Private Health Care Consumption in Italy

THE SECTOR AT A GLANCE

[*Executive summary OCPS report*]

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Private healthcare consumption (PHC) is an important part of the responses that advanced societies give to health and social needs...

Although most healthcare systems across the globe are characterized by a wide and deep public coverage, the presence of a relevant component of private finance and provision is a common feature.

The coexistence of public and private mechanisms and institutions in healthcare has always and everywhere been subject of discussion. A fundamental starting point for any analysis and judgement about public and private involvement in healthcare is the distinction between sources of funding on the one hand and providers on the other.

Looking at funding sources, they can be either public or private.

Public financing schemes are the dominant option across EU countries and imply that resources derive from one or more public channels/sources:

- general taxation;
- social health insurance;
- other compulsory prepaid schemes.

Private financing schemes imply that resources derive, directly or indirectly, from households or enterprises, via:

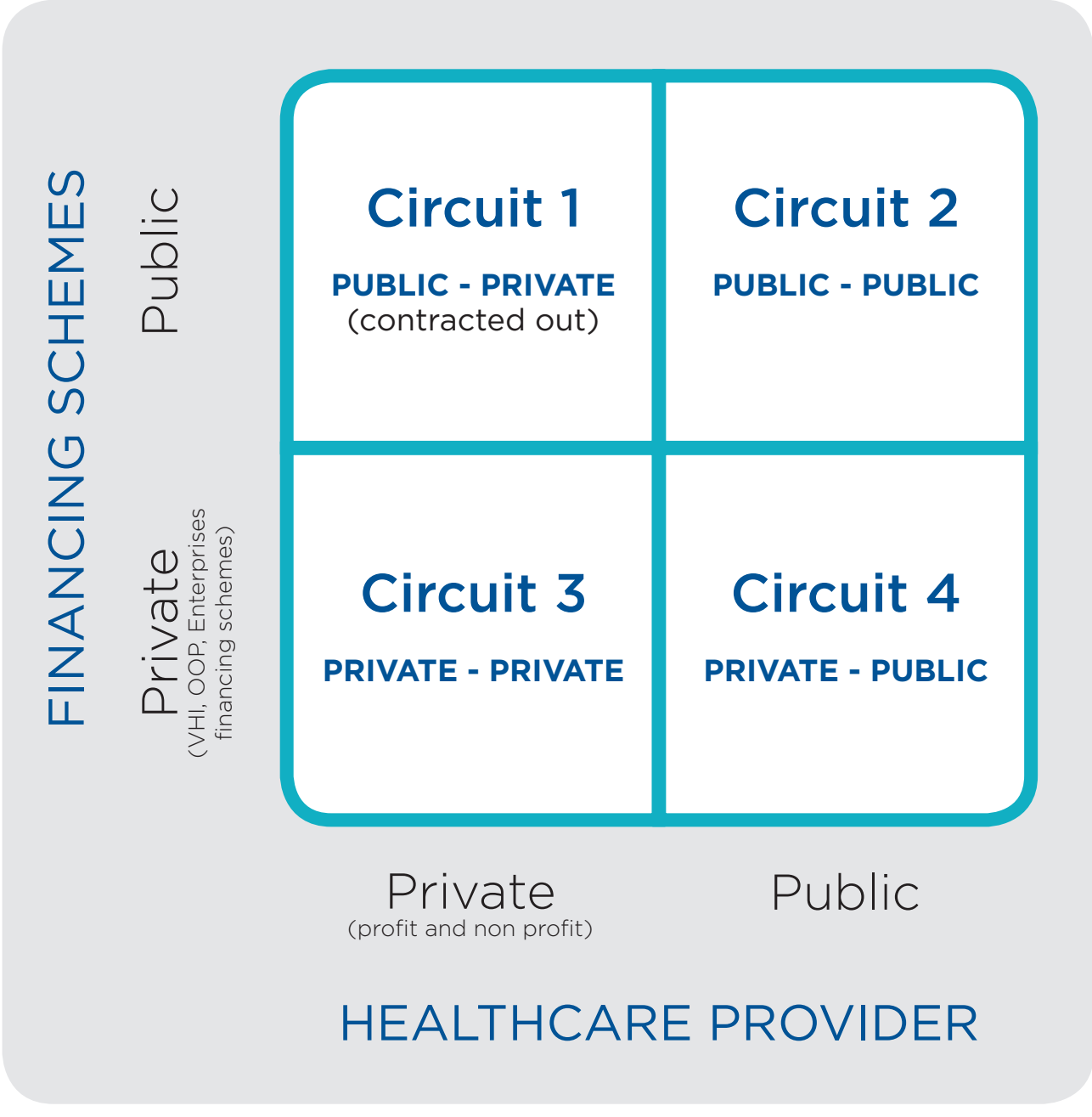
- out of pocket expenditures (OOP);
- voluntary health insurance (VHI);
- enterprises financing schemes (occupational medicine);
- other private voluntary schemes.

Irrespective of their funding sources, the providing organizations can be either public or private (either for profit or not for profit).
This results in a well-known two by two matrix that singles out different circuits in healthcare consumption (Figure 1). Each circuit has its own characteristics and dynamics, but a fundamental distinction remains between public (circuits 1 and 2) and private (circuits 3 and 4) consumption.
The mission of OCPS is to provide data, analyses and interpretations for a better and more systematic knowledge of private consumption role in fulfilling healthcare needs of the Italian society.
There are two main reasons that make private consumption a relevant issue in the analysis of healthcare systems.
The first is the constant need to find alternative sources of funding in environments experiencing severe limitations to the growth of public expenditure.
The second, although less considered, is the growing interdependence between public and private consumption: consumers are approaching healthcare as an integrated package made up of a mix of goods, services, providers and financial schemes.
Additionally, phenomena such as the ageing population, the diffusion of chronic conditions, the modification of individual attitudes and behaviors towards health services have been transforming healthcare-related consumption from a sequence of random events to a more continuous and systematic experience, in which individuals use and mix public and private resources to satisfy their perceived needs.
The Observatory on Privately Financed Health Consumption (OCPS) at SDA Bocconi is dedicated to the study of this specific sector, taking also into account the interrelationship it develops with the rest of the healthcare system.
OCPS researchers believe that, under certain conditions, private consumption can have a positive impact on the dynamics of healthcare systems and that:

- healthcare should remain a sector largely governed by collective decisions;
- the role of public providers in maintaining a general framework of public governance is fundamental.

FIGURE 1

PUBLIC AND PRIVATE MIX IN FINANCING AND PROVISION



IN A SNAPSHOT

39.7 billion
euros in 2017
Private health expenditure (26% of total health expenditure)

Dental care counts for **21%** **of the sector**

11 out of 60 milion
people covered with some form of voluntary health insurance

10%
of private health expenditure returns to the public system

40%
of specialist consultations financed totally through out-of-pocket

PRIVATE HEALTHCARE CONSUMPTION IN PUBLIC HEALTHCARE SYSTEMS: HOW ITALY COMPARES

Private health expenditure (PHE) in Italy is worth 39.7 billion euros, approximately the 26% of total health expenditure

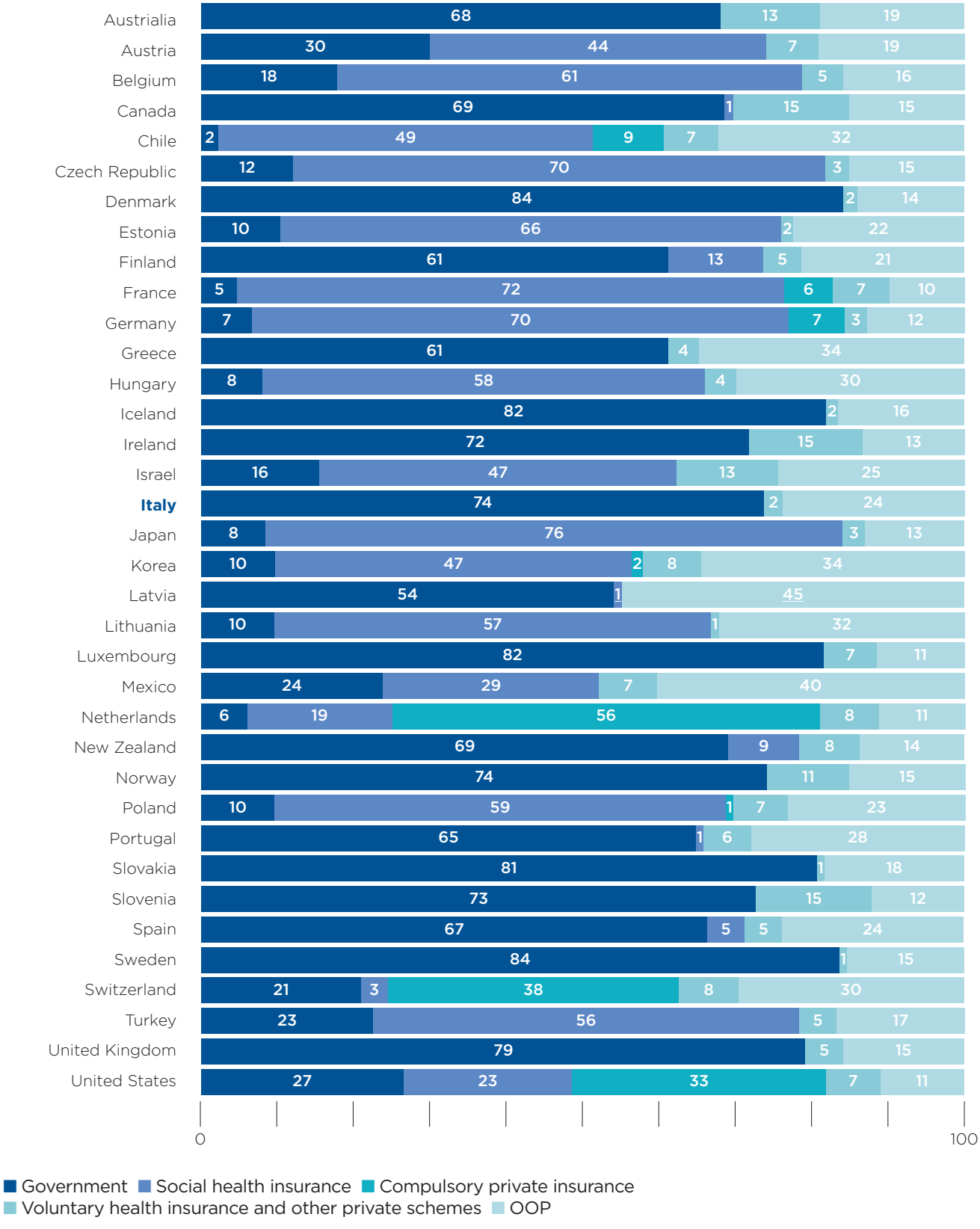
Such figures are in line with average levels recorded in OECD countries and with the figures of those countries characterized by universal coverage such as France, Germany and the UK.

