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# Health in Lombardy

## HEALTH SYSTEM AND HOSPITAL ACTIVITY BETWEEN 2003 AND 2008

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# *Part I*

## *The health system in Lombardy*

# *1. The uniqueness of the Lombardy health system*

The Italian National Health Service (SSN) instituted by Law no. 833 of 12th December 1978 can be classified among the "Beveridge" types of health systems, whose forefather is the British National Health Service (NHS) on which the Italian model is explicitly based on.

Both systems are implemented on the principle of universal coverage (extended to all citizens) and solidarity (funding through fiscal or *parafiscal* taxation), but beyond all lexical similarities, they strongly differ as to organizational profiles.

The Italian National Health Service, in fact, originated as a composite organism in which regional differences rapidly gained great importance.

The British model is a substantially centralised and unifying system, whereas the Italian health reform already in its first version introduced a centrifugal drive in the organisation of a health system capable of producing different organisational models in every region. This circumstance radically opposed even the former Italian setup, which availed of uniform healthcare activities across the nation comprising mutuality institutions, the public health operators and hospital trusts.

This phenomenon was further boosted by the so-called "Reform of the Reform" passed with Legislative Decrees 502/92 and 517/93, and with the Reform of Section V of the Constitution approved by Constitutional Law no. 3 of 18/10/2001.

A closer analysis reveals that in reality the different organizational models adopted by the regions and Autonomous Provinces of Trento and Bolzano can be considered from the organizational standpoint as important regional variations of a common scheme.

*A scheme that takes as reference point the centralistic principle, even if done regionally, tends to assign to a sole entity all the main functions of fi-*

*nance, governance, production, supply and control of all the health activities concerning prevention, healthcare and rehabilitation.*

This entity is represented by the Region (which finances and governs).

Through its own instruments (*ASL*, Local Health Authorities) it produces, supplies and monitors all the services (prevention, primary care, specialist and hospital care, and rehabilitation).

This model tolerates external health providers not belonging to the dominant entity (such as accredited private facilities) only within strict planning and control of volumes and types of "contract" services.

This excludes any form of competition and makes of centralised planning its own fundamental governance tool.

It had been pointed out that, the Italian National Health Service conceived as such is full of strong conflicts of interests, particularly evident at Local Health Authorities (*ASL*) levels, where the provider of all the health services is also the same entity controlling its quality and adequacy.

Attention was also called to how, in such a compact and centralised model, the wellbeing of the users (the citizens, the sick) is exclusively entrusted to the "benevolence of the prince" given the overwhelming disparity between the strength of the system (which aggregates policies, bureaucracy and professions) and that of the single citizen.

Structured on the norms mainly expressed in Regional Law no. 31/97 (see the following Appendix), *Lombardy's health system distinguishes itself from the systems of the other regions, because it does not follow any of the many regional variations of the national scheme, but presents a unique organizational model, so constructed as to be able to face and resolve some serious critical points arising from the original implementation of the Italian National Health Service.*

With regard to general principles, the Lombardy model fully incorporates the principle of universal coverage and financing solidarity set as the basis of the Italian NHS, but alongside these, it introduced, in a vigorous manner, the right of freedom to choose, made concrete through the principle of subsidiarity.

The uniqueness of Lombardy's outstanding organizational profile can be traced to two fundamental aspects:

1) The effort to eliminate (or at least greatly reduce) the conflicts of interests arising from the centralistic and the oligopolistic conceptions characterising the other regions;
2) The transfer of power from the health organization, with its interests and bureaucratic procedures, to the citizens by activating processes that make the principle of freedom to choose the place of treatment a very concrete reality.

The *first point* can be translated into the clear separation between the functions entrusted to the *ASLs* (organisation of public health activities, of basic care and control of specialist and hospital activities) and the organisation and production of specialist and hospital services entrusted to public or private Hospital Enterprises, all subject to the same accreditation paths and control systems carried out by the region and the *ASLs.*

This solution ensures that Lombardy will not repeat the paradoxical conditions typically and normally present in the other regions, where the *ASL* inspectors monitor the hospitals of the same *ASL* and report to the Director General on whose authority both the inspectors and hospitals depend and who may have to adopt provisions against his own self.

The separation between the *ASL* and the Hospital Enterprises instead foments a permanent debate between the *ASL* and hospital care providers which has produced numberless corrective measures in the daily run of healthcare activities, to increase efficiency and adequacy.

