CORTE DEI CONTI

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THE ANALYSIS OF THE CORTE DEI CONTI ON THE HEALTH POLICIES

The Choices After The Rebalancing

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Presentation Scheme

1. The different kind of controls of the Corte dei conti in the field of public health.
2. The last analysis on the healthcare policies: the choices after the rebalancing
   - 2.1. The last analysis
   - 2.2. The rebalancing
   - 2.3. Reduction in Services offer
   - 2.4. Disparities among local areas offer
   - 2.5. Measures adopted and open questions
   - 2.6. Future risks
   - 2.7. The choices after the rebalancing

1. Introduction: the different kind of controls of the Corte dei conti in the field of public health

Corte dei conti plays a specific role

- deriving from being an autonomous and independent judiciary body
- and thanks to its central and territorial organization.

This aspect is particularly relevant in the **Italian National Health Service (SSN – Servizio Sanitario Nazionale)**, because almost all levels of government are involved in the "health system": State, Regions, healthcare Authorities and municipalities.

According to the principle of subsidiarity, the health and care service is organized in different levels of responsibility and government:

- **central level** - the State has to act as guarantor for the citizens to ensure that their health rights are fully and uniformly respected through the Essential Levels of Assistance (Livelli Essenziali di Assistenza - LEA);

- **regional level** - the Regions have direct and exclusive responsibility for the management and the expenditure to achieve the country's health objectives.

The overall level of resources available to the National Health Service (SSN) is established annually by State law; **to finance the health system contribute**:

- the **State** through the revenues of the National Health Service authorities (tickets and revenues deriving from the intramoenia activity) and through other items of the State budget (participation in VAT, excise taxes on fuels and National Health Fund);

- in addition to the **Regions** taxation (IRAP - Tax on Revenues deriving from productive activities - in the income component allocated for health financing and Additional regional Personal Income Tax).

Almost all the resources allocated are dedicated to the **Essential Assistance Levels (LEA)**, namely, the services and standard services that the National Health Service must provide freely or jointly through the resources acquired thanks the tax system to every citizen.

The LEAs themselves are redistributed allocating:

5% to the individual and collective prevention;

45% to hospital assistance;

50% to territorial assistance.

Each Region must use its own resources for higher levels of care than those provided for in the National Health Plan, and also to cover any operating deficits of the health authorities.

It is a complex system that the Corte dei conti is able to audit, both at accounting and performance level, as well as with regard to the analysis of the health policy which is a major point of interest in this context.

- The **accounting and performance audit** is concentrated at the local level, and carried out by the Regional Audit Chambers on the Regions and on the individual Health Authorities, also in synergy with their internal bodies.
- Instead, we find the main analyses on Public Health Policies in a **Report on the "Coordination of public finance"** which concerns all levels of government. This document underlines the comparison between the results available on the previous financial year and the programmatic objectives for the current year, considering the revisions already occurred on both the programmatic path and public finance measures.

2. The last analysis on the healthcare policies: the choices after the rebalancing

2.1 The last analysis

Also the last report, soon to be published, has dedicated, as usually, a considerable attention to the analysis of policies on healthcare matters and highlighted some aspects here summarized.

2.2. The rebalancing

- In the international comparison, Italy recorded a reduction, in real terms, of the resources allocated to healthcare by 3 tenths of a point per year between 2009 and 2016.

- In 2016, the total healthcare expenditure is the 8,9% of the Italian GDP. Three-quarters of the Italian healthcare expenditure are financed by public resources, this figure is under the EU and principal economies average.

- The analysis highlighted that the **latest 2017** healthcare expenditure **data** confirm the **positive results** of the measures aimed at guaranteeing a financial balance:

    - all Regions have a substantial financial equilibrium once recorded Regional tax revenues aimed at covering healthcare expenditure;

    - between 2013 and 2017 the average of the National Healthcare system expenditure grew by 0,9% per year in nominal terms, rate lower than product growth (1.3 per cent on average over the period).

