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NATIONAL HEALTH SERVICE REFORM AND REGIONAL DEVOLUTION IN ITALY: ARE THEY CONSISTENT WITH THE PUBLIC FINANCE STRATEGY? A CRITICAL ANALYSIS OF THE PRESENT SITUATION IN THE FRIULI VENEZIA GIULIA REGION

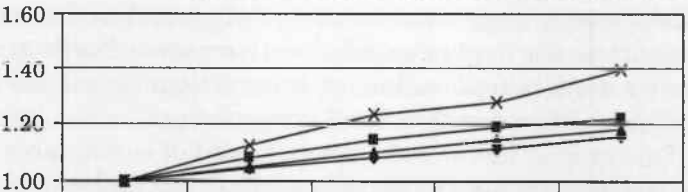
1. Introduction

In accordance with the National Health Plan 2006–2008 "a first approach to verify the problems in the health sector, arising from this situation, might be a comparison of GDP and the total National Health budget, considering the trend in health expenditure over the last five years". In Fig. 1 (which illustrates the growth of the National Health budget and the Regional Health budget in Friuli Venezia Giulia (FVG) and the growth of National and Regional GDP since 2000), and in Fig. 2 (which illustrates the national and regional health budget versus national and regional GDP over the same period) it can be observed that:

– from 2000 to 2004 the difference between indexed national GDP and indexed regional GDP is two points in favour of regional GDP;

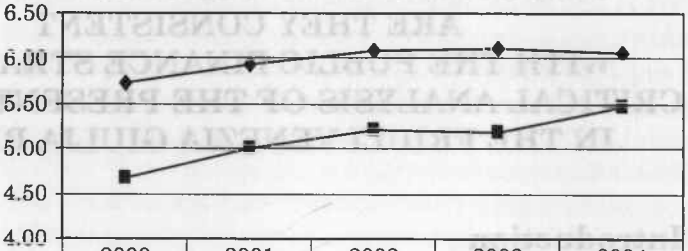
– in the same period the difference between indexed national health budget and indexed regional health budget is 17 points in favour of the regional budget;

– from 2000 to 2004, the difference of the ratio between the national GDP and the national health budget is 6 percentage points in favour of the national health budget. In Friuli Venezia Giulia the difference for this ratio is 19 percentage points and regional GDP is growing faster (0.81%) than national GDP (0.32%).



	2000	2001	2002	2003	2004
GDP	1.00	1.04	1.08	1.12	1.16
National Health Fund	1.00	1.08	1.15	1.19	1.22
Regional GDP	1.00	1.05	1.10	1.15	1.18
Regional Health Fund	1.00	1.13	1.23	1.28	1.39

Fig. 1. GDP and health funds
Source: ISTAT, 2005.



	2000	2001	2002	2003	2004
% HNF/GDP	5.74	5.93	6.08	6.12	6.06
% HRF/Reg. GDP	4.66	5.00	5.22	5.20	5.47

Fig. 2. Health fund as a percentage of regional and national GDP
Source: ISTAT, 2005.

The increase in health expenditure is greater than growth in national and regional GDP. This trend will continue till 2050, from 5.5% points in 2000 to 7.2% points in 2050, according to economic estimates, in spite of the stability pact between the State and the Regions signed in 2001.

In Italy and in Friuli-Venezia Giulia the aging population (due to an increase in life expectancy and reduced birthrate) has a great impact on the social system. Tab. 1 presents the actual situation. The regional birthrate in 2004 was 8.0 births per 1000. The national birthrate in 2004 was 9.1.

Fig. 3 and Fig. 4 illustrate the estimated demographic structure up to 2050.

With reference to the aging population, the mean age in the region is three years higher than in Italy as a whole and the population of the over 85 age group is increasing faster than the other age groups (Figs. 3, 4 and Tab. 1).

Table 1. Demographic indicators (January 2004)

Indicator	Friuli Venezia Giulia	Italy
Mean age	45.1	42.3
Age dependency ratio	50.8	50.2
Old age dependency ratio	33.0	28.9
Birth rate (per 1000)	8.0	9.1
Death rate (per 1000)	11.7	9.5
Female fertility rate	1.15	1.26

Source: Regional Health and Social Plan 2006–2008 (Draft), Regione Friuli Venezia Giulia, 2005.