In Italy the largest part of private health expenditure (24%) is made up of household OOP payments

That is a peculiarity if compared to other European countries. In France for instance, where the private health expenditure accounts for 23% of total health expenditure, the share financed by households amounts to 10% of it. However, healthcare operators and analysts forecast an increase in voluntary health insurance (VHI) expenditure in the coming years.

FIGURE 2

EXPENDITURE ON HEALTH BY TYPE OF FINANCING IN OECD COUNTRIES (2017, OR CLOSEST YEAR)



Source: OCPS-SDA Bocconi on OECD Health Statistics, 2017

THE BROAD PICTURE: FACTS AND FIGURES

Looking at the dynamics of public and private health expenditure, the ratio between the two has been stable over the last ten years, with a slight increase of the private component of health expenditure occurring in the past three years (from 24% in 2013 to 25% in 2016).

Not surprisingly, private health expenditure depends on GDP while public expenditure is limited by budgetary policies

Over the past ten years the growth rates of public and private health expenditures have converged to low figures, in line with GDP growth rates. This is the result of two trends. On the one hand, public health expenditure has seen a reduction of its growth rate from 11% in 2004 to almost 1% in 2016, due to "cost containment" policies imposed by budget constraints (Table 1, Figure 3). On the other hand, private health expenditure has been following GDP growth rates throughout the whole period. Therefore, trends about the total health expenditure for the country are uncertain: the public component is likely to remain stable even if the economy recovers, while the private component is expected to grow as a result of the economic upturn.

TABLE 1

TOTAL, PUBLIC AND PRIVATE HEALTH EXPENDITURE

(2012-2017)

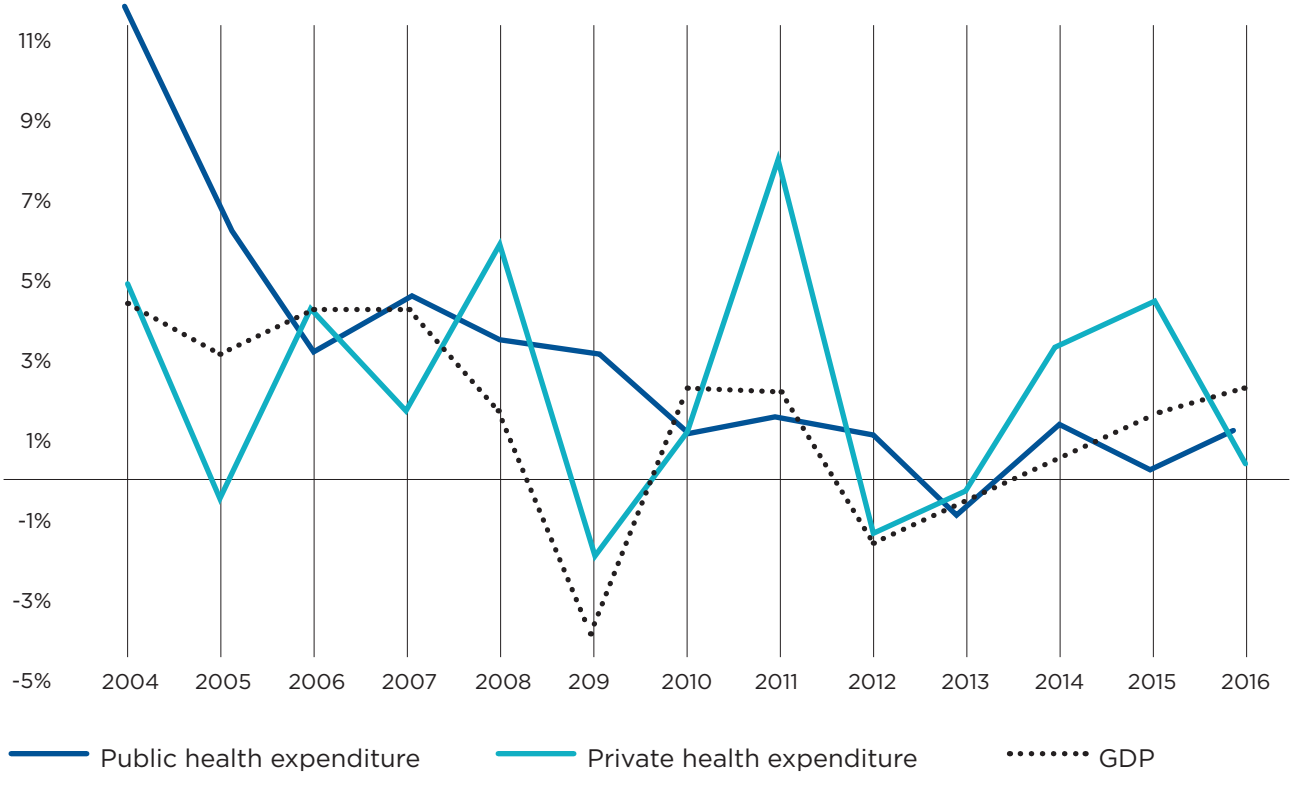
	2012	2013	2014	2015	2016	2017
Total health expenditure						
Bilion €	144.5	143.6	146.2	148.5	150.2	152.8
In % of GDP	9.0	9.0	9.0	9.0	8.9	8.9
Public health expenditure						
Bilion €	110.0	109.3	110.6	110.8	111.8	113.1
In % total public expenditure	76.1	76.1	75.6	74.6	74.5	74.0
% of GDP	6.8	6.8	6.8	6.7	6.7	6.6
Private health expenditure						
Bilion €	34.5	34.4	35.6	37.7	38.4	39.7
In % of total health expenditure	23.9	23.9	24.4	25.4	25.5	26.0
In % of GDP	2.1	2.1	2.2	2.3	2.3	2.3

Source: OCPS-SDA Bocconi on ISTAT SHA, 2018 (Total, Public and Private Health Expenditure) and ISTAT National Accounts, 2018 (GDP and Public Expenditure)

FIGURE 3

PUBLIC HEALTH EXPENDITURE, PRIVATE HEALTH EXPENDITURE, GDP

(GROWTH RATES, 2004-2016)



Source: OCPS-SDA Bocconi on data from Cergas-SDA Bocconi (Public Health Expenditure) and ISTAT National Accounts (GDP and Private Health Expenditure), 2017

On average, families spend a higher share of their budget on alcoholic beverages, tobacco and narcotics (4.1%) than on healthcare (3.5%)

Private health expenditure has been stable over the years, especially when compared to other household consumption items. Over the period 2009-2017, households have kept expenditure on health stable at around 3.5% of their total expenditure (Table 2).

TABLE 2

COMPONENTS OF HOUSEHOLDS' EXPENDITURE

(% OF TOTAL HOUSEHOLD BUDGET, 2009-2017)

	2009	2010	2011	2012	2013	2014	2015	2016	2017
Food and non-alcoholic beverages	14.8	14.5	14.3	14.3	14.4	14.3	14.3	14.3	14.2
Alcoholic beverages, tobacco and narcotics	4.1	4.0	4.0	4.2	4.2	4.1	4.1	4.2	4.1
Clothing and footwear	6.5	6.6	6.6	6.3	6.2	6.3	6.3	6.2	6.1
Housing, water, electricity, gas and other fuels	22.6	22.6	22.6	23.7	24.4	23.9	23.8	23.6	23.4
Furnishings, household equipment and routine household maintenance	6.7	6.9	6.8	6.4	6.3	6.3	6.2	6.2	6.2
Health	**3.2**	**3.1**	**3.3**	**3.3**	**3.3**	**3.4**	**3.5**	**3.5**	**3.5**
Transport	12.3	12.2	12.3	12.2	11.9	12.0	11.9	12.2	12.4
Communication	2.8	2.8	2.7	2.7	2.5	2.3	2.3	2.3	2.3
Recreation and culture	7.0	7.2	7.1	6.8	6.5	6.5	6.6	6.6	6.6
Education	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Restaurants and hotels	9.4	9.4	9.4	9.6	9.7	9.8	10.0	10.1	10.4
Miscellaneous goods and services	9.6	9.7	10.0	9.6	9.7	10.0	9.9	9.9	9.9
Total household expenditure	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**

Source: ISTAT National Accounts, 2018

According to OCPS, private health expenditure is worth 39.7 billion euros and the figure grows up to approximately 46 billion when considering a wider definition of pharmaceutical products (homeopathic, vitamins and minerals, supplements etc.)

Inpatient services related to acute care and LTC amount to 5.5 billion euros, outpatient services to 20.6 billion and medical goods to 13.7 billion euros (Table 3). Health services make up the 65.4% of PHE whereas medical goods constitute the 34.6% of it.