HEALTHCARE CONSOLIDATED ACCOUNTS

(millions euro)

	2013	2014	2015	2016	2017	2014	2015	2016	2017	average rate
HEALTHCARE										
Social benefits in kind	**102.616**	**103.914**	**104.035**	**105.150**	**106.415**	**1,26**	**0,12**	**1,07**	**1,2**	0,91
related to goods and services produced by market producer	*39.337*	*39.956*	*39.470*	*39.544*	*39.561*	*1,57*	*-1,22*	*0,19*	*0,04*	*0,15*
medicines	8.616	8.392	8.245	8.100	7.605	-2,6	-1,75	-1,76	-6,11	-3,06
generic medical care	6.666	6.663	6.654	6.688	6.695	-0,05	-0,14	0,51	0,1	0,11
specialist medical care	4.699	4.744	4.604	4.699	4.844	0,96	-2,95	2,06	3,09	0,79
hospital care in private nursing home	9.166	9.610	9.373	9.246	9.421	4,84	-2,47	-1,35	1,89	0,73
rehabilitative, supplementary and prosthetic care	4.045	4.008	3.932	3.903	3.945	-0,91	-1,9	-0,74	1,08	-0,62
other healthcare	6.145	6.539	6.662	6.908	7.051	6,41	1,88	3,69	2,07	3,51
related to goods produced by non-market producer	*63.279*	*63.958*	*64.565*	*65.606*	*66.854*	*1,07*	*0,95*	*1,61*	*1,9*	*1,38*
hospital care	37.716	36.903	36.926	37.345	37.970	-2,16	0,06	1,13	1,67	0,18
other health services	25.563	27.055	27.639	28.261	28.884	5,84	2,16	2,25	2,2	3,11
of which compensation of employees	32.984	32.783	32.498	32.381	32.425	-0,61	-0,87	-0,36	0,14	-0,43
of which intermediate consumption	26.463	27.295	28.081	29.291	30.532	3,14	2,88	4,31	4,24	3,64
Different contributions	1.428	1.489	1.597	1.679	1.616	4,24	7,31	5,1	-3,74	3,23
Administrative services	4.725	4.772	4.850	4.836	4.888	0,99	1,63	-0,29	1,08	0,85
of which compensation of employees	2.686	2.639	2.584	2.523	2.492	-1,75	-2,08	-2,36	-1,23	-1,86
of which intermediate consumption	1.973	2.036	2.154	2.207	2.291	3,19	5,8	2,46	3,81	3,81
Other expenditures	845	786	757	708	680	-6,98	-3,69	-6,47	-3,95	-5,27
TOTAL	**109.614**	**110.961**	**111.239**	**112.373**	**113.599**	**1,23**	**0,25**	**1,02**	**1,09**	**0,9**
Per capita expenditures	1836,5	1825,5	1829,7	1852,3	1874,9					

Source: ISTAT data processed by Corte dei conti

- All the expenditure items of the National Healthcare system **grow in a very limited way** (such as personnel spending), or decrease (such as the affiliated pharmaceutical and other healthcare services), or are substantially stable (as, from a general point of view, seem to be the services rendered by private subjects accredited).

- The only item that **grows in a significant way** is the spending on goods and services, which is mainly affected by the growth of hospital pharmaceutical expenditure and that for medical devices.

- The **reduction in spending on infrastructural and technological investments** also continues: in 2017 there is a decrease of over 5% of payments. The reduction is accompanied by the confirmation of an average rate of obsolescence of the technologies available in public and accredited system. Despite the slight improvement compared to 2016, about a third of the equipment has been operating for more than 10 years and the distribution of these technologies has significant differences among local areas.

PAYMENTS RELATED TO INVESTMENTS IN THE HEALTH AUTHORITIES, PUBLIC HOSPITALS AND IRCCS (Institutes for recovery and Healthcare with scientific purpose)

Millions Euro	North West			North East			Centre			South			Islands			Total		
	2015	2016	2017	2015	2016	2017	2015	2016	2017	2015	2016	2017	2015	2016	2017	2015	2016	2017
Land Buildings	169,7	142,1	126,7	183,5	176	159,9	120,7	106,6	125,6	154,9	130,6	105	87,5	48,9	57,6	716,3	604,2	574,7
Plant and Equipment	40,9	39,9	22,2	20,9	20,5	18,8	30,5	26,4	18,8	16,5	7,8	5,9	21,4	10,4	11,1	130,2	105	76,6
Health and scientific equipment	131,2	82,8	85,7	111,9	142	130,6	71,9	58	68	160,5	93,2	98,4	77,9	70,2	56,8	553,4	446,1	439,5
Forniture	14,9	11,1	10,6	16,5	14,5	16	13,3	9,6	9,3	18,4	10,5	10,1	7,4	5,7	8,7	70,6	51,4	54,7
Vehicles	3,9	1,8	2	5,3	4,1	6,9	3,1	4,2	7,3	4,6	4,2	2,2	2,1	2,5	1	19	16,8	19,4
Other material asset	32	25,9	30,5	99,8	72,6	53,1	41	41,9	41,6	18	11,3	10,1	22,8	23,7	30,7	213,6	175,4	166,1
Intangible assets	20,8	15,6	11,5	33,6	31,6	26,7	12,8	13	15,7	10,8	14,1	10,7	16,5	6,9	7,2	94,5	81,1	71,8
Total	**413,4**	**319,2**	**289,2**	**471,5**	**461,3**	**412**	**293,3**	**259,7**	**286,3**	**383,7**	**271,7**	**242,4**	**235,6**	**168,3**	**173,1**	**1797,6**	**1480**	**1402,8**

