Phasing Out Market Mechanisms in the Italian National Health Service

Eugenio Anessi-Pessina, Elena Cantù and Claudio Jommi

The Italian National Health Service introduced quasi-markets, regionalization, and managerialism in the 1990s. Under quasi-markets, large providers have been separated from purchasers and funded by ‘activity’—the quantity, mix, and possibly appropriateness of services provided. Under regionalization, each of Italy’s 21 regional governments is able to design its own funding arrangements. The regions have generally been trying to mitigate the effects of quasi-markets and are now increasingly ‘governing’ them. The system is producing some desirable results, including a shift from ordinary to same-day hospitalizations and a reduction in length of stay. Hospital admissions increased initially, but only where the regions encouraged this. Financial effects are more controversial.

The Italian National Health Service (INHS) offers some important lessons for regionalizing and introducing quasi-markets into a health care system. The INHS was established in 1978 and was modelled after the British National Health Service. In the 1990s, jurisdiction over health care was devolved from central government to Italy’s 21 regions. Since then the regions have been experimenting with different organizational and funding models.

This article follows up on a nationwide study carried out in 1998–99 with respect to 1997 (Jommi et al., 2001), and describes the funding arrangements of five representative regions in terms of objectives, features and effects.

The INHS
The INHS covers the entire Italian population, it is tax-funded and provides most care free of charge. It has three tiers:

• Central government.
• Regional government (21 administrations).
• Two hundred local health units (LHUs), each of which is responsible for the whole population’s health in a given area, and 100 independent INHS hospitals (IHs) which are similar to British NHS trusts.

In addition to LHUs and IHs, providers include private hospitals and professionals. Private providers meeting specific requirements may apply for accreditation by the relevant region, thus becoming eligible for INHS reimbursement. Non-accredited providers have to directly charge their patients.

For 15 years until 1992, the INHS had centralized funding based on actual expenditures. Only central government could raise taxes and funds were allocated by central government to the regions and the regions funded the LHUs (there were no IHs then). However, the majority of LHUs overspent their budgets, and central government picked up their deficits. The LHUs had no incentives for cost containment and, at the same time, they operated under acute uncertainty, because they did not know when and to what extent central government would intervene (Borgonovi, 1985; Ferrera, 1995; France, 1991; Mapelli, 1995).

In the 1990s, a series of reforms introduced managerialism, regionalization, and quasi-markets to the INHS (Fattore, 1999). Managerialism gave LHUs and the newly-formed IHs considerable discretion over their affairs, but required them to improve their performance and encouraged them to adopt private sector management techniques.

Regionalization in Italy has been a gradual, and sometimes erratic, process. The Italian regions now have jurisdiction over health care and significant fiscal autonomy. They appoint the general managers of LHUs and IHs, provide them with goals and guidelines, and fund their expenditures with regional taxes and user charges (with an equalization fund to compensate for cross-regional differences in fiscal capacity: see Arachi and Zanardi, 2000; Giarda, 2000; Taroni, 2000). In managerial terms, the region can be

Eugenio Anessi-Pessina is Professor of Management Theory at the Catholic University in Rome, Italy.

Elena Cantù is a researcher at Bocconi University in Milan, Italy.

Claudio Jommi is a research fellow at Bocconi University in Milan, Italy.
thought of as a ‘parent company’, with LHUs and IHs as its ‘subsidiaries’. In health-policy terms, Italy is moving from one national to 21 regional health services.

Quasi-markets require money to ‘follow patients’. Each region sets the total amount to be spent on health care and allocates it to LHUs on a (possibly adjusted) capitation basis. This is supposed to cover all services provided to LHU residents by the LHU itself and by other providers, i.e. other LHUs, IHs, and accredited private providers (APPs). LHUs then reimburse other providers for care given to their residents. Reimbursements are DRG-based for hospital discharges and fee-for-service for out-patient services. For simplicity, both cases are referred to in this article as ‘activity-related funding’. Within this framework, each of the Italian regions has been almost completely free to design its own funding system.