The *second point* resolutely addresses one of the crucial issues for all the European health systems and a critical problem which has been denounced for decades.

The traditional structure of the health authorities and hospitals tends in fact to organize and create procedures oriented more towards satisfying internal demands rather than addressing the needs of users.

Contrary to the many affirmations on the centrality of patients, and of the need to humanise the hospital and the ethical commitment of administrators and operators, the daily conditions of out-patients' departments treating multiple specialisations and hospitals (not only in Italy) were for decades characterised by low occupancy rates of hospital beds, reduced use of equipment and complex structures such as the surgical and intensive care departments, long waiting lists and objective difficulties in accessing treatments, especially the most specialised ones. All this goes to the disadvantage of the culturally and socially weaker users.

Even the more disciplined and programmed health systems suffer from similar critical dysfunctions which at times provoke periodic cases of violent accusations by the media, mostly generating numberless painful cases which do not go unnoticed by the public.

It is not surprising that the most relevant of these critical situations is furnished precisely by the British National Health Service, the low satisfaction levels and the long waiting lists of which are clear evidences of the historical limits of the centralistic healthcare planning methods.

In such a diffused context in the European Union and in Italy, Lombardy faced the problem in an unique way and concretely focused on the

citizen and the patient not by merely affirming principles, but by planning and implementing a health organization capable of effectively give power to the users of the health system: the power to choose the hospital services and specialised outpatient care from different providers, and the power to weigh the economic advantages or disadvantages of a healthcare provider that is paid only for the services chosen by the patient and effectively supplied.

To reach this goal, Lombardy from 1997 onwards through Regional Law no. 31 promoted the development of a mixed system, made of public and private hospital providers which in a very short time reached a rate of 2/3 and 1/3 of the entire offer respectively.

Unlike all the other regional systems, which make great use of the private component although within a strict planning scheme, Lombardy encouraged a certain degree of competition between all the providers; leaving each hospital enterprise ample flexibility for the use of beds available and specialised services, allowing them to adapt to the fluctuation of the demand, and in the first years of the reform, avoided enforcing strict budget ceilings to the service volumes provided by each public or private hospital enterprise.

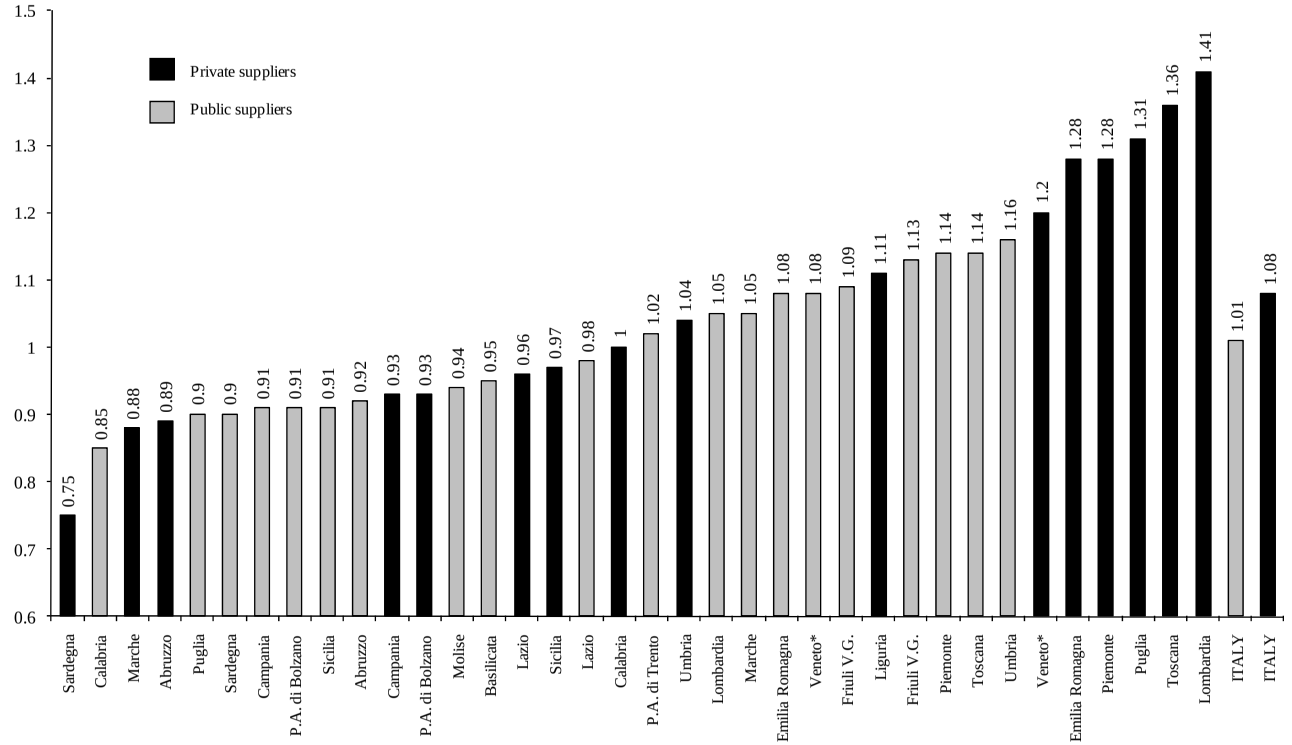
In this manner it implicitly stimulated the growth of a private component with increasingly high quality levels, operating in the low, medium and high specialisation, in the emergency care, and in general and specialist rehabilitation, generating a considerable flow of risk capital which has led to great investments and has created a modern and efficient hospital network.

