Equity in health and health care access: how does Italy compare?
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Discussant
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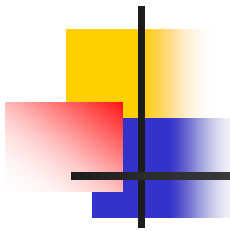*Email: m.giannoni@unipg.it*

Aim of the presentation

- To discuss the main findings of recent international comparative studies for EU and OECD member states in order to draw some lessons for the Italian situation.

- Focus on:

- 1- income-related health inequalities

- 2- income-related inequities in health care access

Institutional Framework

- The Italian NHS has experienced several reforms
- In the last decade most of responsibilities on health care policies have been increasingly transferred to regions
  - Regions have been made financially accountable for their health care budget
  - The basket of Essential Levels of Care provided by the sector is set at the National level, regions may provide additional levels of care at their own expenses
  - copayment policies vary across regions (e.g.
- There are fears that this process is widening the between regions of the country

Relevance of equity issues for Italy

- Equitable access to health care is a core objective of the Italian health care systems.

  Despite having achieved close to universal coverage for a fairly comprehensive basket of health services for decades, there is mounting evidence that not all individuals in equal need are treated equally, with inequalities systematically associated with income.

  Rising medical care costs makes it increasingly difficult to ensure access to (costly) treatments;

  Devolution from the central government to regions raised fears of increasing inequalities in health and inequities in access to health between areas of the country

1- Inequalities in health (Van Doorslaer and Koolman, 2004)

- Comparison and decomposition of the degree of income-related health inequality in 13 EU countries

- A lower degree of income inequality helps in reducing health inequalities, <u>however</u> not the sole or the main driver of the inequalities

- Cross-country differences not primarily associated with differences in income inequality, but with differences in the way income is protected when people retire from the labour force.

Policy implications for Italy

- **1- Regional differences in health and income matter:**
- **"** *if there were no systematic regional disparities, clearly income-related inequality would also be lower "(van Doorslaer and Koolman, Health Econ., 2004, p.627)*
- **2- Italy's relatively modest degree of income-related inequality in self-reported health w.r. to other EU countries**
- **However:**
  - **studies (mostly epidemiological) based on Italian data show that inequalities are persisting over time, if not increasing**
  - As the study was based on ECHP 1996 data this could suggest that more recent evidence is needed

Some issues

- External validity of using the Canadian threshold values for health utility to scale the SAH categories in the interval regression (*Ibid.*)

- Potential endogeneity / unobserved heterogeneity problems (panel data needed)

- Lifestyles might be relevant (e.g. for smoking status, Contoyannis & Forster, JHE, 1999)

Possible further developments:

- A fundamental target of the NHS is to improve not only the health status but also the quality of life of citizens

- Role of income-related inequalities in quality-of-life / QALYs achieved

2- Measuring horizontal inequity in health care use (Van Doorslaer, Masseria et al. 2004; 2006)

The papers provides important empirical evidence on

- Different types of health care services
- Different countries
- Different contributions of need and of non-need factors to inequities

- **Critical issues (Wagstaff e Van Doorslaner, 2000; Masseria, 2006):**

  - Measurement problems/comparability (cultural differences etc.)
    - Need measurement:
      Self assessed health vs more objective health measures
  - Access vs utilisation
  - Models specification etc.

More evidence for Italy

- Results from van Doorslaer et al. studies have induced further work in Italy where regional differentiation in access and utilisation of health care services is a major policy concern.

- Studies based on mor recent data show that over time, there is a positive and statistically significant income-related inequity in using specialist visits and diagnostic procedures, but, overall, no inequity in using inpatient , emergency and GPs services (Masseria & Paolucci 2005; Masseria & Giannoni, 2005; Giannoni & Masseria, 2006; Giannoni, 2007). In the latter studies need factors appear to be the main determinants of the probability of utilising health care services. Also insurance coverage status and regional supply side factors appear to be relevant (ibid.).

- A clear differentiation in the kind of care used by the rich and the poor seems to emerge and the need of monitoring inequities at regional level.

- Inequities however are different for different types of chronically ill people. There seems to be a need for monitoring not only efficiency but also equity in defining "path" of care for chronic diseases (*ibid.*).

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| Inequity indicator	Dep.variables	Indep.variables	Period	Data	i	Authors/i
HI = -0.0002	Probabilita' Visite al medico di base (GP)					Van Doorslae X. Koolman
HI = -0.0322	uso dei servizi (conditional positive number of visits) N. di visite effettuate dal GP		1996- 12 EU countries		ECHP-Eurostat	M. Jones (200
HI = -0.0349						
HI=+0.009	Probabilita´ Visite al medico di base (GP) Visite allo specialista (almeno una visita nell'ultimo anno)	Need variables: 1) Self-perceived health (very good – very poor: 4 dummies)	SHARE survey – 10 EU countries		2004 Popolazione anziana (>65 anni)	Allin e Masse (2005)
HI= +0.06		2) 2+ symptoms lasting at least 6 months 3) Demographic variables (age and sex) 4) Overweight and obesity (BMI>=25) Non-need variables: relative rank in (household) income distribution, assets, education, involvement in caring and leisure activities, risky behaviours (smoking and drinking)				
		need/non need				Giannoni e Masseria (200
			Istat Multiscopo 1999-2000			Masseria e Paolucci (200:
Prob. inpatient Italia (2000) (HI= 0.050, t=2.57) etc						

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Practical relevance of the results

- Useful for identifying potential targets for policy action (e.g. specific groups of patients, types of care):

    - specific diseases (higher expected homogeneity of of care, identify critical areas of intervention e.g.community vs.hospital care)
    - Role of different health care policies (e.g. copayment systems, role of the private sector)

