The financial crisis in Italy: Implications for the healthcare sector

Antonio Giulio de Belvis, Francesca Ferrè, Maria Lucia Specchia, Luca Valerio, Giovanni Fattore, Walter Ricciardi

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Italy has a tax-funded National Health Service (Servizio Sanitario Nazionale, SSN) that guarantees the universal provision of comprehensive care throughout the country.

Ministry of Health

Government-Regions Committee

Patti per la salute

(3 years)

Regions

LEA

Resource allocation

Policy and planning frameworks

Organisation

Delivery of services

Background

2001–2010 period → 38 billion € of deficit

(4.2% of total expenditure)

↓

69% Lazio - Campania - Sicilia

• The SSN is largely funded through national and regional taxes supplemented by co-payments for pharmaceuticals and outpatient care.

• In 2010, 78.4% of healthcare funding derived from public sources, and the remainder was private, mainly in the form of out-of-pocket payments (especially for pharmaceuticals, outpatient care and dental services).

• Only about 3% of the total healthcare expenditure was funded by private insurance

Global recession

	Italy	European union (27 countries)	
2008:	-1.2%	+0.5%	
2009:	-5.1%	-4.3%	
2010:	+1.5%	+1.8%	
2011:	+0.7%	+1.6%	(prediction)

+ Italy maintain positive public primary deficits (that is, the difference between revenues and public spending, not including interest payments)

+ Italy have one of the lowest stocks of private debt among the EU countries

- Italy has a high debt/GDP ratio, approximately 100–120%, which has been stable over the last decade but requires 3–4% of the GDP for interest repayment.

Global recession

• the slow economic growth restrains both public and private health sector expenditures, making it difficult to meet the health needs and expectations of the population

• a significant national debt stock implies the need to improve public finances to avoid default

The article

• summarises some macro-economic figures

• reports available evidence about the effects of the crises

• analyses Italian health policy for the last two years

• provides reflections on policy options

Funding and healthcare expenditure

• Since 2007 ten of twenty-one regional health systems have adopted

"**Piani di rientro**"

Piemonte, Liguria, Abruzzo, Molise, Lazio, Campania, Puglia, Calabria, Sicilia and Sardegna

Between 2006 and 2011, the regional health systems that were subject to recovery plans reduced their healthcare expenditure in real terms by 0.6%, compared to an increase of over 9.4% in the other regions

• In 2010, the total deficit of the public healthcare sector was 2.33 billion, which is approximately one-third of the peak in 2004 (€ 6.42 billion) and is estimated to decline by 0.2 billion in 2011.

• In 2010, 108.842 billion in public funding was available for healthcare, an average of 1.803 € per capita.

Funding and healthcare expenditure

Table 1
Italian public and private healthcare expenditures, funding and deficit 2001–2010 (Million Euros).

	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Public health care expenditure (Million Euros)	77,686	79,549	82,290	91,222	96,797	99,615	103,805	107,138	110,219	111,168
Over the previous year %	10.7	2.4	3.4	10.9	6.1	2.9	4.2	3.2	2.9	0.9
% on GDP	6.2	6.1	6.2	6.6	6.8	6.7	6.7	6.8	7.3	7.2
Funding (Million Euros)	73,908	76,658	79,967	84,800	91,062	95,131	100,095	103,669	106,967	108,842
Over the previous year %	10.4	3.7	4.3	6.0	7.4	4.5	5.2	3.6	3.2	1.8
Deficit (Million Euros)	−3778	−2891	−2323	−6422	−5735	−4483	−3709	−3469	−3252	−2326
Over the previous year %	17.0	−23.5	−19.6	176.5	−10.7	−21.8	−17.3	−6.5	−6.3	−28.5
% on funding	−5.1	−3.8	−2.9	−7.6	−6.3	−4.7	−3.7	−3.3	−3.0	−2.1
Private health care expenditure (Million Euros)	23,622	25,155	25,981	26,613	27,285	27,841	28,303	29,244	29,750	30,591
Over the previous year %	−3.1	6.5	3.3	2.4	2.5	2.0	1.7	3.3	1.7	2.8
% on GDP	1.9	1.9	1.9	1.9	1.9	1.9	1.8	1.9	2.0	2.0
Total healthcare expenditure (Million Euros)	101,308	104,704	108,271	117,835	124,081	127,455	132,107	136,381	139,969	141,759
Over the previous year %	7.2	3.4	3.4	8.8	5.3	2.7	3.6	3.2%	2.6	1.3

Source: Adapted from Relazione Generale della Situazione Economica del Paese (RGSEP) 2010 and Minister of Health and Finance and ISTAT (Italian Bureau of Statistics) 2011.

