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A Deep Dive into the American and Italian Healthcare Systems - What Can We Learn?

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Introduction

It is no secret that the American healthcare system needs improvement. Yet, little has been done to effectively make those improvements. The United States healthcare system has substantial challenges and is underperforming on almost every measure when compared to other health systems. It seems one of the only bright spots in the American system is that it is innovative when it comes to improving the quality of care and lowering costs. As Ezekiel Emanuel says in his book *Which Country Has the World's Best Health Care?* healthcare is path dependent. Institutions constrain and limit our ability to change the system and each country prioritizes its different values (Emanuel 1). Therefore, you cannot simply "lift and shift" the world's best healthcare system into the United States.

However, comparing systems and seeing which ones excel at which dimensions and how they do it can help inform the design of particular reforms in other countries. That is precisely the goal of this paper – to learn from what Italy's health system does well and how those lessons can be implemented in the United States to improve its system. To realize this goal, it is important to break down the healthcare systems both in America and Italy, compare each system on critical measures like cost, health outcomes, access to care, and quality of care, and finally, draw on successes in Italy's system and suggest improvements for America's system.

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Section I. A Breakdown of the Healthcare System in America

Contrary to most developed countries around the globe, healthcare in America is not universal. It is seen as a privilege, not a right in the United States. Because of this, about 10% of the U.S. population (28 million people) lacked health insurance in 2017 (Emanuel 26). There is no single nationwide system of health insurance. Health services are organized and provided at the local level. Healthcare is financed by federal, state, and local governments alongside private insurance companies and individual payments made by patients. There is no healthcare planning at the federal level, and planning efforts by states vary (De Lew et al.). Hospitals, insurance companies, and healthcare providers are free to make their own decisions about where they are established, whom they cover, and when they are available to provide services.

Hospitals can choose to open or close according to community resources, preferences, and finances and physicians can establish their practices wherever they choose. This sometimes leaves remote, rural areas or inner cities underserved when it comes to access to quality healthcare resources. In those areas, federal and state-funded programs provide some primary care to populations who are not otherwise served by the fee-for-service (FFS) system (De Lew et al.). Municipal and county public health departments also provide limited primary care services through public health clinics and regulate sanitation, water supply, and environmental hazards (De Lew et al.). On top of that, there are efforts by federal, state, and local governments to support public health clinics with a primary mission of providing care to those in need. Many of those public health expenditures support preventative health measures such as vaccinations, cancer screenings, and childcare and are often available to all, although fees according to income

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may be charged (De Lew et al.). Still, there is no universal system for healthcare coverage in the United States.

About 2/5 of physicians are in solo practice with a vast majority in private practice and working on a fee-for-service basis (De Lew et al.). They see patients in their offices and admit them to hospitals. A relatively small proportion of physicians are employed by the government, corporations, managed care networks, and hospitals. Most hospitals are owned by private non-profit institutions, while others are owned by governments or for-profit corporations (De Lew et al.). The structure of the healthcare system in America is extremely complex and care is coordinated by multiple levels of government, corporations, non-profit institutions, and individuals.

In addition to the extreme complexity of the U.S. healthcare system, it is expensive. The United States spends more on healthcare services than any other nation. To make matters worse, those costs only continue to rise. After adjusting for inflation, the annual cost of health care increased from $1,832 per capita in 1970 to $11,172 per capita in 2018 (Emanuel 21). In 2017, the U.S. spent 17.9% of its GDP, about $3.5 trillion, on healthcare. Some states have created somewhat successful cost-control initiatives, but those solutions are not universal and there is still more effort to be made to get rising healthcare costs under control.

For years there has been a focus on controlling the rapidly rising health costs and increasing financial access to healthcare in America. Unfortunately, costs have continued to escalate despite efforts at federal, state, and local levels. Physicians and hospitals have made some efforts to offset healthcare costs as well. Charity care and bad debt represented 5% of

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hospital expenses in 1988 (Coulam and Gaumer). Estimates of physician charity care are difficult to make because they do not provide detailed cost reports to the federal government, but it is estimated that physicians provide $3 billion worth of free services and nearly $4 billion of reduced-free services annually (Mello et al.). This cross-subsidizing of care for the uninsured is not sustainable and may decrease as insurers and employers make efforts to control their costs. At the end of the day, more needs to be done about the rising costs of healthcare in America.

To help cover the costs of their medical bills many Americans look to obtain health insurance. The United States relies primarily on individual employers to voluntarily provide health insurance to their employees. The American healthcare system has four components and a myriad of smaller programs to provide health insurance to 290 million citizens (Emanuel 22). Government health insurance programs are specifically designed for the elderly, disabled, and some of the poor. Health insurance can be obtained through private insurance companies, often provided by employers, or through public governmental programs like Medicare and Medicaid. A majority of the uninsured are employees or their dependents because not all employers offer health insurance for their workers.