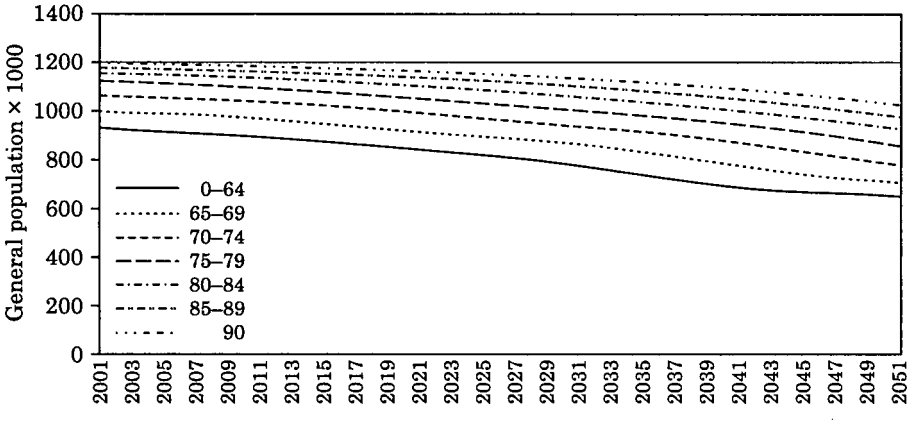


Fig. 3. Population according to age groups in the Friuli Venezia Giulia region
Source: Regional Health and Social Plan 2006–2008 (Draft), Regione Friuli Venezia Giulia, 2005.

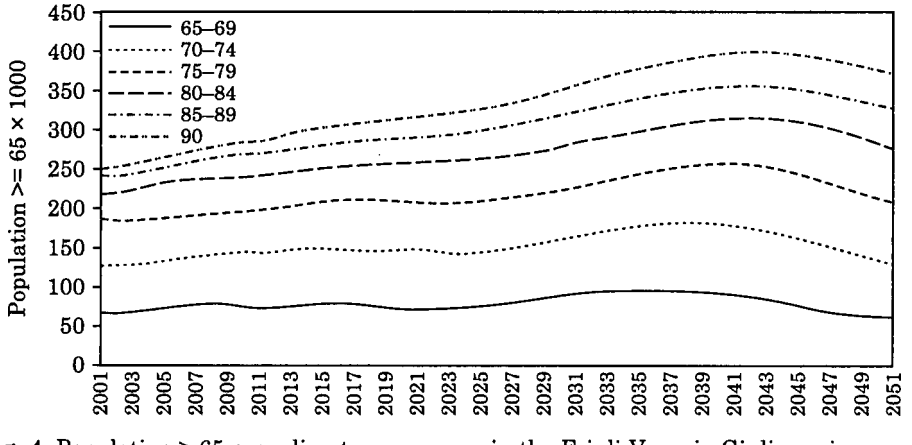


Fig. 4. Population ≥ 65 according to age groups in the Friuli Venezia Giulia region
Source: Regional Health and Social Plan 2006–2008 (Draft), Regione Friuli Venezia Giulia, 2005.

The demographic and epidemiological transition and the increased share of public health spending in total spending over the last 35 years has forced the central government in Italy to reform the National Health Service.

2. The institutional structure of the Health Service and financial criteria

In Italy the National Health Service was reformed in 1978, in accordance with the Beveridge model. It was an universal health system, financed by national revenue tax and whose administration was centralized in the National Ministry of Health. Increasing expenditure on health associated, on the demand side, with increasing GDP and the aging population and, on the supply side, with the increasing structural costs linked, for example, to the introduction of new technologies, obliged the central government to implement cost containment policies, founded on economic and administrative control, "closed – ended grants", introducing payment at the point of use. Nevertheless expenditure on public health and thus total public expenditure was not cut and the national debt/GDP ratio continued to increase.

In 1992 and in 1999 the National Health service was reformed again. The cornerstone of the 1992 reform was the transfer of responsibilities to regional administrations. The municipalities, which had previously played an essential role in health service administration before this reform, were in fact excluded from management responsibilities.

The regions acted in Local Health Units (LHUs) and Hospital Units (both regionally controlled public concerns).

This was a first step towards the decentralization of responsibilities and at the same time towards the separation of responsibilities for policy making from management responsibilities. This organizational model founded on regionally controlled public concerns was confirmed by the 1999 reform, which was followed by the social services reform, in which responsibility was assigned to the municipalities.

The principles on which these national health service reforms were based are as follows:

– the setting of the national health budget and its allocation to the regions on the basis of a per-capita quota [horizontal and vertical equity (capacity to benefit, burden of disease, preferences)];

– the distinction between the role of purchasers and providers. The LHUs had both these roles and they were instituted by the regions in accordance with the principle of economic scale with reference to the former LHUs;

– each LHU was active in a district (involvement of the municipalities) and in the FVG region the there were 3 LHUs, each covering large areas;
– the General Director was appointed by the Regional Administration in each LHU;
– other producers (for example, private producers) had to be authorized and accredited by the region;
– a perspective payment system and tariff system were introduced, particularly with reference to admissions into hospital (DRG);
– consequently, budgeting was introduced;
– the supply of health and emergency services are prescribed by the National and Regional Health Plans, in order to guarantee essential levels of care;
– the National Health fund continued to be financed by the general taxation system.