TABLE 3

PRIVATE HEALTH EXPENDITURE BY PURPOSE (2017)

COICOP (classification of individual consumption according to purpose)	Bilion €	%
Inpatient services	5.5	13.6
(acute and rehabilitative cares in hospitals and LTC delivered in facilities with medical supervision)		
Outpatient services	20.6	51.8
Medical services	5.0	12.6
Dental services	8.5	21.4
Paramedical services	7.1	17.8
Medical products, appliances and equipment	13.7	34.6
Pharmaceutical products	8.8	22.2
Other medical non-durable goods	1.4	3.6
Therapeutic appliances and equipment	3.5	8.8
Total private health expenditure	**39.7**	**100**

Source: OCPS-SDA Bocconi estimates on data from Agenzia delle Entrate (Italian Tax Authorities), AIFA (Italian Medicines Agency), Corte dei Conti (Court of Auditors), Federfarma, GFK, ISTAT (SHA and Household Budget Survey), Ministero della Salute (Department of Health)

About 10% of private health expenditure returns to the public system through cost-sharing and private practice in public organizations

Private spending is typically associated with private sector supply and market mechanisms. Yet, a significant part of private expenditure involves the public system directly. Firstly, private spending can be the result of co-payment schemes (tickets and the price differences for branded drugs). Tickets can be charged both on goods (0.5 billion euros in revenues for the government) and services (1.3 billion euros in revenues for the government). Secondly, the public system also plays a role on the "free market". In fact, private practice in public hospitals (the so-called *intramoenia*) amounted to 1.0 billion euros (Figure 4). As regards the goods, it should be noticed that about 1.1 billion euros within total PHE is the result of the price difference between branded and generic equivalent drugs that citizens choose to fund with their own finances.

FIGURE 4

PRIVATE HEALTH EXPENDITURE FLOWS BY RECIPIENT AND NATURE OF EXPENDITURE

(2017 OR CLOSEST YEAR, VALUES IN BILLIONS €)

		Type		Total	
		Services	Goods		
Recipients	**Public**				
	Co-payments	1.3	0.5		
	Private practice in public organizations	1.0	Ø	**3.9**	**9.8%**
	Branded-unbranded difference	Ø	1.1		
	Private	23.7	12.1	**35.8**	**90.2%**
	Total private expenditure	26.0	13.7	**39.7**	**100%**

Source: OCPS-SDA Bocconi on data from AIFA, Corte dei Conti (Court of Auditors), ISTAT, Ministero della Salute (Department of Health)

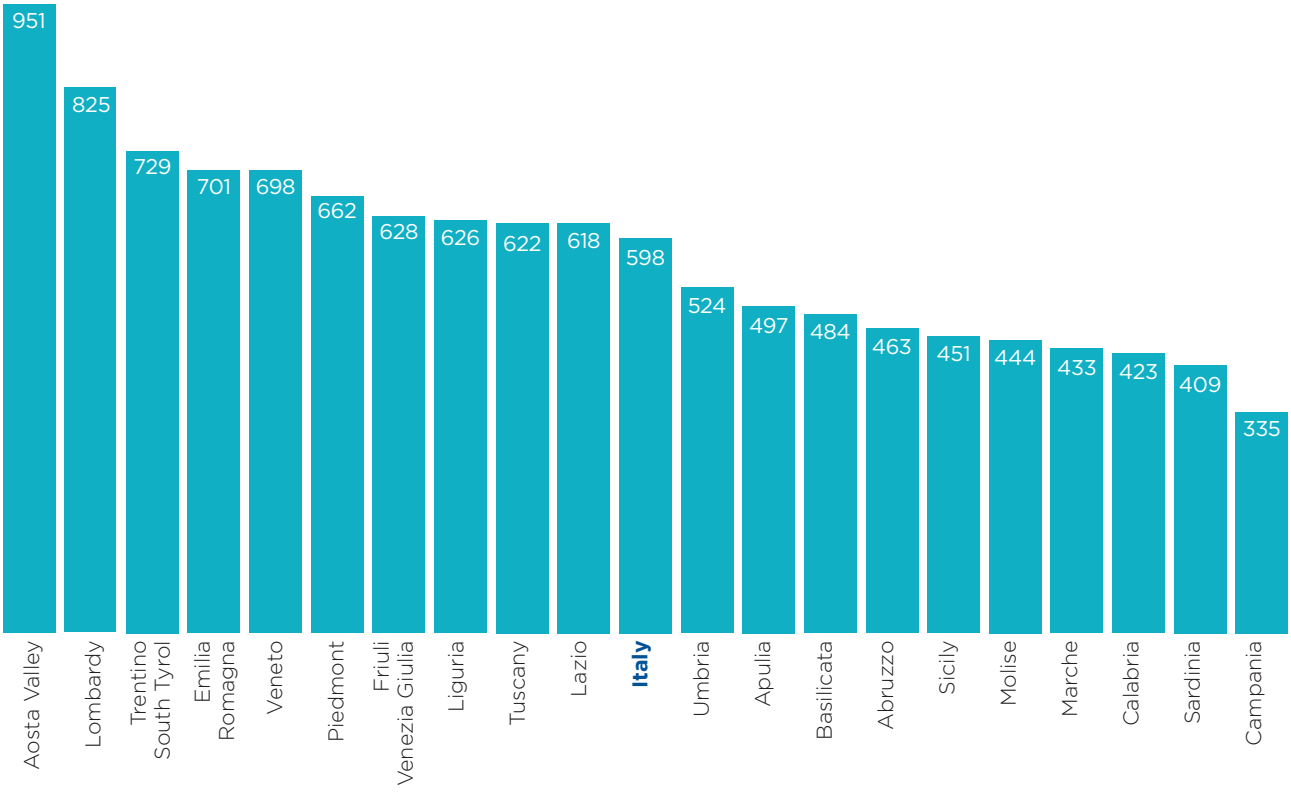
In terms of regional differences: private health expenditure is higher where GDP is higher and where the public healthcare system works better

The regions characterised by the highest levels of private health expenditure are Aosta Valley, Lombardy, Trentino South Tyrol and Emilia Romagna. At the other end of the spectrum, Calabria, Sardinia and Campania stand out (Figure 5). Such distribution mirrors the North-South divide in economic conditions. Indeed, there is a *positive correlation between the healthcare expenditure of households and income levels*. At the same time, also public systems show better results where the economy functions better. Hence, private healthcare expenditure is positively correlated with the *quality of the public service*.

FIGURE 5

AVERAGE HOUSEHOLDS' HEALTH EXPENDITURE PER CAPITA, REGIONAL DIFFERENCES

(2015-2017)



Source: OCPS-SDA Bocconi on data from ISTAT Household Budget Survey, 2015-2017

Socio-economic differences are a key factor in explaining private healthcare consumption

To further investigate the role of the economic conditions in explaining private health consumption, OCPS has divided Italian households into five socio-economic classes, according to the total equivalized household expenditure. Such representation confirms that, despite differences in public health systems, economic conditions constitute the dominant variable in explaining private health consumption. Indeed, the top 5% of households (which spend more than 5,200 euro per month) spends approximately the 13% of the cumulative households' health expenditure. The most significant variation with respect to the economic conditions is registered for the expenditure in dental services; instead, the expenditure for medical services and goods do not change significantly due to the economic conditions. Table 4 shows how the propensity to spend on health varies greatly with economic conditions: within the bottom 5% group, the 49% of households spend on health, and they spend on average about 51 euros per month; within the top 5% group, the 91% spends on health and such expenditure amounts on average to approximately 254 euros per month. Therefore, the positive correlation between economic conditions and households' health expenditure is accompanied by a growth in the number of households that spend on health.

TABLE 4

PER HOUSEHOLD PRIVATE HEALTH EXPENDITURE (PHE) BY SOCIO-ECONOMIC CLASSES

(2016)

Socio-economic classes Intervals of monthly equivalized household expenditure (€)	**Bottom 5%** (0-839)	**30%** (839-1,708)	**30%** (1,708-2,550)	**30%** (2,550-5,199)	**Top 5%** (5,199-19,738)
Monthly per household health expenditure (€)	24.67	56.87	99.12	165.43	254.09
% of households spending for health	48.73	72.14	81.37	86.10	90.96
Monthly per household health expenditure, for households spending for health (€)	50.62	78.83	121.82	192.14	279.34