Funding and healthcare expenditure

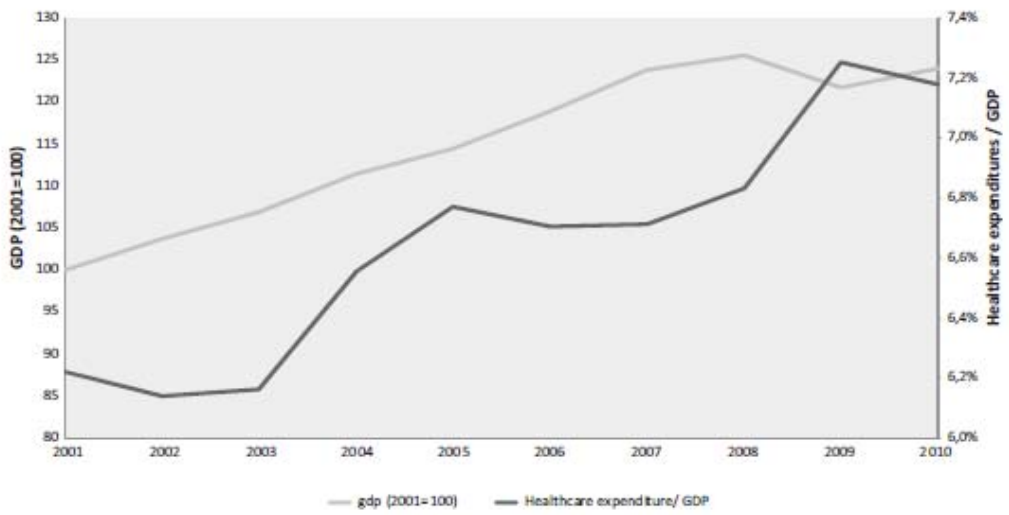

Fig. 1. GDP (2001 = 100) and public healthcare expenditure/GDP ratio (2001–2010).

- From 2007 to 2010, the average public healthcare expenditure growth rate was 2.3%, compared to 5.1% in the 2001–2006 period.
- In private expenditure may be two contrasting forces:
  - the crisis reduces disposable income and, thus, privately paid demand
  - because of cost containment policies in the public sector, patients may be forced to pay higher co-payments or to go fully private.

Policy responses to the economic downturn

• When the crisis began, Italy had already been struggling for years to tighten control over regional spending, and restrictive policies of cost containment were already in place.

[2] Restrictive policies include the introduction of regional prescription charges; the adoption of extensive efficiency mechanisms on goods and health services procurement; the inclusion of more stringent quasi-market contracts with private health care providers; a partial block of personnel turnover and incentives for early retirement; the reclassification of drugs that are charged to the INHS; the introduction of extended forms of co-payment; the imposition to increase mark-ups to the regional tax rates (e.g., business tax IRAP; surtax on the national personal income tax IRPEF and vehicle tax); and the rationalization and reconfiguration of hospitals together with incentives to sell properties [10].

The main effects of the global financial crisis on Italian healthcare policy accelerated ongoing policy changes rather than triggering the introduction of radically new ones.

2010–2012 Health Pact

• reduce the number hospital beds (4 beds per 1000 population vs. 4.5 currently)

• hospital admissions (by increasing the use of appropriateness criteria to avoid unnecessary admissions)

• the average length of stay.

Policy responses to the economic downturn

• the number of hospital beds was reduced to 4.2 per 1000 in 2009, reaching a ratio that is well below the European average of 5.5 per 1000 inhabitants.

• the national government cut central transfers to regions and local governments for disability, childhood, migrants and other welfare policies.

• This reduction in central funding was compensated primarily by higher co-payments and cost-saving measures to reduce pharmaceutical expenditures.

• Beginning in October 2011, regions had to introduce a €10 co-payment for visits to public and private accredited specialists and a €25 charge for visits by patients aged 14 or older to hospital emergency departments that are deemed inappropriate.

• the national government allowed regions to decide whether to apply these copayments in full or to enact regional rules that allow for varying co-payments according to gross family income or service tariffs.

Pharmaceutical expenditure

- 12.5% reduction in the prices of generic drugs
- the adjustment of reimbursements for generic drugs to the average European level
- the introduction of a system to monitor pharmaceuticals to compare regions and identify benchmarks
- controls over hospital budgets for pharmaceuticals through the centralisation of procurement procedures
- changes in the distribution channels
- for NHS-covered drugs, the reduction of prices and margins
- use of pay-for-performance schemes
- the introduction of price revisions according to scientific evidence of efficacy.