- Future work?
- Use of regional administrative data at EU/Italian level (such as e.g. Hospital records, Cancer Screening registers)
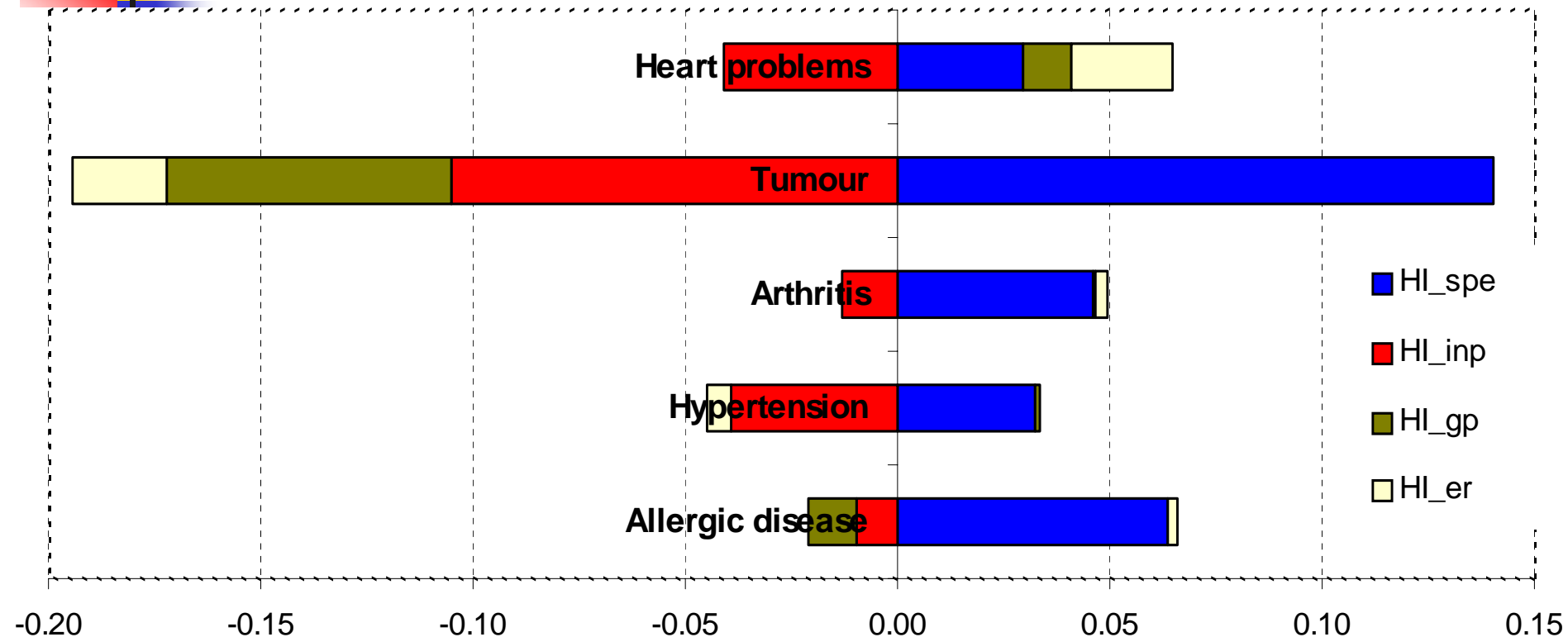
- *Thank you for your attention*

Appendix

Figure 6. Horizontal inequity index
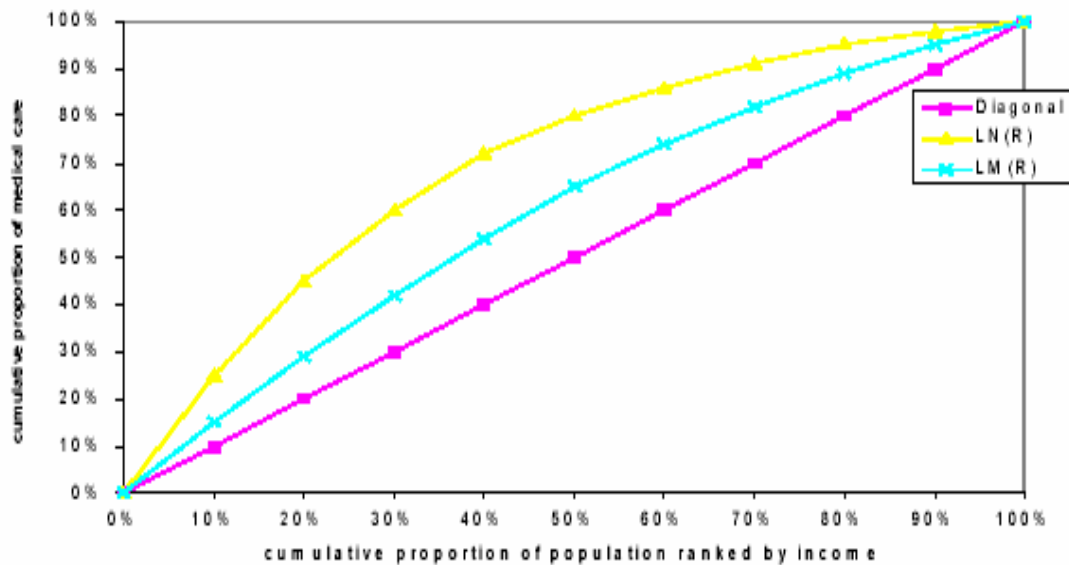
Inequity by 5 chronic diseases in Italy(Masseria & Giannoni, AIES Conference , 2005)

HI statistically significant: HI_sp (+) for allergic diseases, hypertension, arthritis, and tumour; HI_inp (-) for tumour; and HI_gp (-) for tumour.