Source: OCPS-SDA Bocconi on data from ISTAT Household Budget Survey, 2017

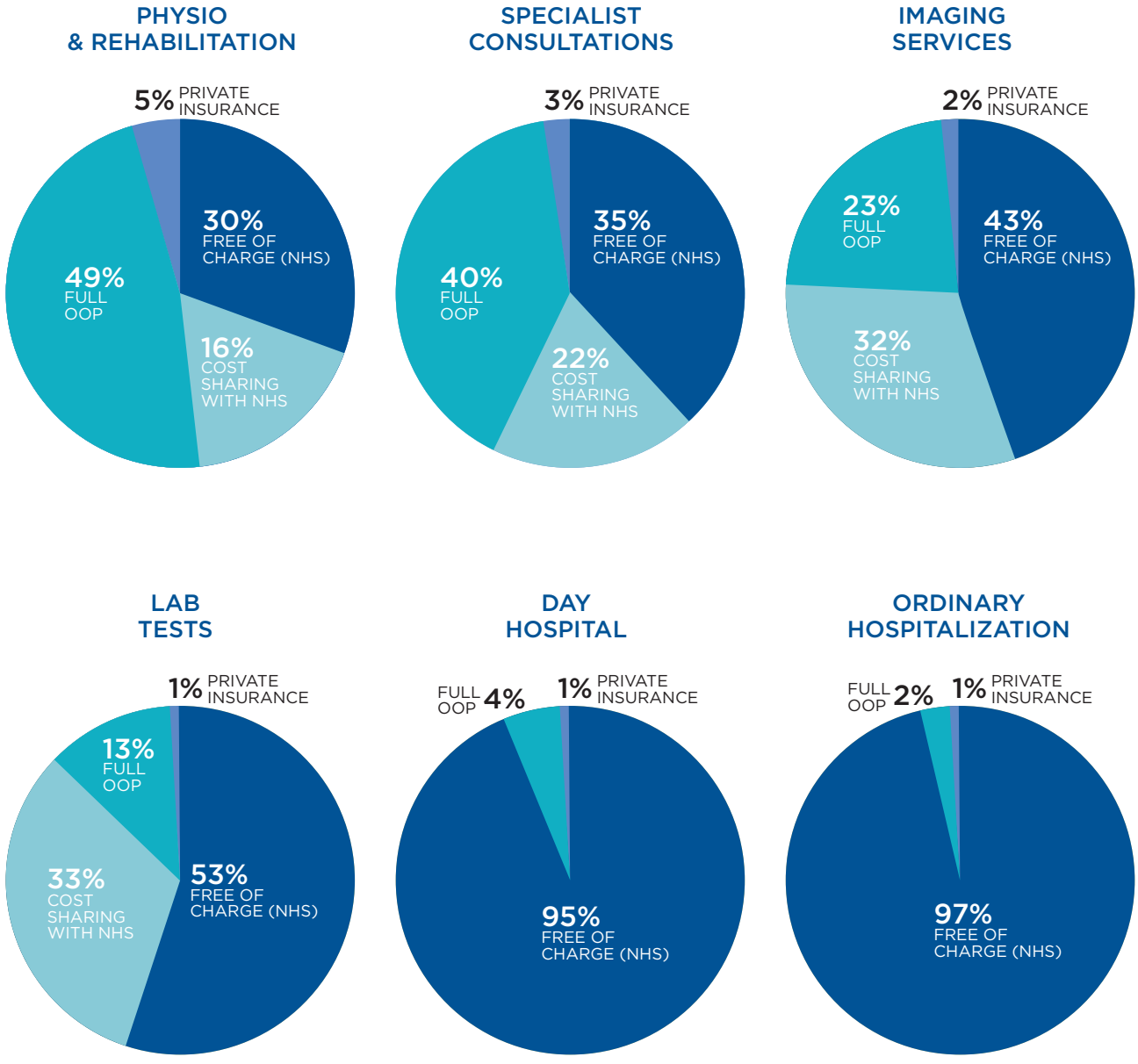
Around 50% of physio & rehab treatments are purchased out-of-pocket, whereas out-of-pocket payments for hospitalization amount to 2%

The mix of sources of payment changes across the various healthcare services. Figure 6 *shows the funding methods for some of the most important sectors in healthcare*. Almost 50% of the cost for rehab treatments is borne by the consumer, and only 30% is provided free of charge by the NHS. Specialist consultations follow a similar pattern, whereas Lab tests and imaging services feature higher shares of public funding and cost-sharing schemes. In contrast, almost all hospital admissions (97%) are provided free of charge by the NHS.

FIGURE 6

PURCHASING METHODS OF HEALTHCARE TREATMENTS. PERCENTAGE OF POPULATION THAT DECLARED A CERTAIN TYPE OF PURCHASING METHOD FOR LAST HEALTH SERVICE

(2013)



Source: OCPS-SDA Bocconi on data from ISTAT Health conditions and use of healthcare services Survey, 2015

PRIVATE CONSUMPTION IN ACUTE CARE

The hospital sector in Italy is composed of two major types of acute care providers: public providers and private providers affiliated with the NHS. Affiliated private providers are either for profit or not-for-profit organizations that deliver healthcare services, with the NHS financing the activities it commissions. Independent non-affiliated private providers exist, but they represent a very small portion of the total.

There are different options to "go private" in acute care

Both public and private hospitals are financed for the most part through the NHS budget. However, they both offer services on the market. A patient may decide to purchase the "full package" in private practice, or just part of it (single items to be added on top of the standard NHS service). When purchasing single items, the patient is actually "buying" the possibility to choose the practitioner/team and/or a special accommodation (a single or more comfortable bedroom - if available). When buying "on top", the patient is still enrolled in the public waiting list. Buying the full package instead translates into all the above-mentioned items, coupled with a dedicated agenda ("fast track" channel to skip NHS waiting times) as well as specific care services (dedicated nurses, for example).

Small numbers: only 2.0% of total hospital discharges are linked to private hospitalizations

Out of approximately 8.5 million discharges in 2016, private (total or partial) inpatients in public and private commissioned facilities amount to 173,164 (Table 5), making up only the 2.0% of total hospitalizations. Additionally, the number of discharges from purely private facilities should also be considered, although comprehensive data on those is not available. These lacking discharges are all entirely private and in 2012 (last data available) amounted to about 50,000.

TABLE 5

HOSPITAL "PRIVATE" DISCHARGES BY TYPE OF "PRIVATE" SERVICE PURCHASED

(2016)

Type of "private" service	Public & commissioned private	%
Entirely private (full package)	101,623	1.19
Partially private (accommodation only)	43,889	0.52
Partially private (accommodation and choice of practitioner)	27,652	0.32
Total	**173,164**	**2.0**

Source: OCPS-SDA Bocconi on Discharged Records Data (SDO) from Department of Health, 2017

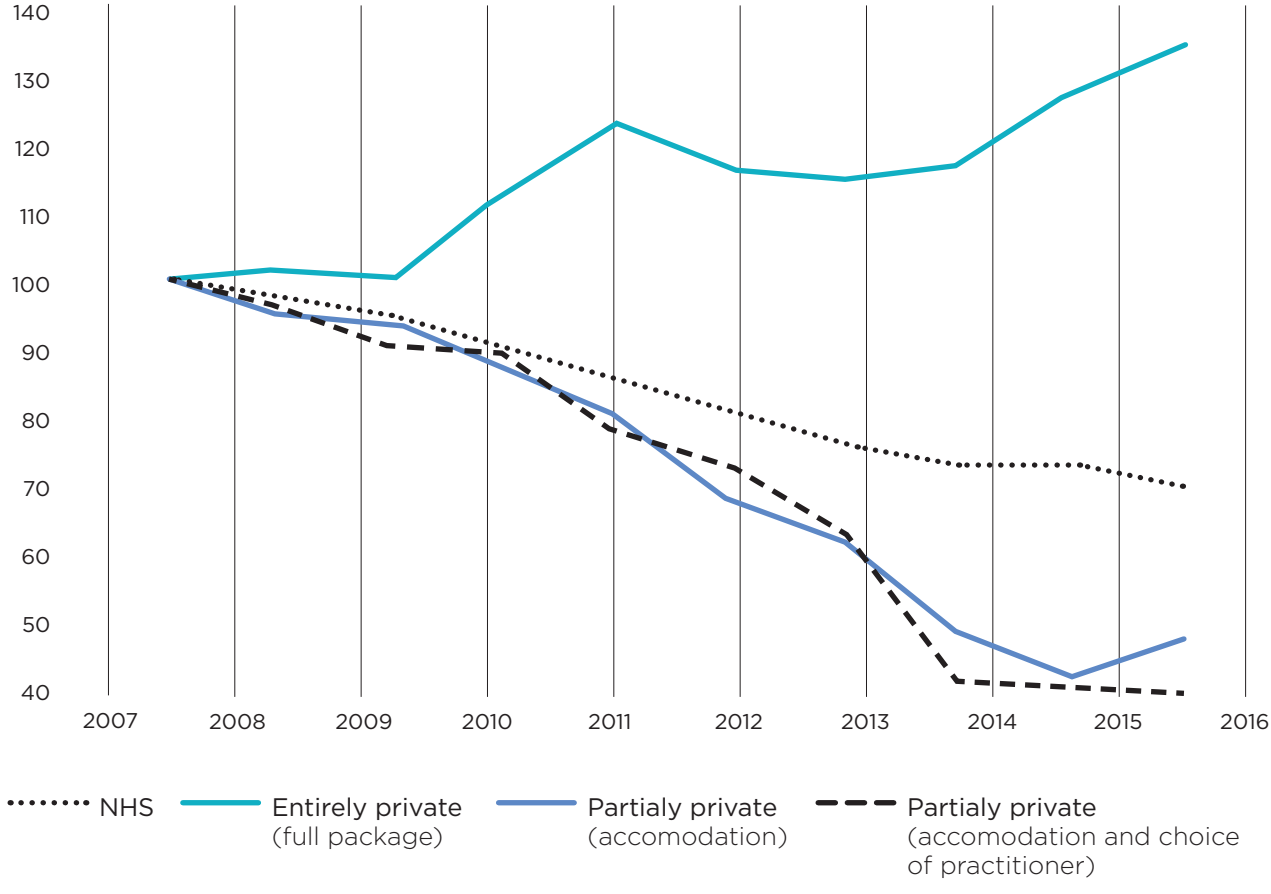
Trends show an increase in entirely private acute care

Between 2007 and 2016, private payments for special accommodations and for choosing the doctor/team have decreased, together with the amount of NHS hospitalizations. On the other hand, discharges referring to fully paid services have increased (Figure 7). The underlying reason is that the first two are closely related to NHS-financed services while the entirely private packages are independent; yet, volumes in this category are not large enough to compensate for NHS cost containment policies.

FIGURE 7

TRENDS OF HOSPITAL INPATIENT DISCHARGES, BY TYPE OF PURCHASING METHOD

(2007-2016, 2007 = 100)



Source: OCPS-SDA Bocconi on Discharged Records Data (SDO) from Department of Health, 2008-2017

Private hospitals are experimenting new strategies to improve their position in the private market

OCPS carried out a survey among members of the Italian Association of Private Hospitals (AIOP) in order to better understand their strategies towards the private market, the revenue streams involved, the proportion of private services with respect to the total and their pricing methods. It appears that the strategies envisioned by the various commissioned private providers have many elements in common. Firstly, they all ought to strengthen their existing productive lines and marketing analysis in order to further develop in those areas of the industry where there is potential to grow. Secondly, they intend to work on fostering commercial policies, such as agreements with individuals and collective actors, and on building effective "product packages" that ensure that better experience of care is delivered to patients. Finally, there is a common need to empower ICT and operation management systems, in order to make costing procedures more transparent.