There are over one thousand private health insurance companies with different benefit structures, premiums, and rules for paying. These insurance plans are regulated by state insurance commissioners, which sometimes specify that certain benefits or providers be covered by all policies sold in the state or regulate insurance premium increases (De Lew et al.). Because of this, most large employers choose to “self-insure” because it exempts them from insurance regulation by the state. Self-insuring means covering health expenses by their employees as they

occur. Again, employer-provided health insurance is voluntary, but it is incentivized. Paying wages in the form of health insurance makes them subject neither to personal income tax nor social security tax (De Lew et al.). Individuals are also able to purchase insurance directly through insurance companies or insurance exchanges created by the Affordable Care Act (Emanuel 25). According to Ezekiel Emanuel, 7% of the population, about 22 million people, buy their own insurance (25). Still, even when Americans have private insurance, it may not cover all their healthcare expenses. As many as 55 million Americans with private health insurance are underinsured (Farley). This is because there is no limit on out-of-pocket health expenses so many people are at risk of being impoverished if they experience a major, costly illness. The vast majority of Americans are covered by private health insurance but are still underinsured and may need to look to multiple forms of insurance or simply hope they do not encounter any serious illness or injury.

Those who cannot afford private health insurance or are unemployed may turn to Medicaid for insurance. Medicaid is a governmental health insurance program for certain groups of the poor that is financed by both federal and state governments. The federal government matches state Medicaid outlays at rates that vary by the personal-income levels of each state (De Lew et al.). According to De Lew et al. in their guide to the American healthcare system, the federal share of total expenditures ranges from 50-83%, with poorer states receiving a higher match from the federal government (De Lew et al.). Further, funding is administered to states under broad federal guidelines which govern the scope of services, the level of payments to providers, and population groups who are eligible for coverage. Medicare covers preventative,

acute, and long-term care services for 25 million people, about 10% of the population (De Lew et al.). To be eligible, beneficiaries must be poor as well as aged, blind, disabled, pregnant, or the parent of a dependent child. Mothers and dependent children make up about 68% of Medicaid recipients, the elderly makeup 13%, the blind and disabled make up 15%, and others make up 4% (De Lew et al.). States typically define eligibility levels even further with some broad parameters like minimum income levels or asset levels for individuals.

Medicaid is a fine option for those who cannot afford private insurance, but it has its drawbacks. For starters, it does not always cover dental work or vision care for adults. Those services may need to be purchased separately. Next, there are too many eligibility parameters. According to Swartz and Lipson (1989), about 60% of poor Americans below the federal poverty line are excluded from Medicaid (*Swartz: Strategies for Assisting the Medically Uninsured*). Childless, non-disabled adults under 65 years old are not eligible, no matter how poor or how high their medical expenses are, nor are individuals with assets about State-defined levels (De Lew et al.). The creation of the Children's Health Insurance Program (CHIP) in 1997 guaranteed coverage for children whose parents earn too much to qualify for Medicaid, but whose private health insurance does not allow them to get the children insured. In 2017, CHIP and Medicaid together covered just over 19% of the U.S. population (Emanuel 62). Changes like the enactment of CHIP and the ACA have improved insurance options for those who cannot rely on private insurance agencies.

Medicare is an alternative federal public health care option for the aged and disabled. It is an inter-generational transfer program primarily funded by taxes from working people to provide

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services to aged beneficiaries (De Lew et al.). It is financed by payroll taxes, general federal revenues, and premiums. It is oriented toward acute care and does not cover services such as long-term nursing home care, routine eye care, and outpatient prescription drugs. Medicare is administered by the federal government and covers about 13% of the population, (De Lew et al.). It covers virtually all people who are 65 years or older (31 million people) and certain people with disabilities or kidney failure (3 million people) (*Board of Trustees, Federal Hospital Insurance Trust... - Google Scholar*). It is a sort of safety net for people in vulnerable groups who cannot obtain health insurance through their employers.

Medicare is divided into two main parts: Part A and Part B. Medicare part A is earned through the payment of payroll taxes during one's working years. It covers inpatient hospital care, some home health services, and very limited nursing home services. The payroll tax charged is 1.45% of payroll for both the employer and the employee up to a maximum of $125,000 of income (Emanuel 27). This totals up to 2.9% in combined taxes from the employee and employer. On the other hand, Medicare part B is voluntarily obtained through payment of income-linked premiums once eligibility for Medicare is established. Part B includes physician visits and other ambulatory services, durable medical equipment like wheelchairs, and certain other services. It is funded through premiums by enrollees, which make up 25% of the program cost, and by general federal revenues, which cover the other 75% of the program cost (De Lew et al.). In 1992, enrollees paid $31.80 per month for part B coverage (De Lew et al.) In 2018, the premium was $130 per month (Emanuel 27). In 2022, the premium is $170.10 per month (*What*

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Does Medicare Cost? | Medicare). This is one stark example of the rising healthcare costs in America over the last thirty years, Medicare has not been able to escape this trend.

