Calabria di Negrar (VR)	First Level Hospital Presidium	Spoke	Nonprofit Foundation ETS
Total IRCSS 4			
Other Hospital Units			
I Level	Number: **5**	Provincial Hubs	Public
I Level	Number: **18**	Spoke	Public
I Level	Number: **1**	Spoke	Private for-profit accredited
II Level	Number: **2**	Provincial Hubs	Public
Basic	Number: **2**	Basic	Public
Remote Areas	Number: **6**	Basic	Public
Integrative structure of the network	Number: **3**	Valid in the ULSS territory	Private accredited for-profit
Integrative structure of the network	Number: **10**	Private Accredited Structure Supplementary of the Regional Hospitals Network	Private accredited for-profit
Single-specialist Structure	Number: **4**	Single-specialist Structure of Psychiatric Rehabilitation	Private accredited for-profit
Single-specialist Structure	Number: **5**	Rehabilitation Facility	Private accredited, 1 ETS
Single-specialist Structure	Number: 9	Rehabilitation Facility	Public
Total OHU	**65**		
Grand Total:	**69**		

Source: Annex A to the D.G.R. 614/2019; Ministry of Health Research – IRCSS updated on 27 February 2024 and Veneto Region – Healthcare Portal, ULSS and Hospital Units.

Note: Out of the 69 hospitals mentioned above, 42 (60,87%) are public, 27 (39,13%) are private, of which 3 (4,34%) are Nonprofit entities (ETS). In the "hospital ranking" the level is decreasing, i.e. the II level has a lower importance than the I level.

Table 21. Percentage of hospital discharge for acute (main diagnosis) Italians and foreigners: Italy – year 2021

Pathologies	Italians	Foreigners	Difference Italians - Foreigners
Infectious and parasitic diseases	1,86	2,70	0,84
Cancer	12,24	7,36	- 4,87
Endocrine metabolic and immune diseases	2,41	2,17	- 0,24
Blood and hematopoietic organ diseases	1,05	1,01	- 0,04
Mental disorders	2,16	2,96	0,80
Diseases of the nervous system and sense organs	4,46	3,57	- 0,89
Diseases of the circulatory system.	14,42	6,96	- 7,46
Diseases of the respiratory system	9,57	8,67	- 0,90
Diseases of the digestive tract	9,02	8,18	- 0,84
Diseases of the genitourinary system	8,20	7,07	- 1,13
Complications of pregnancy, childbirth and puerperium	7,02	25,29	18,27
Skin and subcutaneous tissue diseases	0,87	0,72	- 0,15
Congenital malformations	1,27	1,62	0,35
Conditions generated in the perinatal period	0,77	1,77	1,00
Symptoms, signs, and ill-defined conditions	2,49	2,15	- 0,34
Injuries and poisoning	7,90	6,75	- 1,14
Factors affecting health status	6,67	6,66	- 0,02
Not mentioned	0	0	0
TOTAL	100,00	100,00	

Source: ISTAT, *http://dati.istat.it/#:* "Dimissioni per acuti e per cittadinanza del paziente: Diagnosi principale", Roma, anno 2021.

Note: Le patologie che sembrano maggiormente affliggere i cittadini stranieri rispetto ai cittadini italiani sono evidenziate con il colore arancione pallido (segno positivo). Esse riguardano le "Complicazioni della gravidanza parto e puerperio" (+ 18,27%), le "Condizioni generate in epoca perinatale" (+1%), le "Malattie infettive e parassitarie" (+0,84%), i "Disturbi psichici" (+0,80%).

Table 22. Nonprofit Outpatient Network in Veneto Region, Italy

ULSS Reference	Outpatient Unit (Name and or Place)	Total users from their start dates to 2022			Users 2022
		Observation Period	Total users	Normalized annual historical average	
ULSS 2 Marca Trevigiana (Treviso)	Outpatient Proximity Unit Castelfranco	April – December 2022	56	84	84
ULSS 2 Marca Trevigiana (Treviso)	Outpatient Proximity Unit Montebelluna	April – December 2022	101	135	135
ULSS3 Serenissima (Venice)	Outpatient Unit "Emergency"	December 2010 – December 2022	12,416	1,035	1,783
ULSS3 Serenissima (Venice)	Solidarity Clinic "A. Monterosso"	March 2016 – December 2022	15	3	5
ULSS 5 Polesana (Rovigo)	Outpatient Unit "Saint Andrew"	August – December 2022	50	50	120
ULSS 6 Euganea (Padova)	"Healthcare Cheap-Popular Kitchen"	2020 - 2022	1,907	636	608
ULSS 6 Euganea (Padova)	Health Clinic "Camper Mobile"	2022	600	600	600
ULSS 6 Euganea (Padova)	Polyclinic "Caritas"	1998 - 2022	5,500	220	85
ULSS 8 Berica (Vicenza)	Popular Clinic "Caracol Olol Jackson"	November 2020 – December 2022	511	245	483
ULSS 8 Berica (Vicenza)	Outpatient Italian Red Cross (CRI) Bassano del Grappa	April – December 2022	68	91	172
ULSS 9 Scaligera (Verona)	CESAIM	2014 - 2022	18,553	2,061	2,162
ULSS 9 Scaligera (Verona)	Barana and Saint Bernardino	2022	345	345	345
Total			**40,122**	**5,575**	**6,582**

Source: Cusinato A., Rigoli G., *Cognitive survey on medical clinics in Veneto managed by Third Sector Entities* 2022, Castelfranco Veneto, 2023, p. 19.

Note: The audience of the concerned Nonprofits is quite varied: 7 Volunteer Organizations (CSV Belluno Treviso, Auser Odv Venice, Caritas Odv Adria and Padua, CRI Odv Vicenza, CESAIM Odv Verona, Medici per la pace odv Verona), some of Catholic inspiration; 1 APS (Caracol Olol Jackson Vicenza), 1 NGO (Emergency Venezia-Marghera), 1 ETS Foundation (Nervo Pasini Foundation, Padua), various Social Enterprises (Coges Don Milani, Cosep, Solar City) for the management of the Clinic "Sant'Andrea" (ULSS Polesana).
With regard to the issue of the transformation of religious bodies into Nonprofits, for the purposes of registration with the RUNTS (Art. 4, paragraph 3, Third Sector CCTS), see, more in depth, Di Gregorio C., Verginella E., *Religious Bodies, ETS, RUNTS: the reasons for a choice*, in Cooperative e Enti Non Profit, n. 1/2023, pp. 20 – 35 and Bagnoli L., *Le fabbricerie e la riforma del Terzo Settore*, in Impresa sociale, n. 3/2023, pp. 53-62.

Table 23. Percentage composition of the pathologies detected in users of Nonprofit Outpatient Clinics in Veneto and in foreign patients discharged from Hospitals in Italy (years 2021-2022)

Pathologies	Nonprofit Outpatient Clinics (Veneto 2022)	Hospital Discharge of Foreigners (Italy 2021)	Difference
Infectious and parasitic diseases	2,95	2,70	0,25
Cancer	1,13	7,36	- 6,23
Blood and immune system diseases	0,67	1,01	- 0,34
Endocrine, nutritional and metabolic diseases	6,76	2,17	4,59
Mental and behavioral disorders	4,00	2,96	1,04
Neuropathies	2,35	3,57	- 1,22
Ophthalmopathies	2,45	..	..
Ear disorders	3,20	..	..
Diseases of the circulatory system	7,87	8,00	- 0,13
Diseases of the respiratory system	9,57	8,67	- 0,90
Gastroenterological diseases	11,10	8,18	2,92
Dermatopathies	7,06	0,70	6,32
Musculoskeletal and connective disorders	12,04	4,39	7,65
Diseases of the genitourinary system	3,57	7,07	- 3,50
Pregnancy, childbirth and puerperium	3,58	25,29	- 21,71
Birth defects	0,01	1,62	- 1,61
Chromosomal malformations and abnormalities	0,10	1,77	- 1,67
Pathological signs, symptoms and laboratory data not otherwise classified	3,95	2,15	1,80
Traumatology, toxicology and other external causes of disease	2,13	6,75	- 4,72
Other external causes of morbidity and mortality	6,61	..	6,61
Factors affecting health status	8,90	5,66	3,24
TOTAL	100,00	100,00	

Source: Cusinato A., Rigoli G., *Indagine conoscitiva sugli ambulatori medici del Veneto gestiti da Enti del Terzo Settore 2022*, Castelfranco Veneto, 2023, p. 27.

Note: Table shows the pathologies found by Nonprofit Outpatient Clinics in Veneto on foreign patients (in the second column). From the comparison with data only related to foreigners discharged from hospitals on the entire national territory in 2021, it is not only doubled the boxes (in yellow) of "sensitive" pathologies, but also detected pathologies that had not aroused interest in the other detection. Among the notable situations, "Musculoskeletal and connective tissue disorders" (+7.65%), "Other external causes of morbidity and mortality", "Dermatopathies" (Diseases of the skin and subcutaneous tissue: +6.32%), "Endocrine, nutritional and metabolic diseases" (+4.59%), previously not detected.

Table 24. List of Voluntary organizations engaged in health care in Veneto, distinguished by ULSS, hospitals and similar units

Local Social and Healthcare Units (ULSS), Hospitals and similar Units.	**Territorial Area**	**Number of Voluntary Organizations OdV**
ULSS no. 1 Dolomiti	Province of Belluno	25
ULSS no. 2 Marca Trevigiana	Province of Treviso	37
ULSS no. 3 Serenissima	Province of Venice (Excluding Eastern Veneto)	39
ULSS no. 4 Veneto Orientale	Eastern Veneto	N.P.
ULSS no. 5 Polesana	Province of Rovigo	25
ULSS no. 6 Euganea	Provincia of Padova	N.P.
ULSS no. 7 Pedemontana	Bassanese (Bassano del Grappa)	72
ULSS no. 8 Berica	Province of Vicenza (Excluding Bassanese)	101
ULSS no. 9 Scaligera	Province of Verona	87
Hospital of Padova (AOU)	National and Regional Hub	99
Hospital of Verona (AOUI)	National and Regional Hub	15
IOV – IRCCS (Scientific Institute for Research, Hospitalization and Healthcare)	Regional Hub	5
	TOTAL	**505**

Source: Portals ULSS Veneto Region, Center for Volunteer Services in Veneto, University Hospital of Padua, University Integrated Hospital of Verona, IOV – Institute of Oncology in Veneto.

Note: Voluntary organizations listed in this table are only those that carry out activities of hospital care, or support to such activity (for example, blood donation, organ donation, etc.) or performed activities of the type "*Hospital-to-Home transition*".

Table 25. Values of nonprofits related to LEA, under the accreditation regime, year 2022 (in euros) (amount in euros).

NPOs	Total revenues and/or total fees 2022	Total turnover (VAT) 2022	Overall Income 2022	Tangible assets 2022
588	2.125.869.676	2.125.615.419	67.158.245	918.199.390

Source: Agenzia delle entrate – DRE Veneto (Italian Revenue Agency – Regional Directorate of Veneto) on data transmitted by "Azienda Zero", related to "accredited" Charitables and Nonprofits which provide health services only pertaining to essential levels of care (LEA: see Table 18, Section "Health Care – SA").

Note: the aggregated data presented in the table are derived from the overall accounting and tax return of the entities included in the list transmitted by "Azienda Zero". Their acquisition seems to be relevant because, compared to Figure 25, fourth column (year 2022 – "PRIVATE/NON PROFIT") in this table they are treated separately from the total of private entities (for-profit and non-profit) reported in Figure 25 cited above (935,646,550 euros), and also because the total amount reported therein is only related to the "Regional Rate" applied.

