

The impact of the three crises on health in Italy: evidence and lack of adequate information systems

Giovanni Fattore

Abstract The crisis currently hitting several European countries has special features and is posing unprecedented challenges to national governments. Although several European countries are facing this situation, Portugal, Italy, Greece and Spain have several features in common in this difficult situation and can be analysed comparatively to identify common health trends and health policy responses. This contribution provides an overview of these countries and suggests some reflections about their policies. Although evidence is limited, there are clear signals that the crisis is impacting people health, due to both harder social conditions and reduced supply of services. So far these countries have made very limited attempts to use the crisis to significantly increase efficiency and effectiveness in the delivery of health services.

1 Introduction

The crisis currently hitting several European countries has special features and is posing unprecedented challenges to national governments. A significant number of European economies are facing a fall, or at best a stagnation, of GDP and an increase in unemployment rate, particularly in the younger segment of the population. For some of these countries, including Italy, this crisis follows a long period of modest economic growth and gradual loss of competitiveness in many salient industrial sectors. The public finance crisis makes the economic crisis harder as it is forcing governments to do anti-cyclical interventions. Started after the massive use of public spending to bail out major financial institutions at risk of bankrupt, the public finance crisis has forced government to take action to reduce government debt and deficit while they are striving to contrast the economic downturn. Although several European countries are facing this situation, Portugal, Italy, Greece and Spain have several features in common in this difficult situation and can be analysed comparatively to

identify common health trends and health policy responses. This contribution provides an overview of these countries and suggests some reflections about their policies. Although evidence is limited, there are clear signals that the crisis is impacting people health, due to both harder social conditions and reduced supply of services. The four governments appear to react in a similar way, with significant increases in copayments and cuts in the supply of services. So far these countries have made very limited attempts to use the crisis to significantly increase efficiency and effectiveness in the deliver of health services.

2 The case of Mediterranean Countries

Greece

The huge public debt of Greece and the lack of confidence of financial markets in the solvency of its government have driven EU and international action to arrange a “soft” default and to force the country to adopt severe measures to reduce public expenditure. However, whether these interventions will succeed and make possible to maintain Greece in the Eurozone area is still uncertain. The critical situation of health and healthcare of the country is documented by an article published in the Lancet recently (Kentikelenis et al. 2011). Perceived health status has worsened, suicide rates has increased by 17%, violence has risen and homicide rates has doubled between 2007 and 2009 and HIV incidence is reported to have increased in late 2010. Although these figures should be taken with some caution, they suggest a tragic situation where the crisis is impacting people health, especially of those who are more vulnerable. The crisis seems to impact on people health for two reasons. The first concerns the general determinants of health. Greek people are more at risk of major events causing ill health, as rapid impoverishment and job loss. Evidence from other economic crises show that unemployed individuals are at higher risk of suicide, mental disorders and cardiovascular diseases (Khang et al., 2005) and that unemployment is associated with 20/25% increase in overall mortality (Moser et al., 1990; Berthune, 1997; Marmot e Ruth, 2009).

The second reasons why the economic crisis is having negative effects on people health concerns access to care. Recent data show that there is a significant increase in the number of individuals that did not go to a doctor or a dentist despite feeling it was necessary (Kentikelenis et al. 2011). Patients give up seeking care due to waiting time or other barriers to access to health facilities, including informal payments to professionals. Access to care is increasingly limited by major cuts in public healthcare funding. The 2011 budget for healthcare was decreased by €1.4 billion, with €568 million saved through salary and benefit-related cuts and €840 million saved through cuts in hospital operating costs. The target is a reduction of 0.5% of public expenditure over the GDP. On the other side, social insurance contributions and copayments have been significantly increased.

Overall, the Greek government is introducing exceptional measures to reduce public expenditure and to raise extra money to fund the system. Most of these measures, like salary cuts and reduction in coverage, may produce negative long-term effects on the

overall functioning of the systems and quality of health care. However, the crisis did drive some action to reform a system that had severe problems even before the crisis.