As will be seen, this has resulted in an absolutely different type of private hospital network compared to those of many other regions. The difference lies in the large number of hospitals involved (1/3 of the entire regional health system) all highly qualified, as already denoted in 2004 from a case-mix index higher than any other public hospital network in Italy (graph 1.1).

All this sets a true basis for the complete fulfilment of the principle of the citizens' freedom of choice, and in effect the production of services within the entire Lombardy hospital network rapidly demonstrated its ability to respond to the demand by shortening the dramatically long waiting lists which had remained the same for decades.

But the presence of a mix of hospital operators alone is not enough to activate all the potentials of the system. We would need an economic engine, represented by the transition from the traditional payment-for-costs of production elements to the pay-for-service system.

*Graph 1.1 – Case-mix index of regional health systems. Year 2004*




Source: Ermeneia (2007). *Ospedali & Salute. Quinto Rapporto Annuale 2007* (Health & Hospitals. Fifth annual report 2007). Milan: FrancoAngeli

The hitches of the pay-for-costs system have been widely analysed in our country since the ’80s. They highlighted the absolute need for a radical change.

In fact, the pay-for-costs system, the so-called “*pié di lista*” (reimbursement of out-of-pocket expenses based on the submission of an expense account), of public hospitals tends to increase their own expenses without producing a proportional increase in quality and quantity of services provided, resulting in the increase of expenditures and waiting lists.

Even if today not all remember, in the ’80s there were numberless journalistic analyses of the damages wrought by out-of-pocket reimbursement.

The best way to escape from the vicious cycle of increased expenditures without a proportional increase of services, as experienced in all of the developed countries, is by paying fair tariffs only for services effectively rendered, forcing the hospitals to make themselves appealing to patients and at the same time avoid overspending.

Actually this evolution was not the product of the Lombardy reform, but was already hypothesized in the reform that started in the ’90s endorsed at national levels by the Amato Government with the Legislative Decree 502/92 and 517/93.

These laws therefore implemented the system of payment-for-services in Italy, adopted from the USA system based on the DRGs; and incidentally, it would be important to remember that our country anticipated an evolution which would have developed more than ten years later in very important European health systems such as those in France and Germany.

