

MANAGING THE ITALIAN HEALTHCARE SYSTEM: THE VIEWPOINT OF THE PURCHASING AND MARKETING OFFICE

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ABSTRACT. Beginning in the early 1990s, reform of the Italian Healthcare Service (NHS) led to a *controlled* competition system. Consequently, managers had to face a new institutional framework, one which was characterized by the following elements: citizens' choice of the healthcare organizations to deliver the services they need; the integration of public healthcare organizations' supply with private accredited organizations; the distinction between producing and purchasing organizations. Consequently, management of the purchasing and marketing functions can have a key role in the new situation. By presenting an analysis of national, regional, and local regulations and case analysis, this paper points out the main aspects concerning procurement policy in the Italian NHS. The implications for the internal market mechanism, the Purchasing and Marketing office's role, and the activities implemented in order to contribute to a wide range of decisions are considered.

INTRODUCTION

As in other European countries Italy's reform of the National Healthcare System (NHS) started at the beginning of the 1990s in order to make the public system more flexible and able to solve the many problems related to healthcare demands and to comply with the budget cap (Abernethy and Brownell, 1999). A higher level of responsibility was given to the healthcare organizations, making them accountable to the community for resources consumed. Thus, a public legal status was

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assigned to the Local Health Authorities (LHAs) and to the public independent hospitals in order to extend the level of responsibility and autonomy related to administrative, financial, patrimonial, qualitative and accounting issues.

The new reform law established (a) which healthcare organizations would produce and deliver healthcare services and (b) which would purchase healthcare. The new law was designed to improve efficiency and create conditions for competition. In a competitive environment, transparency of managerial process and of information is fundamental. Consequently, LHAs are required to assure a minimal and uniform standard of medical care with the primary purpose to improve the health protection of citizens (Law Decree No. 502/1992, article 1). LHAs deliver healthcare services both directly and by buying them from accredited public and private health care organizations (art. 8 – Law Decree n° 502/1992).¹

Therefore, the relationships set up between the LHAs and the healthcare organizations producing care services are a particular innovation drawn by the reform law. Contracts can be agreed upon by accredited organizations. In order to manage the above-mentioned relationships and the related market forces, the development of a special administrative service, a purchasing and marketing office, has been required. The Purchasing and Marketing Office's task is to efficiently and effectively analyze the level of healthcare services management.

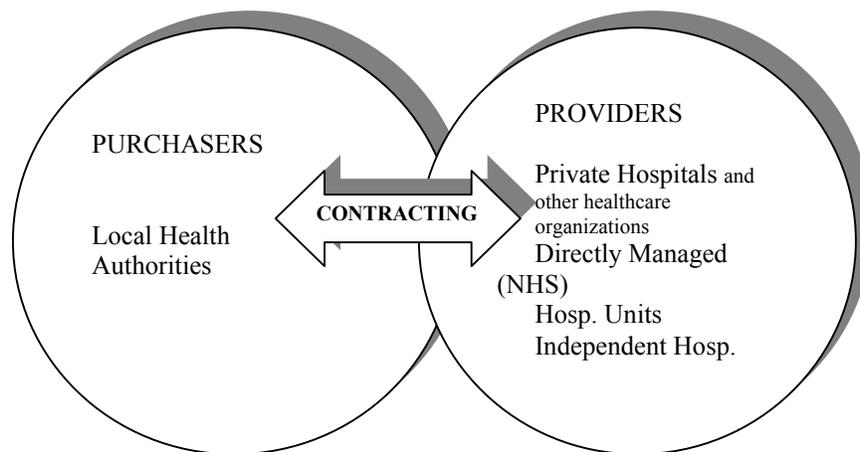
Given this evolution of the healthcare system, purchasing and strategic marketing principles take on a relevant role, since their related actions are devoted to improving the resources allocation and the quality and efficiency dimensions of services. In addition to shedding light on the *quasi-market* principles and the objectives of the NHS reform (Zamagni, 1998), this paper aims to analyze the changes that could affect LHAs and public independent hospitals, particularly from the point of view of purchasing and marketing activities. The paper builds on the results of the contracts and healthcare services literature, and examines the strategic relationship between a health purchaser and providers under conditions of controlled competition, as established by the reform law (Culyer & Jonsson, 1986; Longo, 1997). Thanks to the empirical support received by the Modena LHA, it is possible to detail the objectives of the new organizational entity, to explain the kind of relationships to manage

and to observe the managerial criticisms that the Purchasing and Marketing Office faces.