**Funding Arrangements in 1997**

In 1997 most regions had organized their systems around the ‘LHU-centred template’. Under this template, the region establishes few IHs (if any) and accredits few private providers. Each LHU is expected to provide its residents with a complete range of services of reasonable quality. Quasi-markets encourage this behaviour: if residents were to look for care from other providers (which have strong incentives to attract them), then the LHU would be financially penalized.

One notable exception was Lombardy, which had opted for a ‘purchaser–provider split template’. Virtually all hospitals have been taken out of LHU control, grouped when necessary to achieve adequate size, and established as IHs. LHUs provide only community care and act mainly as ‘purchasers’ for their residents. Lombardy has encouraged public–private competition, emphasised patient freedom of choice, and presented itself as the regulator of the entire regional system rather than the ‘parent’ of LHUs and IHs (Regione Lombardia, 2001). LHUs have strong incentives to limit provision by IHs and APPs which, conversely, have equally strong incentives to increase volumes. The critical issue is patient freedom of choice, which is weakening the LHUs’ ‘purchasing’ role and turning them into ‘third-party payers’.

A few smaller regions in northern and central Italy, while formally espousing the LHU-centred template, were at least partly implementing a ‘region-centred template’, with LHUs acting mostly as providers, the region playing the purchaser’s role, IHs and APPs kept to a minimum and funded directly by the region on an activity basis.

Finally, several central and southern regions were still funding their health care organizations based on actual expenditures.

**Goals, Methods, and Limits of the Study**

In 1997, the regions had just started to experiment with activity-related funding. Since then, three conditions have gained increasing acceptance. Capitation and activity-related funding are now generally considered as neutral and objective ‘rules of the game’, set by the region to provide health care organizations with the ‘right’ financial incentives (for example reduce length of stay; increase volumes and reduce waiting lists for some procedures; shift inpatient procedures to out-patient settings). Both, however, have to be fine-tuned to ensure equity and eliminate opportunistic undesired effects.

Some services (for example accident and emergency) are difficult or inappropriate to fund on an activity basis, so a third ‘funding channel’ is required, which is inevitably less neutral and objective than the previous two. This channel involves lump sum funding of specific services.

The three ‘channels’ are still insufficient to provide all and only the desired incentives and to reconcile activity-related funding with cost containment. Quasi-markets must consequently be ‘governed’ by the region. Among the tools to this end is a fourth ‘funding channel’—the discretionary allocation of ‘extraordinary funds’. Table 1 shows which ‘funding channels’ apply to which health care organizations.

This article describes the way that funding arrangements have evolved since 1997 and looks at the extent to which they still continue to rely on quasi-market mechanisms. The study was carried out in 2001–2002, it covers the period 1998 to 2001 (including provisions for 2002), and focuses on five regions. These five regions—Lombardy, Veneto, Tuscany, Marche, and Sicily—account for 41% of Italy’s population and public health care spending, and are representative of different geographical areas, political orientations, and policy choices (see table 2). Funding was analysed in terms of current appropriations. Capital funding (which is extremely small) and cash flows were disregarded.

A structured checklist was used to analyse regional documents. In addition, key regional officials were interviewed. These interviews were essential for understanding the ‘implicit’ components of the funding systems and the gaps between formal statements and actual behaviours. The main source of utilization data was the National Health Department.

This study has two main limitations:
It highlights the incentives that different funding arrangements create for health care organizations, but stops short of exploring the providers’ view, i.e. how managers perceive the opportunities and threats posed by such arrangements and translate these perceptions into actions.

The scarcity of reliable data has prevented a systematic analysis of the relationship between funding systems and utilization rates, let alone service quality and appropriateness, patient satisfaction, and health outcomes.

**Funding Models**

In 1997, Lombardy had introduced a purchaser–provider split. The other four regions had formally opted for the LHU-centred template, but Marche had hybridized it with the region-centred template, while Sicily still footed its health care organizations’ actual expenditures. In 2001, this situation was virtually unchanged, except for Sicily, which was moving towards a region-centred template, with IHs reimbursed directly by the region. Nevertheless, all regions had been continuously adjusting their systems.

