



ADVISORY

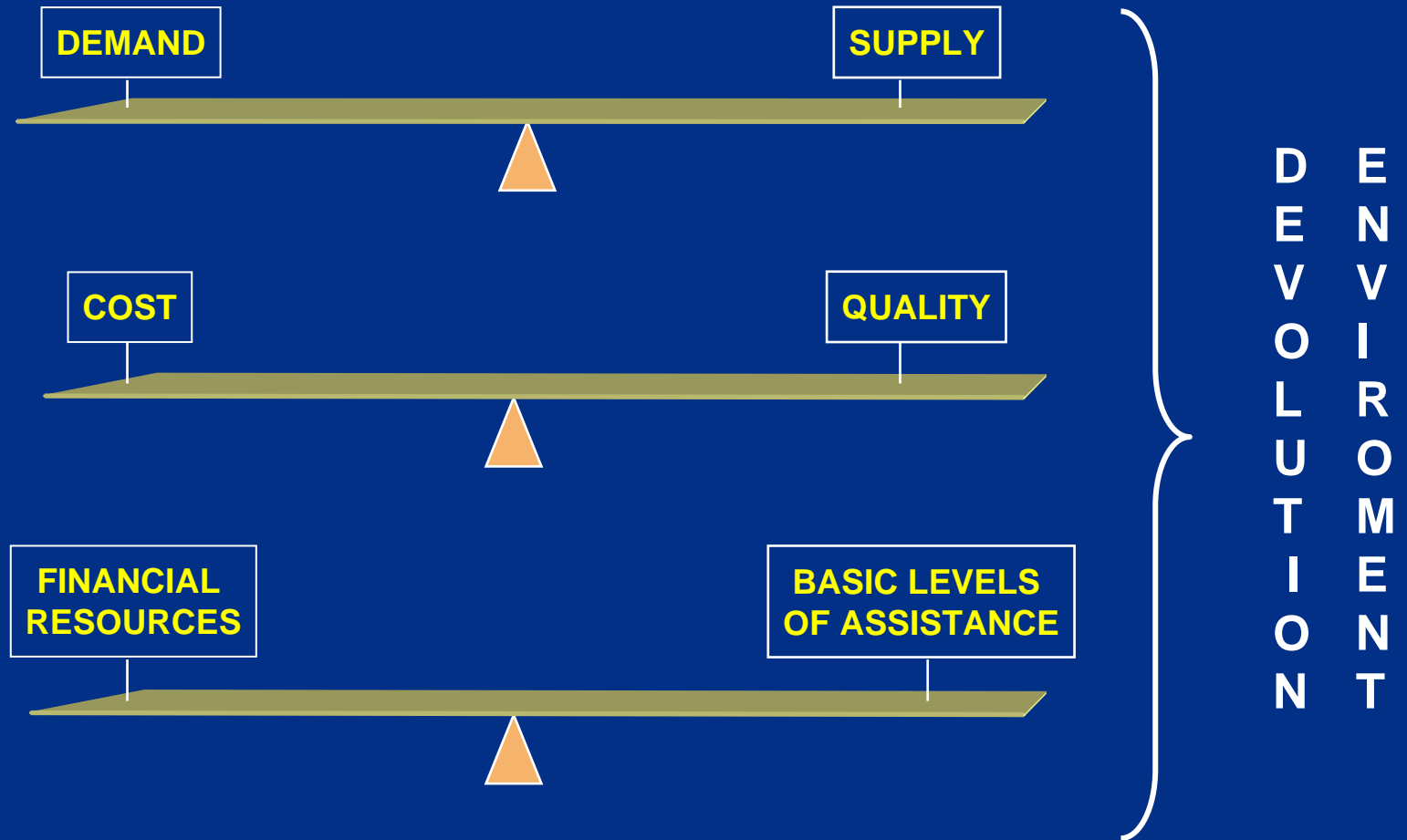
The evolution and the trends of the Italian healthcare sector

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The healthcare challenge: three balancing



Actions in progress: Phase I

Definition of the **basic levels of assistance (LEA)** through **measurement methodology and data**

Methodology: statistical evaluation of the **variability** of the services given to citizens living in the different geographical areas