HEALTHCARE SERVICES MANAGEMENT: AN OVERVIEW

Before describing the main features of the actual quasi-market model based on the use of the purchasers and providers, it could be useful to briefly mention the kind of relationships the healthcare organizations developed prior to the 1990s. Law No. 833/1978 gave planning responsibility to the regions, while the management of the healthcare services was assigned to the municipalities, through the LHAs.² In that model, LHAs assumed a key role in territorial health policy. In the early 1990s, it was determined that the LHAs were not working according to the guidelines provided by law No. 833 and the government was persuaded to reform the national healthcare system. As a matter of fact, it was not easy to measure and assess the LHA's effectiveness and efficiency levels: the accounting tools used to evaluate the needs of healthcare services seemed to miss the objectives. In addition, no proceeding had been adopted to control and assure the quality level of healthcare services to patients, and no evident criteria had been defined to assess the healthcare organizations' performance and strategy. Besides the managing and operational rigidity of LHAs, and political interference in planning processes, the need to differentiate the role of the public healthcare entity as purchaser and provider (see Figure 1) of healthcare services put pressure on the NHS to change and reform the model in force (Borgonovi, 1995). The British experience³ was considered the preferred model to follow. In fact, many European healthcare systems had been experiencing at various stages the shift from the hierarchical model to the market governance one based on actual implementation of competition mechanisms. The public nature of the healthcare sector makes particularly difficult the search for the suitable governance model in healthcare. Many factors have to be considered, such as changes of principles, a different impact of organizations on social institutional environment (Ferlie, Ashburner, Fitzgerald & Pettigrew, 1996), increased costs and prevention of new risk situations (Lapsley, 1993). As from the New Public Management theory (Hood, 1995), the public healthcare organizations differently affect social, economic, and institutional environment according to the kind of output they deliver, according to the style of leadership, according to the authority structure,

FIGURE 1
The Italian NHS Framework



and according to the way the relationships between the organization and other actors are regulated. Those aspects are different from one country to another, thus making choices in terms of healthcare governance models is very difficult. The earliest reform, in 1992, focused on the following main aspects:

- Definition of the new set of LHAs, in view of their number reduction;
- Shift of LHAs into public health organizations provided with particular flexibility for decisions and managerial responsibility;
- Accountability of regions for the healthcare expenditures;⁴
- Dissolution of the general agreements (conventions) with the private healthcare organizations and the introduction of the accreditation system as a criterion to produce health care and assure quality standards to the community;

- Recognition of all citizens' free choice to avail themselves of public or private healthcare organizations without limitation to their locales;
- Redesign of the accounting information system, emphasizing the introduction of cost accounting systems,⁵ budget, financial and non financial reporting, and a multiyear budget that could allow managers to make comparative costs and analyze results;
- Rigidity of the budgeting model; and
- Accountability of directors over the results achieved and the introduction of temporary job contracts for General Directors, Administrative Directors and Medical Directors.

The above-mentioned key aspects of the NHS management are aimed at achieving two fundamental objectives: to improve both the level of efficiency and effectiveness and to improve the quality of the NHS and the transparency attitude of managers.

Efficiency objectives have been at the center of the management restoration that is taking place according to the external approach (the introduction of a quasi-market based system), and the internal approach (following the quasi-market situation). LHAs' accounting systems have been renewed (Guthrie, 1998). The accrual accounting system allows LHAs to determine costs and results of the delivered healthcare services; and the findings, focusing on the prices fixed by regional authorities, are assessed.

