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Quasi-market and cost-containment in Beveridge systems: The Lombardy model of Italy

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ABSTRACT

In the very recent past, the Lombardy health care system – established in 1997 on the quasi market model – has caught the interest of researchers and politicians in different OECD countries[1]. Its merits, compared to other Italian regional systems, are the control of health care spending and the balanced budget, in a frame of good quality of services and patient choice.

From the theoretical point of view, an appealing aspect of the Lombardy model is its gradual shift from a quasi market (QM) to a "quasi administered" system, which maintains all the typical features of the QM orientation – separation between purchasers and providers, the co-presence of public, not for profit and public providers, and patient free choice – but has deliberately sacrificed competition in order to control health expenditure. Another aspect of the Lombardy model is the sharp presence of private providers: the evidence that private sector is mainly concentrated in the long term care, where risks of complications are lower and financial remuneration is higher, suggests that a closer control should be exerted on hospital activity. Furthermore, possible distortions such as cream skimming and cherry picking by the private providers need more consideration. Another concern is linked to health spending control: equity issues could arise when observing a still relatively high share of private (out of pocket) health care expenditure. The paper stems from a literature review and tries to analyse the evolution of this regional system, the institutional path that brought to the implementation of the model, its theoretical basis, its merits and criticism. The period considered ranges from 1997, when the reform was enacted, to 2010.

1. Introduction

In the Italian and international literature, the "Lombardy model" is always mentioned for its uniqueness, compared to the other Italian regional systems [1,2]. With the regional law 31/1997 the legislator set a quasi market model, privileging the separation between purchaser and provider of health care and patient free choice. This analysis investigates the main features of the Lombardy health care reform in 1997 and the evolution of the model in the following years. The perspective that drives the study is mainly economic, hence aspects such as the theoretical framework of the quasi market (QM) model, the financing criteria and the problem of incomplete information in a free choice context are inspected. Only health care services are examined, while social services are not investigated. The different steps that brought to the quasi market choice are considered from the juridical, institutional and theoretical points of view, the main features of the model are highlighted, as well as its merits and criticisms.

After this brief introduction, the next section presents and analyzes the health care reforms of the nineties in

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[1] See for example the Wall Street Journal, Tuesday, April 13, 2010, R2.

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the Italian NHS, up to the process of devolution, Section 3 illustrates the main theoretical aspects of the QM setting according to the literature, while Section 4 explains, with the support of original data, the organization of the Lombardy model, the way it is financed, the role of its stakeholders, its merits and criticisms. The conclusions complete the work. Despite the authors' efforts at providing a thorough vision of the Lombardy health care system, some aspects, mainly the technical ones (i.e., waiting list for hospital access), have been neglected, due to the choice to focus on structural features.

2. The main reforms of the Italian NHS

During the nineties the Italian NHS was deeply reformed by different regulatory acts to promote managerialism, regionalization, and to introduce competition criteria in the quasi market, largely on the basis of the 1991 British NHS reform [3]. These changes, briefly described herewith, paved the way for the regional law 31/1997 and the setting of the internal market within the Lombardy healthcare system. With the decree laws 502/92 and 517/93, the Local Health Units (LHUs), which represented the third level of Government after the Central Authority and the regions, were transformed into public firms. General Managers were appointed by the region, but each LHU followed a management accounting and its own profit. LHUs' larger hospitals were required to become independent hospitals, able to contract with LHUs for number and kind of services, and to compete among themselves and with accredited private hospitals. In order to improve regional autonomy, social contribution, till then devoted to the national Fund, became a source of regional financing. The financing law of 1995 introduced the use of DRG as prospective payment for hospital activity. This method was functional to the new rules of the Italian NHS, such as the separation between provider and purchaser [4,5]. The next decree law (446/97) established more autonomy in the regional health care financing: together with social contributions, which were replaced by a production tax (IRAP), a percentage of the personal income tax (IRPEF) was committed to regional financing. The 1999 health care reform (decree law 229/1999) had been designed to stress the main objectives of the Italian NHS in view of the imminent process of devolution, which was institutionally formalized in 2000. Specifically, it reaffirmed the original goals of universalism, comprehensiveness, and public funding of the INHS [6], and highlighted the separate functions of central Government and regions. It also provided a clear orientation on the issue of competition, alleviating the emphasis that had arisen from the reform 1992–1993 and suggesting that all regions adopt a model of "contractual planning" [36]. With the decree law 56/2000, fiscal federalism was ratified, the national Fund was formally abolished, regions were required to autonomously finance their Health Services and a new balancing Fund was created in order to compensate for cross-regional differences in fiscal capacity[2].

In 1997, Lombardy was the first region to apply the decrees 502/92 and 517/93, with the setting of the quasi market model. The main features of the Lombardy health care system are the following (regional law 31/1997):

- Separation between health care purchasers and providers.
- Competition between public and private accredited providers in the presence of a third part payer.
- Patients' free choice between providers.

Furthermore, the principle of subsidiarity as a way of sharing competencies and activities between private actors, public sector and civil society (persons, families, and non-profit organizations), is deeply stressed [7].

3. The theoretical framework of quasi market in health care and its application in Lombardy

The theoretical principle of the quasi market model consists of introducing competition into the system, in order to improve the quality of services and to control health care expenditure [8,9]. The multiplicity of providers – both public and private accredited – and the presence of an independent third part payer are the most common features of the QM models. Purchasers have strong incentives to limit provisions by providers, while providers aim at increasing volumes and quality to attract patients. In this way, the possible distortions embedded in the publicly run systems should be avoided, or at least reduced [1,10]. The basic intuition is that the public sector can be the best insurer (granting financing and universal coverage), but not necessarily the best producer. The widespread, albeit not binding, use of fixed tariffs, leads to a competition on quality[3], while the negotiation on volume and typology of services between third part payers and providers ensures transparency in the financing criteria and introduces planning as a tool for controlling health care expenditure. The mechanism works in the presence of strong budget constraints, enforced by tariff caps in cases where services and/or accesses override the planned budget. Patient's free choice is granted – from the supply side – by a network of

[2] The National Health Fund has only been formally abolished. Actually, in 2005 it was still active and transferred part of the resources directly to the regions, driving other resources from the newly set balancing Fund, whose purpose was to redistribute financial flows from the richest to the poorest regions. The balancing Fund is financed by value added tax (VAT) revenues, the amount of which is set annually by the Government with the aim of ensuring that all regions have adequate financial resources for the minimum health care levels [32]. For an analysis of the "missed fiscal reform", updated to 2006, see [19], pages 65 and following. For an overview of the principal steps that introduced the devolution process see [21].

[3] Not all the health care systems with patient choice referring to QM settings have fix payment for services. Some studies carried on in the UK and in the USA, show the difficulty in reaching homogeneous results when the prices vary. The presence of many variables (capacity of evaluating separately price and/or quality, heterogeneity of qualitative variables, presence or not of a third part payer, mix of financing subjects) makes the analysis of the results difficult to perform [12,26–29].