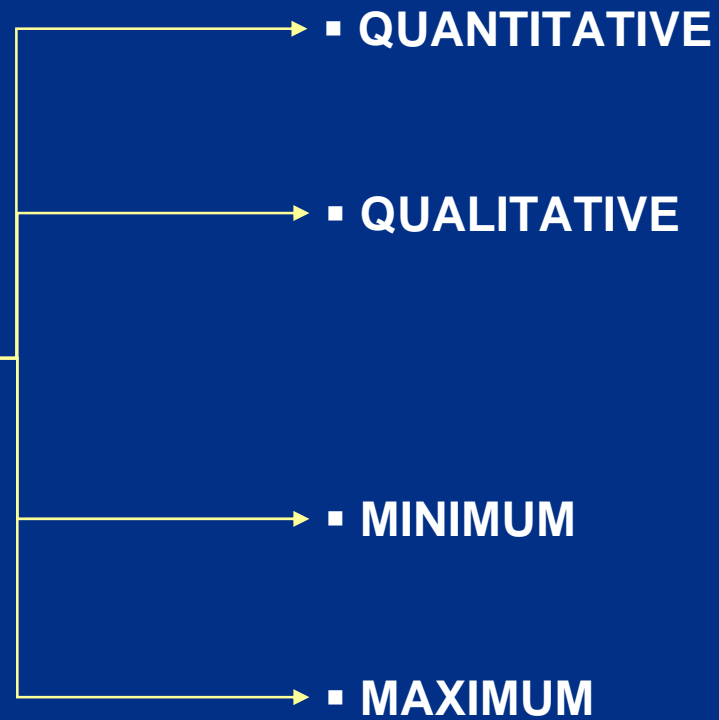
Data: hospitalisation-surgical procedures

ACC = Aggregati Clinici di Codici ICD 9 CM

CSS = Clinical Classification Software

Actions in progress: Phase II

**Standard
identification**



Objective for the standards

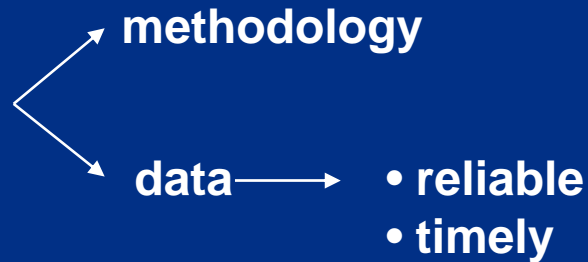
- fighting inappropriateness
- consistent treatments
- mobility regulation



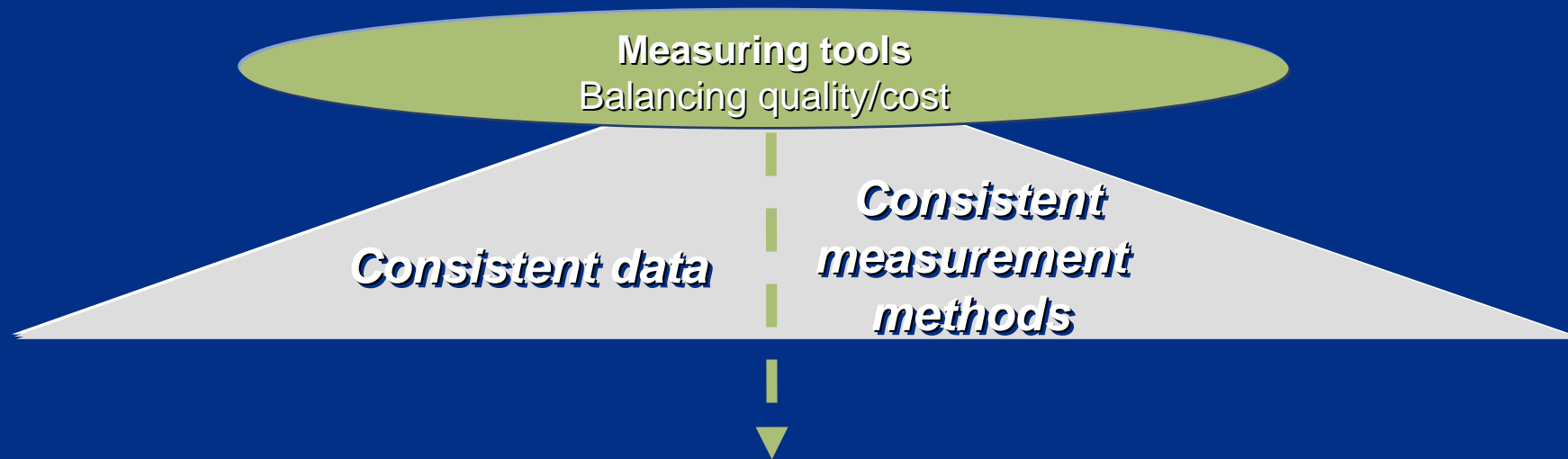
- optimisation of cost allocation
- comparison between different assistance models
- financing distribution adjustment

CRITICAL ISSUES

lack of quantitative analysis



The new health information system (NSIS)



TO LEAD THE CHANGE OF THE CARE



The national health service (SSN) “Bricks”