**Capitation**

In 1997, capitation was generally accepted as equitable and efficient. Most regions (but not Sicily) had introduced adjustments for age, gender, mortality, and population density. Some (including Veneto and Tuscany) had split capitation funding into several components covering different types of care (for example inpatient) and used a specific set of adjustments for each component; the underlying assumption was that needs vary across population groups, but do so differently for different types of care.

Since then, three major trends have occurred. Adjusted capitation has been extended to all the five regions, including Sicily in 2001. Conversely, the regions using complex adjustments have gradually simplified them, since they were both technically difficult to manage and often criticised by LHUs as arbitrary and based on unreliable data. Finally, all the five regions (including Lombardy from 2002) have been splitting capitation funding into several components with different weighting systems.

**Activity-Related Funding**

Activity-related funding is intended to increase efficiency, improve quality, and reduce waiting lists. However, it can create incentives to excessively increase volumes and reduce appropriateness. Moreover, it assumes a level playing field, while public organizations are often disadvantaged, since they provide a wider range of services, experience a more severe case mix within each DRG category, enjoy less flexibility in the management of personnel and other inputs.

Pros and cons were differently stressed by the regions. Many have applied activity-related funding only to limited extents, as measured by the number and size of IHs, the number and size of APPs, and the range of services funded on an activity basis. All have tried to mitigate its effects through a differentiation of fees by provider, lump sum funding, and/or extraordinary funds. All are increasingly ‘governing’ their quasi-markets with expenditure caps, ceilings, or targets, regional planning and control systems, bilateral contracts between health care organizations, and/or utilization reviews.

In our five-region sample, the extent of activity-related funding has remained virtually stable over time. The two extremes are still Veneto, with only two IHs, private provision in a marginal role, and activity-related funding for only inpatient and specialist out-patient care; and Lombardy, with 29 IHs, a large number of APPs, and activity-related funding extended to psychiatric care (see tables 2 and 3).

Fees vary across regions. The National Health Department defines a schedule of maximum fees, which individual regions are free to reduce. Lombardy, Veneto, and Tuscany have all set their own fees for both inpatient and out-patient services. They have also established committees that periodically review

<table>
<thead>
<tr>
<th>Table 1. Funding channels by type of health care organization.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>LHUs</strong></td>
</tr>
<tr>
<td>Capitation</td>
</tr>
<tr>
<td>Activity-related funding</td>
</tr>
<tr>
<td>Lump sum funding</td>
</tr>
<tr>
<td>Extraordinary funds</td>
</tr>
</tbody>
</table>

*Under the ‘region-centred’ template, also for some services provided to the LHU’s own residents.
such fees to ensure consistency with costs and generate the desired incentives. Marche and Sicily, on the contrary, refer to the national schedules.

Some regions also differentiate fees across providers. Tuscany introduced a differentiation in 1995 to reward hospitals with specialized emergency departments and intensive care units, and revised the classification of hospitals in 2002. Veneto discontinued it in 1999. Sicily introduced it in 2002 across six classes of hospitals. Lombardy and Marche are planning to introduce it according to hospitals’ organizational features.

**Lump Sum Funding**

Lump sum funding covers services for which activity-related funding is deemed inapplicable or inappropriate. It is used to reflect a service’s regional or national importance (for example tissue banks); to ensure availability regardless of actual utilization (for example accident and emergency services); when fees do not cover the relevant costs or inadequately reflect the service’s positive externalities (for example organ transplant centres); and to promote specific projects, services or settings (for example out-patient versus inpatient treatment).

To some extent, lump sum funding is an alternative to the differentiation of fees across providers. The presence of an organ transplant centre, for instance, can be funded on a lump sum basis or through higher fees for some or all the services provided by the relevant hospital.

Our five regions have all resorted to lump sum funding, although to limited extents (see table 4). The range of services covered is very mixed; the allocation criteria have rarely been fully disclosed and often refer to generic conditions (for example ‘high organizational complexity’). There is a legitimate suspicion, therefore, that lump sum funding may often be extraordinary funding under false pretences.