Therefore, payment for hospitalization days in public or private organizations is based on the evaluation of the particular diagnosis treatment, classified according to the Diagnosis Related Group (DRG) Scale, and no longer according to the daily expenditure per stay in hospital. This scenario challenges private and public healthcare organizations to improve quality, to attract more patients and to reduce costs, thus meeting the budget cap restrictions. By meeting these goals, general directors could redirect resources to quality programs and a wider range of healthcare services.

THE ACCREDITATION SYSTEM

The introduction of the accreditation process in the healthcare sector of many European countries (Baltoni & Riva, 1998; Cambieri, Catananti & Guglietta, 1998) follows the longer experiences of the United States,

Canada (Larouche, 1998; Mihalik, 1998; Williams, 1997) and the European regulations for quality assurance and quality certification.² The process is a significant mechanism to assure transparency about policy making. As a consequence of the renewed financing system based on DRG, increased patient awareness and competition mechanisms among the healthcare organizations, citizens become privy to information about the level of medical care and hospital services provided to them. Citizens have a right to the disclosure of efficiency and effectiveness information. Furthermore, the General Directors of independent hospitals, LHAs and private organizations operating for the NHS should share information regarding the continuous control for efficiency and quality of services provided by their own structures in order to guarantee and create conditions for the new competition market (Lapsley, 1993).

Public and private healthcare organizations can enter the public health care market – at NHS’s expense – according to the following procedure:

1. A special authorization is delivered by the regional authority to the healthcare organization to manage care. Obtaining authorization doesn’t automatically assign membership in the NHS to the organization. Membership depends on the attainment of the structural, technological and managerial standards outlined for different kinds of healthcare services delivered;
2. Public and private healthcare organizations that have obtained the authorization should require the issuing of accreditation to their regional authority. Since the “accreditation system” is based on adherence to minimal standards, a relevant change has been introduced in comparison to the “general agreement based system” established by law in 1978. General agreements were established on the subsidiary criterion of private organizations’ offers and on the possibility for public LHAs to choose private healthcare organizations according to discretionary criteria. There were weak objective evidences of the dimensions determining the organizations’ choices as well as of the quality and efficiency of services delivered.

In order to be accredited, the fundamental dimensions that a healthcare organization must consider are as follows:

- Possession of minimal requirements as established by the central government (Ministry of Health, 1995), in terms of structural facilities, technology, and management activity;

- Acceptance of the healthcare services' funding scale in force within the NHS. Funds are transferred according to the regional scale linked to the DRGs (for acute hospital care, day hospital services and rehabilitation services) and to the ambulatory patients' grouping system;
- Implementation of a quality control system; and
- Acceptance of an external quality control system operated by the LHA.

3. The contractual agreements established between the regional authority and the LHA, on the provider's side, and the accredited organizations, on the producer's side, are considered to be the third step to access to the NHS. The contracts have to specify the quantity and the range of healthcare services to be delivered, funding details (prices for health services), payment, quality dimensions, the control system and the sanctions.

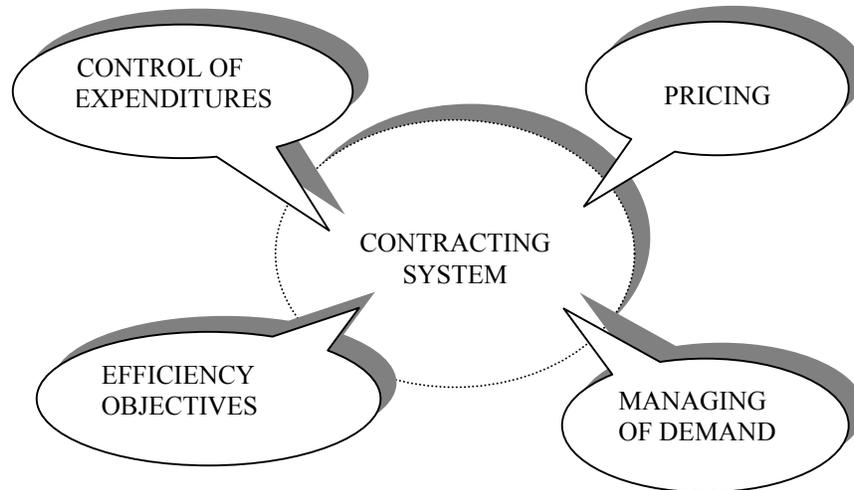
Finally, it is useful to point out that accreditation is a necessary requirement, but it is not enough to provide healthcare services for the NHS. The agreement about a specific contract will enable the organizations to deliver the demanded healthcare services. Therefore, it is a direct contract signed by the LHA and the accredited organizations that affects access to the NHS.