Values of the Nonprofit Health Structures accredited by SSR, according to the codes "ATECO" – period 2021 – 2023 (in thousands of euros)

Order number	Typology	Numerical Consistency	Revenues 2023	Costs 2023	Assets 2023	Revenues 2022	Costs 2022	Assets 2022	Revenues 2021	Costs 2021	Assets 2021
1	General Hospitals and Nursing Homes	11	287.741	287.860	78.530	279.288	280.079	89.655	279.004	262.207	84.470
2	Specialist Hospitals and Nursing Homes	17	47.092	41.114	2.633	74.630	70.658	3.168	85.841	88.293	10.969
3	Hospitals and long-term Care Homes*	9	6.966	6.997	108	8.083	8.075	76	7.489	7.820	53
4	Services of General Practitioners**	23	1.917	1.793	13	1.809	1.627	15	1.353	1.237	9
5	Aesthetic medicine centers**	29	3.266	2.238	68	5.064	3.998	537	5.337	4.411	944
6	Other Medical Specialized and Outpatient Care	608	365.078	350.464	56.615	386.040	371.017	36.520	355.948	328.198	34.681
7	Dental Practice Activities**	960	329.676	299.194	14.213	382.072	350.718	18.428	337.536	307.673	18.679
8	Ambulance Services, Blood Banks and Other Health Care Services n.e.c.	78	19.868	18.751	719	27.532	27.443	2.796	30.239	27.662	2.570
TOTAL		**1.735**	**1.061.604**	**1.008.411**	**152.899**	**1.164.518**	**1.113.615**	**151.195**	**1.102.747**	**1.027.501**	**152.375**

Source: Agenzia delle Entrate — Direzione Regionale Veneto (data updated as of 30 October 2024)

Note:

* They are not Nursing Homes for elderly (502, according to the data provided "Azienda Zero" Authority), but real hospital structures. See Table 18, item "Elderly".

** The Centers or services indicated are located or provided within hospitals or outpatient structures. Whether they are identified separately depends on the identification by "ATECO" codes, which corresponds to a single category and a tax code or VAT number, regardless of the tax domicile (that of the Hospital, Outpatient or Polyclinic in which NPOs health care workers operate).

"Agenzia delle Entrate" is the Italian Revenue Agency and "Direzione Regionale Veneto" is the Regional Directorate of Veneto.

Table 27. Waiting lists by region: planned surgical admissions, year 2023

Piano operativo di recupero ricoveri				Monitoraggio intero anno 2023						
Regioni/PP.AA	Liste di attesa al 01/01/2023	Volume di prestazioni inserite nel POR (numero interventi chirurgici da effettuare anno 2023)	Finanziamento stimato	Volume di interventi erogati	% recupero rispetto al programmato	interventi cancellati	Residuo in lista d'attesa	Totale spesa sostenuta residuo L.234_2021	Totale spesa sostenuta 0,3% FSN	% spesa rispetto al programmato
Abruzzo	3.778	2.128	2.274.560 €	2.230	105%	905	643	- €	1.597.975 €	70%
Basilicata	-	-	- €	-	-	0%	-	- €	- €	0%
Calabria*	3.982	1.224	1.784.805 €	1.348	110%	141	2.493	2.039.436 €	335.430 €	133%
Campania*	35.915	24.355	49.000.000 €	18.931	53%	8.763	8.221	7.447.798 €	15.511.527 €	47%
Emilia-Romagna	44.609	35.687	- €	18.029	51%	15.913	10.667	- €	- €	- €
FVG*	13.919	1.063	1.367.174 €	7.189	52%	3.949	2.781	448.834 €	- €	33%
Lazio*	41.670	26.437	- €	29.597	112%	2.796	9.277	- €	- €	0%
Liguria*	37.096	3.983	1.951.644 €	5.222	131%	16.784	15.090	- €	3.061.295 €	157%
Lombardia*	95.891	62.515	26.000.000 €	42.051	67%	16.902	36.938	- €	2.300.827 €	9%
Marche	18.838	18.838	2.033.353 €	9.627	51%	2.848	6.363	- €	2.598.674 €	128%
Molise*	216	-	- €	-	0%		-	- €	- €	0%
PA Bolzano	150	150	50.827 €	31	21%		119	11.736 €	- €	23%
PA Trento	-	-	- €	-	-	0%	-	- €	- €	- €
Piemonte	46.014	46.014	13.131.738 €	45.624	99%	390		- €	12.842.636 €	98%
Puglia	15.863	15.863	34.342.249 €	11.434	72%	4.200	229	9.600.000 €	24.742.249 €	100%
Sardegna	2.558	479	559.703 €	982	205%	1.206	370	645.638 €	- €	115%
Sicilia	38.369	15.975	14.662.278 €	15.324	96%	13.906	9.139	2.244.813 €	1.851.641 €	28%
Toscana*	18.000	18.000	10.000.000 €	20.478	114%	6.083	-	- €	3.368.951 €	34%
Umbria*	10.958	9.197	1.011.819 €	4.741	52%	1.908	4.309	266.811 €	373.213 €	63%
Valle d'Aosta	2.540	2.540	452.600 €	1.183	47%	539	818	15.299 €	141.514 €	35%
Veneto*	45.373	45.373	2.536.083 €	25.424	56%	10.508	9.441	- €	1.919.638 €	76%

Source: Ministry of Health on request from the Court of Auditors, Central Section, on the management of the State Administrations Resolution 13 November 2024, n. 90/2024/G, p. 128, Table 28

Note: The blue box, second column, shows the total number of patients on the waiting list for surgery as of 1 January 2023. The pink box shows the interventions carried out during the same year (fifth column) and the recovery rate compared to the planned interventions (sixth column), but also the number of interventions cancelled (seventh column). The eighth column shows the remaining patients on the waiting list as of 31 December 2023.

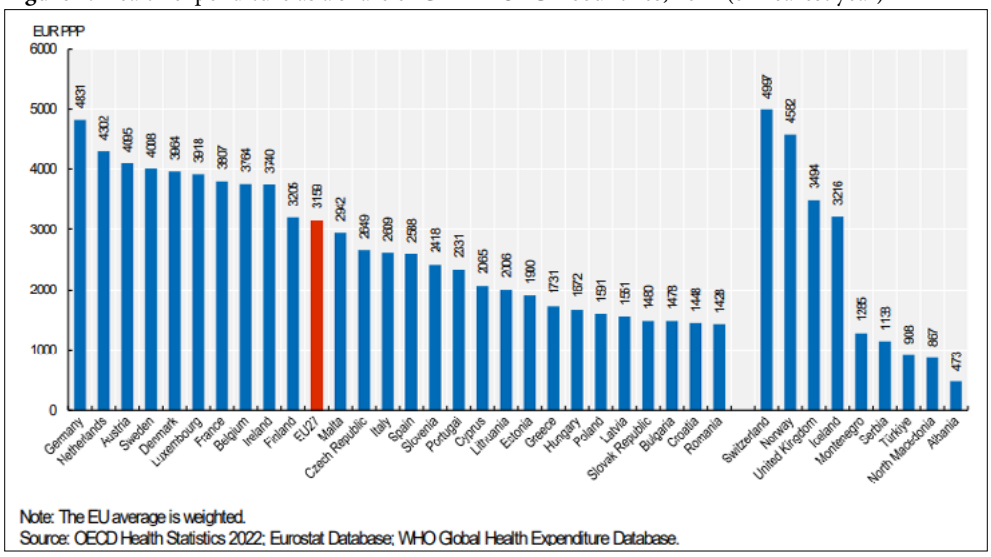
Table 28. Waiting lists by region: oncology screening, year 2023

Regioni/PP.AA	Piano operativo di recupero screening					Monitoraggio intero Anno 2023						
	Liste di attesa al 01/01/2023		Volume di prestazioni inserite nel POR									
	Inviti	Prestazioni	Inviti	Prestazioni	Finanziamento stimato	Volume inviti inviati	% recupero inviti rispetto al programmato	Volume prestazioni erogate	% recupero prestazioni rispetto al programmato	Totale spesa sostenuta residuo L.234_2021	Totale spesa sostenuta 0,3% FSN	% spesa rispetto al programmato
Abruzzo*	81.017	39.408	34.084	12.111	371.577 €	29.219	86%	8.389	69%	- €	179.961 €	48%
Basilicata				-	- €	-	0%	-	0%	- €	- €	0%
Calabria*	-	-	-	-	- €	-	0%	-	0%	- €	- €	0%
Campania*	539.255	124.824	269.628	37.447	- €	535.144	99%	93.823	251%	- €	- €	
Emilia Romagna	-	-	-	-	- €	-	0%	-	0%	- €	- €	0%
FVG*	34.105	23.974	-	940	29.746 €	34.105	100%	23.975	100%	- €	- €	0%
Lazio	-	-	-	-	- €	-	0%	-	0%	- €	- €	0%
Liguria*	-	66.534	-	2.518	52.166 €	-	-	1.555	62%	- €	48.193 €	92%
Lombardia	-	-	-	-	- €	-	0%	-	0%	- €	- €	0%
Marche	75.506	45.809	75.506	45.809	364.018 €	14.897	20%	2.365	5%	- €	95.687 €	26%
Molise	-	-	-	-	- €	-	0%	-	0%	- €	- €	0%
PA Bolzano	-	2.061	-	2.061	38.823 €	-	0%	2.061	100%	38.834 €	- €	100%
PA Trento	-	-	-		€		0%		0%	€	€	0%
Piemonte	7.040	24.502	7.040	24.502	738.262 €	7.040	100%	24.412	99,60%	- €	722.008 €	98%
Puglia	-	-	-	-	- €	-	0%	-	0%	- €	- €	0%
Sardegna*	34.157	2.542	n.d.	28.038	173.919 €	51.691	151%	19.036	68%	171.561 €	- €	99%
Sicilia*	217.476	67.608	n.d.	157.295	1.046.560 €	314.900	145%	44.875	29%	167.810 €	- €	16%
Toscana	-	-	-	-	- €	-	0%	-	0%	- €	- €	0%
Umbria	-	-	-	-	- €	-	0%	-	0%	- €	- €	0%
Valle d'Aosta	-	-	-	-	- €	-	0%	-	0%	- €	- €	0%
Veneto				-	- €	-	0%	-	0%	- €	- €	0%

Source: Ministry of Health on request from the Court of Auditors, Central Section, on the management of the State Administrations Resolution 13 November 2024, n. 90/2024/G, p. 132, Table 30.

Note: The blue box highlights the waiting lists as of 1 January 2023. The pink box shows the residues still in existence on 31 December of the same year. As you can see, the Veneto region has no patients on the waiting list at the beginning or end of the year, having completed all the oncology screenings scheduled during the year.

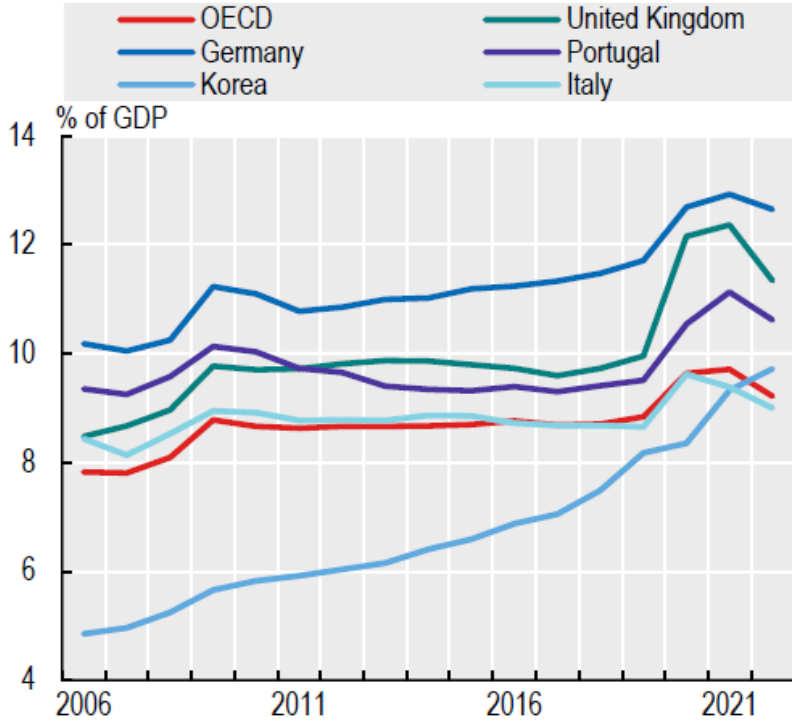
Figure 1. Health expenditure as a share of GDP in OECD countries, 2022 (or nearest year)



Source: *Health at a Glance 2023. OECD Indicators*, OECD Publishing, Paris, *https://doi.org/10.1787/7a7afb35-en,* Fig. 7.1., p. 155.