**Extraordinary Funds**

Extraordinary funds are funds that are not allocated on a capitation basis, on an activity basis, or as the lump sum funding of specific services. Their peculiarity lies in their discretionary nature. Between 1997 and 2000, their importance decreased steadily. In 2000, they accounted for less than 2% of current health care spending in three of our regions (see table 4). Since then, their size has increased. For example, Lombardy, which has used them extensively (7.2% in 1997), reduced them to 4.3% in 2000, and then raised them to 5.1% in 2001 and 6.2% in 2002. These figures are consistent with the purposes of extraordinary funding: mitigate the transition to the new funding system (Lombardy’s reforms were the

### Table 2. Main features of the five regions.

<table>
<thead>
<tr>
<th>Region</th>
<th>Lombardy</th>
<th>Veneto</th>
<th>Tuscany</th>
<th>Marche</th>
<th>Sicily</th>
<th>Italy</th>
<th>Five region %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population on 1 January 2001</td>
<td>9,121,714</td>
<td>4,540,843</td>
<td>3,547,604</td>
<td>1,469,195</td>
<td>5,076,700</td>
<td>57,844,000</td>
<td>41.1%</td>
</tr>
<tr>
<td>Current public health care spending, 2001 (Euro M)</td>
<td>11,804</td>
<td>5,952</td>
<td>4,762</td>
<td>1,905</td>
<td>6,240</td>
<td>75,167</td>
<td>40.8%</td>
</tr>
<tr>
<td>Location</td>
<td>North</td>
<td>North</td>
<td>Centre</td>
<td>Centre</td>
<td>South</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Current ruling coalition</td>
<td>Right</td>
<td>Right</td>
<td>Left</td>
<td>Left</td>
<td>Right</td>
<td>Right</td>
<td>-</td>
</tr>
<tr>
<td>No. of LHUs, 2002</td>
<td>15</td>
<td>21</td>
<td>12</td>
<td>13</td>
<td>9</td>
<td>197</td>
<td>35.5%</td>
</tr>
<tr>
<td>No. of IHs, 2002</td>
<td>29</td>
<td>2</td>
<td>4</td>
<td>4</td>
<td>17</td>
<td>100</td>
<td>56.0%</td>
</tr>
<tr>
<td>No. of accredited private hospitals, 2002</td>
<td>57</td>
<td>16</td>
<td>27</td>
<td>13</td>
<td>49</td>
<td>503</td>
<td>32.2%</td>
</tr>
<tr>
<td>Accredited private beds as % of total public and private accredited beds, 2000</td>
<td>17.09</td>
<td>5.03</td>
<td>13.02</td>
<td>13.08</td>
<td>16.06</td>
<td>17.02</td>
<td>-</td>
</tr>
</tbody>
</table>

most radical) and support public health care organizations in financial trouble (INHS finances deteriorated in the late 1990s).

Extraordinary funds may eliminate the desired incentives of activity-related funding. This is particularly true if they are assigned ex-post and based on actual expenditures. However, if assigned ex-ante and combined with incentives to improve the entity’s financial conditions, they can increase the funding system’s credibility, and contribute to longer-term efficiency. The regions are gradually adopting this latter approach. Lombardy has related extraordinary funding to efficiency and effectiveness improvements as measured by specific indicators (for example decreased hospitalization rates, increased attraction of patients from other regions), Veneto to deficit-reduction plans, and Tuscany to cost containment.

### Towards ‘Governed Competition’

In 1997, it was assumed that appropriate funding rules, together with simple performance targets, would be sufficient to steer the behaviour of health care organizations. Since then, the regions have gradually reinforced ‘hierarchies’ and ‘institutions’ to supplement market incentives. Regional health services are therefore increasingly ‘governed’ by the relevant region.

### Caps, Ceilings and Targets

Costs were traditionally contained by setting detailed expenditure caps by object (for example supplies) and function (for example inpatient care). In 1997, some southern regions (including Sicily) were still doing this but most of the others had introduced funding ceilings or targets.