Like many insurance options in America, Medicare is not without its issues. For starters, expenses are increasing faster than revenues and as the population ages, there will be fewer workers supporting each beneficiary as time goes on. There were five workers for each beneficiary in 1960, three workers per beneficiary in 2000, and it is predicted that there will be 1.9 workers per beneficiary by 2040 (*Welcome to Green Book. House Committee on Ways and Means. | Green Book. House Committee on Ways and Means.*). Moreover, Medicare does not cover all the costs associated with healthcare. About 68% of Medicare beneficiaries have private supplemental plans, either provided by former employers or self-purchased (Bureau). The elderly spend an increasing share of their after-tax income on health expenses, climbing from 7.8% in 1972 to 12.5% in 1988 (De Lew et al.). According to Waldo et al. (1989), Medicare covers less than one-half of the total medical care expenses of the elderly (Waldo et al.). It also does not cover dental care. These examples go to show areas for improvement in the American healthcare system.

Perhaps one of the bright spots in American healthcare reform is the enactment of the Affordable Care Act (ACA), which was signed into law on March 23, 2010. The ACA is the most significant regulatory overhaul and expansion of insurance coverage since the enactment of Medicare and Medicaid in 1965. This bill retained the structure of Medicare, Medicaid, and the employer market, but individual markets were radically changed. The ACA forced insurers to accept all applicants without charging based on preexisting conditions or demographic status

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(except age), forbid insurers from dropping policyholders when they become ill, and required insurers to cover a list of essential health benefits plus preventative care and screenings for women, required insurers to spend at least 80-85% of premium dollars on health costs, and required them to implement an appeals process for coverage determination and claims on all new plans ("Affordable Care Act"). The law also required states to ensure the availability of insurance for individual children who did not have coverage from their families, banned annual and lifetime coverage caps on essential benefits, made all policies provide an annual maximum out-of-pocket payment cap for an individual's medical expenses, and prohibited preventative care, vaccinations, and medical screenings from being subject to co-payments, co-insurance, or deductibles ("Affordable Care Act"). After going into effect, increases in overall healthcare spending slowed, including premiums for employer-based insurance plans.

While seeming like a step in a positive direction, the Affordable Care Act, also termed Obamacare, is not popular among everyone in the U.S. One of the main reasons for opposition is the individual mandate, which requires everyone to have insurance or pay a penalty. Resisters to the bill argue forcing people to buy insurance is unconstitutional. However, the individual mandate was designed to minimize the free rider problem and prevent the healthcare system from succumbing to adverse selection. The Tax Cuts and Jobs Act of 2017 got rid of the fine or tax for violating the individual mandate starting in 2019 ("Affordable Care Act"). Still, the ACA is a hot topic for debate among U.S. citizens.

Since the ACA became law, the uninsured rate has declined by 43%, from 16% in 2010 to 9.1% in 2015 (Obama). This decline is shown below in Figure 1. By 2016, it is estimated that

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an additional 20 to 24 million people were covered by insurance (“Affordable Care Act”). Research has also shown accompanying improvements in access to care, financial security, and health. The ACA also began a process of transforming healthcare payment systems, with an estimated 30% of traditional Medicare payments now flowing through alternative payment models (Obama). It seems the ACA has succeeded in constraining healthcare costs and improving the quality of care in the United States.

