

The Impact of Market Thinking and Italian Culture on National Health Service

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This article is a new version of the report (2003-4) on *Italian National Health Service and the Market Ideology* commissioned for the book *Medicine and the Market. Equity v. Choice*, by Daniel Callahan and Angela A. Wasunna, The John Hopkins University Press, Baltimore, 2006.

1. Introduction

In Italy current problems concerning the relationship between medicine and the market are encapsulated in the debate, both in the past, and in the current legislature of the government and parliament, on both health policy and the redefinition of health rights in the light of the new role some would give the Italian National Health Service (INHS).

The purpose of this contribution takes into consideration indicators of health policy at national level, the main strategies with regard to the principles of NHS as well as analysis of the new equilibrium between the State and the market in health. It concerns the role of government and the private sector, their aims of providing better ways of health care, in order to address the issues of the effect of market thinking and its impact on equitable access to health care, system efficiency, outcome for both individual and population, and on the doctor-patient relationship.

First, the paper analyses a brief recent history and description of the Italian health care system and the key role of regions in health policy.

Second, we examine the INHS principles and the changes in National Health Planning in recent years; what we would like to do here is consider whether they are market-oriented or not.

Third, after the analysis of the essential levels of health care as basic health needs within an universalistic model, we look at some empirical evidence concerning services like primary health care, specialist treatments, hospital care etc., and focus on the opinions expressed by Italian people on their satisfaction with the Italian National Health Service. This has implications not just on health financing, but also on preference for a public or a private system. In this way, we try to examine the impact of market thinking and its practice in Italy on the equity and efficiency of the INHS.

2. Are the INHS principles market-oriented?

The short answer is no.

Health is, according to the Italian Constitution, a fundamental right of each individual in the interest of society (article 32 of the Constitution). The Italian National Health Service basic principles are within a *universal system* of care and comprise (www.ministerosalute.it; Italian Ministry of Health (2003)):

- “*Human dignity* according to which every individual must be treated with due dignity and have equal rights irrespective of their personal characteristics and role in society;
- *Protection* according to which the health of the individual must be protected before it is threatened;
- *Need* according to which those in need have a right to health care, and available resources must, as a priority, be allocated to the promotion of activities aimed at meeting the primary health care needs of the population and overall public health;
- *Solidarity*, especially towards the more vulnerable: resources must be allocated primarily to the support of groups of people, individuals and for certain diseases that are socially, clinically and epidemiologically sensitive;
- *Effectiveness and appropriateness of interventions* to which resources must be channelled for services whose effectiveness is scientifically based and for individuals who can benefit the most from them;
- *Cost-effectiveness* which stresses that when choosing between different supply patterns and types of activity, priority should be given to solutions which offer optimal effectiveness rather than cost;
- *Equity* which guarantees that no geographical and economic barriers should prevent any individual from accessing the health care system, and that any lack of information or any behavioural differences should be overcome to avoid health discrimination between individuals and groups of people; equal access and availability of health care must be guaranteed in the light of equal needs”.

With regard to equity, a propos the health of immigrants in Italy, we note that it has passed beyond the initial emergency legal and medical phase and is now at the stage of consolidation in terms of promotion and recognition. This also reflects the crucial issue of access and use of public health services and concern not just dependence on the right to health as a function of the existing legislation, but also the capacity of the health services themselves to provide appropriate responses to the health and welfare needs of new patients, whose cultural background is different from those of Western patients.

In Italy in the 90s and at the beginning of the millennium, as part of the process of implementation of the measures for the reorganization of the NHS, the role of the regions is taking on increasing importance. This is in line with the importance that had already been identified in the institutional structure outlined by law 833/78 of the health reform, endowing it with new functions such as planning the regional health or social and health system and the management as well as distribution of the Regional Health Fund. We have, therefore, witnessed the creation of regional health services, quite individual different from each other, but in harmony with the idea of health federalism or neo-regionalism. This autonomy granted to the regions relative to determining the creation of the social and health system has led to the establishment of different regional models; this differentiation is inevitable, in view of the considerable differences regarding the dimension of territorial, economic and socio-cultural nature between the regions which lead to the presence of health policies and levels of service which are very particular and different. The process of reorganization of the

NHS which began in 1992 - and which has continued with different rules of implementation during this decade - has not however led to the complete and uniform adoption of the reform, especially within the regional health services. This delay can be attributed both to the regions and to national governments, which have followed on since the start of the wave of reforms.

However, especially since 1999 health policy has attempted to guarantee greater protection of people's health, aiming to improve quality and efficiency of health care on the one hand and, on the other - with the introduction of fiscal federalism - to attribute a new role to the regions in the management of care services and programming of resources allocated to them.

Currently, the NHS in Italy is conceived as a system where the supply of health care services moved from central to regional governments, under the monitoring of the regions, and the kind of services delivered are divided by means of the Essential Levels of Health Care (ELHC), distinguishing between free charge services (for which people don't pay anything) and co-payment services (for which people pay for a ticket). The national and regional governments must agree on health objectives to be achieved within a period of time, as indicated in the National Health Plan, and it's the regional responsibility to establish the best practices needed in order to realise those objectives. Control over the actual realisation of the contents of the National Health Plan as a whole remains in the hands of central-national government.