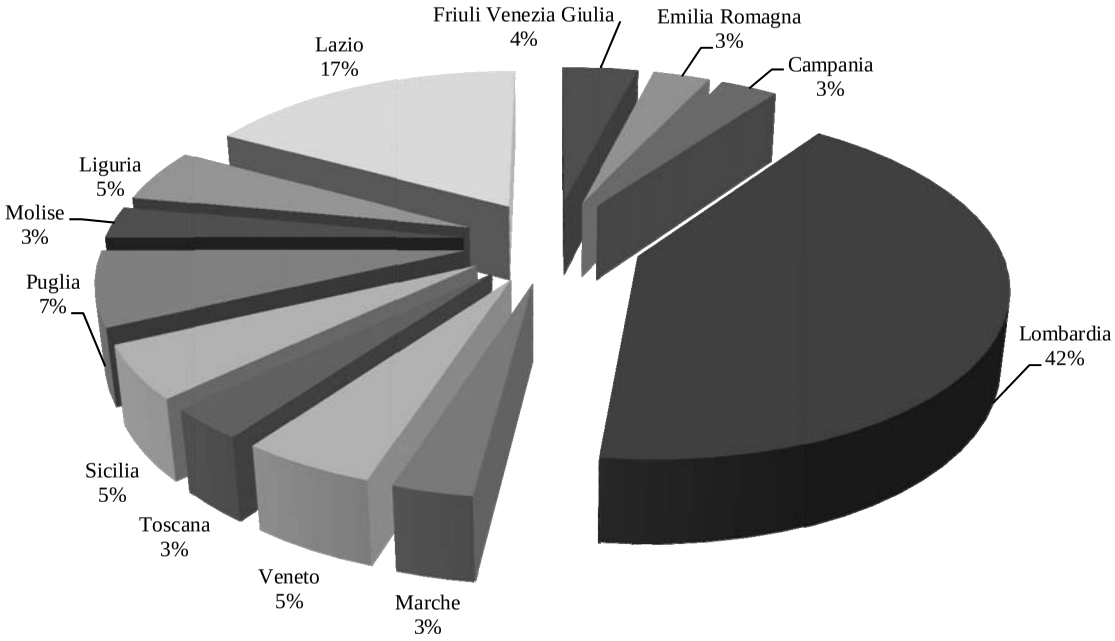
Lombardy’s merit consists in being the first in Italy to apply the same tariff system to all the public and private healthcare providers, even if today the public component still has not reached the efficiency levels of the private one and continues to require the levelling of its annual operational deficits.

Precisely because of this, the constant comparison between the private sector which offers more complex services at significantly lower prices and the public component is a fundamental stimulus to improving the services of the public providers.

Lastly, we must remember that to pursue utmost excellence, a health system cannot do without adequate investments in the field of scientific research, and the Lombardy example confirms its validity in this sense.

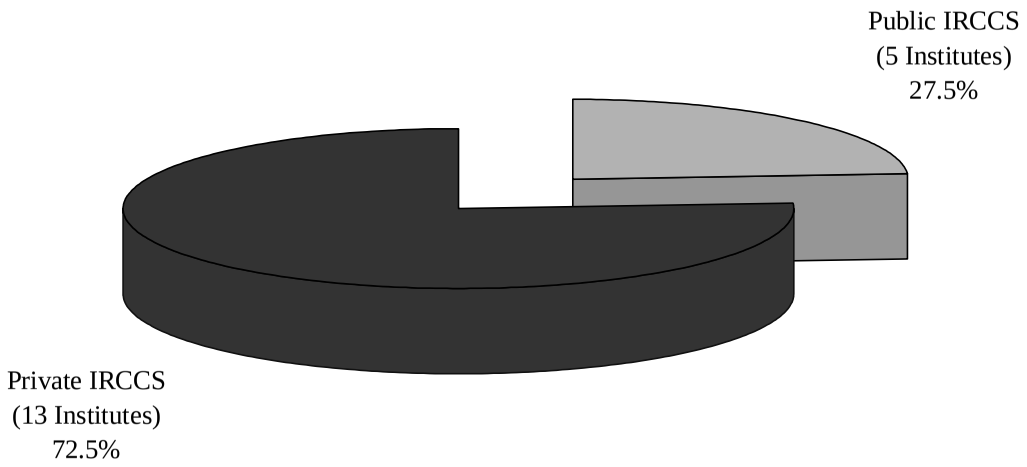
It would suffice to note in graph 1.2, that 42% of all the Italian Scientific Institutes for research, hospitalisation and healthcare (IRCCS) are located in Lombardy and 72.5% of these are represented by private facilities (graph 1.3).

*Graph 1.2 – Distribution of public and private IRCCS over the national territory*




Source: *Ministry of Health*

*Graph 1.3 – Distribution of public and private IRCCS in Lombardy*




Source: *Information System of Lombardy Region, 2009*

*Such a clear-cut reform policy, which in some measure contains in itself revolutionary elements with respect to the "Beveridge" system adopted in the whole country, could not but instil a strong and hostile resistance.*

Beyond all the ideological oppositions, it is evident that the concrete achievement of a health system centred on the citizen's free choice and the presence of a high quality and strong private healthcare providers contrasts with preset interests (professionals, trade unions, financial institutions), limits the field of political discretion and power of bureaucracies, and obliges greater transparency and disclosure in a system that is traditionally non transparent and closed up in itself.

The most frequent criticisms focus on the possible offer of non-essential services and of probable opportunistic behaviours, whereas single episodes of medical malpractice often attract the exasperated attention of the media. This does not occur for similar cases in the more conservative regions.