Note: As it can be seen, Italy, with 9% of GDP, is immediately below the OECD average (9.2% of GDP). The amount is covered to the large extent by the SSN (darker shade of blue in the histogram, designated with the expression "Government/Compulsory", and for the rest by voluntary contributions (lighter shade of blue, designated with the expression "Voluntary/Out-of-pocket", literally "out-of – pocket"). These are expenses for supplementary health insurance or "ticket" fees that remain payable by patients. The latter share is slightly above the OECD average.

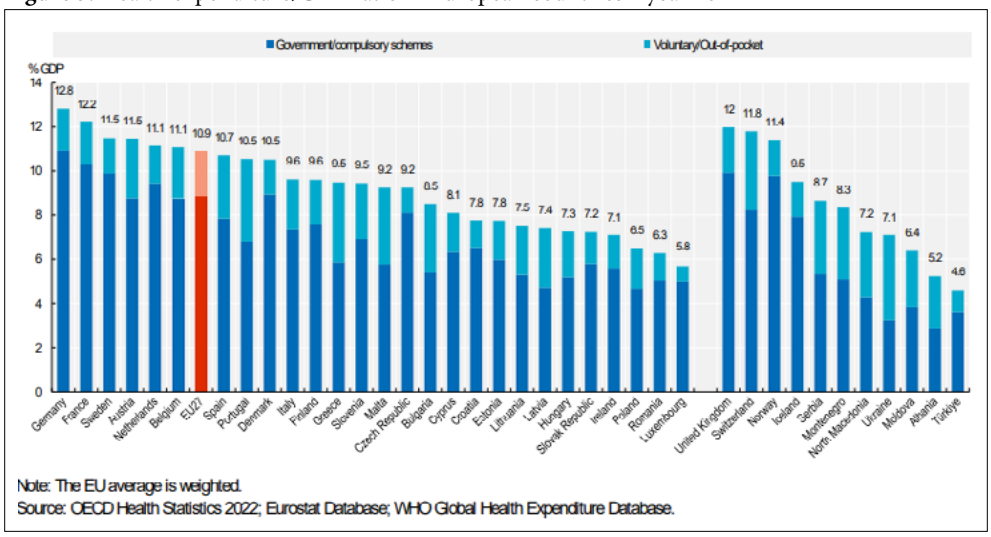
Figure 2. Health expenditure as a share of GDP, selected countries, 2006-22



Source: *Health at a Glance 2023. OECD Indicators*, OECD Publishing, Paris, *https://doi.org/10.1787/7a7afb35-en*, Fig. 7.3., p. 155.

Note: Among the selected countries, apart from South Korea where, although it has been steadily growing from 2006, healthcare expenditure remains below the OECD Average, except in 2020-21, due to the Covid-19 pandemic crisis. In Italy, Health spending remains in line with the OECD average for the whole considered period, having a peak in 2020, as a result of the pandemic crisis, and falls below the OECD average from 2021 onwards.

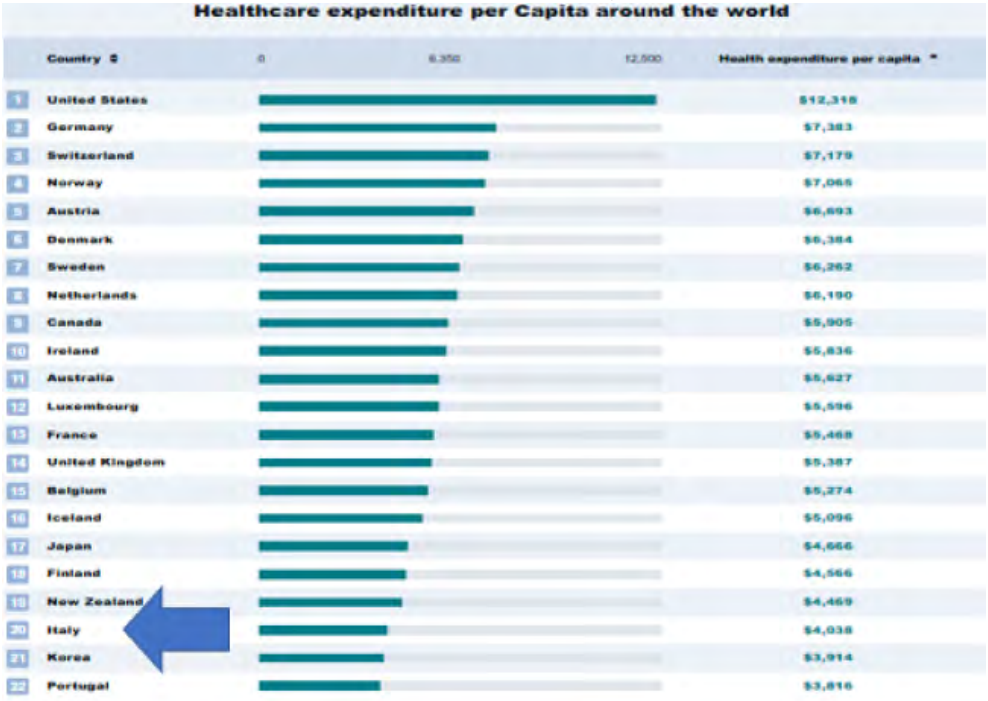
Figure 3. Health expenditure/GDP ratio in European countries – year 2022



Source: OECD, *Health at a Glance*: *Europe 2022*, Fig. 5.3, p. 131.

Note: Compared to Fig. 1, Italy is also below the EU average, ranking at 10th among the countries of the European Union, although the Italian expenditure/GDP ratio is estimated at 9.6%, instead of 9.2%, still with a share to be borne by patients (lighter shade in histogram).

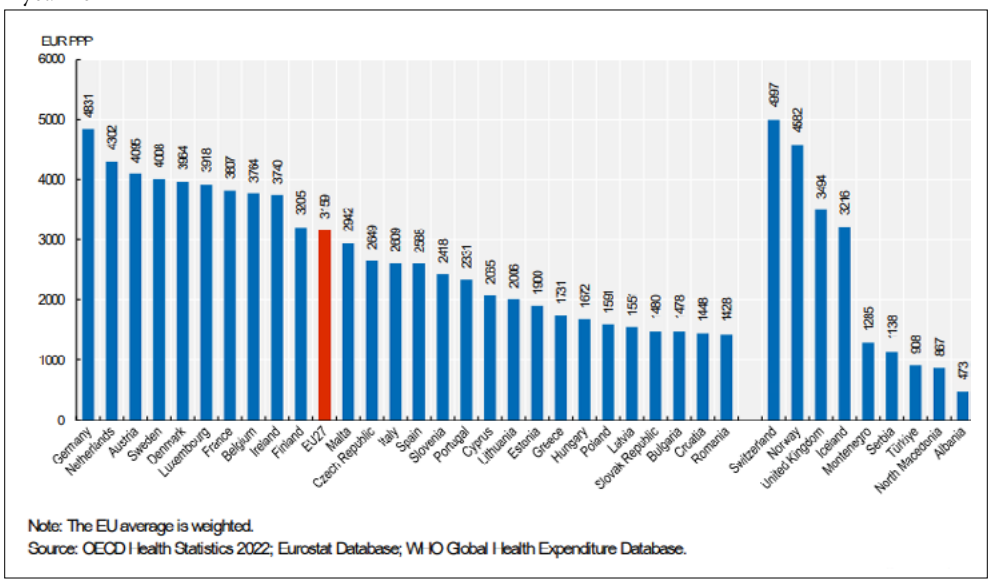
Figure 4. Health expenditure per capita in OECD countries – year 2022



Source: Biancheri G., *Il privato in sanità. La vera posta in gioco*, cited above.

Note: at first the figure shows the 2022 Italy's ranking among 22 selected OECD countries, and secondly what is the average health expenditure per capita (4,038 US dollars, inclusive of the share borne by patients). The author also points out that Italian national health expenditure is considerably lower not only compared with that of Germany, France and the United Kingdom, but also compared with that of Ireland, Belgium and Finland and only slightly higher than that of Portugal.

Figure 5. Amount of average health expenditure per – capita borne by NHS in European countries – year 2022



Source: OECD, *Health at a Glance*: *Europe 2022*, Fig. 5.1, p. 129

Note: the figure shows, first, how Italy is significantly below not only the average of the European Union countries (– 550 euros per capita), but also of the one of Ireland, Finland, Malta and the Czech Republic.

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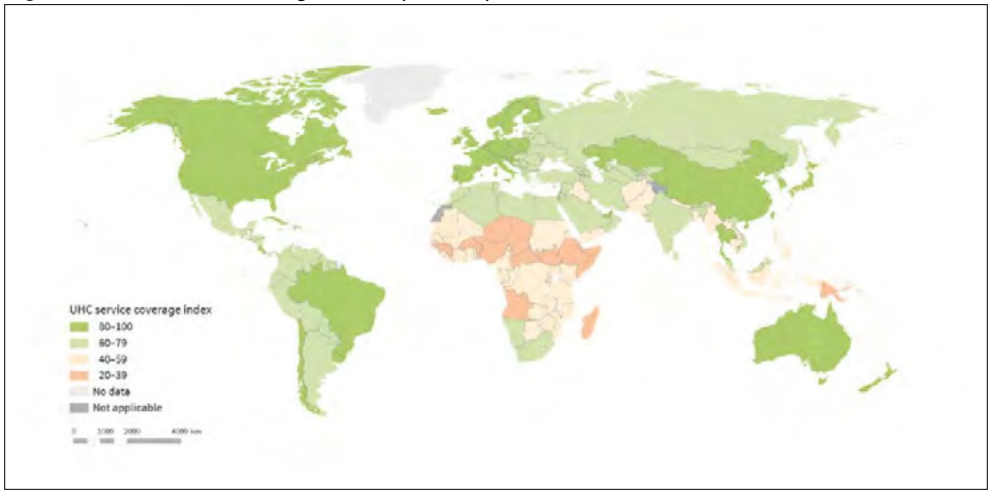
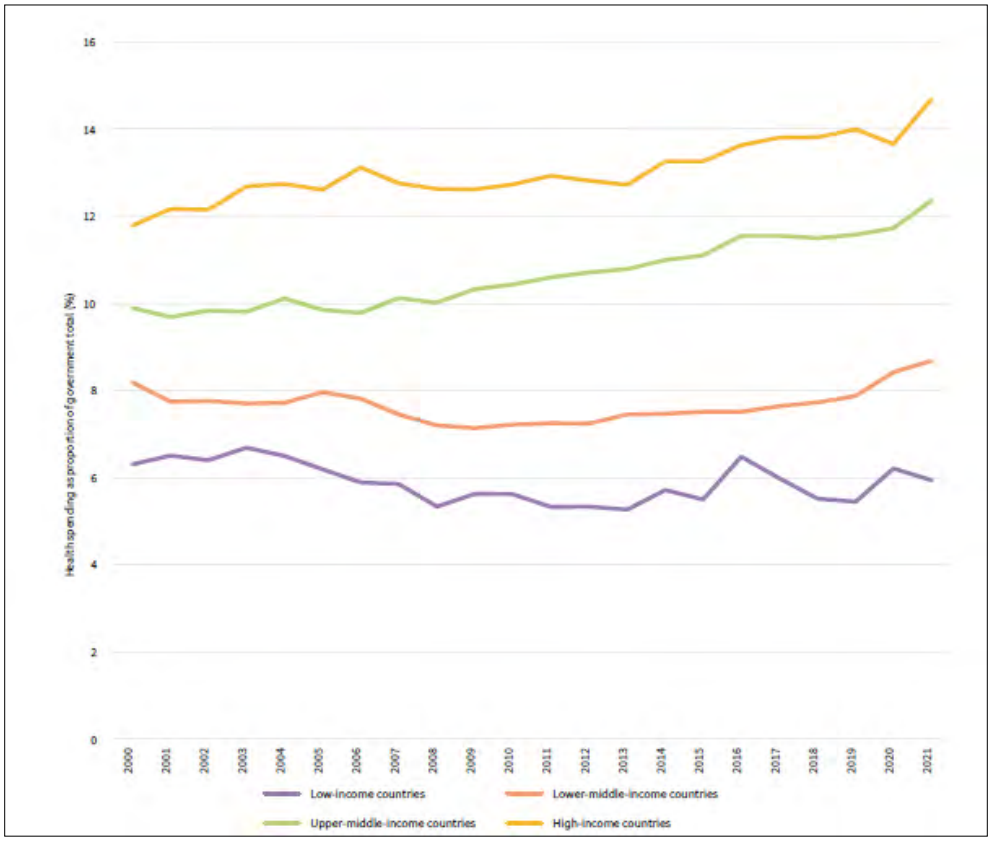
Figure 6. UHC service coverage index, by country, 2021 (WHO data)



Source: WHO, *World health statistics 2024: Monitoring health for the SDGs, Sustainable Development Goals*, Geneva, 2024, p. 44, Table 2.12. available in *https://iris.who.int/bitstream/handle/10665/376869/9789240094703-eng.pdf?sequence=1.*

Note: As it can be seen, the coverage of essential health services (access to basic medicines and vaccines) is ensured at the highest level (80-100%) in the G7 countries, Northern Europe, China, Australia, New Zealand, Brazil, Chile, gradually decreasing as the survey goes ahead towards developing countries.

