Has decentralization of health care in Italy affected horizontal equity?

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Background

Decentralization in health care is regarded as a pro-equity reform, nevertheless; there is no clear evidence on its impact on the equity dimension.

Italy underwent 2 mayor decentralization reforms in the 1990s that granted regions significant autonomy:

→The devolution of political power

→The fiscal federalism reform

My Hypothesis

The decentralization process is undermining horizontal equity and is widening the north-south equity divide.

Aims of the study

→Explore the pathways to bridge decentralization and the horizontal equity dimension in Italy

→Analyzing the decentralization of the INHS both in the European context as well as in the Italian policy context

→Assessing 10-15 years of decentralization reform by looking at changes in some key equity parameters

Design and Method

Part 1. Retrospective evaluation of the decentralization process in Italy looking at:

→ Shifts in ownership of the legislative function from the CG to Regions

→ Financing: implication of the fiscal federalism reform (changes in the taxation regimes and introduction of OOP payments)

→ Planning of the INHS: the NH Plans

Part 2. Data analysis

→ Regressivity index

→ Burden of co-payment index

→ Simple correlations

My basket of Indicators

Equity in financing:

-Progressivity of the taxation system

-Introduction and burden of co-payment

-Changes in regional per-capita expenditure

-Correlation between the average cost of prescription and per capita GDP

Equity in the access:

-Increase in the population response and participation in the screening programs

-Number of physician visits/year (number of per capita prescriptions)

-Patient mobility

Equity in the health outcomes:

-Infant mortality rate

-Level of satisfaction with the regional health system

How Italian Regions compare?

	Per capita GDP 2004 Thus.€	% /Total pop.	% Poor people 2006	% Pop. Over 65 2004	Increase Pop. Over 65 1990-2004	no educ. self-reporting good health 2005	LE +65 F+M 1990	LE +65 F+M 2004	Stnd. Rate people with at least 1 chronic disease
PIEMONTE	31,39	7,4%	6,68	22,32	5,33	52,97	16,5	19,3	11,86
VALLE D'AOSTA	30,63	0,2%	9,93	20,05	4,4	57,74	16,5	19,3	10,61
LOMBARDIA	29,47	16,1%	4,96	19,28	5,19	56,8	16,2	19,5	12,61
TRENTINO A.A.	28,70	1,7%	7,14	17,55	3,22	66,55	16,7	19,6	11,51
VENETO	28,68	8,1%	5	19,05	4,29	54,24	16,6	19,6	13,05
FRIULI V.G.	27,66	2,1%	7,69	22,38	3,36	54,65	16,2	19,1	11,13
LIGURIA	26,25	2,7%	7,37	26,52	5,45	49,18	16,6	19,5	11,01
EMILIA ROMAGNA	25,90	7,1%	4,01	22,68	3,65	52,44	17,2	19,8	13,09
TOSCANA	25,86	6,2%	7,69	23,13	4,08	48,28	17,1	19,9	12,97
UMBRIA	24,18	1,5%	7,91	23,27	4,55	46,72	17,1	20,1	14,02
MARCHE	23,75	2,6%	6,72	22,47	4,54	44,72	17,4	20,2	12,97
LAZIO	22,23	9,0%	8,4	18,95	5,25	50,65	16,5	18,9	12,8
ABRUZZO	19,02	2,2%	13,16	21,17	4,74	51,83	17,1	19,5	13,18
MOLISE	18,46	0,5%	20,05	21,86	4,77	48,55	17,1	19,5	14,08
CAMPANIA	17,19	9,9%	24,18	15,18	4,36	59,07	15,6	18,4	13,43
PUGLIA	16,59	6,9%	22,34	17,1	5,19	57,62	16,7	19,7	13,13
BASILICATA	15,63	1,0%	24,55	19,73	5,81	49,01	16,8	19,4	13,8
CALABRIA	15,41	3,4%	31,4	18,13	5,05	48,67	16,8	19,4	14,79
SICILIA	15,41	8,6%	31,51	17,83	4,41	54,42	16,2	18,9	12,89
SARDEGNA	15,36	2,8%	19,45	17,38	5,16	52,19	17,1	19,7	13,93
ITALIA	22,88	100,0%	12,91	19,6	4,7	53,84	16,6	19,4	12,81

Why Equity?

→ Equity is a very "sensitive" policy goal to decentralization dynamics

→ Italy presents wide and persistent cross-regional health inequalities and a well marked decentralization policy environment

→ Poor equity discourse among Italian policy makers and lack of studies on the linkages between decentralization and horizontal equity

What equity?