Source: SIOPE data processed by Corte dei conti

The table shows not only the **reduction in payments for investments** over the years, but also the different effect on different geographical areas. In the central-south areas the results are the worst.

2.3. Reduction in Services offer

- The necessary rebalancing phase to absorb the structural imbalances has affected on the offer of services.

- The National Healthcare system activity **has been reduced** in all assistance frameworks:

  - The **hospitalizations** decrease to 8.7 million in 2016 with a reduction of 11.7 percent between 2013-2016;
  - In particular, the number of the hospitalizations for the population over seventy-five continues to decline in all Regions, in 2015 the national value is 346 out of 1,000 elderly inhabitants, in 2016 it decreases to 265.

- This data can indeed correspond to a **better efficiency** of the rendered service, as a consequence of the reorganization of the assistance network and a more appropriate use of the facilities.
- However, the local assistance is **not always adequate**, in particular when it is addressed to the "weaker" part of the population, i.e. the elderly and the disabled.
- The **problem of waiting lists** in the specialist practice is hard to find a solution.
- There are growing **problems in access to services** due to the constant growth of the average age of Italians. Currently, public resources cover 95 percent of hospital spending, but only 60 percent of outpatient services expenditures and 46 percent of outpatient rehabilitation (ISTAT - National Statistical Institution, 2017).

- Significant **critical issues** emerge in the provision of services relating to the **area of prevention**, in particular with reference to the area of cancer screening.

- **Critical issues** are **also** found with regard to **vaccinations**, for which there is a trend to reduce coverage, caused by a decline in demand due to a loss of trust in the benefits of vaccination by a part of the population.

- Finally, the extended attention to the expenditure, the **inconvenience caused by the reorganization processes** of the health structures on the territory and the difficulties in adapting the public offer to changes of the demand for assistance have been affected in worrying acts of giving up on treatment.

2.4. Disparities among local areas offer

- Once the most acute phase of the bail-out plans of the Regional health systems in deficit has finished (it still remains the need of an **effective monitoring**).
- The final 2015 monitoring data and the partial 2016 data indicate the persistence of **North-South gaps** in the **quality and availability of services**.
- The effect of **health mobility from the South to the North** is increasing: the amounts paid for mobility in 2017 have increased compared to previous years, as the patients that have treatment in the Northern regions grow on the total number of patients residing in the South. Moreover, the coverage rate of needs for Long Term Care (LCT), already low in the North, are drastically reduced in central-southern Regions, generally poorer in beds, both for acute/severe and rehabilitation cases, and also for intermediate structures as well as for protected structures.

2.5. Measures adopted and open questions

In any case, **public finance constraints** have not prevented the adoption in the last period, in the health sector, of measures able to determine some progress and making available to operators and Institutions specific tools to make the activity more efficient:

- In the **Health Pact**, between different level of Government, there is the possibility to define a common strategy between State and Regions leaving the logic of linear cuts and assuming the common task to start efficient operations with the aim to make resources free for health sector;
- the **Essential Levels of Assistance (LEA)** have been revised to improve the appropriateness of services provided;

- to **promote and achieve more efficiency** in regional health services, the budget law 2017 has set the possibility for the regions to propose an improvement program and redevelopment of **specific areas of regional intervention**:
    - The access to an increased quote of the premium funding is conditioned by the achievement of the objectives defined.
    - The premium quote is paid in two phases: the first one, of 30%, at the approval of the program, the second one at the accomplishment of the intervention (the programs presented in 2017 are mainly addressed to improve territory assistance, emergency - urgency intervention as well as prevention measures for vaccines and for increasing the screening);

- the **program for waiting lists** as well the national plan for chronicity and for vaccine prevention have been set;
- the **measures to reduce the effect of goods and services costs** have been increased by reducing the differences not much justifiable in the supply costs through the obligation for entities of national health service to turn to Aggregator Subjects the supply procedures for various object. It should be noted that often the long times to achieve the operation of some procedures risk to affect the result expected by the centralized procedure in terms of savings, as well as affect, in some cases, the adequacy of high technical goods and therefore characterized by rapid obsolescence. Moreover, the administration has not made any evaluation on the actual savings achieved by these measures;

- the **reorganization of the hospital assistance system and the bail-out plans for hospitals and healthcare companies** have been set;

- the **management tools** of the health information system have been strengthened.