THE PUBLIC/PRIVATE MIX FOR SPECIALIST CONSULTATIONS

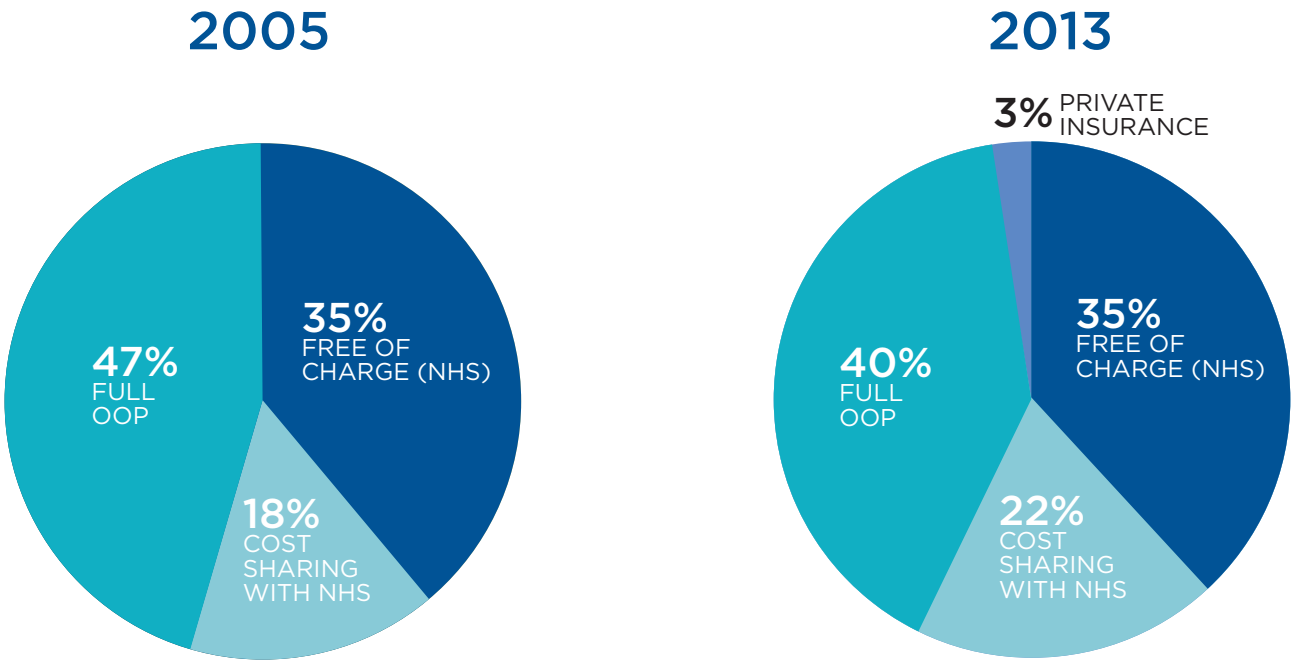
Specialist consultations are one of the services in healthcare most frequently used by the population. According to ISTAT, in 2013 around 50% of the Italian population have had at least one consultation. The large volumes of specialist consultations result in a complex mix of purchasing channels: 35% of visits are free of charge, 22% are purchased through cost-sharing with the NHS, 35% fully OOP, and 3% are purchased through private medical insurance.

The introduction of the "super ticket" in 2006 has contributed to a full crowding out of OOP consumption, that has been largely replaced by the ticket (co-payment)

Between 2005 and 2013 there has been a decrease in the share of visits paid OOP, from 47% to 40% (Figure 8), while those purchase with the ticket (cost sharing with the NHS) have experienced a slight increase from 18% to 22% and free of charge visits have remained stable at 35% of the total visits. Such variations may be the result of an inelastic supply and rigid prices despite the economic recession that has occurred in those years. The supply side conditions, however, are changing: for instance, new business models are emerging in the market, such as the ones based on the "low cost-high value" paradigm.

FIGURE 8

PURCHASING MIX FOR SPECIALIST CONSULTATIONS: 2005-2013 COMPARISON



Source: OCPS-SDA Bocconi on data from ISTAT Health conditions and use of healthcare services Survey, 2015

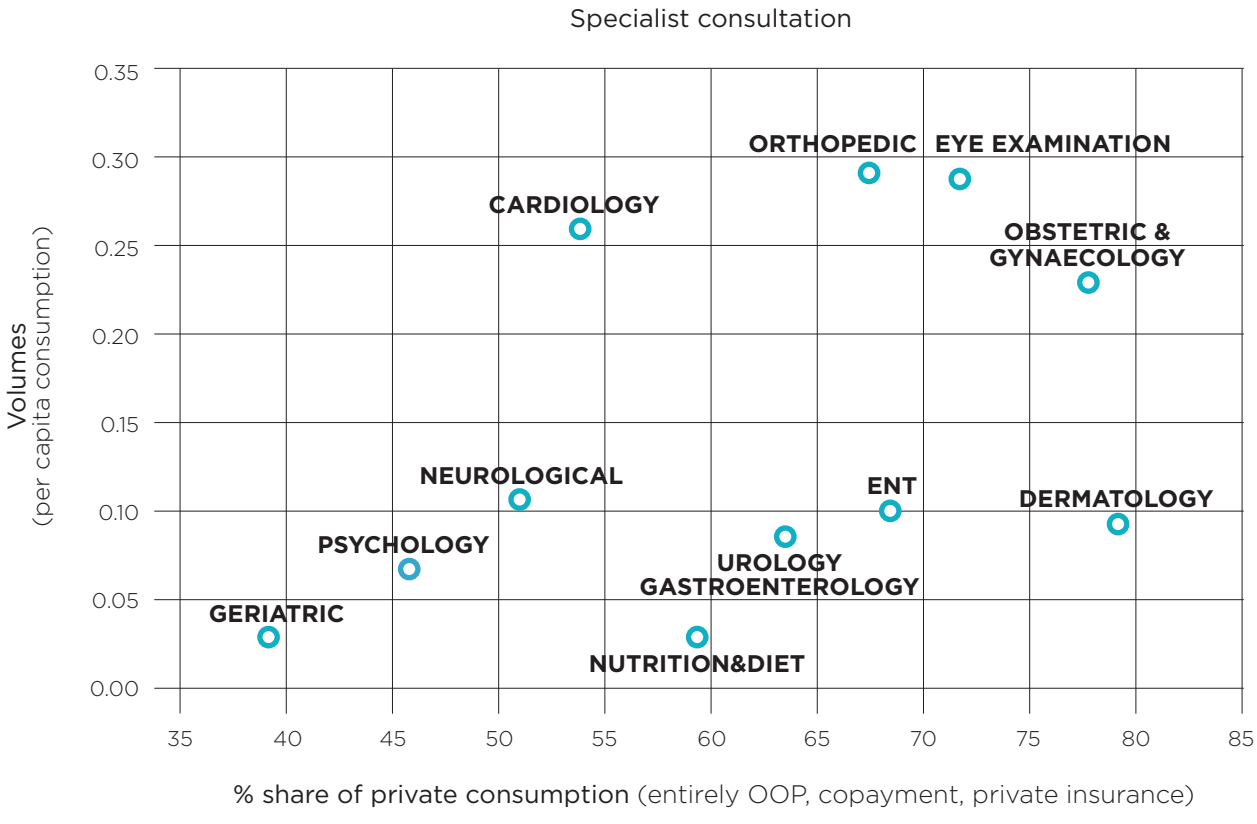
Cardiology, orthopedic, gynaecologic and eye examinations are the top four specialist consultations in terms of OOP funding

Orthopedic and gynecology consultations present similar figures in terms of total volumes of out-of-pocket consumption (Figure 9), but the latter relies much more on OOP payment channels. Furthermore, cardiology is one of the areas of highest patient affluence, but OOP is not among the most preferred funding methods.

FIGURE 9

SPECIALIST CONSULTATIONS: TOTAL CONSUMPTION VS. OOP CONSUMPTION

(2013)



Source: OCPS-SDA Bocconi on data from ISTAT Health conditions and use of healthcare services Survey, 2015