3. Is National Health Planning changing?

In accordance with the principles, the fundamental objectives of prevention, treatment and rehabilitation and the general outline of the INHS are contained in the main planning act of National Government exemplified by the National Health Planes on a 3-year scale. The National Plan attributed particular importance to the people's general health needs and not only to the delivery of health care. This attitude is in line with the indications of the World Health Organization and in particular with their "Health for All Strategy". The plan makes a strong plea to create a real nationwide "solidarity health pact". The institutions include responsible for the safeguard of health operators, institutions, voluntary workers, profit and non profit producers of health related goods and services, media and the national and international society. However, this plan also defined some strategies in order to change health care.

As the institutional system in Italy is in a transitional phase rapidly moving towards federalism, the health plan takes on a new significance as it also define the basic outlines of health policy as unifying elements of the health system in Italy.

Nevertheless the federal policy requirements have not modified the basic principles of the INHS still remain fundamental points of reference. These principles, noted above, are the right to health, dignity and inclusion of "all people" (including immigrants), equity within the system, quality of services, attributing responsibilities to the relevant bodies, social-health integration, development of knowledge and research and safety for the people. Furthermore, efficacy and quality of health care indicators have been identified in agreement with the Regions and defined in the Ministerial Decree. Indicators have been divided into several

groups: some indicators have been identified for the levels of collective health care in life and work environments; other of them for district health care levels and for hospital health care.

In the light of this, the Ministry of Health develop the draft of the national health plan which has been preliminarily approved by the National Governments (the centre-right or centre-left wing) and is presently being evaluated by the Regions (as part of Permanent Conference for Relations between the State, the Regions and the Self-governed Provinces).

The main issues of the plan are (Italian Ministry of Health, 2003):

- “to specify the scope of the guarantees uniformly ensured by the health system to all people (hence, how to realize essential levels of care and how to monitor that they are actually achieved);
- to define the priority health objectives of the population, with regard to epidemiological circumstances with the aim to prevent diseases and promote a healthy lifestyle as well as to ensure proper public health awareness;
- to define further strategic objectives, such as the development of scientific research and the training and education of personnel.”

The plan also contains proposals on the main operational measures for carrying out these priority objectives. The central level's role is to guarantee equity of the health system, while the regional level's role is to organize and provide health services. The objectives indicated by the plan are defined in line with EU health policies and those of the other international organizations such as WHO and the Council of Europe.

The following strategic objectives, are crucial (Italian Ministry of Health, 2003):

- “implementation of the agreement on essential and appropriate levels of care. To achieve this objective and to guarantee an equitable access to health care in a universal fashion, it is necessary to define a monitoring system for the delivery of health care across Italy with appropriate indicators and to reduce and control waiting list for the delivery of health care”.

Currently there is of course another means of getting round the waiting lists (jumping the queue) to access health care: the health care private sector not under contract with NHS, but, of course, available only to the upper-middle classes who can exit from the INHS because of their capability to pay for accessing to the market system(see later);

- “to create a climate within the health system which facilitates more equitable conditions for the delivery of health care to all categories of the population that require care. Apart from conditions that threaten the health of the "weaker" subjects, other factors which must be take into account, are cultural, psychological and social aspects that cause discrimination in the access to health care particularly for the poor and marginalized social classes”.

Other objectives are the following:

- “developing emergency services: a specific objective is to avoid inappropriate use of emergency wards, to ensure that general medical consulting rooms are open 12 hours a day, seven days a week;
- establishment of an integrated network of health care and social services for chronically ill, the elderly and the disabled;

- guaranteeing and monitoring the quality of health care and biomedical technologies, including citizens charter, certification of the quality of the providers of the INHS, public and private sectors;
- realisation of quality permanent training in medicine and health care;
- redesigning the hospital network giving new roles to Centres of excellence and for the other hospitals;
- promotion of biomedical and biotechnological research and health care research;
- promotion of a healthy lifestyles, information on prevention readily available to the public on health related issues” (Italian Ministry of Health, 2003).

3.1. Essential Levels of Health Care as basic health needs within an universal model

The Essential Levels of Health Care (ELHC) are services that the *INHS is expected to deliver to people, free of charge at the point of access or upon payment of a small pro capita charge*. The ELHC costs are covered by public resources that are collected from general taxation yield. The ELHC can be divided into three large groups (www.ministrosalute.it):

- “collective health care in day to day life and working environments, including all the prevention activities related to the population and to individuals, including protection from the effects of pollution and industrial-accident risks, veterinary public health, consumer protection, prophylaxis for communicable diseases, vaccination and early diagnosis programmes, forensic medicine;
- district health care, including the health and social care services distributed throughout the country; from primary care to pharmaceutical assistance; from specialised and diagnostic out-patient units to supplying the disabled with prostheses; from home care services for the elderly and chronically ill people to local consulting services;
- hospital care, in emergency wards, ordinary hospitalisation, day hospitals and day surgery, structures for long-term hospitalisation, for rehabilitation and so on”.