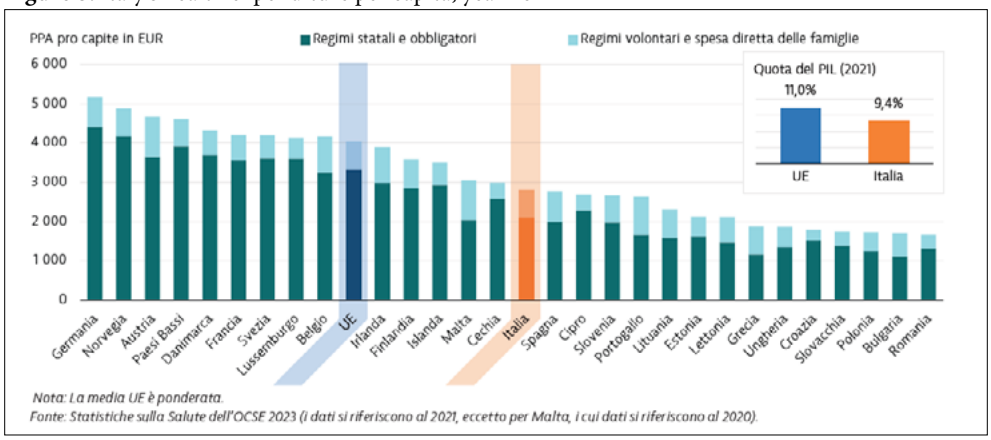
Figure 7. Proportion of total government spending on health (%), by World Bank income group, 2000–2021



Source: WHO, *World health statistics 2024: Monitoring health for the SDGs, Sustainable Development Goals*, Geneva, 2024, p. 50, Table 2.16, available in *https://iris.who.int/bitstream/handle/10665/376869/9789240094703-engpdf?sequence=1.*

Note: In high income countries (yellow line) health expenditure is constantly growing, with an inflection between 2007/2008 in correspondence with the financial crisis (Lehman Bros.) and again in the period 2020/2021 in correspondence with the pandemic emergency by Covid-19. While the above – mentioned circumstances have had identical effects in high-middle income (green line) and low-income countries (purple line), the trend of health expenditure in the lower-middle income countries (orange line) appears constant over time.

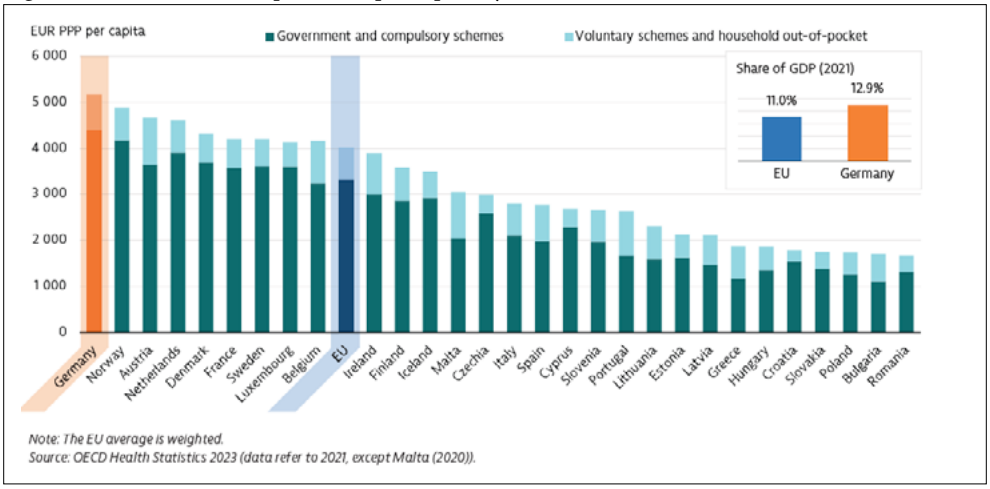
Figure 8. Italy's health expenditure per capita, year 2021



Source: OECD Report – *European Observatory on Health Systems and Policies*, State of *Health in the EU: Italy. Country Health Profile, 2023. Italy*, OECD Publishing, Paris, p. 10, Fig. 9.

Note: health spending per capita in Italy is almost a third lower than the EU average. Preliminary 2022 data also indicate a significant decrease on an annual basis which, according to the OECD Observatory, is due to a significant reduction in direct expenditure (-6 %) and a more moderate decline in public health expenditure (-3.5 %), linked to the lower incidence, compared to 2021, expenditure related to COVID-19.

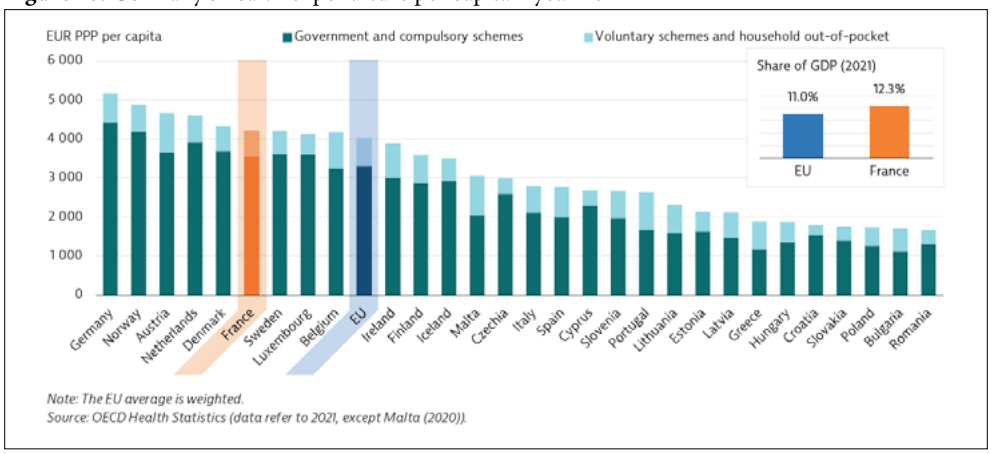
Figure 9. France's health expenditure per capita – year 2021



Source: OECD Report – European Observatory on Health Systems and Policies, *State of Health in the EU, France 2023: Country Health Profile*, OECD Publishing, 2023, Paris, p. 9, Fig. 8.

Note: France's per capita health expenditure is higher than most other EU countries, but lower than Germany's. In addition, almost 95% of French citizens have supplementary insurance. The health costs not covered by the public system concern dental care and certain specialist care, both hospital and outpatient. They are represented more clearly in the histograms (Voluntary schemes and household out- of-pocket).

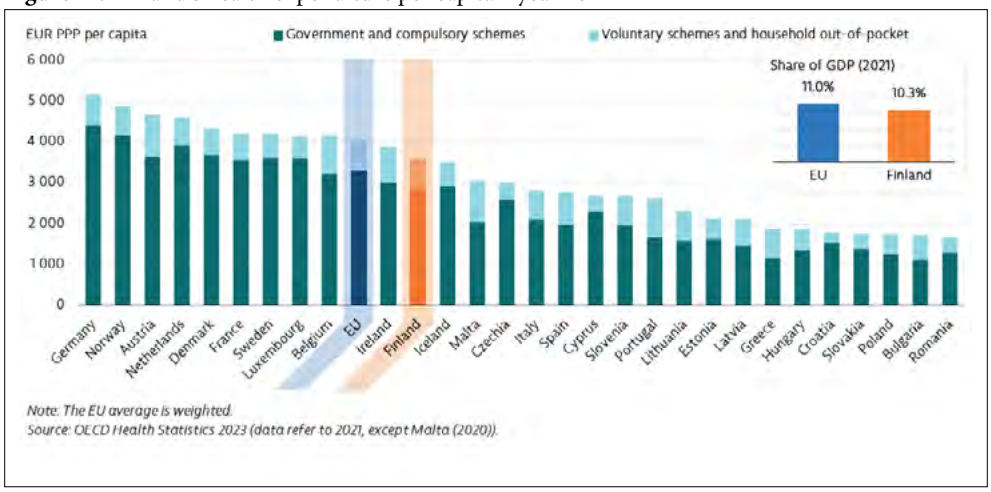
Figure 10. Germany's health expenditure per capita – year 2021



Source: OECD Report – European Observatory on Health Systems and Policies, *State of Health in the EU, Germany 2023: Country Health Profile*, OECD Publishing, Paris, p. 9, Fig. 7.

Note: Germany's per capita health expenditure is the highest of the EU countries. The hospital sector is very large with 7.8 beds per 1000 inhabitants, the second in the EU, after Bulgaria, 2021.

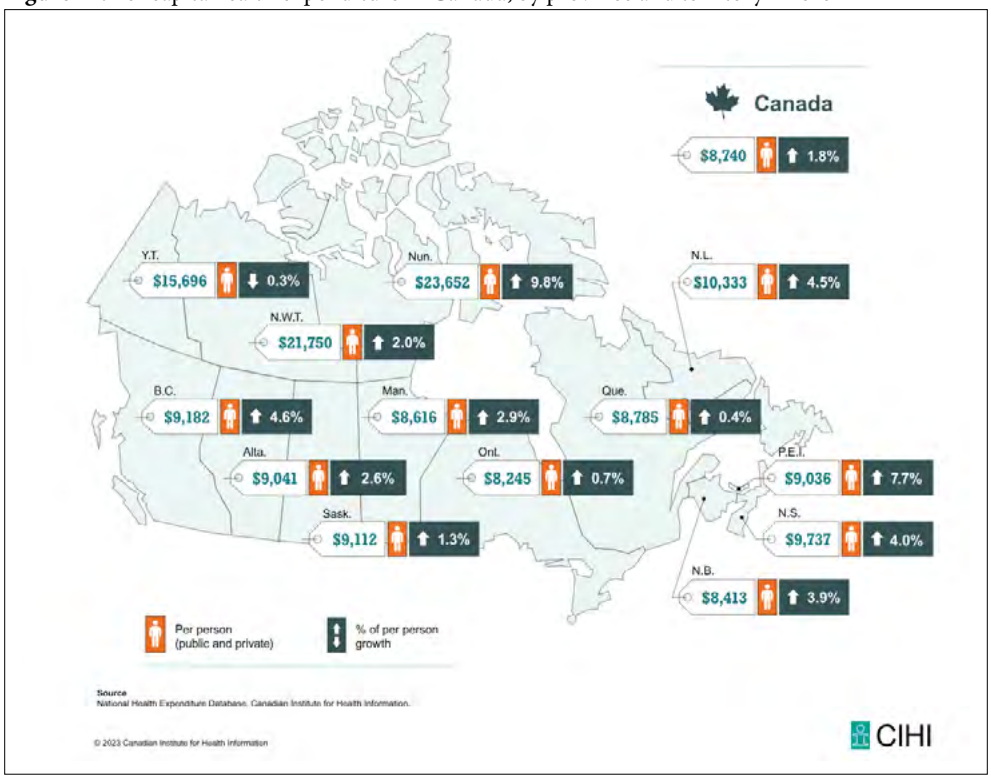
Figure 11. Finland's health expenditure per capita – year 2021



Source: OECD Report – European Observatory on Health Systems and Policies, *State of Health in the EU, Finland 2023: Country Health Profile* OECD Publishing, Paris, 2023, p. 9, Fig. 10.