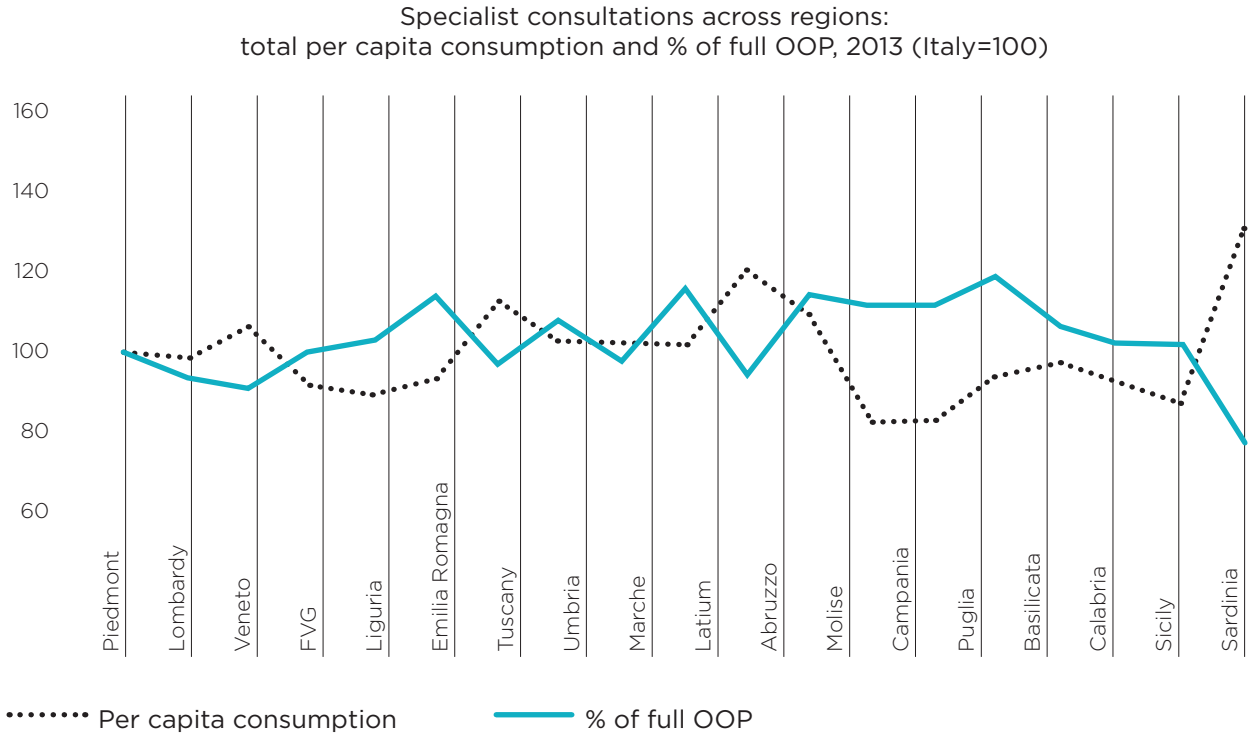
No large variations in OOP levels among regions

It is interesting to note that, despite the well-known disparities in regional health systems (RHS) and socio-economic characteristics, patterns in terms of specialist consultation consumption and percentage of OOP do not vary extensively across regions (Figure 10). Indeed, the variation coefficients for both variables (specialist consultation consumption and percentage of full OOP) are 13% and 12%, respectively.

FIGURE 10

SPECIALIST CONSULTATIONS: TOTAL CONSUMPTION VS. FULL OOP CONSUMPTION

(2013)



Source: OCPS-SDA Bocconi on data from ISTAT Health conditions and use of healthcare services Survey, 2015

DENTAL CARE: CONSUMER BEHAVIOUR AND PERCEPTIONS

Dental care lies largely outside public boundaries as only 12% of dental care is provided through the NHS. Public oral healthcare is limited to only three categories/conditions: dental healthcare programmes for children (0-14 years); people in particularly vulnerable conditions (very poor people and sick individuals with oral health at risk); emergencies, as all citizens have direct access to a "first treatment" in the case of severe and urgent infections, trauma and pain.

Regarding the structure of the industry: there are 36,400 individual firms out of 44,000 providers

Care is mostly provided by private dental practices, with a large number of small-size dentist offices classified as individual firms (36,400) and dentistry companies (2,300). However, there are signs of an increase in new models of supply both in the form of new modes of delivery (franchising, low-cost) and of joint public/private care.

Expenditure for dental care is one of the largest components of private health expenditure (about 21%)

Households expenditure on dentistry was estimated in 2017 to approximately amount to 8.5 billion euros. Dental care expenditure reaches up to 2,080

euros per year in the "top spender" group, while it decreases to around 355 euros when considering people that show at least "one purchase" of a dental service during the year (37% of the population).

There are strong North-South regional differences

In Trentino South Tyrol about 46% of the population has had "at least one privately purchased dental service" during the year, while in Campania, the percentage drops to the 26% of the population.

TABLE 6

PEOPLE WITH AT LEAST A PRIVATELY PURCHASED DENTAL SERVICE DURING THE YEAR (% OF TOTAL POPULATION AND AVERAGE SPENDING PER CAPITA), PER REGION

(2016)

Regions	Italian population		People with at least a dental service purchase	
	Residents	Annual dental spending per capita €	% of total residents	Annual dental spending per capita €
Piedmont and Aosta Valley	4,457,374	164	42	393
Lombardy	9,946,718	268	41	660
Trentino South Tyrol	1,039,603	242	46	521
Veneto	4,871,562	137	44	309
Friuli Venezia Giulia	1,209,152	169	47	360
Liguria	1,557,759	123	41	297
Emilia Romagna	4,415,364	134	44	304
Tuscany	3,723,719	114	40	282
Umbria	885,160	178	44	406
Marche	1,533,736	97	39	251
Latium	5,852,235	81	32	252
Abruzzo	1,320,746	115	39	295
Molise	310,381	100	34	289
Campania	5,825,173	30	26	116
Apulia	4,051,436	114	28	404
Basilicata	570,107	110	32	343
Calabria	1,959,525	60	31	194
Sicily	5,021,409	49	29	172
Sardinia	1,649,850	34	33	105
Italy	**60,201,008**	**130**	**37**	**355**

Source: OCPS-SDA Bocconi on data from ISTAT Household Budget Survey, 217 (spending per capita and population) and European Health Interview Survey, 2017 (people with at least a dental service purchase)

Elderly people show higher access to oral care

2015 data show that the percentage of people aged 24 or less who have never been to the dentist amounts to the 12.4% of the group, although national guidelines for preventive dental care recommend undergoing a check-up at least once a year. However, there has been a decrease in people who have never been to a dentist between 2013 and 2015. Nevertheless, except for elderly, almost 50% of people in each age group stated that they had at least one dental treatment in the last 12 months.

TABLE 7

PERCENTAGE OF PEOPLE WHO HAVE NOT BEEN TO THE DENTIST/ORTHODONTIST, BY AGE GROUP (2015)

Age groups	In the last 12 months	More than 12 months	Never
15-24	49.4	36.9	12.4
25-34	47.0	42.5	8.6
35-44	48.3	44.5	5.7
45-54	50.2	43.7	5.0
55-64	46.6	47.6	4.5
65-74	42.6	51.0	5.0
More than 75	28.9	63.3	6.9
More than 65	35.7	57.2	6.0
Total	**45.2**	**46.9**	**6.6**

Source: ISTAT European Health Interview Survey, 2017

Access to dental services in the last year (2015 year of interview) varies according to the type of treatment/service

Consultations (79.9%) constitute the service category with the highest rate of consumption. Remedial treatments (36.5%), extractions (18.3%), periodontal cares (20.6%), rehabilitation treatments (6.3%) and corrective appliances (5.0%) follow. Northern regions present a higher access for consultations while southern regions are characterized by higher frequency of tooth extraction.

TABLE 8

PROPORTION OF THE POPULATION THAT HAS GONE TO THE DENTIST/ORTHODONTIST IN THE LAST YEAR, BY GEOGRAPHICAL AREA AND TYPE OF TREATMENT (2015)

Geographical area	Extractions	Remedial treatments	Consultations	Corrective appliances	Periodontal care	Rehabilitation treatments
North-West	18.8	36.8	82.1	5.3	23.1	6.4
North-East	14.0	33.7	84.2	3.7	19.2	5.9
Center	18.4	34.4	78.7	4.9	21.8	7.0
South	21.3	39.9	75.6	5.7	18.7	6.1
Islands	21.5	40.4	73.6	6.0	17.8	5.7
Italy	**18.3**	**36.5**	**79.9**	**5.0**	**20.6**	**6.3**

Source: ISTAT European Health Interview Survey, 2017

Just a few private insurance plans cover dental care

Private insurance plans typically exclude dental care from the covered services and just a few plans include routine dental care and some prosthetic devices. However, since 2008 this market has been evolving as a consequence of the new willingness to develop dental plans as a part of the coverage provided by corporate medical insurance through preferred provider networks. However, since 2008 the sector has been evolving given the willingness of the players to develop dental plans with networks of preferred providers as a part of the coverage provided for by corporate medical insurance.
Some insurance companies offer individual plans that provide for check-ups, emergency treatments and access to a network of dental centers at favorable terms.

Top spenders in dental services tend to be endowed with private insurance

Top spenders count for 4% of the total population and make up 17% of total healthcare expenditure: the average expense of insurance premiums is about 1,900 euros per year and almost 46% of the cluster enjoys a private health insurance coverage.

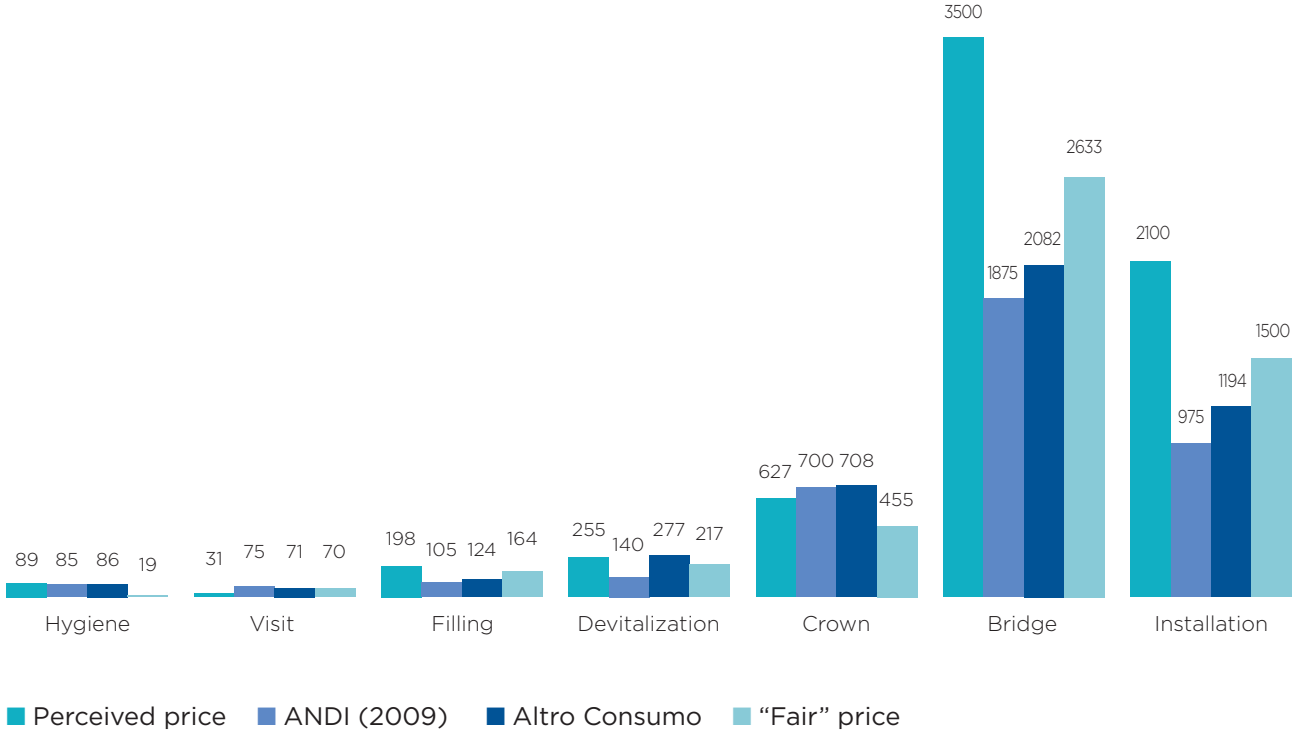
Top spenders in dental services are aware of the different alternatives on the market and the prices of consultations and treatments