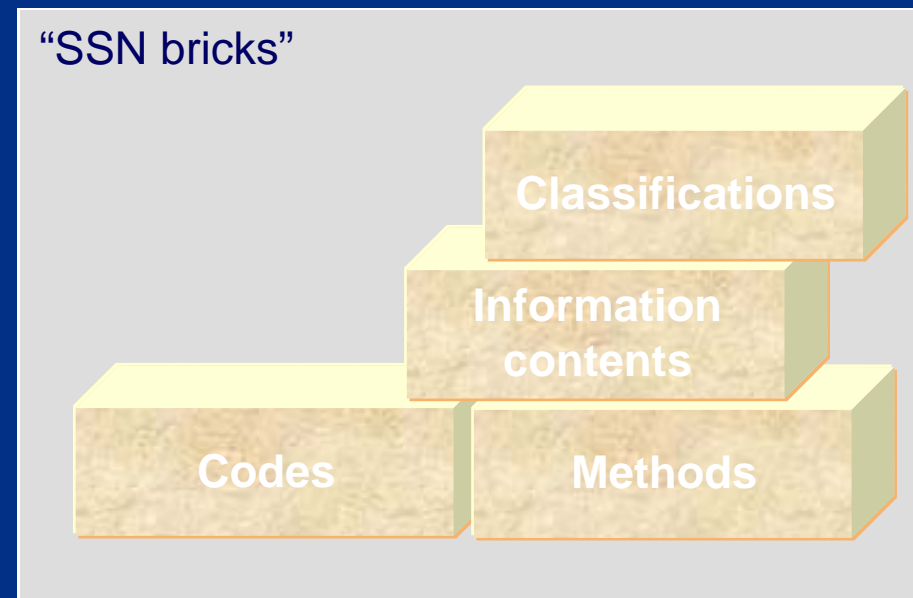
In this context, the SSN “Bricks Project” was developed

Bricks = the **building elements** for:

- the **information system**
- the **healthcare system**

Reference date:

- **10 December 2003:**
Bricks Project approved by the
State and Regions Conference



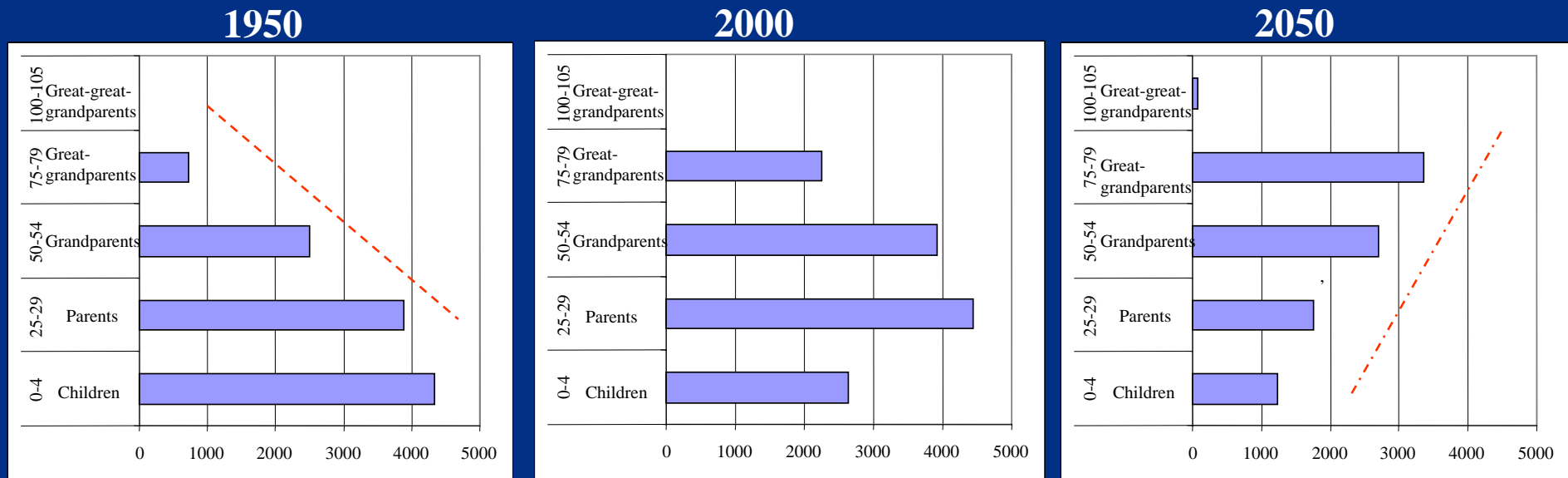
The fifteen bricks: National/Regional job