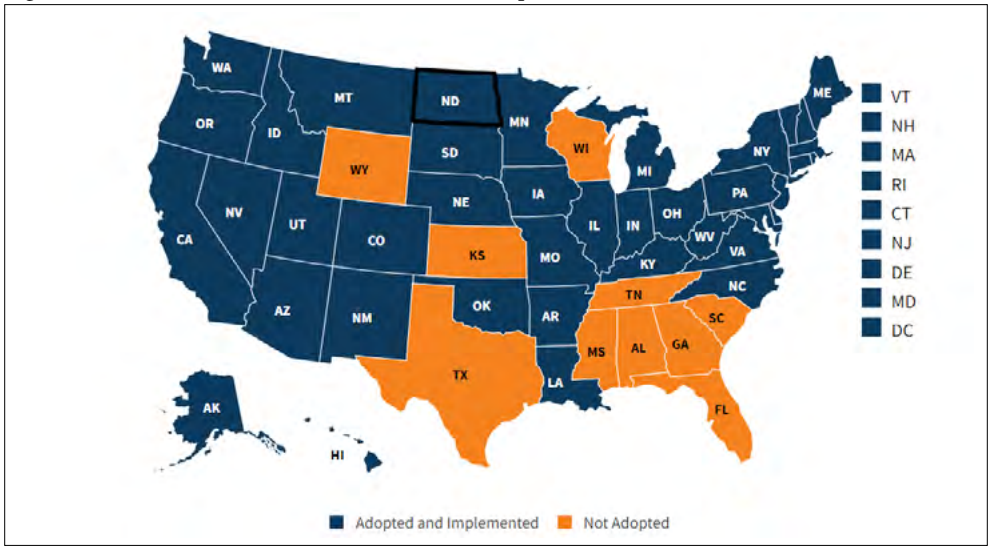
Note: Finland's per capita health expenditure is lower than both the EU and Nordic average. Over 40% of healthcare expenditure is directed to outpatient care, 22% to hospital care and 18% to long-term care.

Figure 12. Per capita health expenditure in Canada, by province and territory – 2023



Source: *National Health Expenditure Trends. How do the provinces and territories compare"?* by Canadian Institute for Health Information – CIHI, 2023, also available in *https://www.cihi.ca/en/how – do-the-provinces-and-territories-compare.*

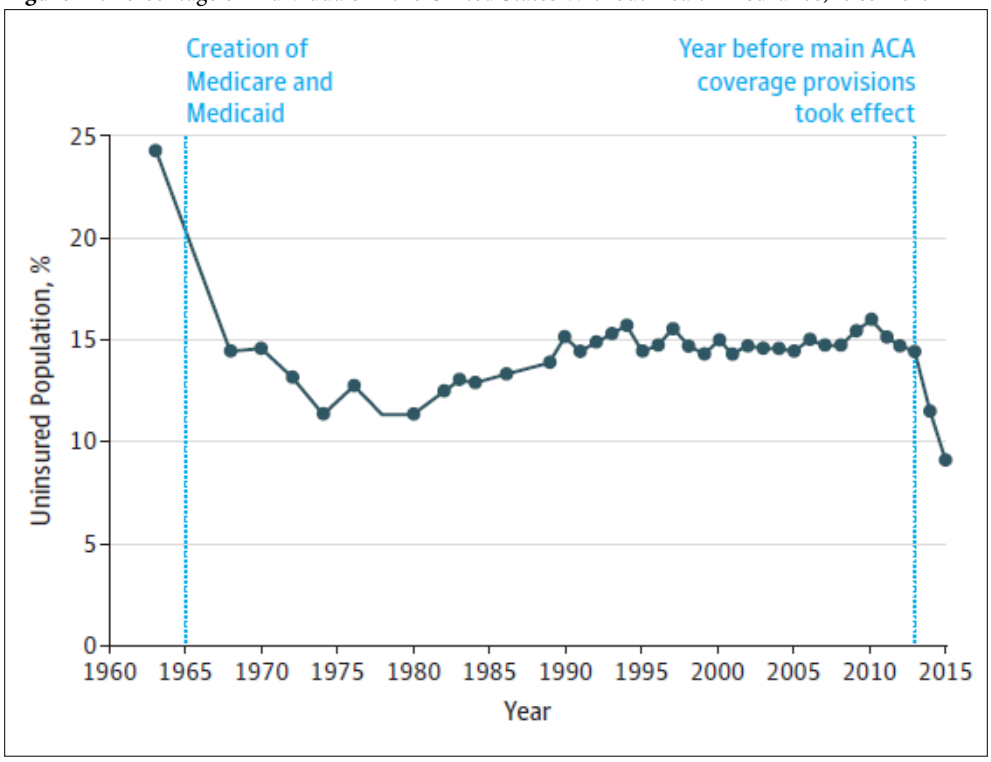
Figure 13. Status of State Action on the Medicaid Expansion Decision – 2024



Source: KKF, *Status of State Medicaid Expansion Decisions: Interactive Map*, 8 May, 2024, available in *https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive – map/.*

Note: In blue color the States where decision has been adopted and implemented (41, to date).

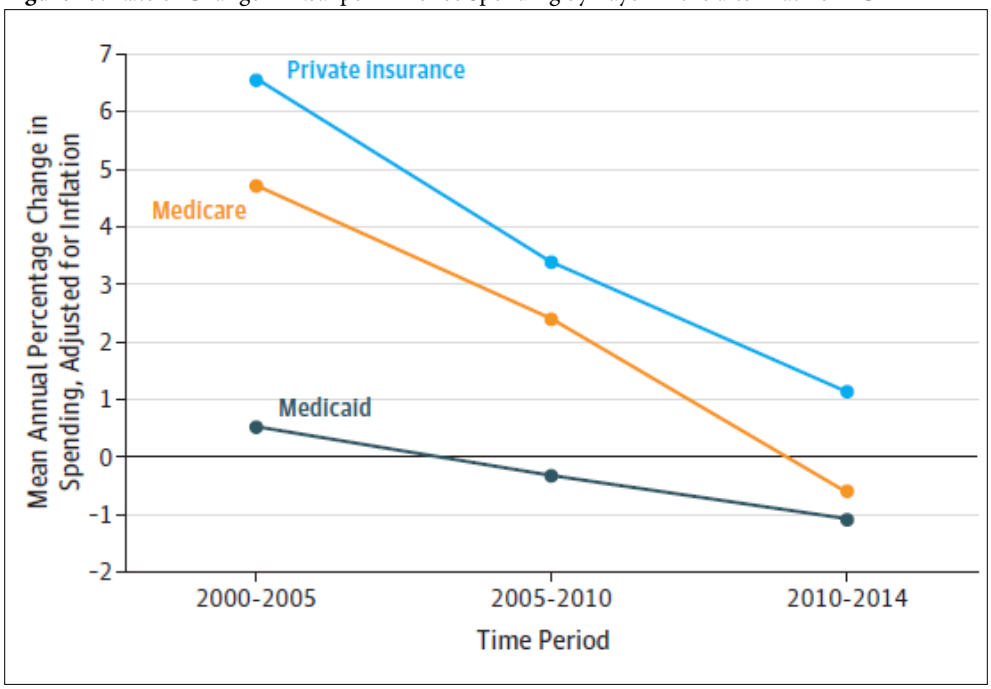
Figure 14. Percentage of Individuals in the United States Without Health Insurance, 1963-2015



Source: OBAMA B., *United States Health Care Reform. Progress to Date and Next Steps*, in Journal of American Medical Association, 2016, 316 (5), p. 526, Fig. 1.

Note: the author reports progress in the US Healthcare System in the aftermath of the Affordable Care Act (2010). The graph shows the sharp decrease of those without health insurance in the period 2010-2015.

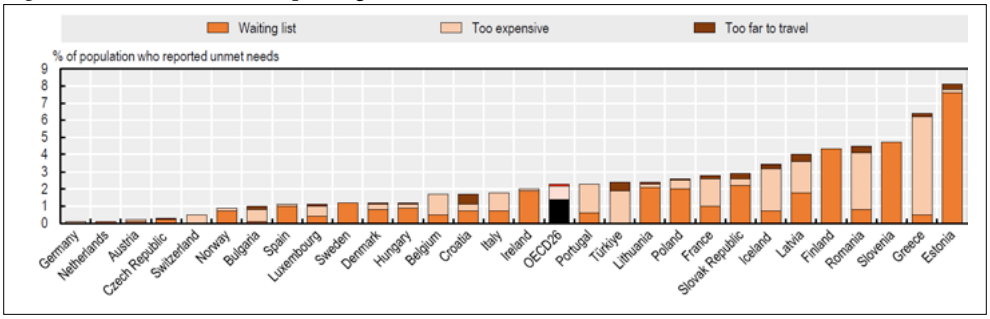
Figure 15. Rate of Change in Real per-Enrollee Spending by Payer in the aftermath of ACA



Source: OBAMA B., *United States Health Care Reform...*, cited above, p. 528, Fig. 4.

Note: the graph highlights the decrease in American taxpayer's Health Expenditure for each new ACA member. Reference data result from the National Health Expenditure Accounts.

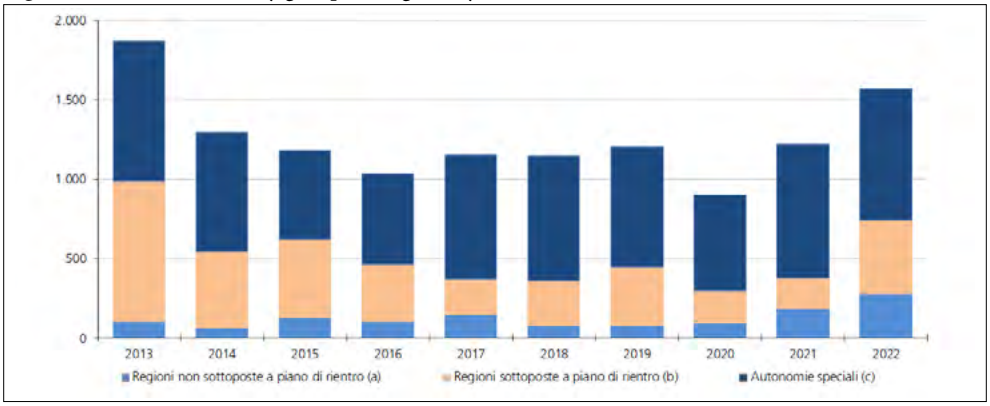
Figure 16. Main reason for reporting unmet needs for medical care, 2021 (OECD countries)



Source: *Health at a Glance 2023. OECD Indicators*, OECD Publishing, Paris, *https://doi.org/10.1787/7a7afb35-en,* Fig. 5.6., p. 103.

Note: Italy is below the OECD average due to needs met less effectively by the SSN compared with the French CPAM Sécurité Sociale. Among the reasons indicated by patients, the first place is occupied by the excessive cost of health services and, immediately after, the length of waiting times, while irrelevant seems to be for respondents the distance of treatment centers.

