http://ijhpm.com
Int J Health Policy Manag 2016, 5(1), 75–76

doi 10.15171/ijhpm.2015.192

IJHPM
International Journal of Health Policy and Management

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Cross-Border Mobility in Italy: Some Considerations in Response to the Recent Commentaries

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Citation: Brenna E. Cross-border mobility in Italy: some considerations in response to the recent commentaries. *Int J Health Policy Manag.* 2016;5(1):75-76. doi:10.15171/ijhpm.2015.192
Received: 11 October 2015, Accepted: 21 October 2015, ePublished: 24 October 2015

The paper "Regional incentives and patient cross-border mobility" received three commentaries, each adopting a different perspective on patients' mobility issue. Starting with Neri,[1] the author deeply examines the paper, by considering and commenting each step of the analysis. He notably addresses the main points of the manuscript, highlighting the importance of the institutional framework in which the cross-border mobility (CBM) is considered, and focusing on both the regional strategic incentives and the entrepreneurial behavior of private providers. Unquestionably, the institutional setting plays a main role in the analysis of CBM: the Italian National Health Service (NHS) is characterized by patients' free choice, a decentralized healthcare system based on regional financial autonomy, Diagnosis-related group (DRG) tariffs for hospital services and the co-presence of private and public accredited hospitals, both contracting with regional authorities in order to plan admissions and be funded for them.[2-4] Another feature of the Italian NHS is the different ability shown respectively by Northern and Southern regions in implementing a well-provided Regional Health Service (RHS), as Neri correctly addresses with appropriate references.[5] In such a context it happens that some regions, namely the ones which accredited better endowed hospitals, may take advantage of this situation, not only to respond to resident demands and needs, but also to balance their budget, attracting patients from cross-border. The purchaser-provider contracts implemented with the quasi-market setting of the Italian NHS (1992-1993 reforms), facilitate these strategies, but, as Neri points out, their role is largely undervalued in the current analysis of the CBM phenomenon. Equally undervalued in the extant literature on the Italian CBM – a part from some exceptions[6] – are the stronger incentives for entrepreneurial and opportunistic behaviors standing for private hospitals compared to public ones. As Neri suggests, this topic deserves more investigation, and I agree on the usefulness of qualitative methods ("interviews to regional ministers and managers, private providers and any other subjects who could lead to a better understanding of drivers, features and consequences of patient mobility"), in order to corroborate the hypothesis of our analysis. I also agree with Neri when he indicates the absence of a central government during the accreditation of public and private providers (between 1992 and 1999), as a cause of territorial inequalities in healthcare access, according to a South–North divide. For these reasons, a more active role of the Italian Ministry of Health (MoH) in managing the mobility phenomenon and in leveling healthcare inequalities between South and North, represents a crucial measure to be implemented. Without it, possible solutions to avoid inappropriate CBM mobility are left up to the collaborative behaviors among single regions. To this regard, as Olivadoti and Cislaghi[7] point out, some regions autonomously enacted interregional agreements in order to contain and control the annual patients' flow. The commentary of these two authors provides a brief insight on the Italian CBM topic, which represents a useful integration of our paper. In particular, the following points deserve consideration. In point 3 of the commentary, the authors address the Italian regions' heterogeneity in shape and size as an important variable in CBM analysis: especially for little regions or for patients living near the borders, "boundary mobility" is somehow a structural phenomenon and has to be considered separately in the analysis (as we actually did). Another interesting aspect emerging from Olivadoti and Cislaghi's commentaries refers to the fact that some people actually live in a region (mainly for study or job motivation), but maintain the residence in the native region (point 6 of Olivadoti and Cislaghi). In this case, the choice to be admitted in the region where a patient is domiciled is not due to a perceived better quality of care, but to practical aspects. Surely this issue warrants more investigation, in particular when examining mobility of people that choose to be hospitalized in regions where progeny, parents or other relatives live. Notwithstanding these considerations on patient choice, the financial question, namely the monetary flow following people admitted outside their resident border, stands. The two authors also correctly highlight the unequal allocation of resources among regions due to patients' migration within the Italian NHS; and produce some commentaries on the private/public hospital choice by patients too. With regard to this last point, in our analysis we only considered admissions in hospitals accredited by the NHS, which means both private and public hospitals, recognized and paid by the NHS. Within our sample, we could indeed observe the patients' preference toward public/private structures, thanks to the availability of data provided directly by the MoH. Finally, the suggestion of introducing a co-payment to disincentive individual mobility represents an interesting solution that deserves more investigation, in order to preserve equity within the Italian NHS.

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The third commentary, by Legido-Quigley,[8] discusses the issue of universal health coverage within member States. It mentions Brenna and Spandonaro analysis at the very beginning, and subsequently opens a debate on free healthcare access within European States. Although this topic is undoubtedly a very interesting one, it goes far beyond the aims of our study, so I will be glad to consider and comment it in other possible circumstances.

Ethical issues

Not applicable.

Competing interests

Author declares that she has no competing interests.

Author's contribution

EB is the single author of the manuscript.

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