At the same time, there are services and activities that are not provided by the INHS (not included in the ELHC) because they are not directly intended to safeguard people's health, their efficacy has not been sufficiently proven from a scientific point of view or the results achieved compared to the costs do not prove to be convincing. This exclusion from the ELHC, for most health services listed (e.g. unconventional treatments, cosmetic surgery and facultative vaccinations), existed prior to the implementation of the decree 29 November 2001, people requesting such services had to cover the expense on their own. The main reason for this exclusion is that some types of services are frequently subject to "hyper-prescription" compared to the patient's essential clinical needs and, therefore, the balance between INHS costs and patient's benefits is generally considered unfavourable. In any case, the possibility exists also for some health care presently excluded from the ELCH to be reinstated to the list upon a decision of the Region providing specific clinical justification.

A third group of services to be supplied to people *only on condition* that the principle of clinical and organizational appropriateness applies; the requirements are that conditions of the patients are such that the

specific services are deemed to be beneficial (clinical appropriateness); and the delivery system for the service (e.g. ordinary hospitalisation, day hospital and day surgery) guarantees the most efficient use of the resources in relation to the nature of the treatment and patient's condition. In these cases, particular conditions and individual cases should be subsequently identified by the Ministry of Health and/or the Region. The INHS will continue to guarantee certain services (it is the case for certain pharmaceuticals that can be delivered at no cost only to patients, affected by certain types of disease).

4. Some empirical evidences

4.1. Services and the public opinion: the verdict on INHS

The services provided by the INHS include:

- community health and hygiene;
- primary health care;
- specialist treatment; hospital care;
- care and rehabilitation of non self-sufficient people.

Regarding the dichotomy of public/private sector, we now focus on primary health care, specialist treatment and hospital care.

In Italy, *primary health care* includes diagnosis, treatment and first level rehabilitation together with prevention, health promotion and education activities and, in particular family doctors and paediatricians, pharmacies and home carers. Primary health care is mainly provided by General Practitioners (GPs) included in an ad hoc list. The main activities of GPs are the provision of medical care, prescribing medicine, ordering diagnostic tests and hospitalising patients. Patients are registered with a GP who acts as a conduit to specialist services. The relationship between patient and GP can be terminated by either party at any time if it is not considered satisfactory. The services of GPs are free at the point of use. GPs have contracts with the INHS managed by the relevant Region, and are paid on a capitation basis, depending on the number of patients enrolled in their lists up to a maximum of 1500 per GP. Patients are registered with the doctor and not the practice and the GP/patient relationship is close. Children under 12 years are looked after by paediatricians (they have the same contracts as GPs but are limited to a maximum list of 1000). There are important geographical variations in the size of GP lists and the availability of their services, and some Regions have smaller physician/patients relationship.

In case of emergency, patients can go directly to the hospital emergency departments. Patients who turn to hospital emergency may have to pay a small amount (so called "ticket"). Public health nurses have the specific function of safeguarding the health of individuals and the community through preventive and health education activities. They establish direct relationships with people in their daily lives and work, families and the community.

Pharmacies have the monopoly of medicine sales but are subject to numerous regulations. A pharmacy can be privately owned (and have a contract with the relevant Local Health Unit) or belong to a municipality or a hospital, in which case the pharmacists are paid a salary. In Italy, there are about 16250 private pharmacies and 1129 owned by municipalities. Given the limited number of public resources available for the pharmaceutical budget, evidence-based medicine and benefits/costs are the main criteria for providing drug treatments within the NHS in Italy. Prescribed essential medicines for chronic diseases are free of charge at the pharmacy (List A) if no more than reference price fixed agreed for medicines belonging to a particular class/therapy, specific dosages and therapeutic indication. Medicine belonging to a given class therapy more expensive than the reference price is not covered by the NHS. Most medicine prescribed under the INHS can have a regional prescription charge (ticket) according to the financial policy of each Regions (i.e. Lombardy). However, exemptions are made on the basis of income, particular medical conditions or special status (e.g. disable persons). The remaining medicines, also known as “comfort medicines” belong to List C and are fully charged patients.

Regarding *specialist treatments*, these include clinics and laboratories (public and private under contract with the INHS), family planning clinics, drug services for addiction, prevention and rehabilitation, departments for mental health, rehabilitation centres. In our country, there are more private than public outpatient clinics, although this depends on the region. The Public clinics are mainly located in hospitals and other structures.

A propos *hospital care*, the INHS guarantees hospital admission for conditions that cannot be treated on a home or outpatient basis, as well as for interventions in day hospital structures. Most general hospitals include at least four basic services: general medicine, surgery, paediatrics, gynaecology and obstetrics. Depending on referral by a GP, care is provided free of charge in public hospitals or in private facilities under contract with the INHS. Patient choice (see below about the free choice of citizens) is respected and as a result there are important cross-border flows between Regions, even though all have at least one general hospital. Hospital services are mainly free of charge at the point of use.