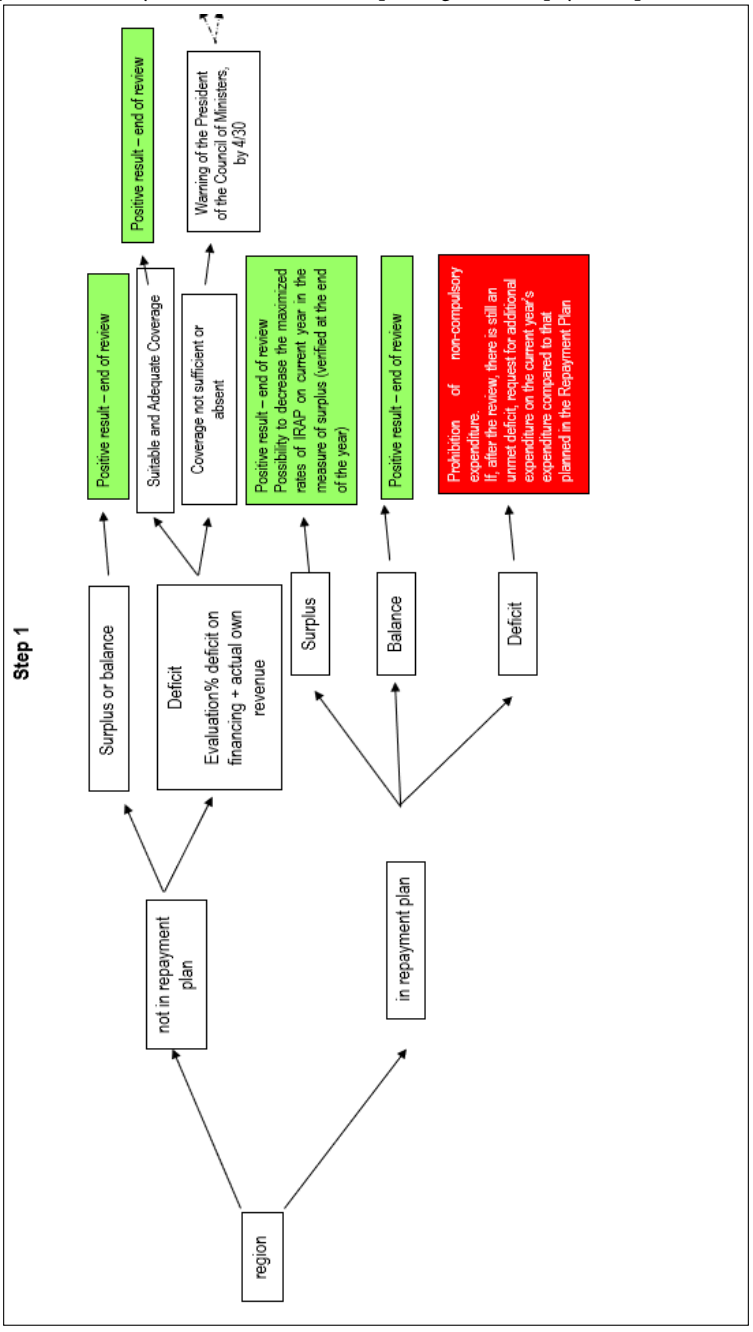
Figure 17. Health deficits by groups of regions (years 2013-2022)



Source: Income Account of Local Health Authorities.

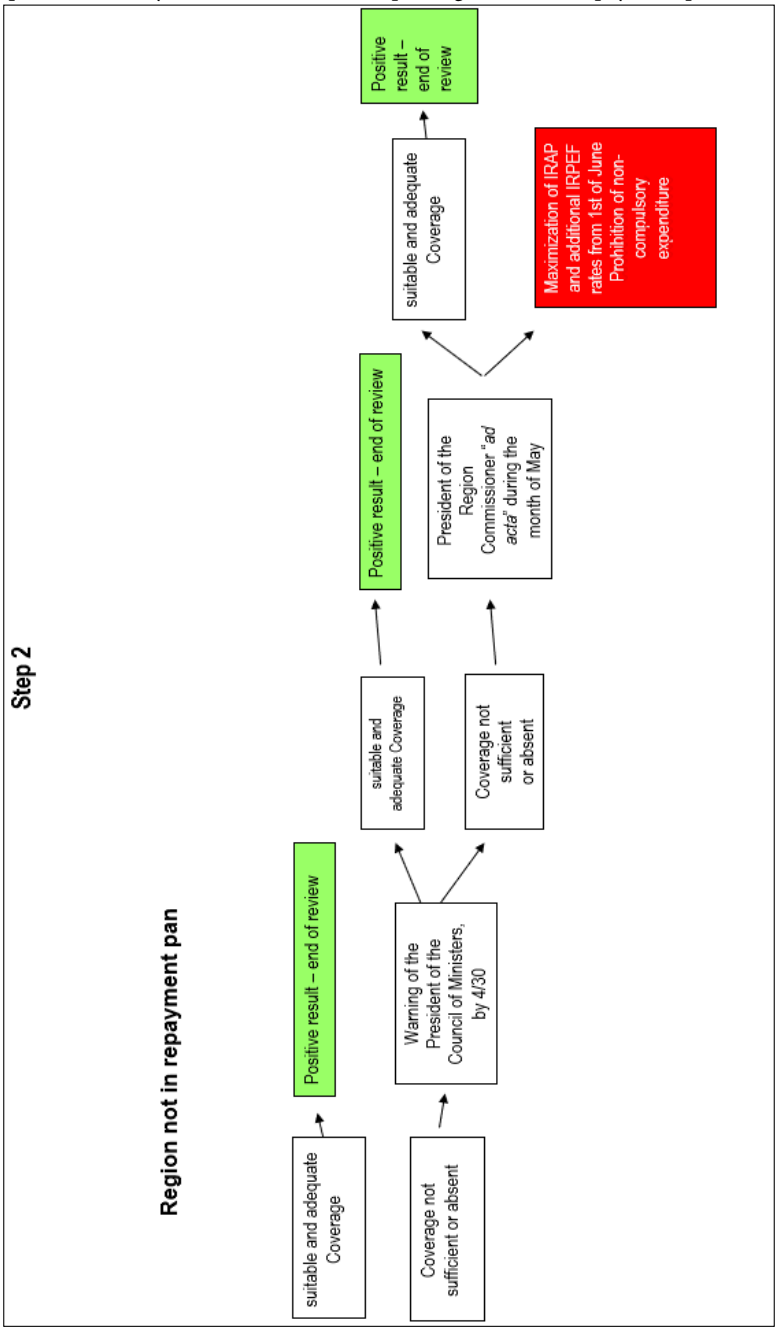
Note: Regions not in repayment plan [light blue] (a) Piedmont, Lombardy, Veneto, Liguria, Emilia Romagna, Tuscany, Umbria, Marche and Basilicata. Regions in repayment plan [light orange] (b) Lazio, Abruzzo, Molise, Campania, Calabria, Sicilia and Puglia (in the latter a "light" repayment plan is applied). Special autonomies [blue] (c) This includes the Valle d'Aosta, Friuli Venezia Giulia, Sardinia and the autonomous provinces of Trento and Bolzano as they provide direct financing for health care in their territory. Therefore, the possible deficit for special autonomous regions, having been determined using the methodology adopted by the "Regional Compliance Review Table" for regions with ordinary status, does not necessarily imply a negative operating result from the reading of the CE (Income Statement) as the excess of expenditure over the allocated financing share for the disbursement of the LEA can be covered by using own resources. For 2022, the deficit was not examined by the compliance review table as it will be done on the end-of-year data.

Figure 18. Implementation of the procedure of art. 1, co. 174 of L 311/2004 on the operating results at the fourth quarter of each year of verification – Step 1 (regions in repayment plan)



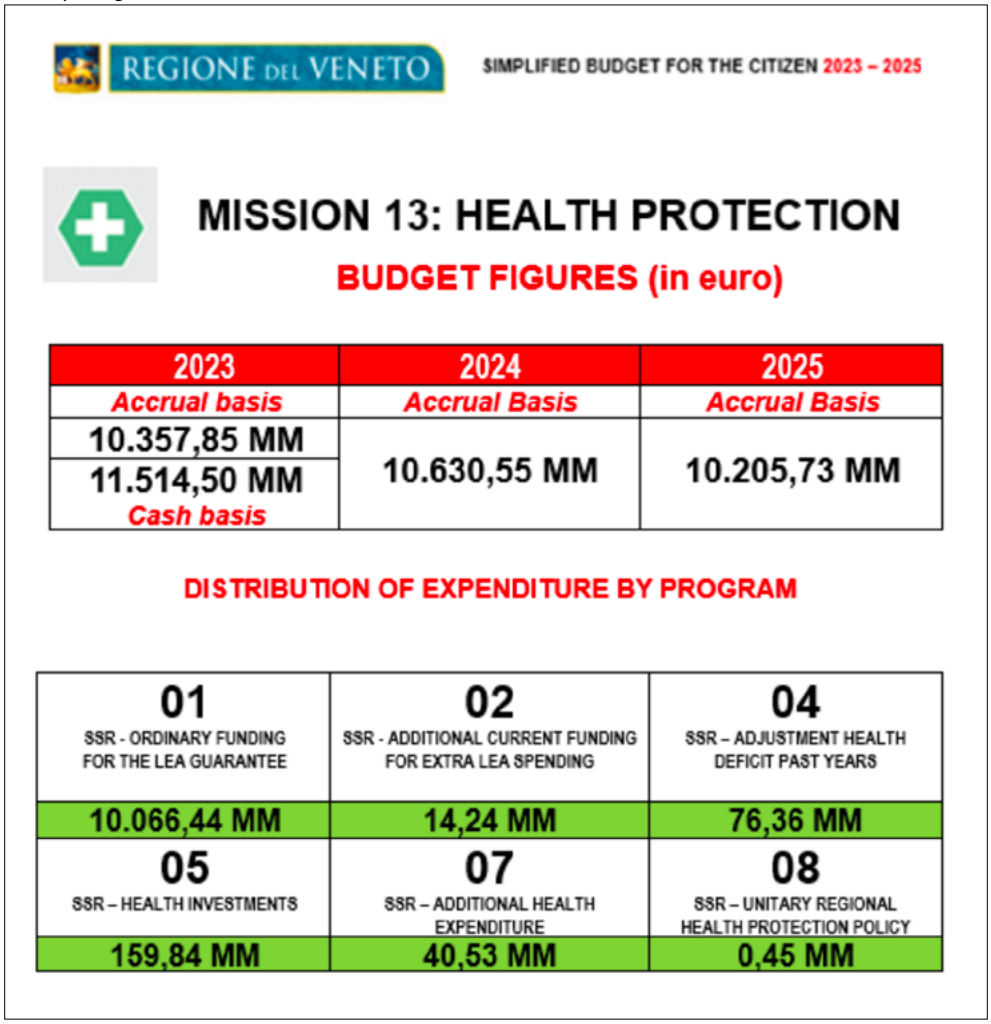
Source: Mef – Ragioneria Generale dello Stato, *Monitoraggio Spesa sanitaria – Rapporto n. 10*, 2023.

Figure 19. Implementation of the procedure of art. 1, co. 174 of L 311/2004 on the operating results at the fourth quarter of each year of verification – Step 2 (regions not in repayment plan)



Source: Mef – Ragioneria Generale dello Stato, *Monitoraggio Spesa sanitaria – Rapporto n. 10*, 2023.