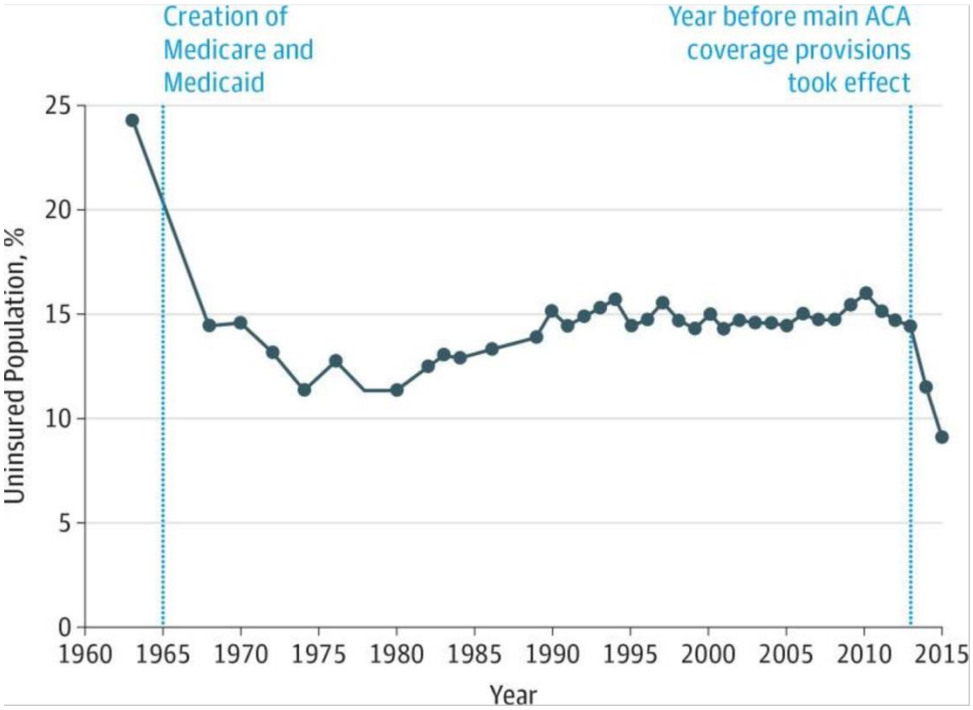

Figure 1. Percentage of Individuals in the United States without Health Insurance, 1963-2015

Overall, the American healthcare system operates well in some areas but has many issues that need to be addressed. A bright spot in healthcare in America is that it is deregulated so patients have more choice in where and by whom they receive care. Consolidation among

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hospital networks and more regulation typically results in higher prices, restricted choices, and lower quality care. Deregulation of the healthcare system also allows for competition and encourages medical and technological innovation, both of which America is a leader in. However, the cost of receiving care in America has become outrageous. According to the Milliman Medical Index, healthcare spending as a percent of income for a family of four now exceeds 30%, up from 10% in 2001 (Geyman). It has also been reported that two-thirds of more than 500,000 personal bankruptcies in America each year are caused by illnesses and medical bills (Geyman). More than that, America has some of the worst health outcomes when compared to other developed countries. The US ranks last among 16 advanced countries in terms of mortality amenable to healthcare and has a shorter life expectancy than all other advanced countries (Nolte and McKee) (Roser). The enactment of the ACA was a step in the right direction, but more meaningful action must be taken to ensure healthcare costs in America are contained, and that citizens have increased access to care to ensure better health outcomes in the future.

Section II. A Breakdown of the Healthcare System in Italy

Opposite to the American healthcare system, Italy has adopted a universal coverage system. In pursuit of this, Italy's National Health Service (SSN) automatically covers all citizens and legal foreign residents. Residents receive mostly free primary care, inpatient care, and health screenings. There are copays for specialty visits, procedures, and some outpatient drugs, but statutory benefits include maternity care, specialty care, home care, hospice care, preventative

medicine, and pharmaceuticals (*Italy*). Durable medical equipment, long-term care, and some other selected services are covered only for patients with certain medical conditions (*Italy*). There are no deductibles for Italian residents and public and private providers under a contract with the National Health Service are not allowed to charge above scheduled fees. However, the SSN does not allow people to opt-out of the system and seek only private care. Substitutive insurance does not exist in Italy, but residents can obtain voluntary insurance to cover services excluded under the SSN essential benefits which offer a higher standard of comfort and privacy in hospital facilities and affords a wider choice among providers (*Italy*). Overall, Italy maintains a universal system with the option to add voluntary private coverage for better accommodations.

The Italian government plays a key role in delivering healthcare to the population, but it is largely decentralized. A breakdown of the organization of Italy's health system is shown in Figure 2. The central government is responsible for setting national health policies and priorities, determining annual SSN funding, and allocating resources to each region. The country is split into nineteen regions and two autonomous provinces where care is provided through local health units, each with its own general manager appointed by the regional governor (*Italy*). The National Health Service is required to guarantee uniform provision of comprehensive care throughout the country, but regions can offer services not included in the national statutory benefits if they can finance those services themselves (France et al.). There are four health agencies and ministries which coordinate care across the country. The Ministry of Health handles care planning, health system ethics, supply of health professionals, and information systems (*Italy*). The National Committee for Medical Devices develops cost-benefit analyses and

determines reference prices for medical devices (*Italy*). The Agency for Regional Health Services conducts comparative-effectiveness analyses (*Italy*). And finally, the National Pharmaceutical Agency governs prescription drug pricing, reimbursement policies, and all other matters related to the pharmaceutical industry (*Italy*). The Italian system is quite intricately organized and places responsibility in the hands of many, while still providing universal coverage.