Portugal

In Portugal the financial rescue plan details a number of adjustments to be made in the Portuguese National Health Service. Main measures do strive for more than just short-run expenditure savings with mechanisms for future control of health care expenditures in the public sector, including performance assessment and benchmark, the use of competition forces in public procurement, and the introduction of best practices in transparency and information in the evolution of the National Health Service (Pita Barros, 2012). However, the focus of government policy and media attention is on the most visible and short-term effects of these policies, namely the increase of co-payments. Also, clear implementation of the measures with long-term structural effects do not appear to have high priority in the policy agenda

The new Portuguese co-payment policy has two main elements. The first is a significant increase in the level of copayment, which potentially creates an access barrier to health care. The second element is a relevant increase in the exemptions to user charges, targeted to low-income and other vulnerable segments of the population. The first element, consistent with the attempt to raise resources and moderate the use of pharmaceuticals, may be offset by the second. It is difficult to predict the net effect of the policy. Likely, its financial effects will not be so substantial to correct the financial situation of a country needing to reduce public healthcare expenditure by 8% in the short run. While in Portugal the financial crisis has revamped the need of major interventions to modernize the healthcare system, it is still too early to understand if the implementation stage is sufficiently backed by the government and whether the measures launched so far are sufficient. It appears that the planned cuts are unlikely to produce the financial savings required to face the crisis.

Spain

Spain crisis is mainly due a low economic performance (and especially a very high unemployment rate), structural imbalances between government revenues and spending (partly due to low taxation rates compared to other EU members states) and high interests payment on the government debt, which is anyway lower than of the EU average. Over the last two years, Spain has introduced several measures aimed at improving the financial situation. Overall, the measures have been poorly coordinated and have not been part a strategic approach nor a common framework for action (Gené-Badia et al., 2012). The main measures in the healthcare area taken by the Spanish government to face the crisis are as follow: a) a 5–7% salary reduction for most health care personnel, b) the introduction of mandatory generic prescribing by medical doctors and c) price reductions of pharmaceuticals. On top of these measures, given the decentralised nature of the Spanish healthcare system, autonomous communities are called to adopt significant measures to reduce the budget for health care. For example Catalonia, one of the most affluent regions of Spain, reduced by 6.8% the budget for healthcare from 2010 to 2011 and, in order to reduce so significantly its expenditure, terminated several thousands of labour contracts, significantly reduced hospital activities (about 3,000 beds were made not operational

in summer 2011), reduced by 5% the budget allocated to private providers, closed primary care out-of-hours emergency services in Catalan rural areas and cancelled all new investment decisions.

It is too early to detect the effects of these measures, but the expectation is that they may have a significant effect on population health (Gené-Badia et al., 2012; Dávila Quintana and González López-Viccarcel, 2009). In Catalonia, in just six months surgical rate was reduced by 6% and people in waiting list increased by 23%. Overall, it appears that the Spanish and the autonomous community governments are acting seriously to reduce public spending, although it is unclear whether these cuts will be enough to overcome the crisis. While probably effective from a financial perspective, these measures may have long term negative effects on the overall performance of the healthcare system and “the crisis situation is not being used as an opportunity to implement reforms needed in the health care system, both on the delivery and the finance sides” (Gené-Badia et al. 2012, p. 27).

Italy

As for the other countries analysed in this contribution, Italy faces a difficult situation characterised by two intertwined issues. On the one hand, the economic recession restrains both public and private health sector expenditures, making it difficult to meet the health needs and expectations of the population. On the other hand, the high national debt stock impels to improve public finances to avoid default, thus forcing unprecedented public spending cuts. In response to the financial crisis and the stricter public budget imperatives of the European Commission and the European Central Bank, the national government has introduced national cost-containment measures and has reduced transfers to regions and local governments. 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. Exemptions defined by the Ministry of Health for low-income, disabled, aged and chronic patients remain in place; however, these copayments were added to existing tariffs, placing a significant additional burden on patients. New cost-saving measures to reduce pharmaceutical expenditure were also introduced (see De Belvis et al. 2012 for details).

