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ITALY: REGIONAL DIFFERENCES IN PUBLIC HEALTH QUALITY MANAGEMENT SYSTEMS

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Contents

This short essay presents a brief review of the **various approaches applied by the different Italian Regions with regard to Quality Management in health care policy**.

Since the **reform** that took place in 1992, **the national legislative system, in fact, has provided a global framework**, a series of basic **tools** and new **perspectives** in the field of Quality Management, but on the other hand it has ensured **plenty of room to the local articulations** of the State [1].

Thus, in the Italian experience, the most important role related to health care policies is that of Regions, which are provided with a wide range of autonomy both from a legislative and operative point of view. Such choice of **decentralisation**, in the intentions of the legislator, responds to a double function: *in primis*, it's meant **to link the health care system to the territory**, paying

attention to the specific items and the peculiar needs of the resident population (for instance, Regions like Piedmont and Calabria are quite obviously provided with a remarkable diversity in health problems and priorities, due to differences in climate, alimentary habits, lifestyles, average wages, and so on).

On the other hand, the authorities were well aware that they had inherited from the past **a set of sanitary realities widely differentiated** and unequally distributed on the national jurisdiction. In particular, **many Regions of the north** were already characterised by favourable starting-points, with some excellent examples represented by advanced structures both in health and management practises.

In the southern Regions, on the contrary, apart from a few exceptions, the situation was very different: old and ineffective structures, widespread inefficiency in the handling of the available resources, scarce links between different health institutions, few and badly equipped voluntary organisations. Such regional differences are the result of a process dating back several decades, and the gap doesn't seem likely to be reduced at least in the short run.

Even the implementation of Quality systems in health organisations was affected by this situation: like many other sanitary issues, it could not be brought on in a standard way; thus, local realities were given the responsibility to find their own developmental path. The role of the State, therefore, was mainly that of enhancing the appropriation of the new tools, fostering the innovation process, controlling the efficient allocation and use of the (limited) resources.

From the answer given (or not given) to the question "how to perform an effective Quality system on a Regional level", many consequences arise about the management of the local health organisations and the philosophy underlying the policies of every single Region. In fact, the reform of 1992 makes it possible to undertake the modernisation of the health sector in partially different directions (each of them coherent in its way, and perhaps more fit to the peculiar necessities of a specific territorial reality).

For southern Regions, the most urgent problem to face is that of establishing the **pre-conditions** that will make it possible to start building a Quality management system. For instance, it is apparent that without **an efficient Information System** it's hard to measure and share the data about the variables to keep under control; on the other hand, the culture of Quality is essentially a culture of quantitative measurement, audit, partaking of experiences, tools, notions.

The immediate practical effect in terms of fast transmission of knowledge and constant monitoring of the critical variables is not the only positive result to be achieved: more substantial advantages can be obtained in terms of overall view of the business phenomena, higher dynamism of workers, gradual development of a shared vision throughout the various organisational levels.

The challenge for Southern Italy consists in this very aim; by working hard **to create adequate infrastructures and networks of integrated health operators and services**, it becomes possible not only to reduce a long-lasting technological, organisational and managerial gap, but even to put the foundations for a new business view, which is an essential pre-requisite for real efficiency in the management of the ongoing processes.

Within this frame, an interesting example is represented by the "**Consorzio Mario Negri Sud**" [2], an institution acting with the purpose of catalysing the various experiences brought about throughout Southern Italian organisations in the public health sector; it operates elaborating and providing a set of operative tools in order to create a network of people, an aggregation of structures and a shared culture based on sanitary co-operation [3].

Other Regions, starting from a far less problematic situation, could concentrate their efforts on the creation of a Quality system in the short term. This is the case, for instance, of **Emilia-Romagna**, a Region of the centre-north where a joint work by the Sanitary Assessorship, Health Agency and Local Sanitary Business Units (the health financing organisations, in Italy called USLs) has been made, with the aim of assuring and promoting the quality of the local health system.

Due to the many-sided nature of the subject, the latter has been developed following many different lines: **customer satisfaction of "consumers"** [4], **quality guaranteed through certification** [5], **analysis and rationalisation of the business internal processes** [6], **diffusion of the new organisational and management culture** [7].

The Region has granted freedom to each USL and Hospital so that they could develop their own operative approach to quality (often based on small, specific projects), but it has carried out an exchange of information and knowledge among managers of different structures, through **communication networks (mailing lists), Regional project groups involving Quality Experts of the local organisations, a data warehouse, and several joint training activities**.