PROVIDING HEALTHCARE SERVICES THROUGH CONTRACTS

In comparison to the old "general agreement system", the 1990 reform highlights a very different relationship between accredited organizations and LHA. The need to implement a transparent contractual system is due to the necessity to develop an effective healthcare expenditures control system that could promote the selection of particularly efficient healthcare services providers (see Figure 2). Healthcare expenditures and efficiency control mechanisms, as well as the pricing policy and the type of the healthcare demand, are the main issues the contracting system focuses on.

Contracts regulate the relationships among healthcare organizations so that purchasers (LHAs) define the real need for healthcare by measuring and assessing the characteristics of demand, and providers define healthcare's supply policy coherently with the resources available.

FIGURE 2
Factors Determining the Implementation of Contractual System



The Italian regulations partially develop the possibility to implement real transactions because of the presence of few ties:

- Coexistence of producer and purchaser in the same organization;
- Lack of a real competitive system among suppliers; and
- Lack of monitoring of trends in health care demand.

Therefore, the contractual system highlights the inconsistency between limited supply and potentiality of demand. Furthermore, the way the contracting system is regulated allows only limited competition. As mentioned above, the LHAs (purchasers) have their own producing organizations (NHS managed hospital units). The emphasis on efficiency objectives as well as on expenditure control can be different between the producers 'belonging' to the LHAs and those other producers outside the LHAs.

In the new system, the main contents of the contracts may be defined as follows:

- Quantity to buy (DRGs, ambulatory care, day hospitals, etc.);

- Pricing policy;
- Kind of healthcare services delivered;
- Control system over the production and delivering process; and
- Characteristics of the resources employed.

Thus, the contracting process requires the definition of roles and responsibilities in healthcare organizations, the implementation of executive plans, the availability of more and more timely information about quality and efficiency of healthcare organizations, the definition of prices of services and of a price policy coherent to the level of effectiveness, quality and efficiency of health care and to the health expenditures. Therefore, the development of managerial skills, the implementation of an effective accounting information system and a management control system⁷ should lead to success of the contracting function.

THE PURCHASING AND MARKETING OFFICE

The Purchasing and Marketing Office holds a new function in the LHAs' organization, and its relevance is growing while the government is further defining the market-based philosophy of NHS. Purchasing and marketing functions respond to quite different objectives, and setting them together could allow those responsible to develop some ties and create other opportunities. The relationships to develop the acquisition and the delivery process require treating different subjects (internal productive units, external productive organizations, potential producers, services offered by other purchasers...); consequently, the need to deal with peculiar tools and methodologies is an aspect to consider. However, opportunities are highlighted for the LHAs' structure: internal units delivering healthcare services are available, and at the same time, healthcare is supplied by external organizations.

In summary, the purpose of the purchasing function is to define and implement managerial procedures to buy goods and services to deliver healthcare services according to established efficiency and quality standards. The LHAs' marketing function is meant to develop a strategy to promote organizational strengths and to disclose information about the quality of services delivered to the stakeholders. While the two functions could be almost separate in private business, they are not so divided in the healthcare sector. Since the objective of the purchasing activities

involves securing healthcare services produced by other public or private organizations, the purchasing and marketing activities integrate each other.