Brick Content	Group leader Region	Associate Region
1. Classification of structures	Veneto	Calabria
2. Day hospital services	Lombardy	Molise
3. Evolution of national DRG system	Emilia Romagna	Basilicata
4. Reference hospitals	Ministry of Health	
5. Identification of standard quantity	Piedmont	Sardinia
6. Waiting times	ASSR regional health service	
7. Appropriateness measurement	Umbria	Trento
8. Outcomes measurement	Istituto Superiore di Sanità	
9. Electronic health record	Tuscany	Sicily
10. Pharmaceutical prescriptions	Friuli Venezia Giulia	Valle d'Aosta
11. Emergency department and emergency call centre	Lazio	Liguria
12. Inpatient and day hospital/day surgery services	Marche	Bolzano
13. General and home health care	Puglia	Lombardy
14. SSN cost measurement	ASSR	Abruzzo
15. Public health	Campania	Emilia Romagna

National health fund (FSN) distribution criteria

ASSISTANCE LEVEL	PERCENTAGE OF THE FUND		NSIS DATA	DISTRIBUTION CRITERIA	
PUBLIC HEALTH	5%		NO	FLAT CAPITATION	
COMMUNITY SERVICES	50%	General practitioner	6.9% ⁽¹⁾	NO	FLAT CAPITATION
		Pharmaceuticals	13%		LIMIT IMPOSED BY LAW
		Specialist visit and exam	13% ⁽¹⁾	YES (61% population/12 regions)	AGE-WEIGHTED CAPITATION
		Other community services	17.1% ⁽¹⁾	NO	FLAT CAPITATION
HOSPITALS	45%		YES (DRG)	AGE-WEIGHTED CAPITATION ⁽²⁾	

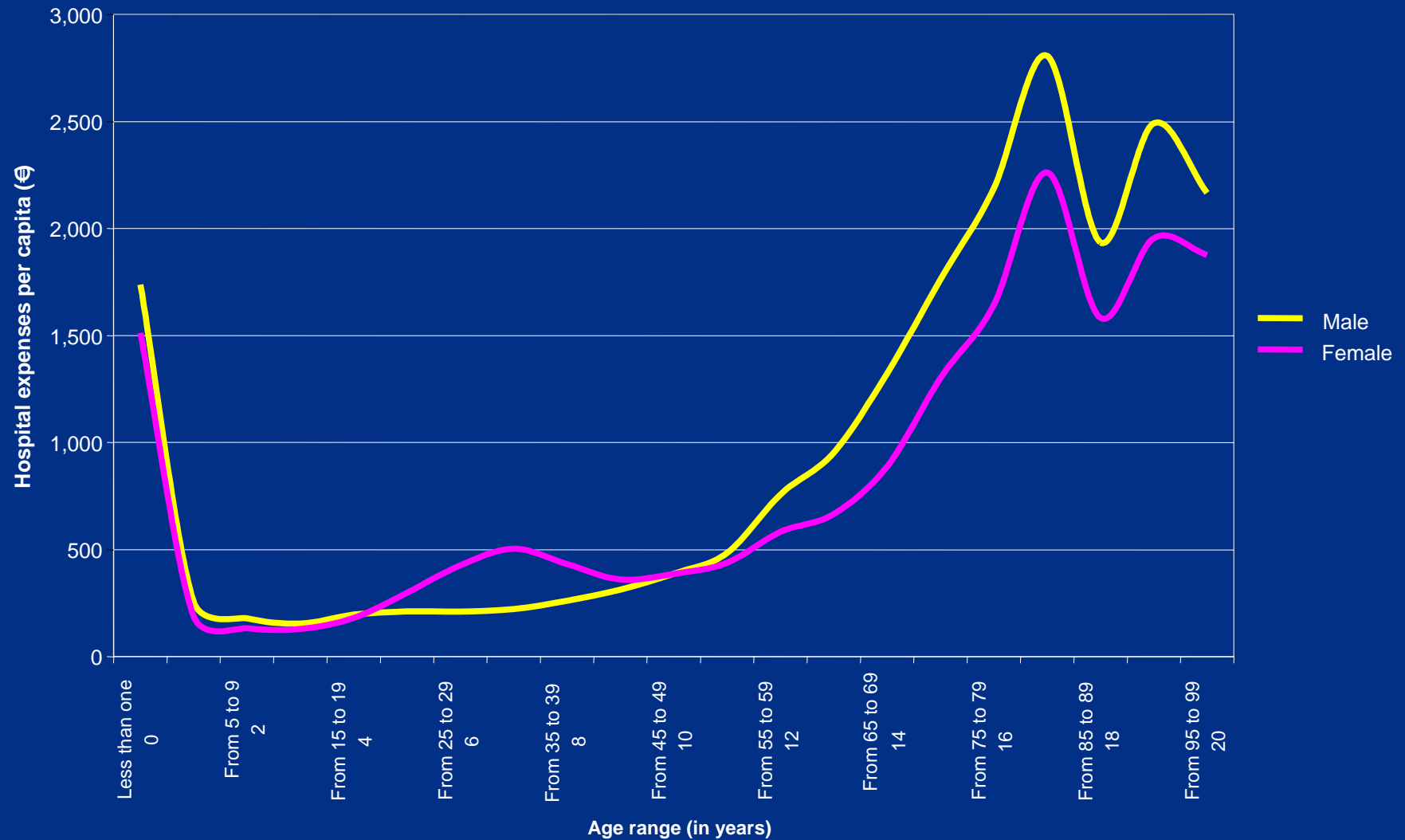
Evolution of five generations: 1950, 2000, 2050