Available data indicates the numbers of beds in different Regions of Italy show that the total number of hospital beds has fallen significantly in recent years. Reasons behind for this trend are containment policies, change in technology, different methods of treatment, reasons that reflect a combination of cost-issues of primary health care and social care.

Furthermore in Italy, as in most countries, with the introduction of the system of the Diagnosis Related Groups (DRGs), there has been an increase in admission rates together with a reduction in the average length of stay (is this an impact of the new market ideology?). The latter trend has accompanied changes in the management of patients, improvements in clinical techniques such as minimally invasive surgery, and incentives to reduce length of stay and ensure that patients who no longer need acute care are discharged to other facilities. In recent times, the progressive ageing of the population and decreasing birth rate has led to a reduction in the number of beds in medical-surgical and maternity-children's wards, as well as an increase in the number of beds in the rehabilitations and long-term care.

In the year 2000, the World Health Organization (WHO) carried out the first worldwide analysis of the performance of NHS of 191 Member States. It concluded that the performance of the INHS, as assessed in terms of “life expectancy corrected by disability”, is the third highest among 191 different countries, whereas, in terms of global performance, Italy is second only to France.

Despite this data, public opinion in Italy remains to some degree dissatisfied with both poor service, and accidents in health related areas, often caused by the lack of a global system guaranteeing standards of quality: the public notes medical errors, long waiting lists, duplication of tasks and services, lack of trained staff and training programmes, the absence of set procedures, bureaucracy and obvious waste etc.

Much research on national and international scales indicates, and as we have already noted, Italian health policy from the beginning of the 90s is in a process of considerable transformation: the objective of this changes is to introduce elements of competition within a system which will remain predominantly public, and that this approach will guarantee a quality service for everyone entitled to it. In any case there are any numbers of different interpretations of how the system will actually work. There are even more variables to be taken into consideration in the analysis of the levels of satisfaction as indicated by the general public with relation to the National Health Service in Italy. Different levels of satisfaction within the public exist in different sectors and clinical specialities (for example basic medicine, testing, examinations, home services and hospitals themselves, surgeries, accident and emergency, reception,) the biggest problems include poor service, long waiting lists, queuing for appointments, and a clarity in information on diagnosis and treatment.

Concerning the organisational method (public or private) surveys in recent years indicate that there are contradictions in the choice between public and private health services, in the sense that they do exist side by side and the users' views seem somewhat incoherent in the way they use the services and the way they evaluate them. Not only the upper class take advantage of the existence of private services in the absolute market sense. In fact in Italy in the last seven years about 35% have been using the totally private sector. Justifying such a choice by circumventing the public sector, especially with regard to the waiting list problem (32%) and lack of confidence (22.8%). Looking to the future, almost 50% of the public are potentially ready to opt for private services. At the same time the actual use of services remains prevalently public (see later). People demand a comprehensive health system and are on the whole respond positive when asked of their satisfaction levels. This apparent contradiction in the service overlap, offered both public and private is interpreted by the users as a further resource which on current legislation offers a freedom to choose, and therefore more personal freedom (more than 80%). The level of satisfaction is nevertheless in line with the geographical response. The situation in the south of Italy is heavily critical.

The main issue in the public debate of the last decade regards the role of the market and of freedom of choice in health care. There is a widespread perception that the introduction of competition in health care can be an important tool in order to regenerate the whole system. When asked about the possibility to have freedom of choice in selecting between public and private providers, 81% of Italians judge it positively because the individual is allowed to follow their own preference and just 11% state that it is negative because it can produce waste and duplication in the delivery of health care. It should be stressed that the 90s' reforms

have introduced competition between private and public providers, but the degree of users' freedom of choice varies substantially from Region to Region. While there is an overwhelming majority of people supporting more users' freedom of choice, attitudes towards health expenditure are more controversial. Italian public health expenditure is – as will be stressed later - below the EU average: this is the consequence of the tight cost-containment policies implemented during the '90s.

4.1.1. "No to public health in the hands of the private sector": the verdict of the electorate