As a matter of fact, when LHAs develop a plan to contract with a healthcare organization, the LHAs' strengths are highlighted by the marketing office and requirements are instituted to select the best quality services for purchase. From the analysis of the objectives of the new service, it is clear that *purchasing* is meant to directly manage the following:

- Supply contracts,
- Efficiency controls,
- Patient/consumer mobility, and
- Healthcare consultants.

Activities to ensure that health care production meets the standards outlined in the supply contracts should support the supply office. The accreditation process affects Purchasing and Marketing Office activities, and lists the potentially accredited suppliers for healthcare.

The control system has to be considered an essential aspect of the relation between healthcare organizations. Parts of the controls are linked to quality elements, and some others are prescribed by Law Decree No. 502/1992 (Article 8), which states that accreditation relationships with public and private units delivering health care services are based on the acceptance of fundamental conditions concerning price, the definition of an internal quality program, and the implementation of a cyclical system to verify technical, organizational, and logistic characteristics.

LHAs control both private and public accredited organizations according to special protocols to assure an equal level of assistance. On the other hand, producers of healthcare collaborate with the LHA's process of control.

Patient mobility⁹ has to be considered an effect of the patients' free choice of a healthcare organization delivering services; patients assigned to a special LHA could switch to other organizations in an emergency or when the patient perceives that better care may be available from a different organization or when one organization delivers special care for a specific illness. Even if there is a level of patient mobility that could be

considered normal part of the phenomenon can be due to the lack of services production, to long waiting lists, to the patients' perception of inferior quality from one or more provider. The latter hypotheses describe a pathological situation that underlines the presence of critical areas that cannot generate an economic advantage. Clearly, managing patient mobility is an important issue for LHAs. LHAs' general directors should be able to strategically plan relations with a service's producers, to assess the make or buy opportunities, and to decide if services delivered by the different producers fulfill the demand and the quality standards. Patient mobility could increase costs duplication, since the LHA has to finance both its own public healthcare units (where use is not optimum) and other LHAs where its patients effectively receive health care.

Therefore, the task of the purchasing area of the office is to manage the economic, financial, and health activities linked to "purchasing" and "sale" of health care. Included in these activities are the following:

- Analysis of the needs expressed by the community;
- Planning of the healthcare services to purchase and/or to produce;
- Market analysis (including prices and innovative activities);
- Management of patient mobility, from the accounting and political point of view;
- Analysis of the budget of health care providers to buy from independent hospitals;
- Assessment of the quality of ambulatory care and hospital care delivered by other health units;
- Accreditation process;
- Method by which the producer has been chosen;
- Invoice monitoring process; and
- Management of the social marketing functions.

Although the experience of other countries (like the United States) shows the relevance of the implementation of the *marketing function* in healthcare organizations (Kotler & Clarke, 1987), it is new to the Italian Health System. The reform does not mention any activities that the marketing area of the new office could develop. So, the experience

planned at the LHA of Modena defines the marketing activities, as follows:

- “Sale” of healthcare services, meaning the determination of health care parcels to offer to citizens;
- Development of a policy price, which will encourage production of specific healthcare services;¹⁰
- Study of market evolution and trends;
- Healthcare services to offer to satisfy the local population’s health needs; and
- Implementation of a communication policy in order to provide information to the citizenry.

The marketing function to develop in the healthcare sector has a focus of social dimension; it becomes a tool to orient the organization to deliver healthcare services which meet the needs of the community (Cesari & Garofani, 1991; Mele, 1993).

Because social marketing aims for patients’ satisfaction, it is necessary to implement a communication process with citizenry and to define the promotion tools available. The effectiveness of the marketing plan is driven by the culture of the personnel, and by the stability of the relationship between the delivering organization and citizens. The last issue requires definition of the elements determining patients’ satisfaction (timeliness, communication, accessibility, assurance), and the implementation of an accounting information system to monitor these variables.

In spite of the complexity of the healthcare system, and of the quasi-market situation, the marketing function could contribute to the best rational definition of the healthcare service mix to deliver and/or produce; it could allow managers to study the health care life cycle, and influence the efficiency dimension.

