ASSESSMENT OF THE CRITERIA OF NATIONAL HEALTH FOUND DISTRIBUTION IN ITALY. DOES THE PUBLIC MONEY FOLLOWS THE SERVICE USER?

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Abstract

In Italy the National Health Service is financed by the distribution of the National Health Fund to the Regional Governments, which have the role of the exclusive management of health services. Hence they have to guarantee the Essential Assistance Levels (LEA) thanks to the Health Regional Services, achieved in the Health Local Units. The National Health Fund and the Regional Health Fund are share out to the Regions and by the Regions to the Health Units on the ground of the "quota pro-capite" rule. It figures so interesting to study the resources allocation criteria in the national context (distribution of the National Health Fund to the Regions on the basis of the "quota pro-capite" rule) and in a Regional scenario (distribution of the Regional Health Fund on the basis of the quota pro capite rule) in order to guarantee the allocative efficiency in a local area. Moreover the study does not evidence a significant correlation between the financement amount to the Health Local Units and the local development model.

Introduction

In Italy National Health Service is financed by sharing of the National Health Fund to Regional Governments (RG's) which, in accordance with the National Constitution, have the exclusive role of health services management.

Hence the RG's have to guarantee the Essential Care Levels (LEA= Livelli Essenziali Assistenza) in their own territory(health interventions correspondent to three levels), thanks to respective Health Regional Services, achieved in the Health Local Units (ASS= Azienda per i Servizi Sanitari) and Regional reference Hospital (AO). A preferential purchaser role is reserved to Health Local Units (Aziende Unità Sanitarie Locali or ASS in Region Friuli Venezia Giulia).

The Hospitals are exclusively providers.

A system of tariffs is provided by the CG. The tariffs are modifiable by the Region.

The National Health Fund is share out to Regions on the ground of the "quota pro-capite" rule.

Here we deal with the central and regional government institutional role with reference to "decentralization theorem" and to benefit's localization. The resources distribution from Regions to Regional Units (in function of the Essential Care Levels and on the basis of the quota pro-capite rule) should guarantee the allocative efficiency in a jurisdictional area even if a formal tariffs system is provided.

We have to consider that the decentralisation of decision making requires smaller LG's and economies of scale require larger LG's or RG's. From this study no direct relationship between financing fee to Health Local Units and local development's model appears.

Besides the study evidence that we have to guarantee to the citizens not only the right of consume the same quantity and quality of services. We have also to take in consideration the citizens preferences in every jurisdiction in order to create a competitive supply and to empower the citizens to choose between the providers. The result should be that "the public money follows the service user"(Bailey), not the provider.

The institutional and organizational scenario in the Region Friuli Venezia Giulia

Since 1997, in Region Friuli Venezia Giulia, all-in cost of regional health service are to be financed by the **regional government** because the Region (which has an exclusive competence with reference to the health matter), is autonomous and for this

reason is excluded from the sharing out of the national fund, according to a bilateral agreement with the central government, which recognise to the RG a quota of fiscal revenues.

Nevertheless the **central government** maintains the competence in matter of national health plan, of economic definition of the employment contracts, of drugs prices, of fiscal drag and in matter of definition of the "essential health care levels" (LEA=Livelli Essenziali di Assistenza), namely all the interventions which are to be guaranteed to the citizens.

The Region can modify the LEA by an incremental approach. The option of more elevated LEA is due by law to all the Regions (autonomous or not).

Three years later, in Friuli Venezia Giulia Region, that agreement was debated, considering the divarication between the services costs trend and tax growing trend. The central government acknowledged to the Region an increase of the regional sharing of the public revenues.

In Italy, owing to national health service reform and State reform constitution modification 2001, the competence in health matter was assigned to the Regions, within above-mentioned limits (definition of the LEA and tariffs by the central government).

The planning of social services, which are in charge to the municipalities and in part are delegated from the municipalities to the health local units management, was not coordinated with the planning of the health services. Above all, the criterion of the quota pro-capite was not applied in the case of the social services. The participation of the municipalities to the local health planning, provided by the national law 229/99 (health services reform) and by national law 328/2000 (social services reform), to the definition of local (district as subunit of the health local unit) health plan and to the definition of the zone plan (district as sum of the municipalities included in the District) was not substantially realized till now.

Even though the citizens can choose freely the producers in the case of the hospital care services and some interventions of speciality ambulatories, the informative asymmetry remains elevated as for the public purchasers (local health unit). Then the system performance, with the reference to the accessibility, and to the standards unit costs among different producers remained diversified.

Besides the regional financement to the health local units was not connected, for example, to the local development pattern (gross provincial product) (Tables 1,2,3)

The quota pro-capite principle.

The CG established to allocate the national health fund among the Regions, following the principle of the quota pro-capite. The autonomous Provinces and Regions, as the Region Friuli Venezia Giulia, are excluded from the fund, but not from the application of the criterion.

