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The Risk of Inequality in Italian Healthcare Due to Covid-19

Carlo Ciardo

Abstract

The Italian National Health Service, characterized by the principles of universality, equality and fairness, has undergone changes over the years that have involved these essential characteristics. The decrease in financial resources was the first element that touched the Italian health organization. The spread of Covid-19 has attacked the balance of healthcare in Italy and put the equality of the entire care system at risk. The reform of the Italian health system, especially through the correct use of European financial resources, is the real test for the Italian health system of the future. It can be a moment of relaunch or the certification of a decline that jeopardizes constitutional rights.

Keywords: healthcare, inequality, Italy, covid-19

1. Introduction

1.1 The fundamental principles of the Italian Health Service and the criticalities of public health expenditure

The Italian National Health Service, characterized by the principles of universality, equality and equity, has suffered over the years an erosion of the aforementioned pillars also due to the systematic decreases in funding. In addition, the balance of the entire social welfare system is today subjected to an unexpected and very significant attack caused by the health emergency dictated by COVID-19.

The Italian model, created by Law n. 833/1978, was invoked evidently to the British experience of the original N.H.S. [1], while being distinguished by an accentuation of the intervention public. Wanting to summarize the criteria of the law establishing the NHS, 5 key points can be identified: a) “universality” of the provision of assistance services, b) “uniqueness” of the management of health facilities and hospitals by the USL (Local Health Units), the real engine of the reform; c) “equality” in carrying out therapeutic treatments; d) planning of assistance objectives and resources financial.

The 1978 reform implemented the constitutional provision of art. 32 of the Constitution, preparing a health network suitable for an organic and global protection of health. Just the art. 1 of the aforementioned law openly recalls the constitutional text, defining the protection of health «as fundamental right of the individual and collective interest» (art. 1, paragraph 1) and in paragraph 2, following the provisions of art. 32 of the Italian Constitution: «the protection of physical and mental health must take place in respect for the dignity and freedom of the human person». Strictly consequential with respect to this regulatory provision,

it is the direct intervention of the public authorities in the organization and in the provision of assistance itself.

In this regard, it is necessary to highlight that the definition of health protection does not only concern the absence of disease or disability. These references are now reductive and simplistic, so much so that the Organization World Health Organization has stated that health must be done to mean “a state of complete physical, mental and social well-being [...] Condition of harmonic functional and physical balance and psychic organism dynamically integrated into its environment natural and social” [2]. Thus, the notion of health cannot yet be linked to the absence of infirmity, but has undergone a significant expansion of both a biological and social nature, alongside integrity physics of a static nature, also a dynamic element e relational [3].

In the light of the constitutional and normative arguments already mentioned, the solidity of the founding principles of the National Health Service outlined since 1978 is of primary importance. Subsequently - already represent a substantial modification of the original structure on which the epidemic from Covid-19 had a decisive impact.

With reference to financial resources, it should be noted that the crisis of 2007–2008 had already triggered a spiral of decrease in economic allocations also through the provision of cost containment measures (for example: increase in the sharing of the so-called ticket and blocking of turnover).

The aforementioned measures have achieved, in the short term, the objectives set, so much so that in 2012 there was a beginning of a decrease in public health expenditure. This reflection, however, must be completed with a broader examination. In order to fully understand the overall picture, it is necessary to highlight that healthcare expenditure depends on multiple components: the aging of the population, epidemiological change, scientific progress and the change in information asymmetries between doctor and patient. The variation of each of these factors determines a change in the demand for services and therefore has an impact on the Health Service and its economic needs.

1.1.1 Factors affecting the organization and financing of health care

The first element to be evaluated is the demographic one. It is undeniable that there has been an increase in life expectancy. In Italy, from 1960 to today, life expectancy at birth has increased by 12.8 years for women and by 13.6 years for men, so much so that the average age of women is 85.2 years and for men it is 80.8 years. The national average is 83 years compared to the 80 years of the OECD average [4].

These data, together with the slowdown in the birth rate, have produced an increase in the elderly population, to which new welfare needs are linked.

The exponential increase in chronic diseases (for example: cardiovascular diseases, cancer, diabetes and dementia) - those most present in the elderly population - has a significant impact on both the organizational structure of the National Health Service and the economic one. Suffice it to say that in Europe in 2016 the treatment of cardiovascular diseases alone cost 192 billion euros, much higher than the expenditure necessary for the diseases that most afflict the younger population [5].