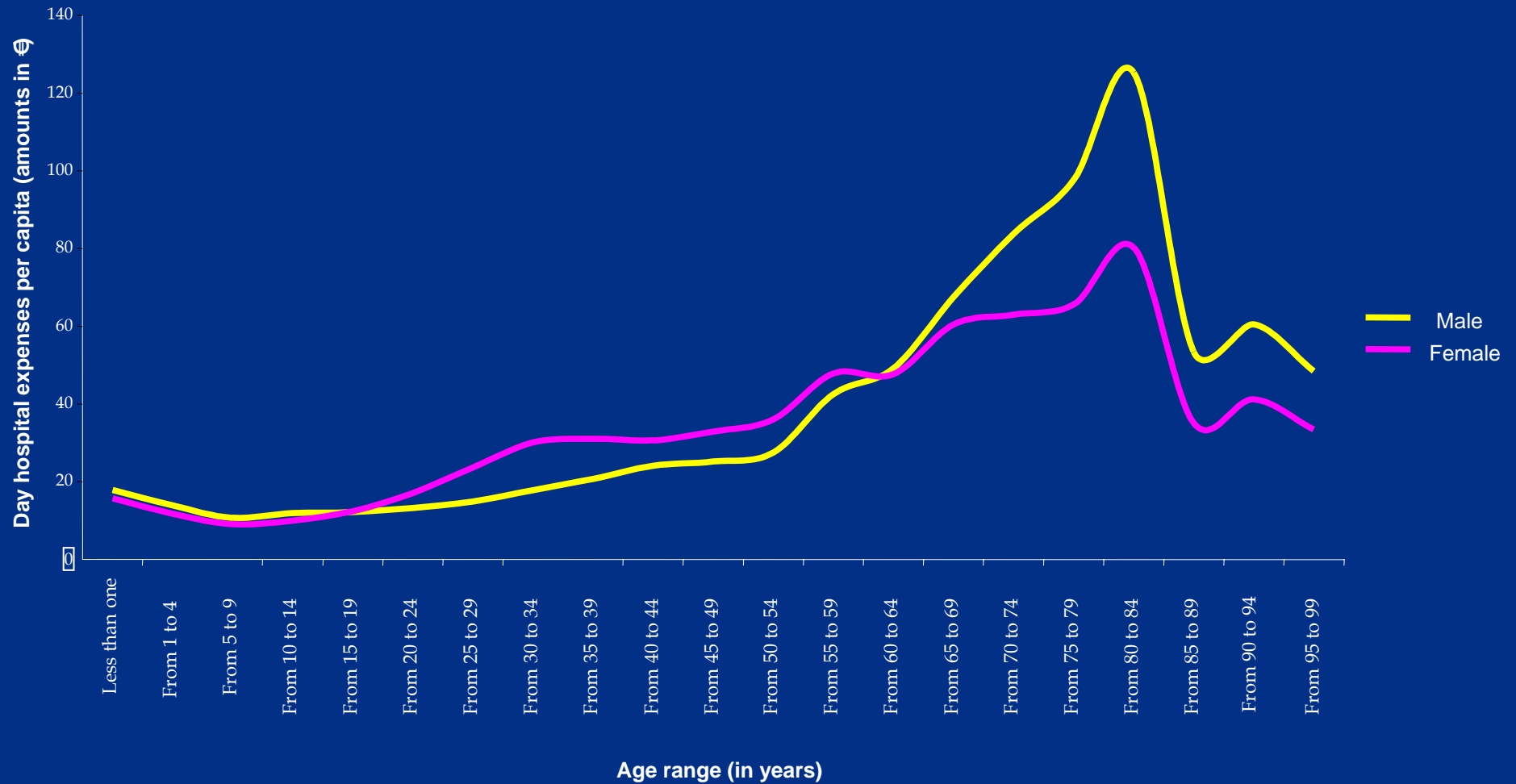
(figures in thousands)

Source: A. Golini, *Ageing society: demographic trends and future scenarios*, Rimini, 11 February 2005, on UN data, *World Population Prospects. The 2002 Revision*, New York, 2003