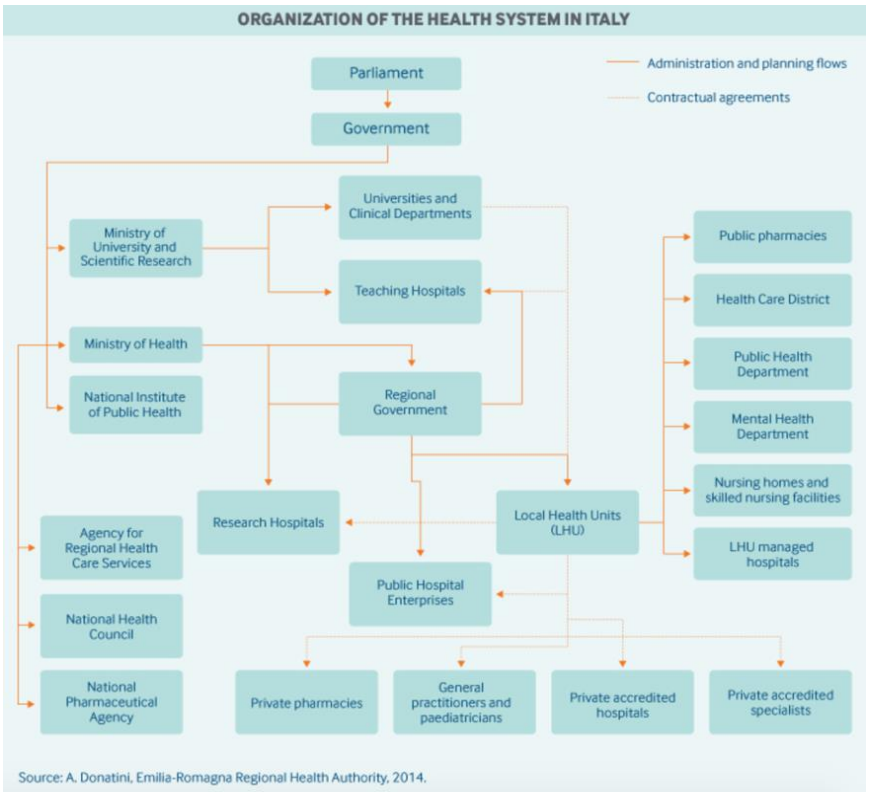

Figure 2. Organization of the Health System in Italy (*Italy*)

The Italian healthcare system allows for a nice balance between public and private health insurance. The public system is financed through a corporate tax combined with a fixed proportion of national value-added tax revenue. The corporate tax is pooled nationally and

allocated back to the regions in proportion to their contributions (*Italy*). This leaves large interregional variations in the corporate tax base and creates inequalities in financing per region. However, each region is allowed to generate its own additional revenue to fund its local health units. Aside from the public system, approximately 10% of the population has some form of voluntary health insurance in addition to insurance provided by the SSN (*Italy*). There are two types of private health insurance: corporate and non-corporate. Corporate insurance companies cover employees and sometimes their families while individuals buy noncorporate insurance for themselves or their families. Having both private and public health insurance ensures citizens will be covered not only for basic, comprehensive services but also for elective and specialty visits and procedures.

Italy employs a cost-sharing technique to deliver healthcare that is free to all its citizens. Primary and inpatient care is free, but procedures and specialist visits must be prescribed. Figure 3 shows a breakdown of typical patient copayments and safety nets in Italy. Copayments for each prescribed procedure or specialist visit cannot exceed a ceiling that is determined by Italian law. Fees for visits range from EUR 12.91 (USD 17.91) to EUR 20.66 (USD 28.65) (*Italy*). The current ceiling is set at EUR 36.15 (USD 50.14) (*Italy*). Public and private providers who are under contract with the SSN are not allowed to charge above those fees. There are also safety nets in place to prevent unreasonable costs. For example, all individuals with out-of-pocket payments over EUR 129 (USD 181) in a given year are eligible for a tax credit that is equal to roughly 1/5 of their total spending (*Italy*). Certain groups are exempt from cost-sharing and can still receive healthcare. Those exemptions include people with severe disabilities, prisoners,

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children under 6 and adults over 65 in households with gross income below a nationally defined threshold (approximately EUR 36,000, USD 40,930), people with rare chronic diseases, and pregnant women. Plus, general practitioners are not allowed to bill patients for any procedures they perform. In effect, Italy ensures people are cared for without having to worry too much about the burden of costs for pursuing medical care.

