

European Issues in Cost Containment - the Italian Case

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In Italy, as in most OECD countries, health care expenditure has steadily increased over time, making its containment a major issue for successive governments. It's the existence of a large public deficit and the need to reduce it drastically to comply with the requirements of the EU that has added importance to controlling health care expenditure. Among existing cost-control interventions, Italy had drastic reform of the pharmaceutical market which has been the most effective, with expenditure on pharmaceuticals halved from 1992 to 1996.

However, health reform, especially the radical change in Italy's pharmaceutical policy in 1994, limits patient choice and will have averse budgetary effects as these cost-containment strategies are never long-run manoeuvres but emergency measures to stop the never-ending increase in healthcare expenditure. To illustrate, Italy's pharmaceutical expenditure increased again after 1999.

This is a common theme in European countries. Therefore, these policies should be altered towards a more consumer-driven model, which both increases patient choice and decreases public spending, without deteriorating public health standards.

The Issue with Healthcare

So the main issue with healthcare is cost containment, not providing the best possible care for everyone. Decentralisation of Italy's healthcare system has created a market of widely differing policies on budget management and cost containment. Devolution of responsibility for healthcare provision to the 20 regions has contributed to differing levels of healthcare quality and investment. Especially demographic trends make it increasingly difficult to pay for health care costs.

The main problem is that no future solutions are being suggested; all policy measures operate within the existing health systems and reforms are always directed to short term results. The major future concerns are acknowledged, the most important being the demographic trends, but the political discussion has not yet focused on the economic unsustainability of the welfare state.

The European trend is thus to increase state involvement, instead of decreasing it.

Cost Containment Tools

Possibly the most common method of reducing health expenditure of one budget is to try to shift it on to some other budget, especially that of patients themselves. Expenditure can be shifted on to patients either directly through introducing charges or co-payments for the use of medical services or indirectly through restricting the range of health services covered for by the health insurer.

Most of the authors who have studied the operations of co-payment systems in practice are skeptical about their supposed benefits ever being achieved to any significant extent. Particularly, the effects of co-payments on drug consumption have found small price elasticities; that is, very little effect on consumption in increases of co-payments. Moreover, the co-payments are usually set too low significantly to discourage use.

Restricting the number and type of treatments that are funded by the insurer can lead to a one-off reduction in healthcare costs. The restrictions can be based on an examination of evidence concerning effectiveness, cost-effectiveness, and/or other considerations such as whether the treatment is largely cosmetic. Restrictions can take the form of *positive or negative lists*. A positive list details the treatments that will be funded by the insurer, negative lists detail those which are not. Most European states have introduced restrictions on pharmaceuticals. These have usually been quite effective in the one off reduction of costs. However, their impact was often reduced by a shift to prescribing patterns towards reimbursable drugs. Various researches show that the tendency of the pharmaceutical expenditure is to raise again after a few years of control, as we can see in Italy.

Last, but not least, budget setting is a way to cost containment. Budgets can be 'hard' in the sense that there are penalties for overspending and perhaps also rewards for underspending. The Netherlands, for example, is currently introducing a no-claim measure, which entails that a patient who does not spend much, will receive a no-claim of €250 euros a year. "Shadow" budgets on the other hand, keep records of the costs of transactions and the agent is 'made aware' of any overspending or underspending. It's more of a 'naming and shaming' tool.

Countries in Europe with national health services, such as Italy, have always operated with 'hard' budgets at some (usually most) levels of the system. As all local health units as well as tertiary hospitals have been transformed into autonomous bodies, almost all regions fail to succeed on their the budgets and escape strategies and waiting lists are common results.

In addition to that, insurers can try to affect healthcare costs through controls on the way in which providers supply healthcare. Fees or payments paid to providers can be controlled, and, in state systems, the price of pharmaceuticals and other medical supplies can be regulated, as can the profits of pharmaceutical companies as of other medical suppliers. This is a trend which is common in European countries, as in the Netherlands, and as in Italy.

The Italian Healthcare System

The national health system in Italy is a complex network of public and private providers. It is financed mainly by the public hand (71% in 98) but covers only 45% of total health care expenditures. There are three kinds of providers: public, private and sub-contractors for the NHS. The latter includes mostly private hospitals, general practitioners and private specialists.