The Region is divided by regional law, into regional owned health enterprises (n. 6 health local units, n. 3 regional reference hospitals and n. 3 IRCSS – Institutes for clinical research and care) (Table 4)

The Health local units have to guarantee in their territory, which is divided in Districts (cluster of municipalities), the essential health care levels (LEA). The Health local units are at the same time purchasers and producers of health services. The regional reference hospitals (AO) have the role of producers and, unlike the hospitals placed in the health local units (ASS-HLU), should be excellence points (Regional reference hospitals)

In the table n.5 is described the composition of the Region health system organization, and, as regards as ASS, n. 6 “Friuli Occidentale” the division in Districts which correspond to municipalities represented in the Syndics Conference at the Regional level, at the Unit Level and at the District level, (in this case the institutional competence is referred to PAT- Territorial/Actions Plan and PDZ – Social Zone Plan).

The LEA correspond to the activities of Prevention, primary health care and hospital care and in fact to the relative organizational structures (department of prevention, health district and hospitals), which negotiate the relative budget with health local unit (Table.6).

The Region has to issue the directives relevant to annual and pluriannual plan. The Health local units and the hospital units consequently outlines the business plan by a negotiation with the Region on the basis of the predefined resources.

We can make some preliminary considerations:

- Actually the health services regional financement, in the Region Friuli Venezia Giulia, is formed on resources coming from taxation.
- The financement of the health local units and of the hospitals takes in account the historical costs.

- The region can modify the theoretical financement, which is calculated essentially using the quota pro-capite rule (health local unit) and the fixed quota (hospital units).
- The financement is then linked to the supply characteristics.
- The transactions amount between local units and Hospitals are in fact previously determined in the annual financement. The effective role of the purchasers is restricted.
- The health local units are included in vast areas (table 2), with a simple coordinative role.
- The citizens can "vote by their feet" with reference to the hospital and specialized ambulatory interventions (table 7a,7b).
- All the producers are credited but the perspective payment is effectively in force only for the hospitalizations (DRG tariffs).
- There are not true transactions between Health Units of different Regions but some interregional mechanisms of financial compensation among regional health systems is provided. In the case the interregional mobility of the patients this financial competition is an important factor of the regional financial balance.
- The costs out of pocket are not reimbursed to the citizen (Nevertheless these costs can be partly deductible contributions, with reference to income liable to tax).

The criterion of the quota pro-capite in practice.

The distribution of the national health fund and consequently of the regional health fund is underlined in the national law 229/99. The Regions have to regulate the financement of the health local units following the quota pro-capite principle. The criterion is based essentially on the resident population, weighted and corrected eventually by the age structure and mortality, on the citizen mobility, on the size of the immovable properties and of the technological installations or equipments.

The care levels have to be financed on the basis of predefined proportions (5%.- 55%- 45%) in order to stabilise the development of the structure whose interventions (prevention and primary care) are directed principally to the resident citizens.

The binding forces of the system seems to be the total amount of resources and the balance equilibrium. The perspective payment based on tariffs does not affect consistently the establishment of a competitive market with particular reference to the hospitals.

In the Region Friuli Venezia Giulia the method by which the theoretical quota pro-capite is defined with reference to each local health unit and therefore to each vast area is delineated in the documents relative to the health regional Service financement. With reference to the year 2004, the regional health fund was distributed to the local health units and regional reference hospitals, by this modality:

1) quota pro-capite, which concerns only the local health units and is based on the population weighted and corrected by mortality (SMR 1-74) and age structure. This quota is further divisible in four fractions: the pharmaceutical and integrative quota (which are based on the weighted and corrected population), the hospital quota, ambulatories quota and territorial quota (which are based on the correction of population) .

- The quota pro-capite is covering also all expenses deriving from perspective payment of the admissions in regional reference hospitals.

2) Fixed quota is composed by two factors:

- a factor connected to the hospital complexity which keep in account of the case mix of the discharges of the patients, of the technological equipment value and of the doctors on duty.
- a factor connected to the functions whose tariffs are partially defined (as intensive care).

Conclusions:

- the pure competences devolution does not means a better performance of the regional health system, if that is not accompanied by the definition a new market structure, on the basis, in a public-private system of producers, of the accreditation and of a system of tariffs (and if one does not take in account the customer's preferences).
- In that situation, the definition of the LEA does not guarantee necessarily the equity if the activities of the single producers are hardly able to reaggregate in processes (poor customers satisfaction in presence of an apparent elevated tutelage) the different interventions and to integrate them with the social interventions (LIVEAS - essential levels of social care).
- The scale factors does not influence the behaviour of the purchasers and the producers (Health local units are larger than municipalities).
- The integration models at local level is not favoured. A recent law (LR 23/2004) establish that the health district, which correspond to the area of zonal

planning of social interventions, assume a role of government as regards as health care and his social issues. Till now the District was identified only as operational structure, with one's own budget responsible of one level of care (primary care). His area correspond to the area of zonal social planning, whose responsibility is in charge to the municipalities. There will be a superimposition of areas of government which should be functional to integration of relative activities.

- The adjoint value of the regional and local health system, which is not integrated with the social services, can be assured only by the cumulative financement (incremental pattern which does not take in account the proximity and socialization economies with reference to local development model).

We have to consider that the optimal jurisdictional area of LG is defined as the correspondence between the benefit area and financing area.

In our case this correspondence is verified only for the Region in the case of health services and only for the municipalities in the case of social services. That demands may be the splitting of the regional health service in two areas with different missions.

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