In 1997 the FVG Region negotiated the terms of an agreement on fiscal revenues with the central government and obtained the status of an autonomous region. In accordance with the philosophy of fiscal federalism, the regional health service was financed by regional fiscal revenue. The regional health fund was distributed to the Local Health Units (six Units in the Region) and Hospital Units on the basis of the principle of a per capita quota.

The financing of these units in Friuli-Venezia Giulia was essentially based on five principles:
– the regional health fund, annually defined in the regional financial act;
– the definition of the per capita quota (equity principle);
– the perspective payment based on a tariff system;
– the balance between essential levels of health care (LEA);
– balancing the budget.

Table 2. Territorial quota (2004)

Local Health Unit (LHU = ASS)	SMR 1-74 RQ	Population	Corrected Population
ASS. N. 1 TRIESTINA	1.019220	243,903	248,591
ASS. N. 2 ISONTINA	1.003577	139,521	140,020
ASS. N. 3 ALTO FRIULI	1.085012	75,965	82,423
ASS. N. 4 MEDIO FRIULI	0.997669	340,014	339,221
ASS. N. 5 BASSA FRIULANA	0.990423	107,539	106,509
ASS. N. 6 FRIULI OCCIDENTALE	0.959272	289,540	277,748

Source: Regional Health Service management lines 2004, Regione Friuli Venezia Giulia, 2005.

The cost of the regional health service was calculated annually, by adding to the historical budget the increasing costs connected with employment, pharmaceutical products, goods and services (inflation and increased costs of improved technology).

The per capita quota, weighted and "corrected" on the basis of demographic characteristics (SMR 1-74 = standardised mortality ratio = aggregate index of burden of disease) and of the pharmaceutical expenditure of the population, was utilized as a criterion for financing the LHUs (Tab. 2).

In particular, the per capita quota is formed by 4 components:

– the territorial quota (the population is corrected on the basis of SMR in each Local Health Unit) (Tab. 2);

– the hospital, ambulatorial and pharmaceutical quota, which consider the weighted and corrected population related to the last available data.

The fixed quota is not based on a per capita quota. The perspective payment system is valid only for hospitals on the basis of a tariff system. The hospitalisation costs (DRG) as based on a per capita quota.

The financing of the Regional Health System on the basis of the principle of a per capita quota is aimed at:

– producing geographical equity with reference to the accessibility and utilization of health services, for the same needs and same conditions (horizontal equity and vertical equity);

– reducing the variability between the LHUs with reference to the profiles of the utilization of services (convergence);

– enabling control of health expenditure.

With reference to 2004, the regional health fund in Friuli-Venezia Giulia was distributed to the Local Health Units and Hospitals Units in the following way:

1) a per capita quota, which only concerns the Local Health Units and is based on the population corrected by mortality (SMR 1-74) and age structure. This quota is further divisible into four parts: the pharmaceutical and integrative quota, the hospital quota, the ambulatorial quota (which are based on the weighted and corrected population), and the territorial quota (which is based on the corrected population).

The per capita quota also covers all the expenses derived from perspective payment for admissions into regional reference hospitals.

2) a fixed quota, which is composed of two factors:

– a factor connected to hospital complexity, which takes into account the types and frequency of cases treated, the value of technological equipment and the doctors on duty;

– a factor connected with the functions whose tariffs are partially defined (such as intensive care).

In 2001 the Constitutional Act was modified and the competencies in the health sector were fully transferred to the regions. The National Health Fund was maintained, but Friuli-Venezia Giulia was excluded from the fund.

In a recent regional law the municipalities were given new responsibilities in programming social and health care in the districts, which the LHUs cover. Social care in municipalities is financed by local taxation and co-financed by the region. Health care at district level is financed by the LHU, that is to say the region.

3. Conclusion

The model for governing the FVG Region and Italy consists generally of the principle of decentralization adopted by the Council of Europe's European Charter of Local Government. That is to say that those authorities which are closest to citizens are responsible for public services, in accordance with the logic of efficiency, equity, effectiveness and sustainability.

Besides, this model is consistent with the principles of social and territorial cohesion adopted by the European Constitutional Charter.

Some critical points should be underlined, with reference to the sustainability of health services:

– The nationally funded health service did not enable control of health expenditure or an appropriate balance between supply of and demand for health services.