In short, the Region provides a reference and a frame to address the Quality policies of the health businesses, granting a common ground [8] to all the health operators and transmitting **a kind of "top-down" support** (without hindering the changes or innovations coming from the bottom, that is from single organisations).

Finally, some leading Regions (headed by **Lombardy**) were characterised by an even higher degree of dynamism and possession of advanced know-how by the public health representatives. Given such situation, the best strategy is probably the one of granting **wide freedom to managers and promoting the communication of the new business culture to all the organisational levels** of the local health structures.

That's why in 1997 Lombardy adopted a Regional reform characterised by a strong "free trader" orientation [9], in order to broaden the autonomy of health organisations and top professionals/ managers operating inside them. **The representatives are given the maximum amount of freedom, together with the instruments for managing the available resources as independently as possible**, relying on the project capabilities, knowledge and dynamism of the top management.

Of course, this doesn't mean either that the management and processes' control system is less strict

than elsewhere, or that "top down" initiatives of co-ordination have been dropped. On the contrary, for instance Lombardy has recently launched a programme aimed at **co-financing selected Quality projects** proposed by Hospitals and USLs, with the double purpose of spurring improvements and communicating new organisational and managerial practises.

The basic difference with the experience of Emilia-Romagna is represented by the **emphasis on the resources brought about by single top managers in the structures they belong to, rather than developing a "group" and "collective" view**. A different accent that may appear of little importance at first sight, but that witnesses a conception of health businesses more similar to a vision of "enterprises" operating in a competitive market [10].

In conclusion, it can be argued that the **various Italian Regions have adopted different praxes of Quality system implementation** in the public health sector, and this probably represents **a positive fact**, since the peculiar aspects of any local geographic context in a sizeable and diversified Country make it advisable to choose several "personalised" ways, depending on the set of opportunities and critical features arising in each specific local and social environment.

NOTES

[1] The Legislative Decree 30/12/1992 n.502 introduces several important features with implications for quality, such as:
- the tie between levels of health services and amount of available resources (aimed at stopping the steady growth of sanitary aggregate expense);
- the separation between Financing health organisations (USLs) and Supplying ones (Hospitals etc.);
- the introduction of a sort of "regulated competition" between public and private authorised structures;
- the adoption of payment by capitation in health services;
- the promotion of a new business identity for health structures (more similar to "firms");
- the greater extent of decentralisation in favour of Regions and Local Administrations in general.

[2] It is located in S. Maria Imbaro (Chieti), Abruzzo.

[3] The "Consorzio", active for years with a series of publications, training and research programmes, has recently developed an information network and a specific data warehouse (called SPES/RISS), presenting a software meant for statistical analysis of local health variables named "DRG Analyst".

[4] Several experiences have been brought about in this field, such as the distribution of handbooks containing practical hints, addresses, phone numbers of health offices and structures (Health Service Reference Books), the researches made or commissioned to external institutes, the choice of quality indicators to measure the customer satisfaction of the citizenship.

[5] The draft of a Certification Handbook and the training of health professionals in the disciplines of auditing and quality inspection are practical examples of the actions undertaken in this field.

[6] Some projects have been directly financed by the Region (and inscribed in a continuous quality improvement programme called CQI); later on, such experiences have been widely divulged, to stimulate future applications in other sanitary organisations.

[7] The Health Agency has promoted a variety of courses and seminars about quality and accreditation of health structures, in addition to the training classes directly carried out by the single USLs and Hospitals.

[8] That is to say, a mix of a shared culture, a phraseology, a set of notions, a toolbox, and the sense of belonging to a common sanitary aggregation.

[9] The Lombard Regional Law 11/7/97 n.31 is characterised by a strain in the direction of privatisation and by a "market economy approach" in the health sector. The basic guideline of the reform is the principle of subsidiary roles: the institutions ought to let room to private initiative, intervening only when and where social needs aren't met in other ways. Consequently, direct intervention by the Authority is reduced, and an equal competition between certified private and public health structures is fostered, with the purpose to attain

advantages in terms of management efficiency and effectiveness.

[10] In fact, Lombardy has promoted a clear-cut division between financing health organisations and supplying ones, in order to allow USLs and Hospitals to concentrate on their specific mission. Even the full equality between public and private authorised subjects, in the purpose of the Regional authority, is meant to introduce competitiveness in the health sector, thus encouraging the birth of a "quasi-market".

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