The NHS covers all medical care but co-payments are significant, especially for ambulatory care. Co-payments are not exacted for in-patient care and for some preventive medicine (for example vaccination of children).

Important of NHS is also that by the end of March 2000, the hospital physicians had to decide if they would work exclusively for the NHS not, that is, they could no longer practise privately. In this case, however, they could carry out an intramonia activity: namely a sort of private activity in public hospitals regulated by ad hoc rules, that are different from those governing the private sector (for instance, higher fees compared to public fees and shorter waiting lists).

The healthcare system is financed by:

- General revenues (31%);
- Regional taxes on manufacturing (Irap replaced by pay roll taxes in 1998);
- Pay-roll taxes (59,5%);
- Specific regional contributions (5,5%), and;
- Revenues of the healthcare sector (4,3%).

Hence, the main sources of income are the regional taxes on manufacturing and mostly the payroll taxes. Note that, considering the demographic trend, especially in Italy where the birth rate is lowest of all European countries, it will be extremely difficult to sustain a healthcare system almost fully based on payroll taxes.

In Italy, the sharp separation between central financing responsibilities and regional and local spending power has been seen as the main reason for the constantly rising healthcare expenditure, which was not perceived to lead to a corresponding improvement in the quantity and quality of health care. Therefore, these measures were taken by the central government. The setting of budget caps and introducing user co-payments were the most important measures in Italy really. Even more efficient was the 1994 reform in pharmaceutical policy.

The effect of these cost containment policies, however, has been a cumulative deficit: € 14 210 from 1994 to 1998. From the OECD graphs can be derived that, relatively speaking, the Italians don't spend that much on healthcare consumption, but they do have a relative high consumption of medicines. Medicines and GP visits are most common healthcare consumptions and cost relatively little. In other words: patients' behaviour of health consumption is crucial to change the macro expenditure. If health consumers will be less inclined to go to GP and consume prescription drugs, self-evidently they will learn to spend less in the bigger picture too. Italy has the highest score of prescription drugs: in other words: the drugs prescribed by the GP. Now it might be easier to understand that cost containment policy are often applied to pharmaceuticals, in the form of reference price systems and the like, because they are most effective in the short run.

Italian Reference Pricing

The turning point for the Italian pharmaceutical sector was the 1st of January 1994, since when regulatory policies have:

- Redefined the positive list
- Implemented a nationwide drug expenditure budget
- Created new price-setting models
- Changed distribution margins
- Introduced generics
- And attempted to influence the prescribing of general practitioners.

Especially the positive list and the new price-setting models are steps which deliver short term financial results, but these are by no means solution to the problem of over-consumption of prescription drugs.

This problem cannot be solved, as many European –and also Italian- governments think, by introducing generics and favouring them by generic prescribing and generic substitution (the latter means that pharmacists are allowed to substitute medicine X for generic medicine Y, as long as they have ‘about the same effect’ in treatment.)

In the long run this kind of policy will only increase the costs, because people will increasingly use less effective medicines, which in turn create more health problems –and thus excess costs- in the long run. More importantly, it demotivates innovation, since in practice, these systems often restrict the access to medicines and categories of medicines that are not reimbursed. Therefore, the industry does not receive enough financial resources to pursue research and it will be increasingly difficult to stimulate the industry to innovate in Europe.

Advocates of free enterprise in healthcare, propagating the value of pharmaceutical innovation for patients and the overall healthcare system, have repeatedly found nothing but resistance. Accordingly, those stressing the importance of investment in R&D and related intellectual property rights have found themselves in a continuing battle with European legislators.

In Italy, Reference pricing was introduced in 2000, mainly because the mentioned reforms did not pay off in the longer run. Off-patent drugs with the same active substance, the same form of administration, and pack size have the same reference price set as an average price of all drugs considered weighted by the volumes sold. Since 2001, the reference price is now even equal to the cheapest price out of the equivalent products on the regional market. Generic substitution reinforces the effect of the reference price.