Public opinion indicates for the most part a preference for public health sector. In two different ITANES (*Italian National Electoral Studies*) surveys, in 2001 and 2006, almost 40% of a representative sample Italian people interviewed in 2001 and 60% of the same sample in 2006, were totally against any private health policy, while only almost 60% in 2001 and 40% in 2006 were in agreement with it. In 2001, many of those who disagreed were found to vote for centre-left parties (83.3%), whilst people who claimed to be in the centre politically numbered (66.7%), and even those who supported the centre right numbered (56.1%). The percentage difference between centre-left and centre-right electorates in 2001 was 24%, while in 2006 it was 22%. Inside the two coalitions, in 2001 there weren't found any appreciate differences among centre-left parties, with left parties, Democratici di Sinistra (DS) and Margherita DL (DL) respectively on 18, 16 and 17 per cent in agreement with private health policy, whilst in centre-right coalition, people voting Lega Nord (LN) who were in agreement with the same issue was 49 per cent, slightly more than Forza Italia (FI) (43%) and Alleanza Nazionale (AN) (41%) electorates. In 2006, the percentage of people voting centre-left parties who were in agreement with private health policy globally decreased, with DL electorate on 12%, more than people voting Left parties (they include Partito della Rifondazione Comunista - PRC, Partito dei Comunisti Italiani - PdCI and Verdi) and DS, respectively on 8 and 6 per cent. Inside centre-right coalition, from 2001 to 2006, Unione di Centro (UDC) electorate in agreement with private health increased 2 per cent, whilst people voting FI, AN and LN decreased respectively of 18, 4 and 6 per cent.¹

¹ The following question was put to interviewees: "Now I am going to read some opinions people often hold on politics and economics. Please tell me how much you agree with each of them. Health care should be in private hands". It was measured by a Likert scale in 2001 and by an ordinal scale from 1 to 7 in 2006.

Tab. 1. *Electorate Agree with Private Management of Health Policy (percentage on overall electorate)*

	Center-left coalition	Center-right coalition	Differences
Survey 2001	18	42	24
Survey 2006	8	30	22

ITANES 2001 and 2006. From ITANES (2006)

Tab. 2. *Electorate Agree with Private Management of Health Policy (percentage on singular party only)*

	Left parties*	DS	DL	UDC	FI	AN	LN
Survey 2001	18	16	17	24	43	41	49
Survey 2006	8	6	12	26	25	37	43

ITANES 2001 and 2006. Source: ITANES (2006)

Tab. 3. *Health Care should be in private hands*

Percent	N	
8.7	280	Agree completely
20.2	647	Agree fairly
22.8	732	Agree a little
41.1	1,318	Disagree completely
7.0	226	Doesn't know
0.2	6	No answer
100.0	3,209	Total

ITANES 2001

Tab. 4. *Health Care should be in private hands for Self-placement (Centre-left; Centre; Centre-right)*

	Self-placement			Total
	Centre-left	Centre	Centre-right	
“Don't agree”	781 83,3%	466 66,7%	502 56,1%	1749 69,1%
“Agree”	157 16,7%	233 33,3%	393 43,9%	783 30,9%
Total	938 100%	699 100%	895 100%	2532 100%

ITANES 2001

Tab. 5. *Health Care should be in private hands for Professions*

	Professions				Total
	teachers	workers	Employer class Self-employed professional	Tradesman Skilled operatives	
“Don't agree”	73 82%	277 68,9%	57 48,7%	122 57%	529 64,4%
“Agree”	16 18%	125 31,1%	60 51,3%	92 43%	293 35,6%
Total	89 100%	402 100%	117 100%	214 100%	822 100%

ITANES 2001

With respect to the professional classes, teachers are the sector with the highest percentage who voiced opposition to a private health system (82%). Followed by the general workers (68.9%), tradesman and skilled operatives (57%). Only the employer class and self-employed professionals offered almost an equal diversity of view 51.3% for the private and 48.7% for the public.

Overall therefore the *majority of Italians are against a market system in the health argument*. The data cuts right across political persuasion and professional class. The suggestion is that there is widespread fear that a move towards a private health system in the future will not guarantee a health service for all, independent of ability to pay.

4.1.2. Differing attitudes of the people towards the public and private sector

The Italian population, with regard to hospital in-patient treatment, on the whole use the public sector. The most recent survey on the family, of the Italian Institution of Statistics (ISTAT 2003) demonstrates: 88% of the population when in need, uses the public sector, 10.8% use private institutions under contract with the INHS, and only 1.2% opt for a totally private hospital.

The centre and the north of the country, taken together, take advantage of public institutions (around 90%) whilst further south and in the islands is only a little less (86%) and if they do use the private system more, it is under contract to the INHS.

Tab. 6. People treated in hospital, identified by sex and geographical region

Geographical Distribution	Public Structures			Structures under Convention			Private Structures		
	Male	female	Tot.	male	female	Tot.	male	female	Tot.
Nord West	89,4	86,4	87,8	9,2	12,3	10,9	1,3	1,4	1,3
Nord East	90	90	90	8,6	9	8,9	1,3	1	1,1
Middle	90,9	89,6	90,2	8,2	8,8	8,5	0,9	1,7	1,3
South	86,1	85,7	85,9	13,3	13	13,2	0,5	1,3	0,9
Islands	85,9	87,1	86,5	12,7	11,3	11,9	1,5	1,7	1,6
Italy	88,5	87,5	88	10,4	11,1	10,8	1,1	1,3	1,2

ISTAT (2003)

As we consider, people of a high level of education, which overall relates to a healthier socio-economic position, the percentage using the public sector levels off a little (83.4% for graduates and high school achievers) and this is mirrored in the increase in hospital stay in the private system but under contract with the INHS (13.3%) and in completely private treatment (3.3%).