SERVICE	FEES PER ENCOUNTER/SERVICE	MAXIMUM OUT-OF-POCKET COSTS PER YEAR (SAFETY NET)
Primary care visit	None	N/A
Specialist consultation	First appointment: 20.66 EUR (USD 28.65)* Follow-up appointment: 12.91 EUR (USD 17.91)*	No maximum per-year caps but individuals with out-of-pocket payments over EUR 129 (USD 179) in a given year are eligible for a tax credit equal to roughly one-fifth of their spending
Hospitalization (per day or visit) including pharmaceuticals	Public hospitals: None Private hospitals: Mostly free; fees vary for patients paying out of pocket	
Prescription drugs (outpatient)	Tier 1 (*Class A*) drugs prescribed by a physician: Nothing for generic drugs and the difference between the reference price and the market price for brand-name drugs Tier 2 (*Class C*) drugs: Patients pay full price Some regions have introduced additional copayments for Tier 1 drugs, ranging from EUR 1–3 (USD 1.39–4.16) per box	

* These are national rates; regions can set their own appointment or procedure rates up to a ceiling determined by law, which is currently EUR 36.15 (USD 51).

Figure 3. Typical patient copayments and safety nets in Italy (*Italy*).

Like all healthcare systems around the globe, the Italian healthcare system has its strengths and its weaknesses. One downfall is that patients do not get their choice of specialist when referred by their general practitioners. They can choose any public or private hospital but get no say in who it is that will actually be delivering care. Patients are also required to register with a gatekeeping primary care physician (PCP). Their choice of PCP is limited by the number of patients each PCP cares for. They may choose any physician that has not reached the

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maximum number of patients allowed and may switch at any time. The standard maximum is 1,500 patients for general practitioners and 800 patients for pediatricians (*Italy*). Another issue Italy faces is balancing centralized and regional control of the health system, creating 20 different health systems, and battling differences in access to care across regions (Ricciardi and Tarricone). There is an increasing gap between the quality of healthcare and access to care in the more urban north versus the more rural south of Italy. The south trails the north when it comes to the number of hospital beds, availability of advanced medical equipment, the number of public and private facilities, and the development of community care services (*Italy*). Splitting healthcare responsibility between the central government and twenty different regions has created ever-increasing complications. Another issue the Italian system faces is that innovation and initiative often lead to spiraling costs and difficulties, which are followed by harsh cost-containment measures (Ricciardi and Tarricone). Those seeking care may also be subject to excessive wait times and information on a patient's after-hours visit is not routinely sent to their general practitioner, leading to unnecessary use of hospital emergency departments. Lastly, although public health expenditure takes a relatively low share of Italy's GDP, in the last 25 years it has consistently exceeded central governmental forecasts. To improve, Italy needs more data-driven planning, prevention, and research, integrated care and technology, investments in personnel, more monitoring of disparities, and more transparency on outcomes and the effectiveness of public health insurance

While healthcare in Italy has its downfalls, it also has much to be admired. One strength of their system is that the National Health Service is required to guarantee the uniform provision

of comprehensive care throughout the country. Everyone is covered by some sort of insurance, and high-quality care is ensured. All healthcare professionals under contract with the SSN must be certified by the central or regional government, which hinges on extensive quality criteria, including appropriateness and timeliness of interventions, health status, and patient satisfaction (*Italy*). Plus, all publicly contracted providers must issue a "health service chart" with information on service performance, waiting times, and the process for patient complaints. The SSN is consistently rated within the Organization for Economic Cooperation and Development among the highest countries for life expectancy and among the lowest in healthcare spending as a proportion of gross domestic product (Ricciardi and Tarricone). According to France et al., the health status of Italians has improved and compares favorably with that in other countries. This all goes to show that despite having its issues, Italy is certainly doing something right when it comes to healthcare and there is much to be learned from how they organize and deliver care.

Section III. Comparison of the American and Italian Healthcare Systems

The American healthcare system has encountered much criticism, especially when compared to other developed countries around the globe. Comparable countries include but are not limited to Italy, Canada, France, Germany, the United Kingdom, Australia, Japan, The United States, Belgium, the Netherlands, Sweden, Switzerland, and other developed countries. According to the Peterson-KFF Health System tracker, the United States leads other countries in premature death rates, disease burden, pregnancy-related deaths, and reported medication and treatment errors ("How Does the Quality of the U.S. Health System Compare to Other

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Countries?"). The same tracker also reported that the U.S. ranks last in a measure of healthcare access and quality ("How Does the Quality of the U.S. Health System Compare to Other Countries?"). In a global ranking of overall health by the World Health Organization in 2002, Italy ranked second while the U.S. ranked thirty-seventh (Emanuel 3). America can learn a thing or two about health care from Italy.

At the same time, no healthcare system is perfect. Common challenges to both the United States and Italy include cost pressure, high and rising costs of drugs, reducing inefficiency in the provision of care and unnecessary care in the system, coordination of care for patients with chronic illnesses, provision of mental health care, and how to provide long-term care and how to pay for it. While struggling with all these things, Italy still seems to perform significantly better than America on many of these measures.