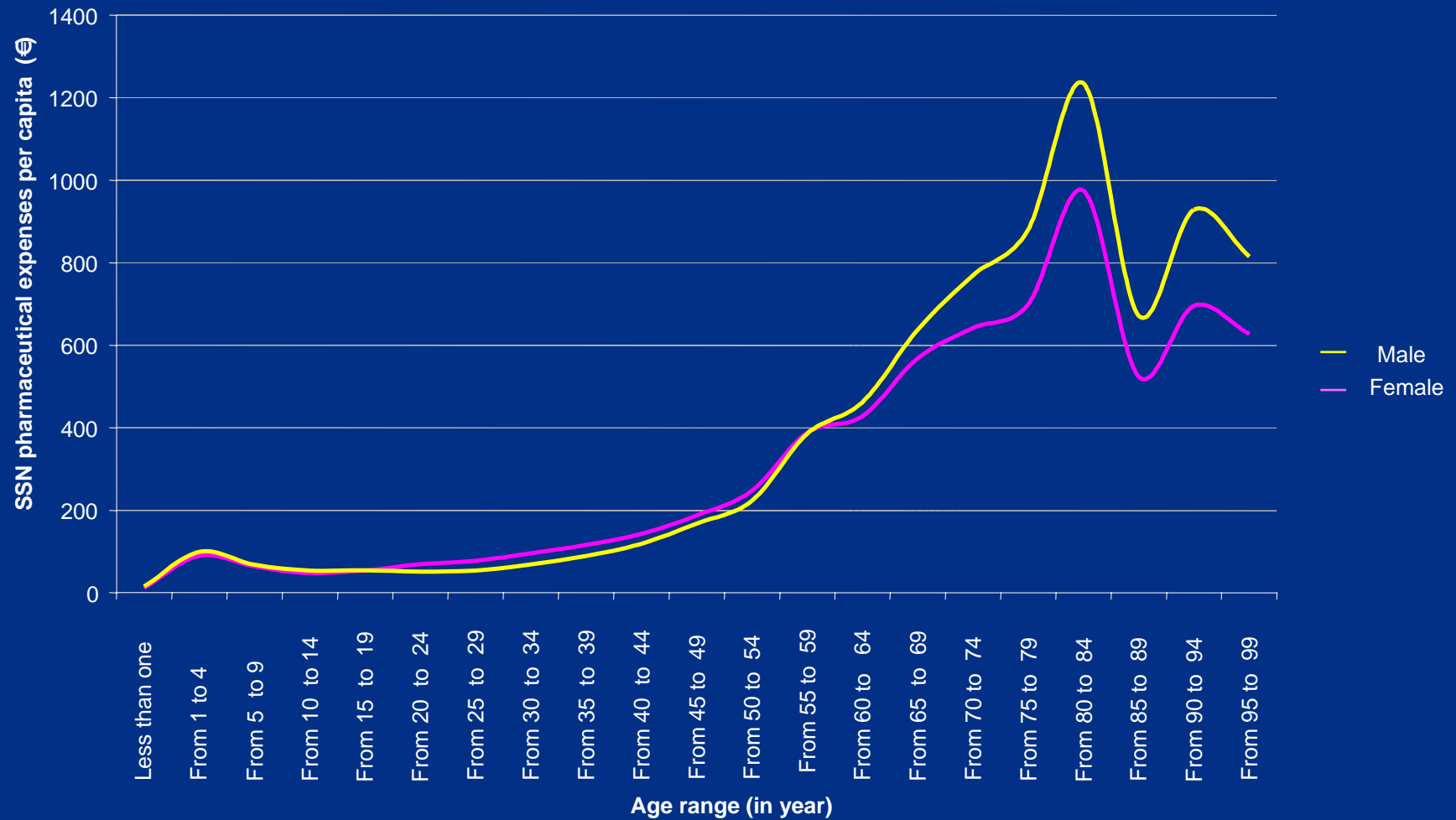
Hospitalization expenses per capita by gender and age (2002)



Ambulatory expenses per capita by gender and age (2003)



Pharmaceutical expenses per capita



Resource allocation weight chart

Assistance level	Weight by age (P)	Less than one year old	From 1 to 4 years old	From 5 to 14 years old	From 15 to 24 years old	From 25 to 44 years old	From 45 to 64 years old	From 65 to 74 years old	Over 75 years old
<i>Hospital</i>	<i>(P osp)</i>	2,539	0,376	0,254	0,392	0,567	0,945	2,105	3,025
<i>Ambulatory</i>	<i>(P spec)</i>	0,242	0,204	0,169	0,228	0,363	0,573	1,000	0,897
<i>Pharmaceutical</i>	<i>(P Farm)</i>	0,047	0,335	0,207	0,203	0,335	1,091	2,295	2,843