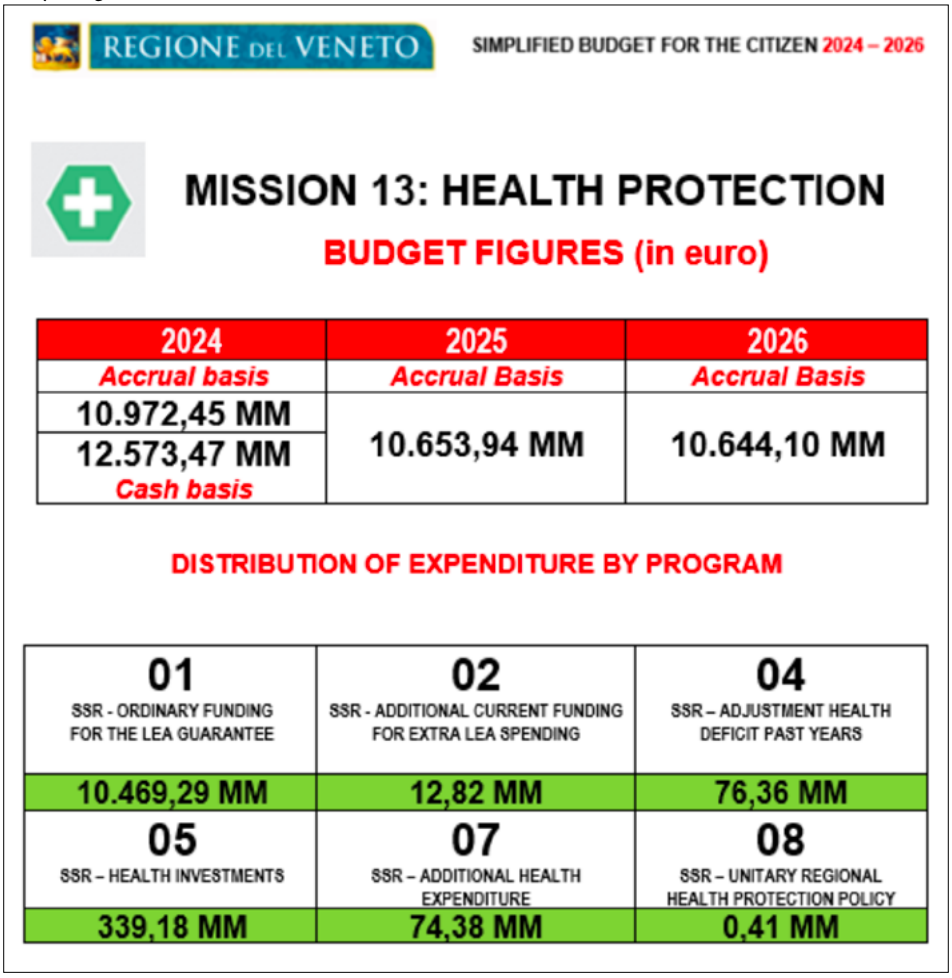
Figure 20. Veneto Region Budget, Mission 13 Health Protection – year 2023. Distribution of Expenditure by Program



Source: Veneto Region, *https://bilancio.regione.veneto.it/tutela-della-salute.*

Note: The LEA (see the "Abbreviations" part) are the essential levels of assistance referred, respectively, to Article 47-ter, paragraph 1, let. b-bis of Legislative Decree July 30, 1999, n. 300 and to Article 3, para. 7, D.M. Health, March 12, 2019.

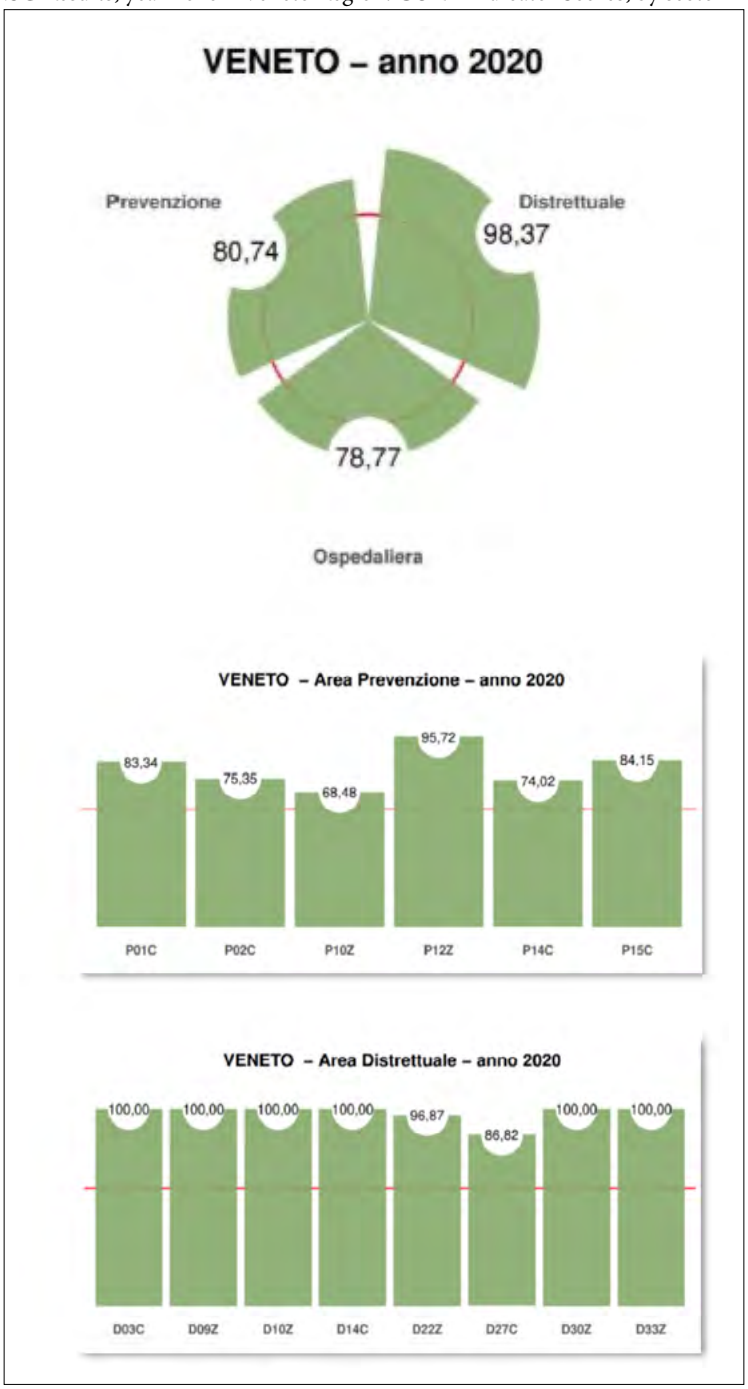
Figure 21. Veneto Region Budget, Mission 13 Health Protection – year 2023. Distribution of Expenditure by Program



Source: Veneto Region *https://bilancio.regione.veneto.it/tutela-della-salute.*

Note: The LEA (see the "Abbreviations" part) are the essential levels of assistance referred, respectively, to Article 47-ter, paragraph 1, let. b-bis of Legislative Decree July 30, 1999, n. 300 and to Article 3, para. 7, D.M. Health, March 12, 2019.

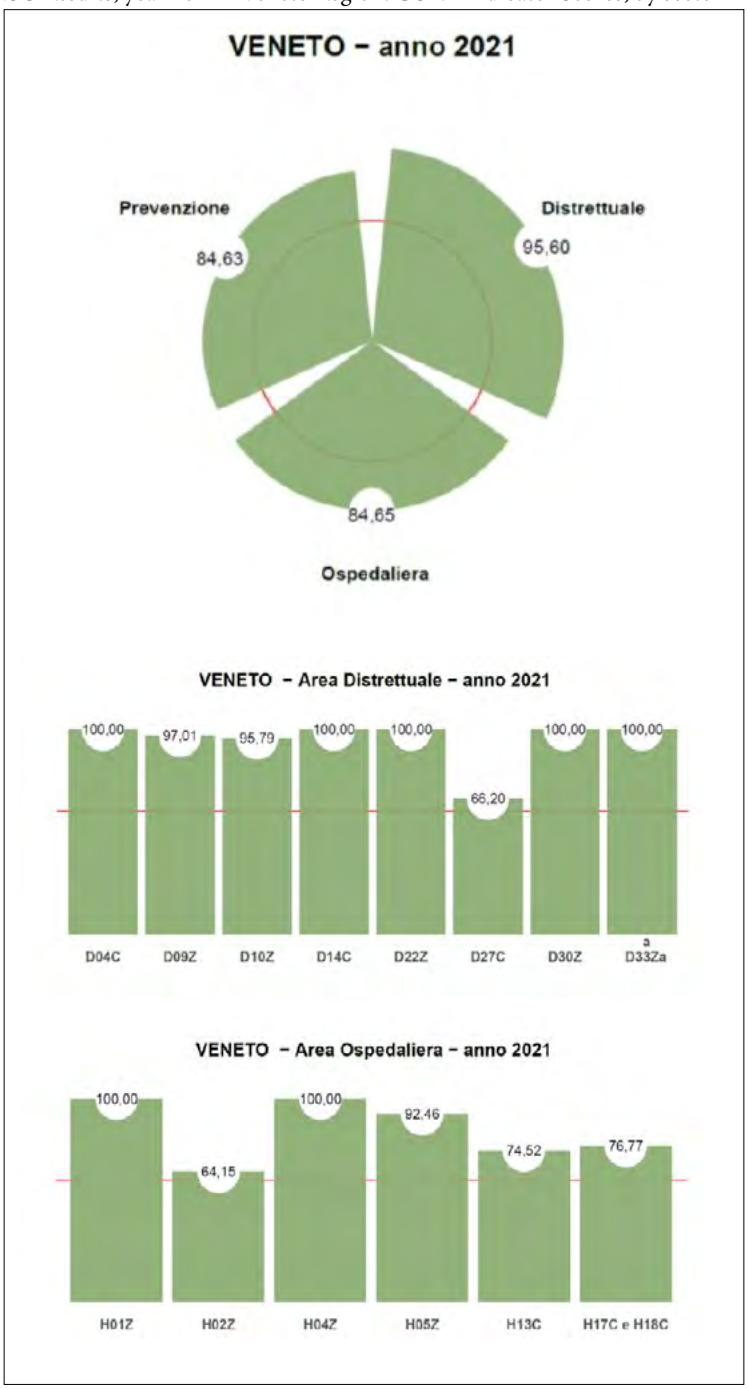
Figure 22. NSG Results, year 2020 – Veneto Region: CORE Indicator Scores, by sector



Source: Ministry of Health – General Directorate of Health Planning – Office 6, *Monitoraggio dei LEA attraverso il Nuovo Sistema di Garanzia. Metodologia e risultati dell'anno 2020,* Rome, 6 March 2023, pp. 53 – 54.

Note: The sectors considered are "Prevenzione" (Prevention), "Distrettuale" (by Health District) "Ospedaliero" (Hospitals").
The abbreviations represent Indicators of the New Guarantee System, by area of assistance (P = Prevention; D= District). The value in the two figures corresponds to a range from 0 to 100.
For the meaning of the abbreviations see the dedicated part of this survey.
It is worth mentioning that, during the considered period, the Veneto Region received the highest score from the Ministry of Health – General Directorate of Health Planning in the sectors D03C, D09Z, D10Z, D14C, D30Z and D33Z (see the part ABBREVIATIONS).
The Veneto Region (see Com. No. 376 (AVN) of 5 March 2024), in the year 2022, reached the national record in the field of offering home palliative care services for the management and care of terminal cancer patients (D30Z) in which, in addition to the services provided by the public structures of the various territorial ULSS, operate 7 Nonprofit entities – ETS (1 Foundation and 6 Odv, located in the provinces of Belluno (1), Venice (1) and Padua (4).

Figure 23. NSG Results, year 2021 – Veneto Region: CORE Indicator Scores, by sector



Source: Ministry of Health – General Directorate of Health Planning – Office 6, *Monitoraggio dei LEA attraverso il Nuovo Sistema di Garanzia. Metodologia e risultati dell'anno 2021,* Rome, 6 March 2023, pp. 51-52.

Note: The reported sectors are "Prevenzione" (Prevention), "Distrettuale" (by Health District) "Ospedaliero" (Hospitals").
The value in the two figures corresponds to a range from 0 to 100.
For the meaning of the abbreviations see the dedicated part of this survey.
It is worth noting that, in the period considered, the Veneto Region received the highest score from the Ministry of Health – General Direction of Health Planning in six fields out of 8 in the "District" sector, further improving performance in the "Hospitals" one (see, for the meaning of the Codes the part ABBREVIATIONS), confirming in he "District" sector the national primacy in the field of the offer of home palliative care services for the management and care of terminal cancer patients (D30Z) in which, in addition to the services provided by the public structures of the various territorial ULSS, in addition to the services provided by the public structures of the various territorial ULSS, operate 7 Nonprofit entities – ETS (1 Foundation and 6 Odv, located in the provinces of Belluno (1), Venice (1) and Padua (4).