When it comes to cost, total health expenditure accounted for 9.2 percent of Italy's GDP in 2012 (slightly below the EU average of 9.6 percent) (Ferre et al.). The United States spends just under 18% of its GDP on healthcare, making it a very expensive outlier (Emanuel 10). The U.S. also accounts for over half of the world's drug spending, with only 4% of the world's population (Emanuel 10). Italian healthcare is far less expensive in private doctors' offices and hospitals, partly because big players in the U.S. can charge whatever they want. The Italian National Health System is funded by taxes and provides everyone with doctor's visits, medications, testing, and hospital care at virtually no out-of-pocket cost ("What Can Italy Teach the Rest of the World about Health?"). Italy also has a more uniform distribution of income and wealth, which is proven to show an overall improvement in health outcomes. The United States,

however, is the world's most unequal country and this affects everyone. Even educated, insured, well-off Americans are sicker than their peers in other rich nations ("What Can Italy Teach the Rest of the World about Health?"). America is in desperate need of action to reduce the costs related to seeking quality health care and can look to Italy for advice on how to contain those costs.

Furthermore, Italian citizens have significantly better access to care than American citizens do. According to the Peterson-KFF Health System Tracker, the United States ranks last in a measure of healthcare access and quality when compared to peer countries ("How Does the Quality of the U.S. Health System Compare to Other Countries?"). In Italy, 100% of citizens are automatically covered by public insurance, with 10% being dual enrolled in private voluntary insurance (*Italy*). In America in 2017, about 10% of the population (roughly 28 million people) lacked any form of health insurance (Emanuel 26). Before the Affordable Care Act kicked in, about 1/6 of non-elderly adults had no medical insurance and 44% of all Americans were uninsured or underinsured at some point ("What Can Italy Teach the Rest of the World about Health?"). While America is worse off overall for providing health care coverage, both countries still struggle to provide consistent care across all regions and in rural areas. As of 2020, more than three-quarters of Americans live in states that spend less than $100 per person annually on public health, ranging from $32 in Louisiana to $263 in Delaware (Geyman). In Italy, the south trails the north in the number of beds, availability of advanced medical equipment, fewer public vs. private facilities, and less developed community care services (Ferre et al.). Regardless,

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America can still learn from Italy's public health care system and draw on those lessons when discerning how to increase insurance coverage and access to care for its citizens.

When comparing the education of health professionals, innovation, and choice, America outranks Italy. The American medical education system is exceedingly rigorous and competitive. The U.S. boasts 154 medical schools offering an MD program plus 38 DO programs. Italy has 29 medical schools and those who earn their medical degree in Italy cannot practice medicine in America without going through an American residency program – also quite rigorous. An American doctor practicing in Italy described the Italian healthcare landscape as "crumbling hospitals" and "doctors trained on books" ("What Can Italy Teach the Rest of the World about Health?"). America has one of the best medical education systems in the world. The United States also exceeds at innovation, both in drugs, devices, and surgical procedures, and in payment systems. For example, in the 1970s the United States pioneered the Diagnosis Related Group, a payment formula for hospitals, and almost all other countries have adopted and adapted it (Emanuel 8). In Italy, innovation and initiative often lead to spiraling costs and difficulties, followed by harsh cost-containment measures (Ricciardi and Tarricone). These difficulties tend to stifle innovation. In this case, Italy may be inclined to use America as a reference point for improving physician education and ramping up innovation in their health system.

The biggest difference between the American and Italian healthcare systems lies in the distinction between public and private insurance systems. Supporters of private insurance argue that competition in a deregulated marketplace brings more choice and value and that it is more efficient than a public system, with shorter wait times (Geyman). Critics of private insurance

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networks argue that consolidation of hospital networks results in higher prices, restricted choices, and lower quality of care. At the same time, public healthcare users complain of unsatisfactory outcomes concerning getting attention from doctors, time taken to get appointments, access to core treatment, and opening hours (Owusu-Frimpong et al.). No one system is perfect. No country has health care delivery completely figured out without challenges, yet each country can learn something from its peers and cater its system design to the specific needs of the people.

Section IV. Proposed Improvements to the American Healthcare System

After a detailed breakdown of the American healthcare system, it becomes clear that many changes must be made. Most everyone can recognize there is room for improvement, but unfortunately, few can agree on how to enact those changes. For decades, policymakers have hotly debated proposed policy and structure updates to the American healthcare system with little avail. With a deep study of the United States healthcare system and its international context, some suggestions for improvement become apparent. Hopefully, policymakers can learn how to adapt some of the good ideas in other countries and avoid repeating their mistakes.