Under a funding ceiling, billed services cannot exceed the ceiling; if they do, fees are proportionally reduced. Under a funding target, billed services may exceed the target, but fees decrease with volumes to discourage excess provision. Ceilings and targets can be system-wide—one ceiling or target for all the services provided in the region; LHU-wide—one for all the services provided to each LHU’s residents; provider-specific—one for all the services billed by each provider; or matrix-specific—one for the services billed by each provider to each LHU. These solutions clearly foster competition to decreasing extents.

Noticeably, even ceilings cannot prevent budget overruns. An IH with expenses exceeding its funding ceiling will report a deficit. This deficit must be covered by the region, which will consequently overspend its health care budget.

Lombardy has been the region to apply ceilings and targets to the largest extent (which is consistent with its extensive application of activity-related funding) and to change the relevant rules most frequently (to better reap the benefits of quasi-markets while containing expenditures and penalizing opportunistic behaviours). In 1997 it assigned a target to each provider and supplemented it with a system-wide ceiling. In 1998 it eliminated the provider-specific targets to foster competition, and replaced the system-wide ceiling with a set of LHU-wide ceilings to reduce cross-LHU disparities in hospitalization rates. In 1999–

---

### Table 3. Characteristics of activity-related funding in the five regions (2002).

<table>
<thead>
<tr>
<th>Service funded on an activity basis</th>
<th>Lombardy</th>
<th>Veneto</th>
<th>Tuscany</th>
<th>Marche</th>
<th>Sicily</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Specialist in-patient</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Psychiatric</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Presence of regional fee schedules

<table>
<thead>
<tr>
<th>Yes/no</th>
<th>Lombardy</th>
<th>Veneto</th>
<th>Tuscany</th>
<th>Marche</th>
<th>Sicily</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No (national schedules apply)*</td>
<td>No (national schedules apply)</td>
<td></td>
</tr>
</tbody>
</table>

### Differentiation of fees across providers

<table>
<thead>
<tr>
<th>Yes/no</th>
<th>Lombardy</th>
<th>Veneto</th>
<th>Tuscany</th>
<th>Marche</th>
<th>Sicily</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planned</td>
<td>Planned according to hospitals' organizational features</td>
<td>In effect until 1999 according to hospitals' organizational features</td>
<td>Yes</td>
<td>Planned</td>
<td>Yes</td>
</tr>
</tbody>
</table>

*For inpatient care, different percentage reductions to national fees for DRGs of different complexity.
2001 it made a further series of adjustments. Currently it is introducing provider-specific ceilings to better control spending and to contain the shift of patients from public to private providers.

At the other end of the spectrum, Marche has been using matrix-specific ceilings and targets since 1998 to limit competition.

Veneto has traditionally relied on provider-specific targets. It is currently moving to a system-wide ceiling, but keeps emphasising that public and private providers should specialize and be complementary rather than competitors. Sicily has introduced provider-specific targets only for APPs; public providers are still at a stage where volume increases would be desirable. Tuscany had initially relied on provider-specific targets for both public and private providers, but later (2000) replaced them with bilateral contracts.

One further element is worth mentioning. Increased fiscal responsibilities and deteriorating finances have recently induced many regions to revive the tradition of detailed spending caps and, more generally, to reduce their LHUs’ and IHs’ autonomy and claim back several functions and responsibilities. Tuscany, for instance, is centralizing procurement and other administrative functions, while Marche has merged all of its 13 LHUs.

**Regional Planning and Control Systems**

Regional planning and control systems allow the region to plan, monitor and assess the performance of its ‘subsidiaries’ (LHUs and IHs). Over time, these systems have become increasingly formalized (except in Sicily), top-down (less so in Tuscany and Marche), focused on the financial dimension of performance, and intended to prescribe or forbid specific behaviours as opposed to setting general performance targets.

Their main limitation is that planning is usually completed well into the relevant year, partly because the regions are still constrained by central government’s decisions and delays. This limitation is also weakening the control phase, which is further jeopardised by underdeveloped measurement and reporting systems. As a further weakness, operating budgets remain decoupled from capital and cash budgeting.