In the Netherlands has known and applied this kind of system for decades already. In the Netherlands, it takes years for innovative products to reach the market as health officials argue over price and reimbursement levels. The dangers are that it leads to a disincentive to innovate, a disincentive to improve existing substances with the same mode of action, and that price regulations lead to an erosion of intellectual property and value of patents.

This policy trend should be distorted to protect the quality of public health.

In Italy, the different groups of medicines A, B, C and H (respectively the groups of drugs for severe illness, drugs of importance not included in group A, drugs not included in A or B,

and drugs provided only by hospitals) are divided by the government based on the vague criteria of 'clinical efficacy', the 'risk-benefit balance' of the therapy, 'acceptability' of the therapy to patients, and the costs of the therapy.

It will be obvious that this causes long negotiations. There is no incentive to innovate, since often a new product is put in a group with low reimbursements and high co-payments, so the investment in R&D does not pay off.

Most importantly, an argument that is not often considered, is that patients -or health consumers for that matter- have no free choice of acquiring medicines. They have no idea what the doctor prescribes for them and they usually don't even know that they are given an older, less effective, generic substitute. Pharmacists often explain that medicines have 'about the same effect in treatment' but patients are not in the position to make a cost-benefit analysis and pay out of pocket if it's worth it according to them. Government officials make these decisions for them, and according to these regulations, all patients fit a 'one size package'.

Also note that international reference pricing is also senseless considering the fact that the average European price method is not often adapted to changes in exchange rates. It seems unimportant now we have the euro, but the changes in exchange rate with the pound, for example, still create an unbalanced outcome.

One Size Fits Alls

The two key problems in healthcare are the 'one size fits all' approach, and more importantly: the third-party payment issue.

Third party payment means any organization, public or private, that pays or insures health or medical expenses on behalf of beneficiaries or recipients. What happens is described by the following vicious circle :

- There is an excess consumption, and as healthcare costs are increasing, this leads to
- Runaway costs, which in turn leads to
- Third-Party rationing, which leads to
- Limited supply of services, which leads to
- Consumer discontent, which leads to
- Governmental interference and out of pocket spending disappearing

Now it can be concluded that the solution should be found in human behaviour of healthcare consumption, especially in the field of medicines and out-patient care.

Can the health consumer change his behaviour as all government policies are directed to help and protect the 'hapless' patient?

Especially the tax code is an huge Italian problem, because Italy has such a low birth rate and it creates serious problem for the sustainability of the welfare state. Moreover, the patient is assisted and protected by all sorts of insurance regulations, provider regulations, but it does not change their mentality about health consumption. It does not mean that patients should consume less necessarily, but patients, right now, have no idea what they consume, what it costs and who pays for it. By paying taxes and/or premiums citizens feel they have the RIGHT to consume healthcare. This mentality should be changed and the only way to change it is to give the money and responsibility "BACK" to the patient.

Cost Containment Policy and its Averse Effect

Sufficient information is lacking on the long term effects of many of the cost containment measures taken by European countries. An obvious difficulty is that one measure is quickly followed by another-before there is time to see the effects of the first measure. The Italian second wave of reform - the reform of the reform- illustrate this. Italy instituted measures to establish an internal market and a process of devolving healthcare powers and financial accountability of the regions. These internal market reforms introduced a partial split between purchasing and providing; and promoting competition. These reforms gave patients free choice over their preferred providers and did not identify contracts as the way to negotiate price, volume and cost and it ultimately allowed citizens to opt out of the NHS reducing their contributions to the public system and choose private insurance schemes instead. Before it was visible what the pay off of these reforms could be in the long run the third reform was introduced which reinforced the regulatory role of the new federal state. These reform measures launched during 97-2000 attempted to reinforce the role of the state in regulating the NHS.

Important to keep in mind is that the effective life of different measures to contain expenditure is sometimes shorter than the time required to develop and introduce them. Moreover, cost containment measures are seldom introduced singly. Where more than one measure is introduced, it becomes difficult to assess the effect of each measure separately. Also important to keep in mind is that what may appear to be the effect of a cost containment measure may in fact be simply a reflection of an international trend, such as effective competition.

Conclusion

A cost containment policy that acts on prices and budgets alone can have serious implications in terms of welfare. Patient choice and patients' financial responsibility should replace 'One size fits all regulations'.