Another factor that affects the health organization and its financing is that linked to scientific progress and technological innovation. This element does not depend on the choices of each individual country, but on investments in research and development by manufacturing companies (especially pharmaceutical companies). The public resources made available in this field have the effect of conditioning the degree of access to knowledge and new technologies. In summary, the

availability of about 14,000 medical device patents each year provides answers to health problems and creates, on the other hand, a new perceived need and, consequently, a new demand for assistance with undeniable repercussions on health care costs.

Think that the growth of technological innovation is much higher than the growth rate of the economy, so much so that between 2008 and 2012 while Italy recorded a decrease in GDP equal to 2.3%, in Europe 1 patent for medical devices was registered every 38 minutes [6], proving the fact that the National Health Service cannot keep up with the technical and scientific developments.

The last element of this picture of factors is represented by the variation of information asymmetries between doctors and patients dictated by the ease of acquiring information through the mass media and, above all, through the internet. If this increases the levels of knowledge of citizens, on the other hand, information bulimia also increases the risk of inappropriate requests, up to the so-called defensive medicine, a prescriptive modality that does not safeguard the patient's health, but removes the risk of professional liability, increasing inappropriate spending.

All the aforementioned affect the National Health Service and determine an ever-increasing and different demand for services, moreover in an emergency context dictated by the spread of COVID-19, which requires new financial flows and imposes a radical organizational change.

2. The right to health protection “conditioned” by financial and organizational resources in the light of constitutional jurisprudence

The entire issue of the health organization must also be read in the light of constitutional jurisprudence.

The Italian Constitutional Court, in implementation of art. 32 of the Constitution [7], has ruled that the right to health protection, understood as a request for services and benefits, is “primary and fundamental” and requires “full and comprehensive protection” [8].

This interpretative orientation changed, however, in the 1990s, when the need to contain public spending was imposed [9]. In the last decade of the last millennium, in fact, the Italian public debt had come close to 100% of GDP, while the public deficit was 11%. Especially since 1992 the situation has appeared out of control, so much so that the successive Governments (the first in this sense was the one chaired by Prof. Giuliano Amato) have begun a new phase of fiscal consolidation, with inevitable effects also on health expenditure [10].

The sentence of the Constitutional Court no. 455/1990 with which, while reiterating that the right to obtain health services must be guaranteed to every individual, he stated that this right is conditioned by the legislative choices of balancing the protection of health with other constitutionally protected interests: “taking into account of the objective limits that the legislator himself encounters in his work of implementation in relation to the organizational and financial resources available at the moment” [11]. For the first time it was established that the right to health protection had to deal with economic and organizational possibilities [12].

The subsequent evolution of constitutional jurisprudence has confirmed the need to achieve a balance between the right to benefits and economic and organizational limits, but has also provided for an essential core of the right to the protection of health that can never be undermined [13]: “in the balance of constitutional values operated by the legislator had an absolutely preponderant weight, such as to compress the essential core of the right to health connected to the inviolable dignity of

the human person, we would be faced with a macroscopically unreasonable exercise of legislative discretion” [14].

Constitutional jurisprudence relating to the patient’s freedom of choice is also of considerable importance. Precisely the need to take into account the limited economic resources and the need for general health planning led the Italian Constitutional Court to establish that the patient’s freedom of choice of the health facility at which to carry out a diagnostic examination or a medical intervention cannot be considered as an absolute right because of the incompressible economic needs [15].

The above is a confirmation, from the wall of the Italian Constitutional Court, of the policies to contain health costs, albeit within the limits of a reasonable balance with the various constitutionally relevant interests.

3. The evolutionary lines of the National Health Service and the legislative choices of the Italian Regions

Looking at the evolution of public policies in the health field, one must take into account the multiple choices made by the Italian Regions in the organization of Regional Health Services.

In most cases there has been a progressive unification of Local Health Authorities (ASL) and Hospitals (AO). One of the first Regions to make this choice was the Marche Region with the creation in 2003 of the Single Regional Health Authority (ASUR). This example was followed by the Abruzzo Region, with only 4 ASLs, and by Umbria, which passed to 2 ASLs.

Further examples can be given on the choice of reduction. Puglia already after the health reform of 1992 had gone from 55 Local Health Units to 12 ASLs, but in 2007 it decided to carry out another merger until it reached only 6 ASLs.

In 2015, the Tuscany Region reduced the ASLs from 12 to 3, and 4 university companies were added to these. In 2014, the Emilia Romagna Region created a single ASL (for the territories of Forlì, Cesena, Ravenna and Rimini) with over 1 million inhabitants, 12,000 employees and a budget of 2.2 billion euros.

In 2015, on the other hand, the Lombardy Region replaced the ASLs with 8 Health Protection Agencies and 25 Territorial Social and Health Companies.