The majority of those treated who have actually paid can be divided into: those who have directly contributed (78.2%), those who have the benefit of private health insurance (16.9%), and finally those who have both directly contributed and taken advantage of health insurance (4.9%).

It is the ageing population who are on the whole the ones who pay directly for their treatment (90.2%) and only 6.8% of the elderly has health insurance.

There is also a correlation between the economic conditions of those less well-off and their need for increased hospital services, particularly for the elderly.

Tab. 7. People treated in hospital identified by their contribution to the expense of their hospital treatment, and broken down into class, age, and geographical region

		Percentage Expenditures				Percentage Contributions		
		Partial Contrib.	Health Expend.	Other Expend.	Total Expend.	Direct Contrib.	Private Assuran.	Mix Dir.+Ass.
AGE CLASSES								
under 64		6	55,1	18,2	29,9	72	22,1	5,9
65 and beyond		6,3	55,1	26	19,8	90,2	6,8	3
Total		6,1	55,1	20,9	26,4	78,2	16,9	4,9
GEOGRAPICAL DISTRIBUTION								
Nord West		6,3	61,2	14,8	20,4	73,4	25	1,6
Nord East		4,4	66,4	18,5	22,1	81,3	11,2	7,5
Middle		7,5	56,3	14,4	35,2	66,7	23,9	9,4
South		5,8	46,1	29,3	25,1	87,2	9,9	2,9
Islands		6,5	45,9	30,8	23,2	87,6	7,1	5,3
Total		6,1	55,1	20,9	26,4	78,2	16,9	4,9

ISTAT (2003)

4.2. DRG: Implications on the efficiency and equity of health structures

The implementation of the system of DRG has had a drastic effect on the Health service in Italy. The principle, imported from the United States had been tried for a period of three years up until the end of 1997 when it was adopted comprehensively. In Italy, as in many other countries throughout the world, this implementation brought with it considerable innovation, incorporating radical change in the relationship between the people and health institutions, and particularly in the system of financing health care. So what exactly was the overall effect of DRG implementation? From 1994 when the experiment started in-patient treatment turnover increased significantly. Looking at the in-patient situation in routine practice, number of diagnosis again increased as well as the number of operations. An overview indicates an increase in diagnosis and in operations on an even grander scale in private as opposed to public health institutions. Taking into consideration the implications of the implementation of the new financial health arrangements brought about by DRG, if not overseen by some form of watchdog it could be subject to manipulation and at the same time favour a type of opportunism, the cost of which would be borne by the Italian public.

In order to illustrate this scenario let us consider some examples from Lombardia (one of the most important regions in Italy). We are taking into consideration here the length of stay in hospital for all categories of diagnosis in both public and private institution. Within public hospitals the average stay decreased only minimally (from around 10.4 to 9.2 days) without radical variations with respect to the period prior to DRG implementation. Whilst within private hospitals the statistics show an increase in the average stay (10 days, but with a significant drop from 1994 (14.1 days) which represents a cut of 31%, exemplifying an optimum adaptation to the financing system. This may well be positive from the point of view of

efficiency, but carries a serious risk of too-early release, when the patient is simply not ready, and often leads to re-admission, and post-operative mortalities etc., classic examples emanating from an opportunistic approach.

To conclude, the philosophy behind DRG is almost directly akin to market thinking and indeed practice, having examined the before and after scenarios of implementation, the major effects on the working of the health system in Italy are:

- an increase in standard in-patient treatment;
- an increase in constancy of day-hospital practice
- a reduction in the length of actual stay

4.3. Health financing: consequences of competition in the INHS

Since 2002, with the introduction of Essential Level of Health Care (ELHC), the State guarantee that the health care services delivered by each regions are monitored. Furthermore, regions with their own additional resources can provide their citizens with more health care services than those guaranteed by the NHS. Within this general framework, it's clear that the public sector still has considerable power. Only 16% of the population has private insurance and only around 16% of all hospital beds are provided by private. Today, in Italy, the private sector alone takes just a small role in health care services, exclusively three areas:

- a) integration with public sector through contracts in basic individual provision, which are completely free of charge (related with the);
- b) the provision of health care services that are not available under the NHS, which are to pay for;
- c) the relief of pressure on the public sector concerning long waiting lists. The overall incidence of the private sector in Italy varies between regions. For example, in Lazio private hospitals show a much higher proportion of public beds, whereas Umbria seems to have very few. Only 1,6% of all patients admitted to hospital care are completely covered by private health insurance, while private hospitals follow a bed-day basis logic, showing a longer length-of-stay and higher occupancy ratios than public hospitals.

The core problem of the INHS concerns neither effectiveness nor costs. The main deficiency rests in the health service's inability to be people-oriented, in its bureaucratisation; it has turned out to be a supply-led service suffering from a number of organisational problems.