In *Which Country Has the World's Best Health Care?* Ezekiel Emanuel suggests solutions to America's biggest healthcare-related problems including excessive cost, the complexity of the system, physician burnout, and the nursing shortage. To contain the costs of care in America, coverage of essential benefits could be made universal, similar to Italy's system, where everyone contributes through tax payments and the government guarantees care for everyone. At the very least, financial agreements can be made to be single-payer like

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Medicare or private insurance companies could be used as intermediates ("What Can Italy Teach the Rest of the World about Health?"). The U.S. does not necessarily need to copy the full Italian model with doctors on government salaries. Americans could still choose to purchase private insurance policies as they please for additional coverage. The federal government should also negotiate Medicare drug prices with pharmaceutical manufacturers (Emanuel 51). For a more general approach, the United States should make efforts to reduce income inequality by giving stipends to the poor, raising pensions and minimum wages so they are high enough to live on, and fixing the tax structure to benefit the majority of people in the country ("What Can Italy Teach the Rest of the World about Health?"). Shrinking the income gap, regulating drug prices, and innovating system delivery and payment systems in America will allow more people to afford their healthcare costs.

Next, America needs to simplify its healthcare system. As it stands now, insurance has numerous deductible and co-pay levels, care locations use complex billing systems, and constantly changing physician and hospital networks make navigating the healthcare system time-consuming and confusing for patients. Ezekiel Emanuel suggests the U.S. simplify eligibility rules for government programs or standardize the number of insurance options and move from annual insurance enrollment to enrollments that last for 2-3 years (53). Making these changes will reduce movement between programs and increase continuity of care. It will also increase access to care and visibility by making finding doctors and paying for care much simpler.

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Finally, addressing physician burnout and nursing shortages are some of the most pressing issues in America. Physicians resent the amount of time spent navigating electronic health records to find clinical data and leave notes in charts. Plus, getting data out of electronic health records is hampered because they have been developed primarily for billing. To combat this, Ezekiel Emanuel suggests doctors and hospitals hire medical scribes to free physicians from screens and improve the flow of patient data to improve care (53). The medical education system and residency programs in particular also need to be reformed to give physicians and residents more breaks and rest so they can better care for their patients and their own mental health. On the nursing side of things, it is estimated that the U.S. will need 1 million additional nurses by 2024 (Emanuel 47). The ACA attempted to increase incentives for nursing faculty, without much success in fixing the shortage. One proposed solution is to use nurses trained in other countries and take advantage of task shifting between nursing staff members (Emanuel 53). Nurses also need safe staffing ratios to increase the amount of time they can spend giving patients the quality of care they deserve. Like the rest of the country, doctors and nurses also need paid maternity leave, sick leave, and proper vacations to combat burnout. Solving these issues will undoubtedly increase the quality of care in America, giving the patients the help they deserve.

Conclusions

At the end of the day, no health system is perfect. Some are better than others but plopping one system into another country may not necessarily solve any problems. As Ezekiel Emanuel says, “healthcare is path dependent.” It depends on the values of the people living in the

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system. Perhaps America has more that needs improvement than most other developed countries and more serious efforts must be made to remedy that in the future. The U.S. can learn how to make some of those improvements by studying the Italian healthcare system.

The biggest challenge faced by the U.S. healthcare system is excessive costs for care. Of all developed countries, it is most expensive to receive healthcare intervention in America, and still, they have some of the worst outcomes. While they still struggle to stay under budget, the cost of care in Italy is significantly less than the cost in America. Another issue is the complexity of the system with multiple different types of insurance, in- and out-of-network providers, and multiple different payment systems. It is simply too confusing for people to navigate. The Italian healthcare system is more straightforward with guaranteed public coverage for everyone. The last main issue in America is a large number of uninsured citizens. Perhaps this is an area where the U.S. could learn the most from Italy. They have managed to provide universal coverage to their residents and have significantly reduced the uninsured population in their country. Small lessons could be taken from Italian healthcare and applied in America to make big improvements.

After all this, a main takeaway is that there is hope that some, if not all, of these challenges faced by the American healthcare system can be solved in the decades to come. The enactment of the Affordable Care Act is a bright spot in the past decade and policymakers should continue to build upon that progress moving forward. Policymakers should continue to implement the Health Insurance Marketplaces and delivery system reform, increasing federal financial assistance for Marketplace enrollees, introducing a public plan option in areas lacking

individual market competition, and taking action to reduce prescription drug costs. (Obama) Analyses of other countries' health systems such as this can help policymakers imagine different ways to improve the care system in America. There is hope that American policymakers can learn how to adapt some of the good policies found in countries like Italy and avoid repeating their mistakes. The United States' experience so far with the ACA demonstrates that positive change is possible, even on some of the nation's most complex challenges.

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