Figure 24. Inpatient/Outpatient care in Veneto Region – Italy, year 2023

	N. RICOVERI	N. PRESTAZIONI
PRIVATO	123.995	9.541.517
PUBBLICO	490.836	58.529.495
TOTALE	614.831	68.071.012

	VALORE RICOVERI	VALORE PRESTAZIONI
PRIVATO	593.765.475 €	351.357.294 €
PUBBLICO	2.034.831.593 €	1.002.421.571 €
TOTALE	2.628.597.068 €	1.353.778.864 €

Source: Region of Veneto – Azienda Zero, U.O.C. Authorization to operate and Technical Accreditation Body.

Note: In the cells "Value of Health Services" and "Private" it should be taken into account the reported data including the services provided by the outpatient network managed by Nonprofit organizations for 122 million euros. Only 1% of those entities are registered in RUNTS (See ABBREVIATIONS). The data concerning the Private Sector (including Nonprofits) only refer to accredited entities providing "LEA" services (see ABBREVIATIONS). Any other eventual estimation, interpolation or extrapolation by third parties about numbers or values relating to Nonprofit institutions are not attributable to the said Azienda Zero – U.O.C.

Figure 25. Inpatient/Outpatient care in Veneto in the three-year period 2021 – 2023 (amounts in euro)

REGIONE DEL VENETO

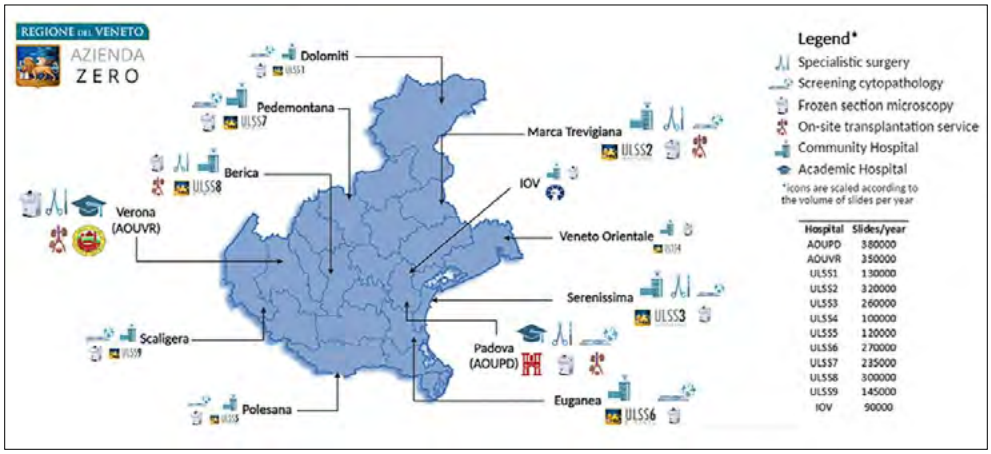
HOSPITALIZATIONS	2023		2022		2021	
	Total		Total		Total	
Type of Structures	No. of Hospital Discharge	Regional Rate Amount	No. of Hospital Discharge	Regional Rate Amount	No. of Hospital Discharge	Regional Rate Amount
PRIVATE/NONPROFITS	125.723	604.101.155	125.121	594.294.357	123.325	581.006.185
PUBLIC	513.032	2.118.145.837	493.706	2.050.151.045	465.278	1.960.814.611
Total Hospitalizations	**638.755**	**2.722.246.991**	**618.827**	**2.644.445.403**	**588.603**	**2.541.820.796**

SPECIALIZED TREATMENS	2023		2022		2021	
	Totale		Totale		Totale	
	No. of Treatments	Amount (euro)	No. of Treatments	Amount (euro)	No. of Treatments	Amount (euro)
PRIVATE/NONPROFITS	9.267.031	346.883.792	9.333.850	341.352.193	9.514.200	330.555.171
PUBLIC	60.834.880	1.010.003.343	58.940.695	1.016.465.455	57.678.222	1.035.633.097
SPECIALIZED TREATMENTS - TOTAL	**70.101.911**	**1.356.887.135**	**68.274.545**	**1.357.817.648**	**67.192.422**	**1.366.188.268**

Source: Regione del Veneto – Azienda Zero, U.O.C. Autorizzazione all'esercizio e Organismo Tecnicamente Accreditante (data as of 26 August 2024).

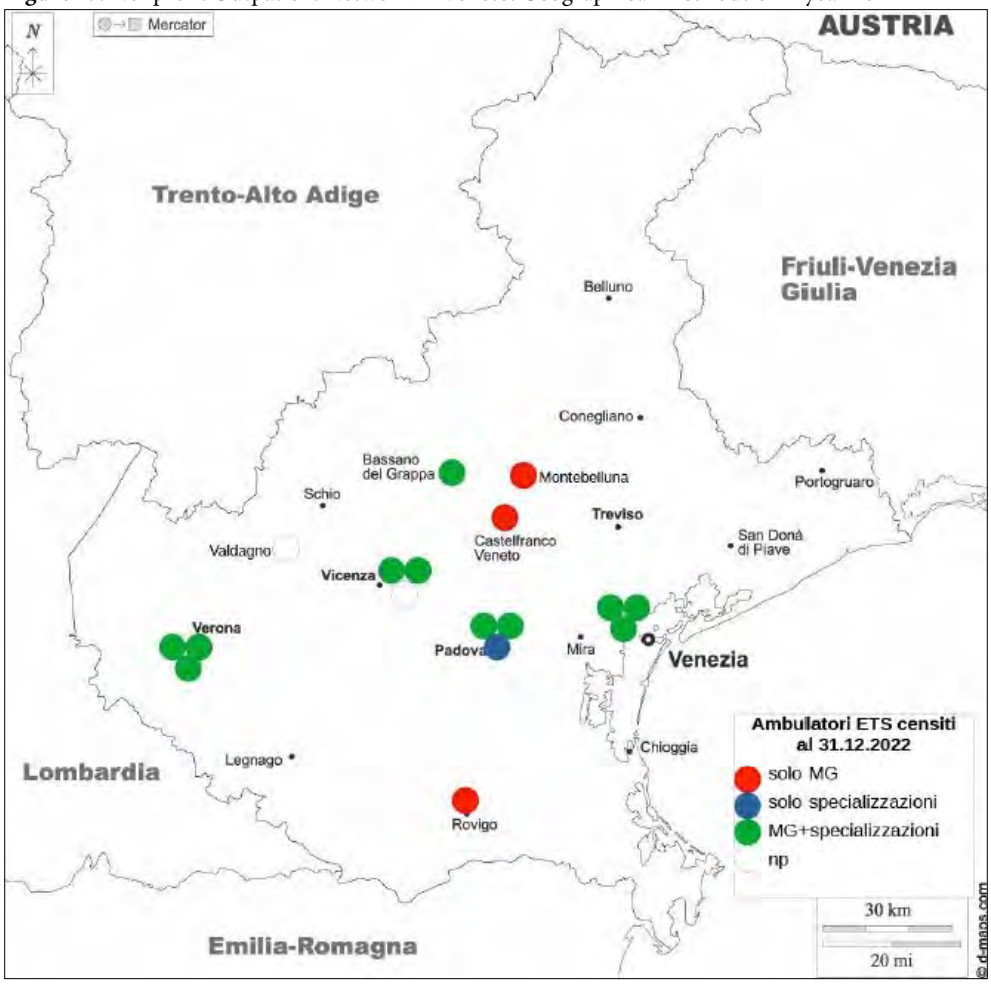
Note: The amounts related to specialist treatments include tickets (out-of-pocket expenses).

Figure 26. Geographical distribution of the major hospitals in Veneto, with indication of the healthcare offer



Source: Eccher et al, *Digital pathology structure and deployment in Veneto: a proof-of-concept study*, in Virchows Archiv (2024) 485, p. 454.

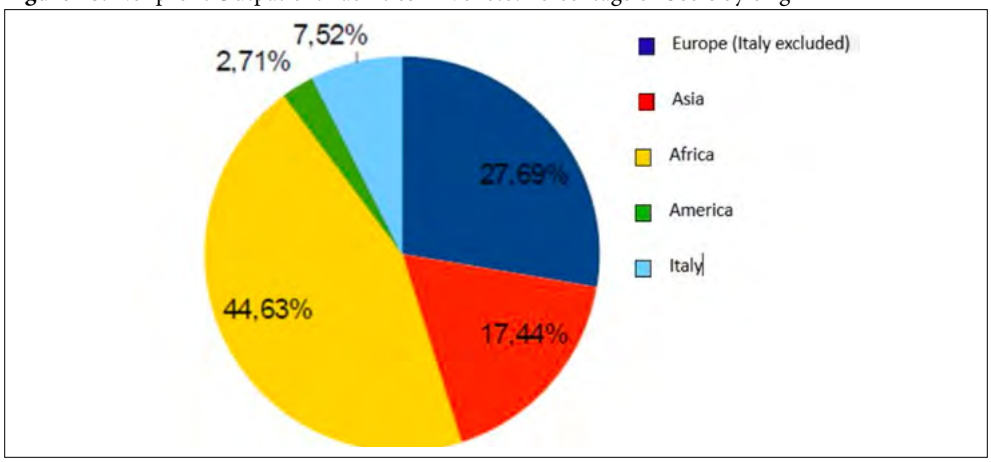
Figure 27. Nonprofit Outpatient Network in Veneto: Geographical Distribution – year 2022



Source: Cusinato A., Rigoli G., *Indagine conoscitiva sugli ambulatori medici del Veneto gestiti da Enti del Terzo Settore 2022*, Castelfranco Veneto, 2023, p. 14, Fig. 2.

Note: the Nonprofit outpatient network leaves the ULSS 1 "Dolomiti" (Belluno Province: mountain area) and ULLS 4 "Veneto Orientale" (East-Veneto), without Nonprofit facilities. Outpatient structures of general medicine are indicated in red, those single-specialized in blue and those "mixed" in green.

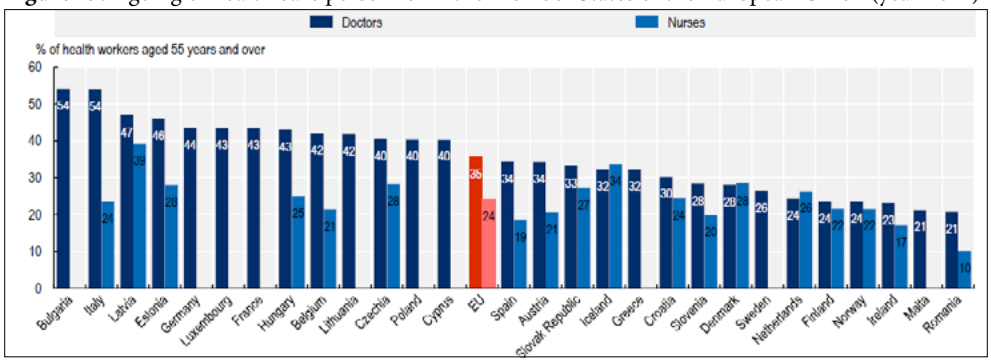
Figure 28. Nonprofit Outpatient Facilities in Veneto: Percentage of Users by origin



Source: Cusinato A., Rigoli G., *Indagine conoscitiva sugli ambulatori medici del Veneto gestiti da Enti del Terzo Settore 2022*, Castelfranco Veneto, 2023, p. 21, Fig. 3.

Note: Among the users, 3,174 are homeless or unhoused, in addition to about 30,000 other users, within which there is an unknown number of people who, for multiple reasons, are excluded from the SSN. This is because they have not (or have lost) the requirements for the Health Card or because, despite being regularly present, they cannot obtain the STP/ ENI card (reserved for 'irregular': please find the meaning of the abbreviations in the dedicated part of this survey).

Figure 29. Ageing of health care personnel in the Member States of the European Union (year 2022)



Source: OECD/European Commission, *Health at a Glance: Europe 2024: State of Health in the EU Cycle*, p. 27.

Note: OECD notes that over one third of general practitioners in the European Union are over 55 years old and more than one quarter of hospital nurses.

Through a comparative analysis of the action carried out by NPOs in the main Western Health systems, the study aims to examine their role within Health System in Veneto, Italy, as well as the social impact they have produced on essential levels of care, in terms of quality, efficiency, sustainability and integration. The volume is enriched by an extensive Appendix, which illustrates the most up-to-date data relating to the various components of the Third Sector in Health Care.

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