**Bilateral Contracts**

Of the five systems, Tuscany’s is the most decentralized. Tuscany has been one of only two regions in Italy (the other being Emilia-Romagna) to control volumes using bilateral contracts, rather than targets and ceilings. Contracts are established between a LHU and an IH or APP. They define the volume, mix, price, and possibly other features like waiting times and quality, to be provided. Over time, they have become increasingly refined.

Contracts are also consistent with Lombardy’s original approach to health care. The region mandated them as early as 1998, but this provision remained on paper. Later, it prepared a template (1999), supplemented it with guidelines (2001), and required the LHU with the highest hospitalization rate to use contracts on an experimental basis (2002). In the meantime, however, Lombardy was shifting towards a command-and-control approach. The negotiation between providers and

---

**Table 4. Distribution of current regional funding on health care, by funding channel (2000).**

<table>
<thead>
<tr>
<th></th>
<th>Direct regional¹</th>
<th>Capitation</th>
<th>Activity-related²</th>
<th>Lump sum</th>
<th>Extraordinary¹</th>
<th>Not classifiable⁴</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lombardy</td>
<td>0.7%</td>
<td>83.6%</td>
<td>0.0%</td>
<td>4.0%</td>
<td>4.3%</td>
<td>7.4%</td>
</tr>
<tr>
<td>Veneto</td>
<td>8.9%</td>
<td>77.9%</td>
<td>0.0%</td>
<td>3.7%</td>
<td>1.2%</td>
<td>8.3%</td>
</tr>
<tr>
<td>Tuscany</td>
<td>1.4%</td>
<td>90.7%</td>
<td>0.0%</td>
<td>4.4%</td>
<td>1.9%</td>
<td>1.6%</td>
</tr>
<tr>
<td>Marche</td>
<td>1.6%</td>
<td>84.9%</td>
<td>0.0%</td>
<td>5.4%</td>
<td>6.2%</td>
<td>2.0%</td>
</tr>
<tr>
<td>Sicily</td>
<td>0.5%</td>
<td>62.8%</td>
<td>18.7%</td>
<td>10.6%</td>
<td>1.1%</td>
<td>6.2%</td>
</tr>
</tbody>
</table>

1. Funds spent directly by the region. In Veneto, the region pays directly for services (for example residential care for the elderly) that elsewhere are paid for by LHUs.
2. Funds allocated directly by the region to health care organizations on an activity basis. Applies only to Sicily, which has adopted a region-centred template. In the other four regions, the region provides LHUs with capitated funding; it is the LHUs that subsequently transfer a share of these funds to other LHUs, IHs, and APPs on an activity basis. To avoid double counting, this share is included in the ‘capitation’ column.
3. Probably underestimated, since some lump sum funding and most not classifiable funds could reasonably be viewed as extraordinary.
4. Supplemental appropriations granted during the year with limited disclosure and, for Tuscany and Sicily, extra funding for personnel pay raises.
purchasers has thus been strongly governed by the region, especially with respect to financial matters.

**Utilization Reviews**

Activity-related funding provides incentives for greater volumes. If based on DRGs, it also encourages shorter stays. Although financially risky, volume increases were initially perceived as desirable, as were shorter stays. Only later did the regions start to worry about unnecessary services and 'quicker-and-sicker' discharges.

Lombardy was the first to tackle the problem—establishing a utilization review unit in 1997. Later, it asked LHUs to establish their own units. The units' mandate has been to verify the medical records for at least 10% of hospitalizations, plus a sufficiently large sample of out-patient diagnostic procedures and specialist visits. The units have focused on high-margin DRGs, significantly shorter or longer than average stays, sharp changes in DRG frequencies, repeated hospitalizations. From a funding viewpoint, their activities have led to revise the regional fee schedules and deny payment for inappropriate services.

More recently, Marche has taken a similar stance: repeated hospitalizations and other undesired behaviours will receive a reduced payment, if any.

**Impact on Utilization**

As funding used to be unrelated to volumes, utilization data in Italy have traditionally been incomplete. This is particularly true for outpatient services, but also applies to inpatient care, especially in some regions (including Sicily, whose data will consequently be ignored, as will national averages). Data collection has only recently started to improve.