Perceived prices are well-aligned with market prices collected by ANDI (the largest dentists' association) and Altroconsumo (a major consumers' association). The more complex the treatment is, however, the more difficult it is for the consumer to perceive the market price. Finally, what is considered the "fair price" is often lower than the "perceived price", but higher than the "true price" of the market.

FIGURE 11

PERCEIVED PRICES, MARKET PRICES (ANDI) AND FAIR PRICES FOR CLUSTER

(€)



Source: OCPS-SDA Bocconi Survey "Dental care: the voice of customers", 2014

Choosing the provider: three types of dental care consumers

According to the perception of and relationship with the supply of dental care and its value proposition, OCPS qualitative research has detected three types of dental clients.

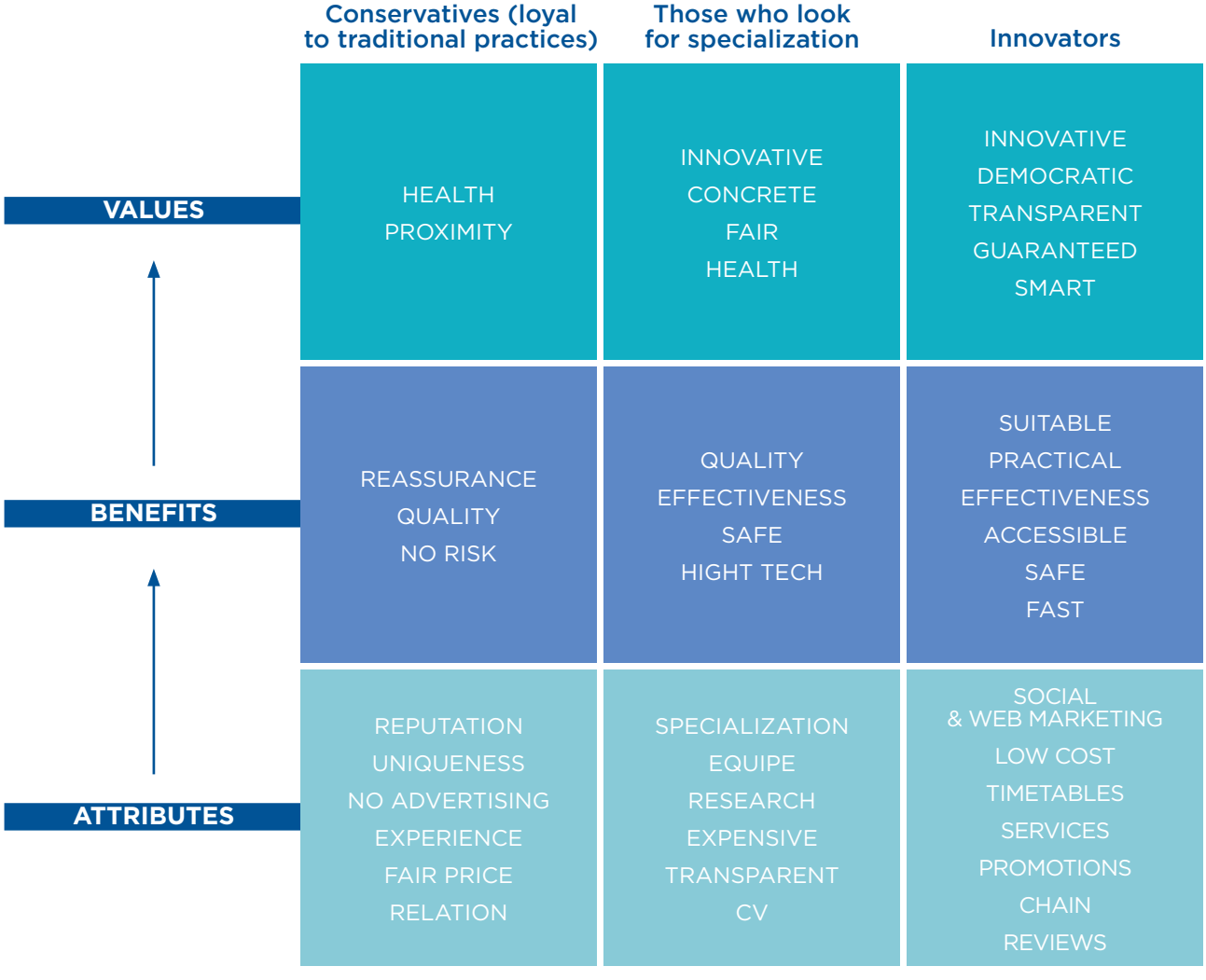
- Conservatives (loyal to traditional practices) who "think that when you have your own dentist, you go there to have any kind of dental treatment, you don't choose different specialists for different treatments. It's like your personal gynaecologist".
- Specialist-oriented, who use a variety of supply formats. They base their purchases on rational trust and prefer specialized professionals or teams of professionals and look for the best or most certified in the sector.
- Innovators select different formats according to their specific needs at that time. They are favourable to medical tourism, Groupon offers and use the web to make choices.

Different clients with different means-ends chain configurations

The means-ends chain shows specific configurations for each cluster. To provide an example, conservatives consider "relation", "reputation", "uniqueness", "no advertising" as main attributes linkable to benefits such as "quality", "no risks" and "reassurance"; those in turn mirror values such as "health" and "proximity" held in high regard by this typology of consumer (Figure 12).

FIGURE 12

MEANS-ENDS CHAINS OF THE DIFFERENT CLUSTERS



Source: OCPS-SDA Bocconi Survey "Dental care: the voice of customers", 2014

LTC FOR OVER 65: A MARKET FOR PRIVATE CONSUMPTION?

In Italy, there are about 13 million individuals aged 65 or more, 23% of which (about 3.0 million people) have functional limitations that impact their daily life. Among them, only the individuals with severe functional limitations and with particular conditions of vulnerability are entitled to receive public LTC (Table 9).

The population of over 65 individuals with limitations shows considerable differences

The percentage of the elderly with functional limitations rises to 32.9% in the over 75 segment (against 7.2% in the population between 65 and 74) and is higher among women (24.4% vs. 14.0% for men). In the South of Italy and the Islands, the proportion of people with functional limitations is significantly higher than in other geographical areas: this is related to the divide in socio-economic conditions that may produce differences in the underlying lifestyle. The most severe cases (confined at home) represent the 9.6% of the elderly group (1.226 milion people).

Long-term care for the elderly consists of residential care (288,000 people), home care (692,000 people), other community services (316,000 people) and cash benefits (about 1.5 million people)

The NHS manages home healthcare services and is responsible for the largest part of residential settings delivered by both public and accredited private providers. Municipalities manage social services at a local level. The National Social Security Institute (INPS) provides non means-tested cash benefits ("indennità di accompagnamento") to disabled people. Since the "indennità di accompagnamento" is a cash benefit it increases overall household income and compensates the household for the burden of informal care provided.

TABLE 9

OVER 65 AND LTC PROGRAM

(2015)

Over 65	Over 65 with functional limitations (target population)	Over 65 enrolled in LTC program			Over 65 receiving cash benefit
		Residential settings	Homecare settings	Others community services	
13,200,000	3,000,000	288,000 (9.6%)	692,000 (23%)	316,000 (10.5%)	1,500,000 (50%)

Sources: OCPS-SDA Bocconi integration from various sources (ISTAT, OCPS, OASI SDA Bocconi)

There is a large North-South divide in the availability of nursing homes or long-term care residential structures

The regional differences are significant, with a much larger supply of beds for the elderly available in the North with respect to the South (8.9 vs. 2.9 beds per 1,000 residents). Most of the elderly residents in the facilities also receive healthcare (89%), with different intensity: low-intensity (22%), medium (47%) and high (31%). The number of hospitalized elderly considered not self-sufficient – declared as such after a multidimensional evaluation – is over 218,000.