However, several **questions remain open**; the main ones are:

- **pharmaceutical governance**, for which it needs to review the real tools available to guarantee the sustainability of expenditure (starting from the payback and the negotiating tools of medicines price). In effect, there are trends in pharmaceutical expenditure exceeding the agreed limit and, overall, strong differences among regional entities. It should be defined ceilings expenditure at regional level and set bail out procedures as well as it should be speeded up the approval procedures of new drugs;

- **integration between social and health assistance** to better face the issue of population ageing and the inadequacy of home care;

- **implementation of regional chronicity plans**;

- moreover, considering the data of the tax declarations of citizens, it emerged a country where the **tax burden weighs** on a very limited number, which, despite a significant tax burden, must pay for health services. Hence the need of homogeneous and systematic solutions to several themes, in addition to the contributions, also: the funding of the system, the mechanisms of allocation and calculation of needs, the simplification of the fiscal system, in relation to medium-term demographic prospects;

- the **functioning modalities of the contribution to expenditure** should be revised:
  - also in 2017 the contribution on health services for assisted people decreased (- 0,9 percent), although it is more moderated than in 2016 (- 4.1 percent);
  - on the other hand, there is an increase in contributions in drug tickets (+1 percent), which compensate the reduction in healthcare services as a whole;

- in any case, the greatest weight is attributable to the **specialist outpatient services**, for which, according to the provisions of the Health Pact, the economic situation of the patient should be taken into consideration ensuring, at the same time, the invariance of revenue deriving from contribution at national level. For that purpose, the indications are:
  - to promote awareness of services costs and, therefore, to encourage a more appropriate demand;
  - to guarantee adequate financial revenues for the regions, while avoiding that too high levels of contribution could favor the displacement from the National Health Service to private facilities, undermining the possibility of guaranteeing adequate levels of assistance.

2.6. Future risks

For the future, a great risk has revealed, related to the **lack of an adequate response** to the need for the assistance **to chronicity, to rehabilitation and to intermediate care**, areas in which the need is increasing due to the constant growth of the average age:

- The population with chronicity is equal to 39 percent of the total, 20.5 percent of which have more than one pathology.
- These patients absorb a large part of the provision of outpatient services, pushing more and more occasional patients to turn to private hospitals/facilities.
- For dependent people (about 3 million) the existing facilities (287 thousand beds allocated to them) and the home care services available today are not an adequate response.

So far, the **family sphere** provided for finding a response to this need. This thanks to the safeguard assured to pension income, even during the crisis.

However, the **current situation** will result in an increasingly less sustainable prospective:

- The demographic and economic forecasts, based on the examination of the trends in the social health care and pension system, report a relationship between the elderly and the active population that will increase in the coming years, just below the level 50 already in 2030, with a population of the over 65 years, 7 points higher than today. This is intended to extend the demand for assistance, above all, to chronic illnesses and to assistance to dependent people.
- If the aging of the population will be accompanied by a reduction of the pension income, due to the complete transition to the current contribution system and to a lower continuity of work paths, the sustainability of the system will become more difficult.

2.7. The choices after the rebalancing

In the **political agenda** of the coming years, therefore, **important choices** are required in terms of adjustment of the structures.In its final evaluations, the **Corte dei conti stressed**:

- the impossibility of finding concrete solutions only within the health sector
- on the contrary, the Corte has highlighted how the response to growing needs can only lead to choices to be taken in close relationship with other areas of public intervention.

In other words, it is **necessary to find consistency among all public policies** and:

- take note of the difficulties that today characterize the redistributive and solidarity system;
- to consider the unavoidable need to encourage growth;
- ensure that the solutions adopted in terms of the contribution required to finance health care are consistent and stable;
- strengthen responsibilities and management margins for the different levels of government to avoid contradictions and poverty traps.

Thank you for your attention