To solve this problem, a key policy theme in the '90s was the introduction of elements of competition in the INHS. Under the 1992/93 reforms a "quasi-market" was established, where public and private providers accredited by the NHS compete, on an equal basis, to deliver services, though since the reforms of 1999 partially modified the "quasi-market" the INHS is slowly moving towards a more integrated system (Mapelli 1999).

The 80s and 90s have been characterised by a continuous growth in the types and dimensions of co-payments of health care. They are now deeply embedded in the INHS and their level is among the highest in the European Union. A significant part of the population is nevertheless entitled to partial or total exemption

from co-payments: this was the case for 21 million Italian people in 1996, some 37% of the population. Co-payments have played an important role in the cost-containment policies of the nineties, which have been characterised, by a strict policy of public expenditure cuts aimed at decreasing the public debt. Health care has been deeply involved in this policy, and its public expenditure has been substantially restrained. Another common feature - shared by health services as well - regards the problems in finding out the real economic situation of applicants and their relatives: in a country characterised by widespread fiscal evasion, it is really difficult to understand whether or not someone (or their relatives) has the possibility to contribute the service they are receiving.

4.4. The new scenario: exit and moving towards market in health care?

Now, which are the new options for health policy? In the health care debate and practice of the '90s the role of exit and market has been crucial. The 1992 legislation provided citizens with the possibility to opt out of the NHS and opt for a private social insurance, but this option was denied after one year. But the 1992/93 reforms also introduced elements of competition in health care. Both the kind of competition and the degree of choice open to the users have been extremely variable from one Region to another.

Italian health policy is characterised by a complex interaction between different ways of financing and delivering services. The NHS aims at providing citizens with all the services they need. The only private health expenditure should therefore - in theory – consist of that requested by the National Health Service for the co-payments or that due to the purchase of “unnecessary” items not provided by the NHS; the reality however, is quite different. Why? In Italy there is a huge level of private health expenditure, now amounting to 42,9% on the Total Expenditure. More than 50% of private expenditure is actually used by Italian citizens in the purchase of services already provided by the NHS itself, but that - for several reasons - people choose to obtain privately.

What we are saying therefore is that Italians could get these services from the NHS, either for free or with co-payments, but choose to buy them from providers not linked to the NHS (paying the whole cost). The private purchase of services one could get from the NHS has been in recent years a major cause of the private health expenditure's continuous growth.

The high level of expenditure on private services that the NHS itself provides is explained by the presence of (often long) waiting-lists, the perceived low quality of services and - for services such as diagnostic tests and specialist consultations – of a really high level of co-payments. A crucial issue worthy of more investigation is whether or not the fact that those who can afford private services often use them, decreases the quality of the public ones. It is in fact likely that in a situation where the middle-class utilises its “voice” option to “exit” (in Hirschman's terminology) for at least some services, this can have negative consequences on their quality. But this is an “exit” *sui generis*, because upper-middle class people who use private services are in any case obliged to finance (through their contributions and taxes) the NHS. The introduction of a “real” chance to exit the service, waiving the duty to finance it for people who would insure

themselves with private insurance, was widely debated over the 2001 AND 2006 campaigns for the general elections. This idea is still debated and some parties (i.e. Forza Italia and overall Lega Nord) in the centre-right coalition flirt with it, but, as we noted in ITANES survey (2001 and 2006), the majority of the people were not impressed by the argument.

The “exit” option has probably been the most passionately debated health policy issue of the ‘90s and at the up to the present along with the role of the market. Local Health Authorities are not in direct charge delivering services to citizens living in their areas any more: public and private providers accredited by the NHS compete - on an equal basis - to provide services to citizens. Regions now have really wide powers in setting their own health care legislation; after the national reforms of the '90s and 2001, each Region has thus enacted its own reform in order to conform to national legislation relative to its own context. The differences between Regions have concerned several issues, including the kind of competition among providers and the role of users’ choice. For the former, the actual degree of competition and the form of contracts used are extremely variable; for the latter, while in some Regions users can directly choose the provider they want, in others they have to use the one their Local Health Authority chooses on their behalf.

How to continue to control public health expenditure in the next years is an issue that worries several commentators, while others argue that expenditure should be increased. Italians share the views of their fellow Europeans concerning which level of public expenditure is most appropriate: some half of the population thinks public health care spending should be increased. When asked how extra-resources for health care should be raised, the supporters of this policy answer overwhelmingly (91,5%) “by spending less on other things” - while the EU average on this answer is 79,7% - and only 2,5% of them say “by raising taxes or health insurance contributions” (EU average 11%). The message is therefore that half of the population would like more public resources to be directed to health care but almost none of them is prepared to pay more money for them.

5. Conclusions

It would seem clear, in Italy, as in other countries throughout the world, that the market will play some role in the future of health care provision.

This inevitability however is absolutely full of *contradictions*. The above paper has tried to highlight some of these. Contradictions in what people say, and what they choose to do, contradictions in the way the various political parties see market-thinking influencing policy within the health service and not for example in let us say education.