Analyzing the different choices of the Italian Regions, in an effort of synthesis it can be said that the mergers were designed to create economies of scale, to simplify administrative procedures, to eliminate duplications. It should also be noted that these choices, in the medium term, can also cause inefficiencies linked to the excessive size of the ASLs and difficulties in creating middle management.

The above must be completed with an assessment of the evolution of the hospital organization.

The Law Decree n. 95 of 6 July 2012 provided for a reduction in hospital beds, so much so that a maximum value of 3.7 beds per 1,000 inhabitants was reached, compared to the previous value of 4 beds per 1,000 inhabitants. To this was also added an evaluation of small public hospitals in order to dismiss these structures and favor home care.

The process of reducing the number of beds and reorganizing the network of small hospitals was implemented with the decree of the Ministry of Health no. 70 of 2 April 2015 which defined the qualitative, structural, technological and quantitative standards. This legislative choice was aimed at reducing health care costs, reorganizing the hospital network and moving health care for many chronic diseases outside hospitals to put it at the expense of “territorial assistance”.

In reality, however, this reorganization made the mistake of having accelerated the rationalization of hospitals by the Italian Regions, but it was not as effective

as regards the creation of a new territorial assistance which, therefore, remained incomplete in many parts of the national territory.

4. Effects of public policies on the National Health Service

After the economic crisis of 2008 there was a gradual reduction in the financing of the National Health Service. In the period between 2009 and 2014, Italian public health expenditure increased each year by 0.7%, while from 2003 to 2008 the growth in health expenditure was equal to 6%.

These policies to contain national health expenditure and the choices of the Italian Regions to reduce their budget, have had undeniable positive effects both on the national budget and that of many Regions that were in financial crisis (think of Regions such as Lazio, Campania and Sicily). At the same time, however, these choices have had an impact on health care.

The first effect of the reduction of economic resources for the National Health Service was the reduction of some assistance services. This aspect had a fundamental impact on citizens as those who had the financial availability were able to turn to private health facilities, while those who could not afford this expense independently had to give up temporarily.

This has also led to an increase in patient waiting lists at public health facilities. The “Annual report on hospitalization activities” of the Italian Ministry of Health (2019) contains some significant data. For example, in 2017 the average expectations were over 27 days for breast cancer, 53 days for prostate cancer, 119 days for tonsillectomy, 90 days for inguinal hernia [16].

In Italy 40% of specialist health visits, 49% of rehabilitation services and 23% of diagnostic tests are paid directly by citizens [17].

In addition, the policies to contain health costs also had a direct influence on medical personnel. In Italy there is no shortage of doctors, so much so that every year there are about 9,000 graduates in medicine and surgery, but only 6,000 graduates each year can receive a specialist scholarship. This means that every year in Italy about 2,000 doctors live in the uncertainty of their professional future, despite the enormous need for new doctors by the National Health Service.

To confirm what has been said, the fact that in the Veneto Region there is a deficit of 400 doctors, in the Piedmont Region and in the Puglia Region there is a need for about 300 doctors. If we look up to 2025, a national shortage of about 16,700 medical specialists is expected. An incredible paradox [18].

5. A change of legislative step and the possible repercussions deriving from the COVID19 emergency

It must be borne in mind that in recent years there has been a change in the choices of health policies. The resources allocated to the National Health Service have been slowly increased, although still largely insufficient. In the 2019 Economic and Financial Document, health expenditure for 2018 was estimated at approximately 115.4 billion euros, recording a growth of 1.6% compared to 2017.

This precarious balance has, however, been completely upset by the emergency caused by the spread of COVID-19 which has imposed a campaign of staffing and a sudden technological and infrastructural investment of which the exact extent is not yet known. In this regard, it must be taken into account that the first legislative intervention approved in 2020, in full epidemiological emergency, was the “Cura Italia” Law Decree, which immediately provided for the following emergency measures: additional

funding for incentives to healthcare personnel (Article 1); hiring by the Minister of Health of 40 medical executives, 18 veterinary executives and 29 non-executive personnel, allocating over 5 million euros for 2020, 6,790,659.00 euros for 2021 and 2022 and almost 1,700 €.000.00 for 2023 (Article 2); possibility for the Regions to purchase medical equipment also from private health facilities (art. 3); an increase in the financing of healthcare for an amount of almost 2 million euros (Article 17).

This was only the first step in a series of economic increases which during 2020 (and also at the beginning of 2021) were expected to address a condition that has upset not only Italian society, but above all the entire National Health Service.

