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Private health care expenditure and quality in Beveridge systems: Cross-regional differences in the Italian NHS

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ABSTRACT

Private health care expenditure ranges from 15% to 30% of total healthcare spending in OECD countries. The literature suggests that there should be an inverse correlation between quality of public services and private expenditures. The main objective of this study is to explore the association between quality of public healthcare and private expenditures in the Italian Regional Healthcare Systems (RHSs). The institutional framework offered by the Italian NHS allows to investigate on the differences among the regions while controlling for institutional factors. The study uses micro-data from the ISTAT Household Consumption Survey (HCS) and a rich set of regional quality indicators. The results indicate that there is a positive and significant correlation between quality and private spending per capita across regions. The study also points out the strong association between the distribution of private consumption and income. In order to account for the influence of income, the study segmented data in three socio-economic classes and computed cross-regional correlations of RHSs quality and household healthcare expenditure per capita, within each class. No correlation was found between the two variables. These findings are quite surprising and call into question the theory that better quality of public services crowds out private spending, or, at the very least, it undermines the simplistic notions that higher levels of private spending are a direct consequence of poor quality in the public sector. This suggests that policies should avoid to simplistically link private spending with judgements or assessments about the functioning or efficacy of the public system and its organizations.

1. Introduction

The coexistence of public and private funding is a feature common to many health care systems. For example, in nearly all of the EU 15 member states, the share of public financed expenditure ranges from 70% to 85% (only Ireland, Portugal and Greece are under 70%) [1]. Since the general trends concerning income inequality and ageing of the population are on the increase, Mou [2] finds that the role of private sources of funding for health care is likely to grow in developed countries.

Private health care expenditure is a complex phenomenon, made up of many economic circuits involving different actors: families, employers, insurers and other intermediaries, and health care providers, both private

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and public [3]. An estimate of health care expenditure can be drawn by viewing these circuits from the angle of final consumption, that is the flow of payments that providers receive. In this case, the estimate should include: direct households expenditures, either on an out-of-pocket basis or reimbursement from insurers, direct payments to health care providers from insurance companies and other intermediaries on behalf of patients, and employers' expenditure for health services, mainly in the area of occupational medicine.

Given the different legitimation basis and political rhetoric that distinguish Bismarck systems from public-integrated models (Beveridge systems), private expenditure poses special problems on the latter. In those instances where entitlement to health care is based on citizenship, and is considered to be a right of individuals rather than being linked to some sort of contribution (even when it is mandatory), private expenditure can be perceived as a failure of public organizations and governments, particularly in public debates and in the political arena, more so than in other contexts. This research focuses the analysis on the private household expenditure in order to give policy makers and academics a better overview of the role of private health care in Beveridge systems. Analysis on health care expenditures can be conducted either at an international level by comparing variables across different countries [2,4] or at a national level, when regional data are available [5]. International comparisons, however, are problematic due to differences in financing, organizational, and political contexts, as well as in the definition of variables and in the ways of collecting data.

In Italy, health care is predominately provided through the state-financed National Health Service, namely, *Servizio Sanitario Nazionale*. The Italian National Health Service – INHS is expected to guarantee the full coverage of the citizens' health needs[1] either directly or through independent private contractors, though, the private sector pays for around 22% of total health care expenditure [6].

The Italian case is interesting because the INHS is composed of 21 regional (public) health care systems (RHSs) which differ in governance arrangements, financial mechanisms and problems, and quality of the service provided [7]. From this point of view, restricting the analysis to one country with multiple sub-governments can improve the reliability and significance of an analysis, especially when – under a single institutional framework – substantial differences can be observed at regional levels.

Italy is also a good example of problems posed by the presence of private expenditures in a Beveridge system. In the Italian political arena, private health care expenditures are often raised as an issue intended to question the ability of regional governments in managing health care systems. Regional governments, especially those with higher shares of private funding, have no incentive to steer public attention towards private health care expenditures because it could be politically threatening. In the same way, public organizations pretend to ignore what is happening "beyond the fence" of a public system that is supposed to give an answer to the population's health care needs. An example of this attitude can be found in the social reports (Bilancio di Missione) published by public health care organizations (LHUs) in the region of Emilia Romagna. These reports provide a detailed description of public service production and consumption; at the same time, they leave out private consumption, which is virtually ignored [8].

The main purpose of this paper is to explore whether different quality levels in RHSs can be associated with different intensities in the consumption of private health care, and, in particular, whether available Italian data support the hypothesis that higher levels of quality in public health care systems are associated with lower levels of expenses in the private sector.

The paper is structured as follows: Section 2 discusses the background of the literature; Section 3 presents the methodology and the materials; Section 4 presents the main results; Section 5 discusses the results and Section 6 proposes some conclusions and implications for future research in the field.

2. Background

Private health care funding ranges from 15% to 30% of total health care expenditure in OECD countries. Yet, the topic of private health care consumption has not been sufficiently explored by empirical studies. Studies investigating this phenomenon use traditional variables such as total (public and private) health care expenditure and its dynamics [9–11]. Di Matteo [12], for instance, examines the determinants of real per capita health expenditures in USA and Canada in a longitudinal study. After controlling for time, he finds that ageing, population distributions and income explain a relatively small portion of health expenditures and concludes that there is a need to better understand the mechanism driving the increase of health care expenditure. There is a limitation when looking at micro and macroeconomic levels of health care expenditure, though. At a macroeconomic level, private health care expenditure data is available but there is a lack of interpreting models. On the contrary, at a microeconomic level, there are models but there is a lack of data [13]. In this second case, the gap between theory and empirical evidence has been slightly reduced in the last decade thanks to "ad hoc" investigations by researchers or through innovative institutional surveys, such as the SHARE (Survey of Health, Ageing and Retirement in Europe) database [14–18].

When considering the relation between public and private consumption, the theoretical debate assumes that it falls somewhere in between complete mutual exclusivity (opting out) and perfect supplementary (topping up) [19,20]. In the first case, private and public services are considered to be *substitutive*, and individuals may choose private services in view of some differential elements that improve the perceived quality of health care services received. An example is the possibility to shorten waiting times for certain services. In the second case, private and public services are *complementary* and do not compete. In

[1] Actually, under certain conditions, the INHS offers full coverage also to non-Italian legal residents and, since 1998, basic services to illegal immigrants. For the sake of simplicity, the study refers to the whole eligible population as citizens.