Horizontal equity: *"Absence of systematic differences in one or more aspects of health across socially, demographically, or geographically defined populations".* (Starfield and Macinko)

Pathways to bridge decentralization with gains/losses in horizontal equity

DECENTRALIZATION REFORM ⇨

Decentralization related policies
- **Increase/decrease of health expenditure**
- **Progressivity of funding**
- **Type of risk adjustment distribution of costs and benefits**
- **Privatization**
- **Cross-subsidization mechanisms**
- **Performance requirements**
- **Monitoring systemand setting of standards (stewardship)**

Availability of resources:
- **-managerial**
- **-economic**
- **-technological**
- **-structural**

⇨

Financial and access barriers

FINANCIAL
- Burden of payment
- Per capita health expenditure
- Introduction of co-payments

SUPPLAY RELATED
- N. doctors and Health Units
- Available technology

GEOGRAPHICAL
- Distance from services

⇨ **GAINS OR LOSSES IN EQUITY**

Key results:

Equity in financing:

→Decrease in PHE

→Lack of convergence in the regional per-capita HE

→Introduction of new forms of co-payments

→Increased regressivity of some regional fiscal regimes

Equity in access:

→ persistence of the north-south gradient of patients satisfaction with hospital care

→ Increase of patient mobility over the last decade

Policy perspectives:

In the perspective of recentralization:

→ Tightening of central control on resources rationing and successful implementation of new fiscal measures.

→ Implementation of an effective monitoring system of regional health systems performance.

→ Compensation of fiscal unbalances trough central transfers.

→ Implementation of tax-freezes and limitation of the burden of co-payments.

In the perspective of further devolution:

→ Foster cooperation across regions to help some regions to catch up with innovation and Management Capacity Building.

→ Boost benchmarking and best practice sharing to avoid administrative and organizational delays.

→ Provision of national directives on issues such as the governance of patient mobility.

Key references

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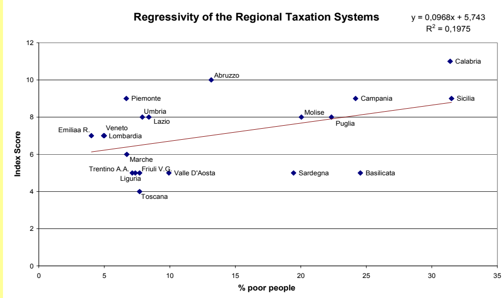
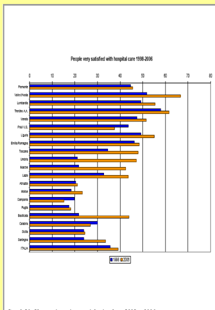
⇨ The implementation of the fiscal federalism turned the taxation systems of poorer regions into more regressive

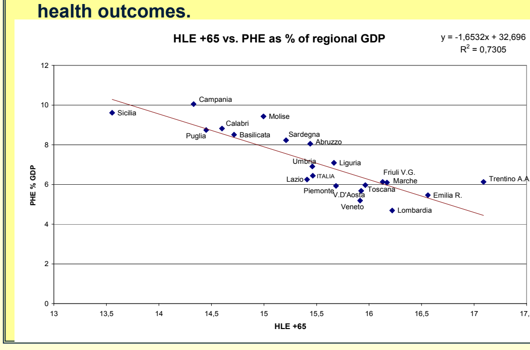


⇨ Decentralization has not been associated with the general increase of patient satisfaction and the decrease of patient mobility.



Graph 10. Changes in patients satisfaction from 1998 to 2006. Data from Helth for All Database for Italy

REGION	PATINETS SATISFACTION 1998	PATINETS SATISFACTION 2006	PATIENT MOBILITY 1996 Tot.	PATIENT MOBILITY 1996 %	PATIENT MOBILITY 2005 Tot.	PATIENT MOBILITY 2005 %
PIEMONTE	44,63	45,59	8411	1,46	28735	6,24
VALLE D'AOSTA	51,82	66,7	1246	7,05	1443	10,56
LOMBARDIA	49,21	55,42	58449	5,46	117186	8,80
TRENTINO A,A,	57,98	61,67	5962	9,35	10240	16,80
VENETO	47,51	51,61	6215	1,23	47179	8,24
FRIULI V,G,	43,58	37,53	12826	6,06	12817	8,42
LIGURIA	49,15	55,11	18123	6,22	24348	11,21
EMILIA ROMAGNA	46,31	48,5	57480	8,14	75095	12,84
TOSCANA	34,49	47,96	22371	3,80	43436	9,91
UMBRIA	21,09	47,18	20883	12,60	15806	14,05
MARCHE	21,63	42,5	15126	7,20	17821	8,99
LAZIO	32,8	43,57	63977	7,56	68759	8,65
ABRUZZO	20,4	21,2	12364	4,84	33366	13,03
MOLISE	18,34	23,36	14321	22,11	14450	24,23
CAMPANIA	19,68	15,16	20092	2,18	18359	2,26
PUGLIA	17,43	18,17	36683	4,58	23726	3,84
BASILICATA	21,73	43,95	10027	9,55	8545	12,32
CALABRIA	29,98	26,93	9740	3,60	9055	3,27
SICILIA	23,96	24,39	n.a.	n.a	12062	1,70
SARDEGNA	23,98	33,6	53	0,08	4462	1,78
ITALIA	35,63	39,14	394349	5,05	586890	7,29

Source: Health for All Database and SDO Reports, 1996-2005, Ministry of Health (Hospital Discharge Forms)

⇨ Due to fiscal federalism southern regions spend a higher share of their GDP on health, yet they show worst health outcomes.