All this must also be taken into account the impact that the national and global financial crisis that was triggered by the pandemic, moreover on the Italian economy, which even before the health emergency had shown signs of weakness [19]. One of the first reports by the Moody's agency supported a possible recession in the Italian economy with a reduction in GDP of over 10%. For this reason, what must be watched carefully is the behavior of both the European Union and that of the ECB.

6. Is Italian healthcare likely to be unequal?

The evolutionary framework of the interventions of economic and organizational policies in the health field gives us a plurality of indices from which multiple inequalities emerge, so much so as to touch the foundations of the constitutional right to the protection of health.

The first imbalance is between Northern Italy and Southern Italy. Already today in the Northern Regions the life expectancy for men and women is respectively 81.2 years and 85.6 years, while in the South the life expectancy for men and women is 79.8 and 84.1 years. Years.

An index of inequality is represented by healthcare mobility between Regions, so much so that in 2017 88% of Nitalians who moved to be treated were hospitalized in Lombardy, Emilia Romagna, Veneto, while 77% of citizens who moved to try to be treated came from the Regions of Central and Southern Italy (Puglia, Sicily, Lazio, Calabria and Campania).

A further sign of inequality is linked to the renunciation of care by the poorest sections of the population. 43% of Italians with serious economic difficulties declare that they are not in good health, while only 23% of those who do not have economic difficulties believe that they are not in good health [Italian Higher Institute of Health, "Report on inequalities", 2019]. It must also be assessed that 55% of people with a low level of education report that they are in poor health (compared to 20% of Italian graduates) and 12% say they have depressive symptoms (compared to 4% of graduates).

This context of inequalities is even more relevant if we consider that over 11 million Italians in 2017 gave up on treatment for economic reasons and 7 million Italians went into debt to take care of themselves.

This fragile health care landscape is also characterized by significant paradoxes, the first of which is linked to the ineffectiveness of care services. It has been estimated that 19% of public spending, 40% of private household spending and 50% of the expenditure incurred by insurance policies, is used for diagnosis or for inappropriate or ineffective health services.

All this represents the photograph of a National Health Service that was already present before the COVID-19 emergency was characterized by gaps and contradictions and that, with absolute probability (if not certain), the spread of the virus will only exacerbate, especially with regard to of the poorest faces of the population, those socially more fragile and, in particular, towards the elderly.

We are in the presence of welfare, territorial and access to care inequalities that risk completely undermining not only the foundations of the National Health Service, but also those of the constitutionally protected right to health protection.

Furthermore, still on the subject of inequalities, the annual reports of the World Bank, the International Monetary Fund and the OECD, which constantly provide data on the increase in the concentration of wealth, cannot fail to have reinterpreted on the welfare state and, consequently, on the gap between the assistance potentials provided by technical-scientific progress and the actual levels of assistance provided.

From the above it follows that the picture of the evolution of Italian healthcare, also in the light of the contingencies that the current health emergency, opens the way to pressing fundamental doubts about the effectiveness of the principles of universality, equality and equity that inspired the creation of our SSN and which today risk being only chimeras.

Faced with this complex picture, it is necessary to think not only about how to convert entire healthcare companies into hospitals dedicated to the care of patients suffering from Covid-19, moving patients with other diseases to other small hospitals, but it is also urgent to already start planning a future in which there are integrated assistance systems, with large hospitals that are centers in which investments are concentrated and specialization is developed, connected in telemedicine with small hospitals.

In this new vision, one cannot imagine addressing the issue of small hospitals only with a view to reducing costs, but it is necessary to plan their use in a perspective of continuity of care and strengthening of territorial assistance.

On the side of medical personnel, the time has now come to face the season of the shortage of doctors and nurses with determination, nor can we think that this problem can be solved exclusively with urgent procedures for the recruitment of usable staff to fight the pandemic. Instead, it is necessary to design new care models and launch real training programs for the phase following Covid-19. The contingent criticality must be transformed into an opportunity to strengthen a poor health system, first of all, from the point of view of the staff. It will be possible to plan the reconversion of services by leveraging the energies and skills of young doctors to be included in the National Health Service.

Furthermore, it would be short-sighted to limit ourselves to asking for economic policies to increase public spending to be allocated to the health service (back to a percentage of about 7% of GDP), nor would it be satisfactory to limit ourselves to hoping for investments for the adaptation of structures. Hospital. Instead, it is necessary, right from the start, to train young doctors and nurses, as well as new professional figures capable of bringing new services.

Finally, any reorganization of the National Health Service would be empty if the problem were not raised (and the solution started) of strengthening local health care, because only through this simple (but essential) Copernican revolution will we be able to address both the needs imposed by the pandemic and the needs that health care has to face every day in order to provide answers to the many health protection questions raised by the population.

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