The effects of the economic downturn

• At the end of 2011, 18.2% of Italians are “at-risk of poverty” and 6.9% are in conditions of material deprivation according to EUROSTAT definitions. (France: 13.5% , Germany: 15.6%).

• In the age group “younger than 18”, the rate is 24.7% in Italy, compared to 18.4% in France and 17.5% in Germany.

• Inequality, as measured by the Gini index, is stable at 0.31, the same value as in 2009 and 2008, and is substantially aligned with the European average of 0.30. However, interregional variability is significant, with Southern Italy scoring 0.32 and Central-Northern Italy scoring 0.29 above and below the European average, respectively.

• 21% of households declared that they had decreased their health-related expenditure for reasons connected to the financial crisis, and 10% had postponed surgical treatments for financial reasons.

• the percentage that described themselves as willing to pay more taxes in return for better services plummeted from 57% in 2009 to 12% in 2011 (in Germany fell from 80% to 38%)

The effects of the economic downturn

It is too early for available systematic information about the incidence rates of diseases that can be co-determined by the economic crisis and by higher barriers to access to healthcare, especially for major categories of diseases, such as chronic and infectious diseases.

• Mental disorders, reduced access to dental care (even for children) and diseases associated with poverty (notably, edentulism)are increasing.

• Decrease in the intake of fruit, vegetables and fibres

• Decrease in the time spent in sports/physical activity (especially in the Southern Regions)

• Increase in unhealthy practices, such as the consumption of junk food and alcohol abuse, among youths and women.

• increase in suicides and deaths related to alcohol use. Italy seems to confirm this hypothesis: sudden increase of 5.3% in suicides in 2008 (3.799, compared with 3.607 suicides in 2006 (but Greece: +17%, Latvia: +17%, Ireland: +13%)

The enforcement of higher co-payments is a first major and visible consequence of the effects of the crises.

The effects of the economic downturn

• Increased co-payments imposed on a population already affected by the labour market crisis combined with longer waiting lists and emergency departments suffering from a lack of personnel and staff have led families to delay important medical care.

• In 2010, a 1 € billion cut to investments in recovery of hospital buildings and technological turnover was mandated by the central government.

• High risk for the safety of health workers and patients because most Italian hospitals are rather old (approximately 70 years old, on average). Recent data have also highlighted a major consequence of funding cuts: the SSN personnel decreased by 0.8% from 2009 to 2010.

• A number of consumer surveys conducted in 2010 found that the number people who believed that the healthcare systems in their regions had worsened in the previous two years was almost three times the number of those who believed that these systems had improved.

• Additional and more severe policies aimed at the most indebted Regions may contribute to increasing the existing regional health inequalities across the country.

Current policy options

- According to the 2011 estimates based on government projections, the amount of additional private expenditure due to the higher copayment for services provided by the SSN could reach € 4.5 billion by 2012 (about € 140 per Italian).

1. Designing interventions specifically targeted to support the poorest households should be the first priority of Italian health and social policy.

- The increase in copayments could also be better organised.

2. The national government, regions and healthcare organisations should prioritise actions that can counter the reduced demand for health services and prevention programs. Priority should be given to financial coverage of existing programs for the promotion of healthy lifestyles and preventive medicine (such as programs to increase vaccine coverage) that rely on general practices, and additional effort should be devoted to their timely implementation.

3. The European Commission put “depression and suicide prevention” among the five priorities identified by the European Pact for Mental Health and Well-being. The Italian “National Plan for Prevention 2010–2012” also included suicide prevention among its main intervention areas. The provisions included in the plan must be implemented rapidly.

Current policy options

- An effect of the crisis could be to furtherwiden regional differences.

4. In all regions (and based on a stronger central role in this respect), the financial crisis can serve to hasten the Health Technology Assessment agenda, which lags in comparison with the initiatives of a number of EU member states.

- Expenditure cuts should not be linear; rather, they should focus on activities with lower priority and value, introducing more limitations to expensive services that may be ineffective or not cost effective and ensuring that a minimum of resources are maintained to sustain innovation.

- Urgent innovations include pilot examinations of the adoption of appropriateness measures, investments in information systems, and organisational arrangements that integrate primary, secondary and social care.

5. It is essential that in such a period of public funding constraints health authorities monitor incidence of diseases and access to care of the most vulnerable groups and specifically target interventions to those who may be disproportionally affected by the crisis.