Contradictions in the way that people's expectations change too. The general public want freedom of choice, and at the same time they are loathe to miss out on the security that 'mother' National Health Service has and continues to offer. The classic example here will show upper classes happy to join the private sector, they are either insured for health or they pay directly in the free market; the middle class would prefer to

choose the private sector - especially in the north - but they continue to use the public services, whilst resenting being asked to pay more in taxation to maintain standards of care therein.

Having said that the market influence is inevitable, we should nevertheless ask why in the first place did Italy in particular enter the world of private/public provision?

More contradictions are here perhaps. The INHS introduced the market system in order to tackle the many problems of efficiency and effectiveness in the existing services (waiting lists, bureaucracy, poor relationship between patient and doctor etc). The market therefore was very much a means but not the end.

Variables on the impact of market thinking on the services provided are many but we note on a general level that the INHS remains an equitable system wherein the populace, including those in disadvantaged socio-economic positions, have the full range of service provision and which remains of a generally high standard. However considerations about the future capability of continuing to provide equitable and overall cover brings us to a more serious question of not only the INHS which must take its place in the larger whole of funding for society itself.

In practice if we look at GNP, the percentage allocated for health purposes is poor; in fact it rests below the European average. It is a problem that is not going to go away with time. Hence we return to the inevitability question. Health has to take its place in the public expenditure round, and it's clear that other areas, take a larger 'slice of the cake' than the social service field.

And of the future? From the point of view of efficacy and guarantees of standards within health provision, if the share of public expenditure falls to an even lower level, we are faced with another inevitability. At the moment the burden of taxation on individual families is high but not unduly excessive. However, despite the fact that the INHS functions adequately and its umbrella is all-encompassing, there are weak points like care for the elderly who continue to be disadvantaged and in some situations must pay for their treatment.

And if we are saying that the INHS does function adequately why then the haste for individuals to join the private practise? The middle classes in particular hurry towards the market system (the majority however under contract to the public service) because for them it's trade-off between cost of treatment (or visit) and the alternative - a long waiting list.

Given that state provision of health care remains of a high standard, the only differences that the private sector brings is a) a more customer-related approach, immediacy of treatment; b) outside of treatment the rest is more cosmetic (comfortable surroundings, better rooms and food, flowers, television etc).

The fundamental provision of health care in Italy remains one which believes firmly in accessibility, free at the point of delivery, and an equitable approach to health care provision.. Italy is a country notwithstanding its many contradictions, with a positive cultural and social make-up, and would find it extremely difficult to take on board totally any idea of a health system top-heavy with the influence of the market.

Bibliography

- Callahan D. and Wasunna (2006), *Medicine and the Market, Equity v. Choice*, The John Hopkins University Press, Baltimore
- Gori C., Pasini N. (2001), *Solidarity and Care: State of the Art in Italy*, in Wil Arts and Ruud Muffels (eds.), *Solidarity in Health and Social Care in Europe*, Kluwer Academic Publishers (series Philosophy and Medicine), Dordrecht/Boston/London, vol.69, pp.133-157
- Istat (2003), *La cura e il ricorso ai servizi sanitari, Anni 1998-2000*
- Istat (2002), *Stili di vita e condizioni di salute. Anno 2001*
- Istat (2002), *Le condizioni di salute della popolazione. Anni 1999-2000*
- Italian Ministry of Health (2003), *Facts and Policies of the Italian National Health Service. Part III*
- ITANES (Italian National Electoral System) (2001), *Perché ha vinto il centro-destra*, il Mulino, Bologna
- ITANES (Italian National Electoral System) (2006), *Dov'è la vittoria?*, il Mulino, Bologna
- Maino F. (2001), *La politica sanitaria*, Il Mulino, Bologna
- Mapelli V.(2003), "Ambizioni e realtà del SSN", in Guerra M.C. e Zanardi A., *La Finanza pubblica 2003*, Il Mulino, Bologna
- Mapelli V. (1999), *Il Sistema Sanitario Italiano*, Il Mulino, Bologna
- Pasini N. (2004), *Health*, in Fondazione ISMU (eds), *The Tenth Italian Report on Migrations 2003. Ten Years of Immigration in Italy*, Fondazione ISMU, Milano, pp.143-156
- Pasini N., Reichlin M. (2000), *Solidarity and the Role of the State in Italian Health Care*, in Health Care Analysis, 8: 341-354, Kluwer Academic Publisher
- Pasini N., Reichlin M. (2001), *Solidarity, Citizenship and Distributive Justice*, in Wil Arts and Ruud Muffels (eds.), *Solidarity in Health and Social Care in Europe*, Kluwer Academic Publishers (series Philosophy and Medicine), Dordrecht/Boston/London, vol.69, pp.309-331
- Van Parjis P. (2003), "La sanità può essere lasciata al libero gioco del mercato"? in *Quanta disuguaglianza possiamo accettare?* Il Mulino, Bologna
- www.ministerosalute.it