

Health & Hospitals in Italy - 14th annual report

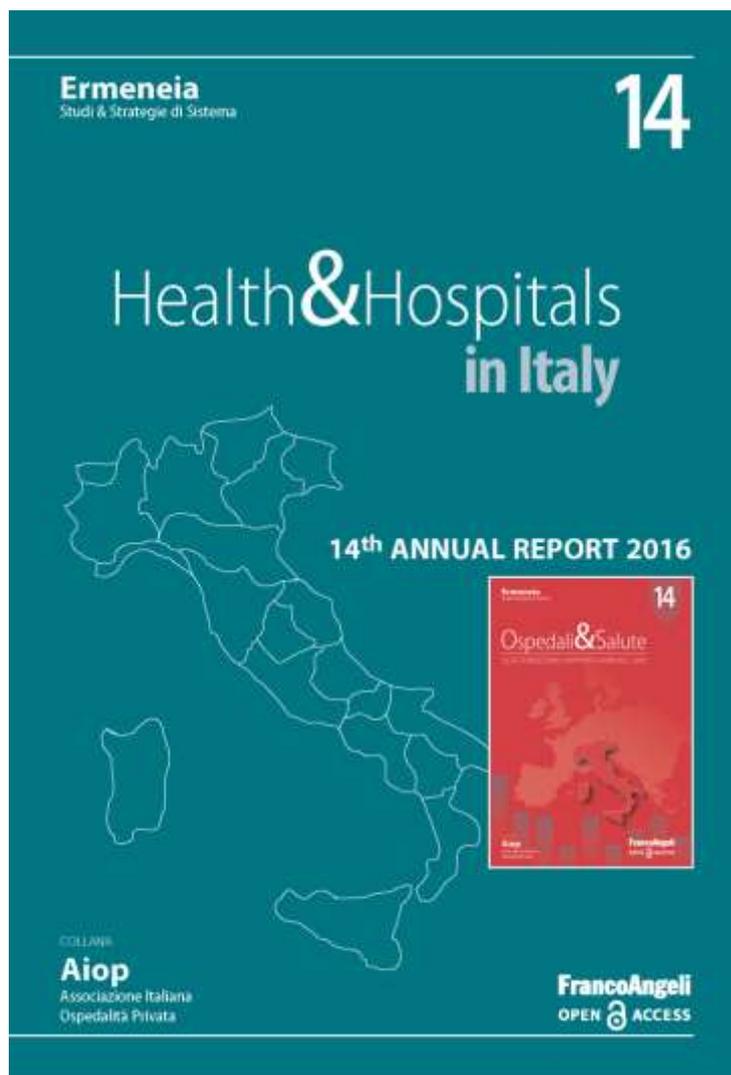
The primary objective of AIOP (Italian Association of Private Hospitals) is to contribute to improving knowledge of the Italian health system at an international level, by providing European institutions, professionals and scholars with data and assessments, which in some cases also relate to 2016.

The English version – Health & Hospitals - is an abstract of the Report on “OSPEDALI & SALUTE”, the 14th edition of which was presented to the Senate of the Italian Republic in 2017.

The abstract highlights major health issues which have emerged in the last year, and analyzes supply and demand issues, focusing in particular on the quality of services and on citizens' opinions, as expressed in a special survey. Moreover it provides a set of indicators regarding equipment, information on hospital activities and expenses, as well as a complete sample of data for the Italian hospital system as a whole.

The introduction written by the President of AIOP, Gabriele Pelissero, concerns the increasing difficulties of the NHS to provide adequate answers to the services demand of citizens and the fundamental role of “the network of AIOP affiliated hospital centers present in all Italian regions providing tens of thousands of hospitalization and ambulatory services to patients who ask for them with confidence, and have demands that go beyond what the hospitals are allowed to offer.” The President Pelissero underlines that in the present political and economic situation “the restoration of the freedom of choice of place of care for all illnesses and for all regions also means triggering a virtuous mechanism that, combined with a real, general application of payment for service in the financing of all public and private providers, may encourage investment, virtuous competition, and the development of excellent centers and networks, contributing decisively to keep the whole NHS in line with the best European health and welfare systems.”

We publish the summary signed by Nadio Delai, President of Ermeneia, the independent research institute charged of the annual report by AIOP. The whole text is available at the UEHP Bureau in Brussels.



INTRODUCTION

First of all we are faced with a process of deflation from underfunding, which, for example, can be seen in the last three years, given that public health spending in Italy is firmly locked at 6.8% of GDP, while that of G7 countries is significantly higher and growing (8.2%). There is also the aggravating circumstance that the Italian GDP has recorded “minus” signs year by year, due to the crisis and the consequent policies (except for a + 0.4% in 2015). And this was also true for overall public hospital spending, fixed at 3.9% of GDP in Italy . But there is also a process of additional deflation from inefficiency, since the public hospital system cannot “free” resources as it could, if it were able to significantly revise its current organizational and management methods: thereby allowing it to invest the reclaimed resources to improve facilities, equipment and services to users...The difficulty of the public hospital system to undertake effective restructuring and reorganization according to a more efficient logic feeds a further deflation process following the transfer of economic and regulatory burdens to entities offering accredited private hospital services as a whole. It is worth mentioning in this regard that the hospital costs for such entities decreased – between 2010 and 2014 – by 4.8% compared to an increase, albeit slight (+ 0.8%), of the costs for public hospital facilities. But it should also be pointed out that the latter account for 86.2% of total public hospital spending, compared to 13.8% for all accredited private hospitals, which, however, provide 28.2% of total hospitalization days. And the objection – sometimes put forward – that accredited private facilities somehow take away resources and for the most part provide low-complexity services, makes it necessary to clarify how in reality:

- these structures contribute in no small part to safeguarding the different territories of the country, given that they provide 23.3% of total admissions for acute cases in Italy (in 2014), and account for much higher shares in individual regions such as Lombardy (30.4%), Puglia (32.4%), Campania (34.1%) and Lazio (45.9%) . Not to mention that it is the public hospital system itself (not just users) that takes the initiative, resorting to accredited private facilities to make up for a shortage of patient beds or in order to free up bed spaces (in highly specialized cases) when dealing with a demand which it has no means to satisfy in acceptable terms and/or in an appropriate manner;
- moreover, private accredited facilities offer services that are on average of higher complexity than those which of public hospitals: 17.5% of hospitalizations at accredited facilities are of this type, compared to 13.9% for public hospitals, to which it must be added that this situation occurs in almost all Italian regions .

But it is clear that systematically transferring additional economic burdens to the accredited component would ultimately trigger an erosion of the services it provides to users.

And finally, there is a process of deflation from the de facto rationing of the services offered within the public hospital system. This system has in fact suffered the impact of the spending review measures that have been applied in these years of crisis (within the context of austerity policies) and has not been able to incorporate significant amounts of efficiency, also due to the well-known rigidity inherent in the public system (starting from legislation relating to personnel). And the result has thus taken the form of a rationing of services aimed at patients in different ways, namely:

- on the one hand, that of supply reduction, seen for example, in the period 2009-2014, in the decrease of the number of patient beds (-9.2%), the decline in the number of hospitalizations (-18.3%), and the decrease in patient in-hospital days (-14.0%); these trends almost certainly include a drive towards greater appropriateness of service and facility reconciliation with international standards, but this was accompanied by a decrease, delay or deterioration of the services provided, also accentuated by the progressive reduction of staff, which decreased by 45 thousand units (-9.0%) between 2010 and 2014 (especially as a result of the failure to replace retired personnel) ;
- and, on the other hand, to an increase in costs for users (co-payment charges, use of paid *intra-moenia* services, use of private services, increase in additional regional income taxes and the lengthening of waiting lists): with the result of driving patients and their families to seek alternative solutions at accredited hospitals or completely private institutions, going to hospital facilities in regions other than the one they reside in, or even postponing or doing without care, the latter – among other things – fuel concerns (to be evaluated) about the possible deterioration in the medium term of the population’s health status .

In addition to the foregoing information, it appears that debt rescheduling plans have applied the economic and financial logic, which has as its primary objective the reduction of costs. But this has had an even more pronounced impact on the quantity and quality of services. The separation of “financial” and “real” healthcare might have improved the maths, but at the expense of the services provided to patients.

At this point we must take note that we are walking a tightrope, as it cannot reasonably be expected to permanently manage a model based on a deflationary process that is reinforced by the ongoing accumulation of user dissatisfaction, with the risk of a possible disintegration of the universal and inclusive principle which – at least formally – continues to be reaffirmed as the basis of the National Health System.

It is thus necessary to repair the latter and render it capable of reinterpreting the aforementioned principle in view of:

- an inevitable growth of demand for services due primarily to the progressive aging of the population, but also of other factors associated with greater information flows that create ever larger and widespread expectations (and which are not necessarily always well-founded) among users;
- the availability of hopefully greater economic resources (perhaps more comparable to those of other countries similar to ours), although it is more likely that we are in a situation of non-automatic increase and that it remains consistent with the increase in demand;
- a gap between top facilities, which feature high quality services, and intermediate facilities that do not always manage to ensure acceptable quality and availability of services offered (and a “holding” system that sees the excellent level of some hospitals rest on an acceptable middle ground);
- and finally, the existence of significant internal differences between similar hospital facilities (whether of high or medium quality) as regards their efficiency and capacity on the managerial front and ability to achieve adequate clinical results.

Consequently, we must develop the ability to do more and better with less, thus managing to free up resources, presently “blocked” by the difficulties of undertaking a substantial restructuring and reorganization of public facilities. In this context, greater transparency of the financial statements of public facilities would help to measure, year by year, the management review commitments actually put in place and allow for more adequate comparisons between the services of public hospital facilities and accredited private ones. Although to date there has been an accumulation of regulatory control, as well as verifiability and certification policies, which are not automatically followed by necessarily consistent behaviour.

In conclusion, we must rethink the very Healthcare Pact as it relates to the protection and promotion of health, in order to take account of changed conditions, with a more pronounced trend in demand oriented towards continued growth and with a system that is too stiff in the way it operates, as well as the reduced availability of public financial resources.

To do this it will be necessary to take an evolutionary path that, beyond creating efficiency, leads to forms of Neo-Welfare, which brings together the responsibilities and resources of the public alongside with the responsibilities and resources of citizens (individuals and groups), businesses (again, individuals and groups), the world of interest groups and non-profit organizations: the aim is to redesign a system to protect and promote health that will continue to respect the universal and inclusive principle, but is also compatible with the conditions in which we live today and that we will live in to-morrow.

We must therefore get out of the deflationary trap that today is punishing the most vulnerable users and undermining the system through its de facto progressive deterioration (as well as in the perception of the people), especially when you consider the services provided by average facilities.

The attempt to bring together the needs of citizens with the (renovated) solutions of the NHS is – and it is worth repeating – a fundamental part of the necessary reconstruction process of the role of institutions, whose adequacy is essential to re-establish consensus and trust between citizens and the ruling classes, which today more than ever seem to be in particularly bad shape.

Nadio Delai, President of Ermeneia