Scenario: balancing supply/demand

BALANCING

DEMAND

SUPPLY

EVOLUTION

ACUTE → CHRONIC

HOSPITAL → COMMUNITY

TIMING

FAST

SLOW



INAPPROPRIATE SUPPLY

- inappropriate demand
- depletion of resources
- low quality

Supply Reengineering

The following steps should be taken:

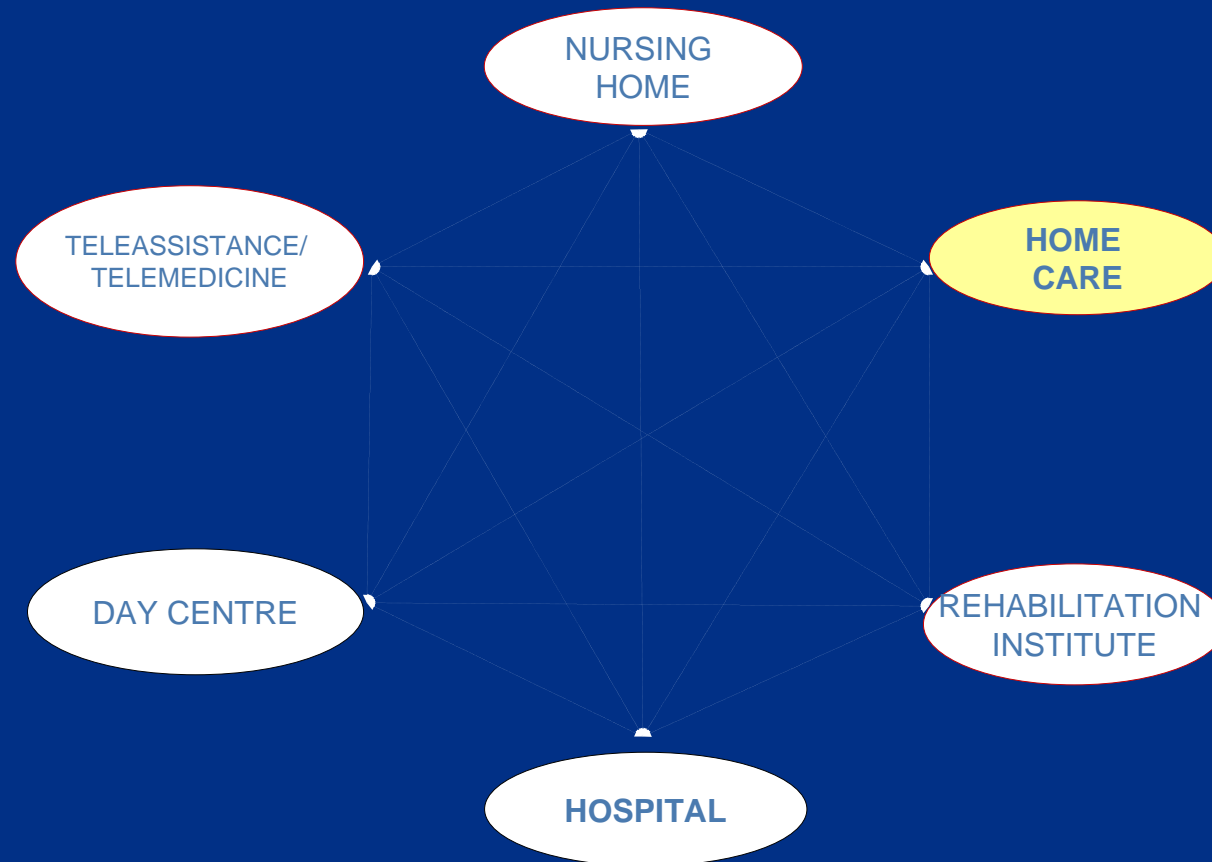
Step 1: development of community care

Step 2: related reduction of hospital admission



Time required: financial squeezing demands **short times**

Community health: continuous assistance to the elderly

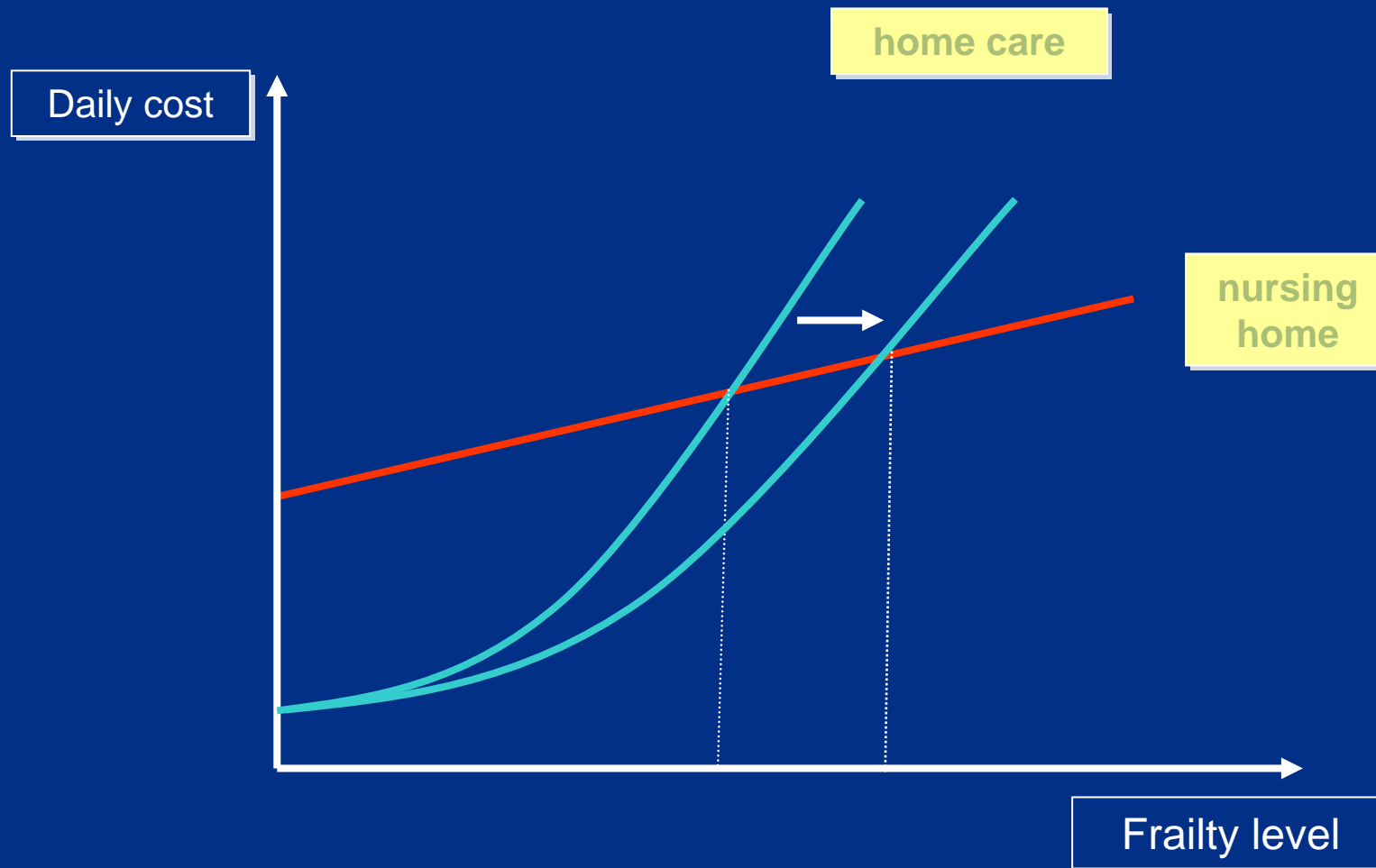


• **THE NETWORK OF SERVICES:** the integration of different centres dedicated to social and health care



THE MAIN OBJECTIVE: to keep the elderly at home as long as possible, **shifting assistance from the nursing home to the home care**

Elderly: quality of life / cost balancing



Centres sizing up

- Development of:**
- ✓ medical know-how aimed at chronically ill patients
 - ✓ organisational know-how for network management, with **priority to home care**
 - ✓ **new information technologies** to improve home care



- Evaluation of:**
- ✓ increasing capability to provide home care as frailty get worse



Sizing up of centres as **home care** subsidiary

Looking for funding: a proposal

To day:

DEMAND

Funding

- ASL ← National health fund
- Municipalities ← Social funds
- **Private** ← Personal/family funding

SUPPLY

Health-social professional/nursing home

- GP = **private** professionals operating within the NHS
- Voluntary organisations = **private profit/no-profit organisations**
- Nursing home = mainly **privately owned**

The private sector is playing an important role in the community care

Tomorrow forecast: the public/private partnership

- The private sector can be helpful for the community care reengineering being a **little challenging to the existing situation**
- The **private sector** can provide:

✓ know-how

TECHNOLOGICAL
ORGANISATIONAL
MANAGERIAL

✓ funding

Public and Private roles

Public role: Ensure that citizens are provided with the level of assistance constitutionally established

Private role: Supply services in the quantity and quality **contractually agreed** with the public role

Development Methodology:

- **PFI for community care** must be developed as for hospital
- Specific **Risk Matrix** (Public Sector Comparator) to prevent the private investment from becoming a public debt
- Experimentation of PPP **at a regional level**