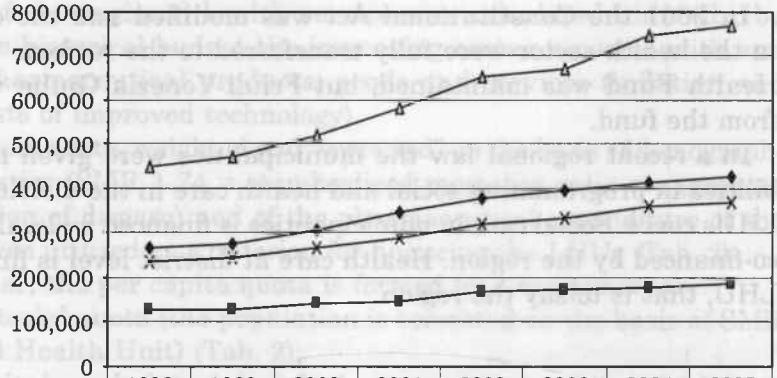
– If financial resources are divided on the basis of predefined proportions with reference to three levels of care (5% environmental hygiene; 55% primary care; 45% hospitalization), the efficiency of allocation does not improve and expenditure on health does not fall (Fig. 5).

– In Friuli-Venezia Giulia, where fiscal federalism was tested, the trend of expenditure on health is no different from the national trend.

– Local governments have rather a passive role with reference to financing the health service and, in particular, getting involved in the political side. This has a greater impact with reference to primary care services.

– The complex methodology used in order to define the per capita quota only partially enabled control over expenditure and the reallocation of resources (Fig. 6).

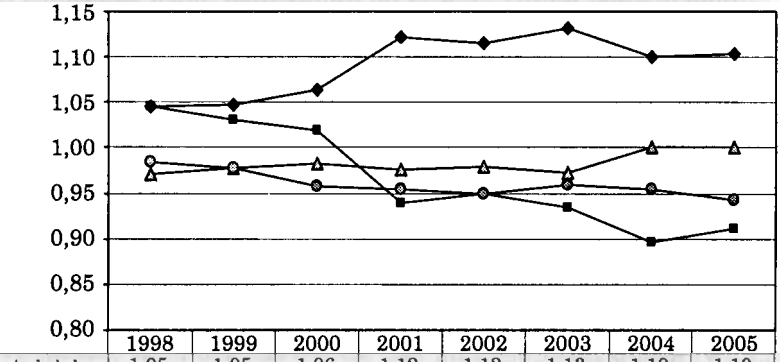
– It may well be that a local tax, more specific in relation to the utilization of public funds, could lead to more active involvement from citizens and give greater weight to their preferences and system of values.



	1998	1999	2000	2001	2002	2003	2004	2005
ASS1 Fixed quota included	265,886.99	276,273,45	306,979.40	346,350.25	378,239.00	393,524.00	413,795.00	427,519.00
ASS2 Fixed quota included	126,809.28	130,149.72	141,367.16	148,478,65	168,228,00	171,134.00	178,589.00	187,660.00
ASS3 ASS4 ASS5 Aggregated Fixed quota included	447,474.41	468,202.78	519,659.96	582,525.25	653,245.00	669,260.00	743,365.00	766,163.00
ASS6 Fixed quota included	236,506.79	243,736.12	265,292,55	288,344.43	318,438.00	334,193.00	356,983.00	367,653.00

Fig. 5. Real finance of health care in the Friuli Venezia Giulia region

Source: Regional Health Service management lines", 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, Regione Friuli Venezia Giulia.



	1998	1999	2000	2001	2002	2003	2004	2005
ASS1 Fixed quota included	1.05	1.05	1.06	1.12	1.12	1.13	1.10	1.10
ASS2 Fixed quota included	1.05	1.03	1.02	0.94	0.95	0.93	0.90	0.91
ASS3 ASS4 ASS5 Aggregated Fixed quota included	0.97	0.98	0.98	0.98	0.98	0.97	1.00	1.00
ASS6 Fixed quota included	0.98	0.98	0.96	0.95	0.95	0.96	0.95	0.94

Fig. 6. Real theoretical finance of health care in the Friuli Venezia Giulia region

Source: Regional Health Service management lines, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, Regione Friuli Venezia Giulia.

– Regional reference or national reference health centres, such as accredited health and medical research institutes, could continue to be financed by regional or national Government.

– The modalities of the fiscal contribution could be reviewed and a local tax, which is highly specific with reference to primary care, could be taken into account, adapted to the local area and under the responsibility of local government.

– Producers may be public or private. The determination and accreditation of the tariff system should be carried out at regional level, but financed by a local tax. This could be an input for the realization of a network of services in primary care, connected with new epidemiological and demographic needs.

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