CONCLUDING REMARKS

Up to the present, healthcare organizations have not implemented a Purchasing and Marketing Office and most of the observations presented come from the project developed at the Modena LHA. The healthcare system reform did not clearly define the objective of the purchasing and

marketing functions in the quasi-market scenario. However, in order to decrease healthcare social costs¹¹ and healthcare expenditures, and to increase the level of citizen satisfaction with the NHS activity, many tasks could be assigned to the purchasing and marketing function.

The 1999 NHS reform law better regulates the accreditation procedure, the contracting system among public and private organizations, and the management accounting system of the activities of the public or private accredited producers. But nothing has been added to the internal market procurement function.

On the basis of the health care plan, regional authorities will define the general guidelines for contract with particular consideration for:

- The identification of the Region and LHA's responsibilities about the way a special contract has to be developed;
- The healthcare activities' planning definition, specifying the kind of healthcare services to develop; and
- The criteria for the payment of healthcare organizations' output when they produce and deliver more than the quantity established in the contract.

The late 1990 regulation gives more relevance to the development of public-private partnerships in healthcare, and specific attention is given to quality control.

The aim to increase competition and the efficiency levels requires not only improving the healthcare organization's internal accounting system. Since the health policy is changed significantly, the focus on inter-organizational relations management becomes a strategic move. The success of the quasi-market reform requires implementing an effective procurement service. And a successful procurement service requires value sharing and collaboration by all National Healthcare Systems actors.

NOTES

1. In Italy, until the beginning of the 1990s, more than 50.5% of the total national healthcare services was produced by private organizations, and half of them were directly financed by the public system (Ministry of Treasure, 1993).

2. Previous the 1990s reform, in the NHS, LHAs were public institutions without managerial responsibility. They were considered to be the “mechanic arms” of the municipalities.
3. The United Kingdom started the reform of the public healthcare sector in the early 1980s, on the basis of a continuing increase of national expenditure for healthcare services. A quasi-market was defined, as well as the purchasers and providers of health care, on the belief that a market situation would lead to a competition among hospitals and to a recovery efficiency and quality.
4. The financial effects generated by the delivery of healthcare services at a higher level than the national standards and the incidental deficits are faced by the Regional Authorities thanks to their own financial reserves (stocks) and/or through increasing regional fiscal pressure. Therefore, Regions are accountable for their level of expenditures.
5. “Different cultural configurations may attach different explicit emphasis to economic factors and may engage in different forms of economic management and thereby invest differentially in forms of economic calculation” (Hopwood, 1999, p. 377).
6. The Italian commission that stated the principles and proceedings for the accreditation of public and private healthcare organizations started from the definition of quality given by the International Standards Organizations (ISO), and from the rules regulating the Certification and Assurance processes to define the meaning of Accreditation in the healthcare sector.
7. The definition of a cost management system in healthcare organizations should be considered the main point of the process. See Shank & Zoni (1996) and (Zangrandi, 1998).
8. See the annual report about the patients’ mobility developed by the Emilia Romagna Regional Authority where special mobility indexes are defined (Agenzia Sanitaria Regionale, 1998).
9. See the annual report about the patients’ mobility developed by the Emilia Romagna Regional Authority where special mobility indexes are defined (Agenzia Sanitaria Regionale, 1998).
10. One marketing tool that could present persistent application problems in health care is price. What price means and where and

how it can be used as a strategic tool is unclear because of apparent consumer price insensitivity, regulated pricing structures, and characteristic lack of price awareness. In spite of the complexity of the quasi-market situation, health care organizations often allocate fixed costs so as to maximize revenue when reimbursement is cost-based.

11. It is made reference to 'social costs' as the costs that citizenry, patients, families has to pay as a consequence of an organization policy and choice (i.e., the costs that a family has to pay if an health care service is not delivered in a region, for travelling to an other region, for the staying in a city far away from where they live).

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