Ordinary acute hospitalizations have increased only in Lombardy and Veneto, and only in the early years of activity-related funding, when the regions were still developing their correctives. Lombardy comes as no surprise, since it applied activity-related funding to the largest extent, fostered competition and, at least initially, encouraged volume increases.

Severity, as measured by average DRG weights, has correspondingly increased in all four regions. The extent to which this stems from desired policies (for example shifting less severe cases to out-patient settings) or undesired behaviours (for example DRG upcoding, inappropriate volume increases) is still unclear.

Lombardy's encouragement of public–private competition also explains the significant shift of patients from public to private providers. In the other three regions, the relative weight of private provision has remained stable.

The use of same-day hospitalizations, as a more efficient alternative to ordinary admissions, is an explicit objective in most regions. Over the years, this objective seems to have been achieved, especially where regions have introduced their own fee schedules to provide hospitals with the necessary financial incentives (Lombardy, Veneto, and Tuscany). Finally, average length of stay has significantly decreased, especially in the private sector, where hospitals had traditionally been reimbursed per diem.

The impact on utilization, therefore, has generally been desirable. Financial effects are more controversial. In the period 1998–2001, the regions have cumulated significant deficits, ranging in our five-region sample from Tuscany's 100 euro per capita to Lombardy's 181, Sicily's 195, Veneto's 207, and Marche's 279. In the same period, the average annual rate of increase in public health care spending ranged from 7.1% in Veneto to 9.9% in Sicily (Jommi, 2002). However, deficits and rising expenditures may be the result of policy choices that are independent of activity-related funding:

- The reintroduction of INHS coverage for costly drugs (1999–2000).

**Conclusions**

The INHS's new funding arrangements seem to have delivered a number of the changes wanted: a volume increase and a shift from public to private provision, but only in the regions that have actively sought them; a shift from ordinary to same-day hospitalizations; a reduction in length of stay. Patients' views have not been systematically analysed, but anecdotal evidence indicates an improvement in patient empowerment and freedom of choice. Financial effects are more controversial: regional expenditures and deficits have increased, but mostly for reasons that are independent of the funding systems.

Worsening financial conditions are the main reason why quasi-market mechanisms have been increasingly governed through hierarchies and institutions. Since 1997, four of the five regions in this study have not changed the general features of their funding systems—Lombardy has confirmed the purchaser-
provider split; Veneto and Tuscany follow the LHU-centred template; Marche hybridizes it with the region-centred template. Only Sicily has made significant changes, moving towards a region-centred template. However, the regions are increasingly ‘governing’ their quasi-markets, reducing the autonomy of individual health care organizations, and encouraging inter-organizational co-operation. Some regions were very cautious of market mechanisms from the beginning. Others initially placed great faith in quasi-markets, but have recently scaled them back and/or counterbalanced them with expenditure ceilings or targets, regional planning and control systems, bilateral contracts between health care organizations, utilization reviews, and extraordinary funds.

Market mechanisms appear to have improved the system’s efficiency, and particularly its use of existing capacity. With regionally-mandated fees and very little power on the payer’s side, however, they were less effective at containing expenditures. This may have been appropriate for a country with moderate health care spending and long waiting lists, but worsening public finances have imposed a policy reversal. Inter-organizational co-operation is hoped to yield economies of scale; a more interventionist role of the region is expected to contain spending more effectively.

Another reason for the recent policy reversal appears to be because quasi-markets have created a degree of specialization among providers. More specialized organizations need better system-wide co-ordination to meet patient needs, therefore the need for stronger co-ordination will continue after the current financial crisis.

Regional governments in Italy now face two important challenges. They need to encourage health care organizations to behave as parts of a network and take responsibility for the network’s overall performance, while preserving and possibly reinforcing the results so far attained in terms of individual organizations’ efficiency and accountability.

Acknowledgements
The research presented in this article was carried out within Cergas-Bocconi’s Observatory on Italian Health Care Management (OASI) and was funded in part by Pharmacia SpA.

References