It is estimated that overall NHS expenditure in 2011 was lower than in 2010. In addition to the effects of national policies, control of expenditure was achieved mainly through policies autonomously adopted by regions. The budget for 2012 has not been finalised yet as it is expected that the Treasury requires additional cuts to those already planned as a part of general spending review launched by the new government.

While some measure to face the crisis are taken by the national government and imposes common rules across regions, most of actions are decided by regions thus creating large disparities. For examples, given a national framework for co-payment policies the implementation stage has made possible to make major differences. While some regions maintain charges irrespective of income (provided that low income citizens are exempted by its payment), other have graduated payments according to income groups. In some regions now co-payment for outpatient care is very substantial and may be close to the price of the service in the private market, where “low-cost” initiatives are on rise (Del Vecchio and Rappini, 2011).

Clear signals of discomfort are still difficult to ascertain. Yet, data are beginning to emerge. Case reports and interviews with specialists and primary care doctors point to a deterioration of health indicators. Mental disorders (Lora et al. 2011), reduced access to dental care (even for children) and diseases associated with poverty (notably, edentulism) are increasing. Furthermore, there is recent evidence of a decrease in the intake of fruit, vegetables and fibres, a decrease in the time spent in sports/physical activity (especially in the Southern Regions) and an increase in unhealthy practices, such as the consumption of junk food and alcohol abuse, among youths and women (Ricciardi and De Belvis 2011).

3 Discussion

All the four countries reviewed are facing a critical situation and striving to reduce significantly public healthcare expenditure in real terms. In all countries co-payments are an important element of these policies. In the two countries with a decentralised system (Italy and Spain) most of the savings derive from a reduction of resources transferred to regions. National governments shift the responsibility (and the blame) of cost containment to lower tiers of government and may produce significant disparities across regions. This review reveals that the health systems of these four countries are facing the crisis and are targeted by cost-containment measures. But it also reveals what countries are not doing.

First, we are not aware of any attempt to pay special attention to the most vulnerable segments of the society who may be disproportionately hit by the crisis and may at high risk of significant health losses. These systems have no activities in place to detect vulnerable individuals (e.g. those who lose their job) and have not introduced any device to assure that accessibility of care for the most vulnerable individuals is protected by additional barriers created by higher copayment and reduction in the provision of publicly funded health care. While there are clear signals that the crisis is having a serious impact on equity in both funding and access to care, no counter-acting measures have been introduced.

Second, the measures adopted by the counties appear short-term and focussed on reducing public spending rather than improving the system in terms of efficiency and effectiveness in the long term. For example, in any of these country it is reported an effort to revise the basic package to focus delivery of services on those services that are more effective and efficient. The use of Health Technology Assessment to better govern the introduction of new expensive technologies, to prioritize interventions and to plan disinvestments, is clearly overlooked. Cost cutting measures are not based on “rational” strategies to focus public resources where the value for money can be maximized. Similarly, there are no attempts to better plan healthcare delivery to reach economy of scale and economy of specialization. Rather than closing small, often inefficient and sometimes ineffective, points of care, measures tend to reducing funding across the board. While the crisis may offer a “window of opportunity” for unprecedented unpopular action, the search for immediate spending is probably prevails. Often, full protection of the interests of government employees and businesses contracting with the public sector prevails over the interest of using better public resources.

Greece, Italy, Spain and Portugal are striving to significantly reduce public healthcare expenditure in a situation that, at June 2012, is still very uncertain, with a systemic

crisis of the Euro zone possible and their economies still in recession. In the next months it is likely that additional measures will be necessary to meet even more stringent budget constraints. Without appropriate actions to improve the performance of their systems these countries are imposing a high costs to citizens, especially those who are more vulnerable, and are missing the opportunity for long-awaited interventions.

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