Though it is evident that a perfect health system does not really exist, we must stress that it is precisely this pluralistic characteristic of Lombardy's health system that allowed the development of a control system and widespread clinical governance without equal in the other Italian regions.

Although no effort was made to carry out a reliable scientific debate, we can see from the case-mix values given in graph 1.1 that the adequacy levels reached especially by the private hospitals of Lombardy are by far the highest in the whole country, an inevitable fact on the other hand, considering the selective pressure they undergo.

As we said, unlike the other regions, Lombardy made use of competition between providers to develop its own hospital system. This move, particularly criticised by the supporters of centralised health systems set on a strong state-controlled scheme, however developed in a highly progressive way.

In the first two years of enforcement of the Regional Law no. 31/97, competition among all the providers of the region was extensive, but later narrowed down to the territorial areas of each *ASL*. From 2003 onwards it practically disappeared, with the imposition of a maximum ceiling for activities of each public or private Hospital Enterprise.

This decision which critics interpreted as a demonstration of the presumed failure of Lombardy's reform was actually adopted with the approval of all the healthcare providers, in the perspective of creating an adequate regional hospital offer that is more integrated between Hospital Enterprises and with the territory to ensure better continuity in assistance.

We have to acknowledge that results were substantially achieved, and in addition, starting from 2005, they enabled the removal of the ceilings for a

series of important services, from emergency care to oncologic surgery, without having to jeopardise the economic stability of the system.

*The Lombardy Hospital network today is a great organization substantially lodged in its fundamental components, economically balanced, composed of public and private elements not subject to changes, and with the tendency to deliver less specialised hospital services with ever increasing adequacy.*

If this trend continues in the next few years, even important resources may be freed and invested in quality, technological and structural development, education, training and scientific research to best meet the future challenges and keep abreast with the best health systems of Europe and the world.

## Appendix – Regional Law of 11th July 1997, no. 31

The Lombardy health system is the product of a complex and continuative legislative and administrative activity which concretely lays down innumerable provisions. The most important aspects, fundamental principles and elements, that are also symbolically more visible, are expressed in the well-known Regional Law of 11th July 1997, no. 31: "Norm for regional health system reform and its integration with the social service activities".

Art. 1 summarises the most important aspects of the "Lombardy model".

Art. 1
(The general principles)

1. In respect of the dignity of the human person and of his or her constitutional right to healthcare, exercised according to the procedures provided by this law, and also through the citizen's freedom to choose, in conformity with the procedures established by regional and provincial health schemes, the Region will govern regional healthcare and social-assistance services establishing the basic principles to be used in:

a) setting the territorial boundaries of the healthcare facilities;
b) reorganising the network of hospital care structures;
c) defining the functions and tasks of the Hospital Enterprises;
d) promoting and favouring the integration of healthcare with social-assistance functions under the competence of local authorities. … (*omissis*);
e) ensuring that the public institutions, the non-profit organisations and private citizens through their specific roles contribute to achieving the integration of social and healthcare services. Equal rights and obligations of public and private healthcare providers within regional schemes are therefore granted.

2. The norms of the present law draw their inspiration from the principle of subsidiarity between persons, families, public and accredited private service providers, in order to deliver citizens with the necessary services.

3. The Region exercises legislative and planning functions, guidance and coordination, monitors and supports the healthcare authorities and the other public or private entities engaged in healthcare and social-assistance activities, and healthcare-related social assistance.

… (*omissis*)

The Law in its final form is actually the result of a long deliberation and institutional bureaucratic process.

After an intense phase of debate, with the onset of the Sixth Legislature, the first formulation was adopted by the Regional Council presided by Roberto Formigoni on 6th October 1995 (resolution VI/03143).

A first complete text was approved by the Third Council Commission during the session of 29th July 1996, after a lengthy and exhaustive debate, and definitively approved by the Regional Council and passed as Law no. 072 of 7th April 1997.

There were great disagreements with the National Government headed by Romano Prodi, and especially with Rosy Bindi, the Minister for Health at that time. Resistance was overcome in May 1997, without changing the framework and the particular aspects the region strongly aspired for.

The definitive letter of the law is dated 11th July 1997 and numbered 31.

Roberto Formigoni, President of the Region, had always affirmed in his institutional capacity or during public debates, that he considered the Regional Law no. 31/97 as holding a fundamental and important role in his political actions and as the fulcrum of a significant turning point in the history of health in Lombardy.