TABLE 10

ELDERLY IN SOCIAL AND HEALTHCARE RESIDENTIAL FACILITIES

(2015)

Geographic area	Beds	Over 65			Levels of healthcare			
		Self-sufficient	Not self-sufficient	Total	Low intensity	Medium intensity	High intensity	Total (with healthcare)
North-West	144,834	20,120	95,949	116,069	17,577	67,808	48,595	133,980
North-East	106,458	11,107	70,529	81,635	26,482	34,164	33,491	94,137
Central	63,787	15,167	26,804	41,971	15,096	24,029	12,443	51,568
South	40,528	12,235	14,780	27,015	10,222	18,431	7,422	36,075
Islands	35,081	10,437	10,558	20,995	7,719	18,529	5,882	32,130
ITALY	**390,689**	**69,065**	**218,620**	**287,685**	**77,096**	**162,961**	**107,833**	**347,890**

Source: ISTAT "Presidi residenziali socio assistenziali e socio-sanitari" Survey, 2017

Within the group of over 65 individuals receiving home care services, comparable portions of people receive either health or social care and only a minority of people receives both typologies of care

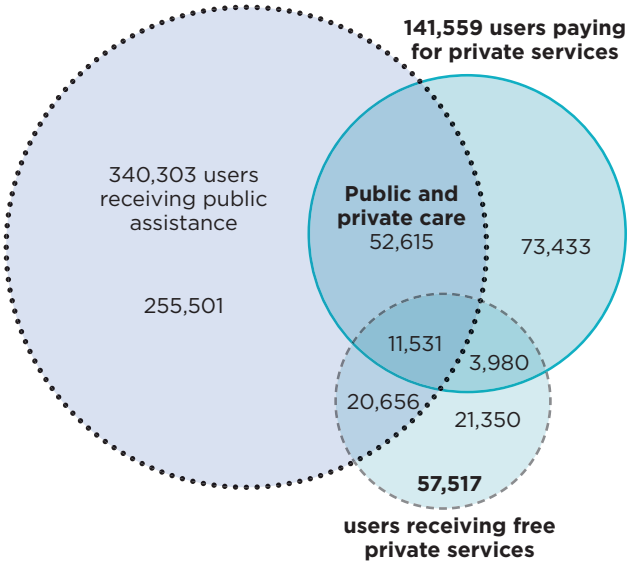
Figure 13 shows that around 440,000 people receive home care services from health professionals and an equivalent amount from other professionals. Around 27% of total recipients (185,000 out of around 692,000 people) receive both kinds of care. The mix of public and private care is different in the three groups of people with paid private services being predominant in the case of social care.

FIGURE 13

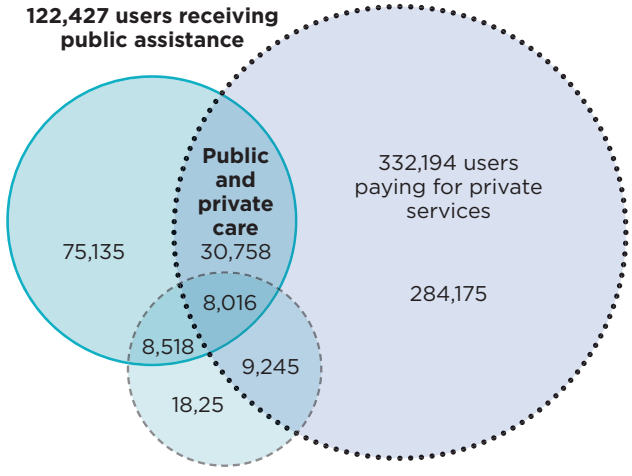
PUBLIC AND PRIVATE CIRCUITS OF HOMECARE FOR OVER 65

(2013)

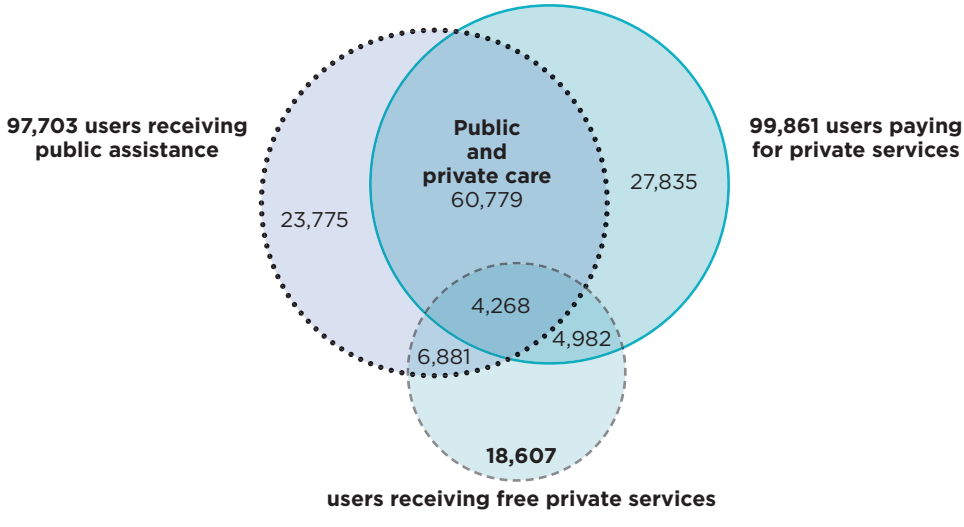
Over 65 receiving homecare services from health professionals (Total = 439,211)



Over 65 receiving homecare services from other professionals (Total = 437,876)



Over65 receiving homecare from health and others professionals (Total = 185,087)



Source: OCPS-SDA Bocconi on data from ISTAT Health conditions and use of healthcare services Survey, 2015

Regarding long-term care private expenditures

Despite the fact that the vast majority of elderly people receiving assistance, including many with several functional limitations, live in private homes, two-thirds of private expenditure is directed towards institutional long-term care. Total annual household expenditure for admissions to nursing homes and other institutions providing long-term support is worth more than 3.2 billion, most of which is likely to cover the co-payment required, according to the level of disability and the family financial situation.

The largest part of home care services paid by families regards non-healthcare services provided at home by informal caregivers

The annual amount of household expenditure estimated for "Disabled assistance" (not classified as healthcare) is about 1.1 billion euros (2016).

54.5% of families find it is barely possible to keep up with essential expenditures, while 45.5% of them struggle less

In 60% of cases, elderly people are economically self-sufficient, while the remaining cases require a financial aid from their families (377 euros on average) (Source: Survey OCPS-SDA Bocconi, 2014).

The presence of functional limitations influences the consumption of health services in the over 65 population

Per capita consumption of different healthcare services among over 65 individuals with functional limitations (living in private homes) amounts roughly to two times the amount spent by the rest of the elderly population (Table 11). Such effect is the result of higher consumption per capita coupled with a higher share of consumers on the entire population considered. Among individuals aged 65 or more lab tests, consultations and diagnostic procedures are the most popular services. With regard to these services, private consumption accounts to the 17.4%, 45.5% and 28.0%, respectively.

Seniors also incur in expenses for medications, supplements and other medical devices. The average monthly cost is 76 euros, with a maximum value at 1,500 euros (standard deviation 130 euros). 23.5% of the respondents spend less than 20 euros per month, 21% of the respondents spend between 20 and 45 euros, 22.5% between 45 and 90 euros, 22% instead spend more than 90 euros (source: Survey OCPS-SDA Bocconi 2014).

TABLE 11

HEALTHCARE CONSUMPTION OF OVER 65 LIVING IN PRIVATE HOMES

(2013)

Healthcare treatments	Over 65 without functional limitations			Over 65 with functional limitations			Expenditure classes (€)		
	Per capita annual consumption	People with at least an access in the previous year	People that incurred expenses	Per capita annual consumption	People with at least an access in the previous year	People that incurred expenses			
Lab tests	2.5	73%	22.3%	4.4	81%	17.4%	<40	40-79	>=80
							35.4	27.4%	37.2%
Medical and specialist consultations	3.2	65%	36.2%	5.7	74%	45.5%	<80	80-199	>=200
							12.7%	35.8%	51.5%
Imaging	1.6	51%	19.1%	2.2	54%	28.0%	<50	50-119	>=120
							22.1%	37.5%	40.4%
Ordinary hospitalization (acute care)	0.2	12%	2.8%	0.4	27%	2.2%	<1,000	1,000-3,899	>=3,900
							24.6%	19.4%	56.0%
Physio&Rehab	3.0	11%	64.8%	5.1	19%	45.0%	<130	130-359	>=360
							23.3%	37.7%	39.0%

Source: OCPS-SDA Bocconi on data from ISTAT Health conditions and use of healthcare services Survey, 2015

Filling the gap in LTC: among the people in need for LTC services the most common limitation is mobility (95.1%)

This limitation is followed by the difficulty in carrying out their daily tasks (85.4%), taking part in social life (78.9%), taking care of themselves (76.6%), relating with others (63.8%) and, finally, (61.6%) understanding and communication (Table 12). The most severe cases, that are conveyed by the highest scores in terms of difficulty, have been recorded in the ability to perform their daily tasks and in the mobility domain (3.9). The elderly with disabilities also show a propensity to co-morbidity, especially as far as chronic diseases are concerned. The over 65 population with functional limitations shows a high prevalence of osteoarthritis and arthritis (78%), bronchitis and emphysema (29.1%), diabetes (26.9), heart disease (23.0), depression and severe chronic anxiety (23.6%), Alzheimer's or senile dementia (17.4%), stroke or cerebral haemorrhage (14.8%) and Parkinsonism (6.2%).

TABLE 12

THE SAMPLE OF OVER 65: EXTENSION AND INTENSITY OF DIFFICULTIES

Difficulty domains	% respontents	Score (1-5)
Mobility (e.g. standing for long periods, walking a long distance, moving and getting around)	95.1	3.9
Cognition (e.g. concentrating on doing something, remembering to do important things, understanding what people say, starting and maintaining a conversation)	61.6	3.5
Self-care (e.g. attending to one's hygiene, dressing, eating and staying alone)	76.6	3.9
Getting along – interacting with other people (e.g. maintaining a friendship, dealing with people, getting along with people, making new friends)	63.8	3.7
Participation in society (e.g. joining in community activities, participating in society)	78.9	3.8
Life activities (e.g. taking care of his/her household responsibilities, cooking, cleaning, make his/her own bed or take care his/her own home)	85.4	3.9

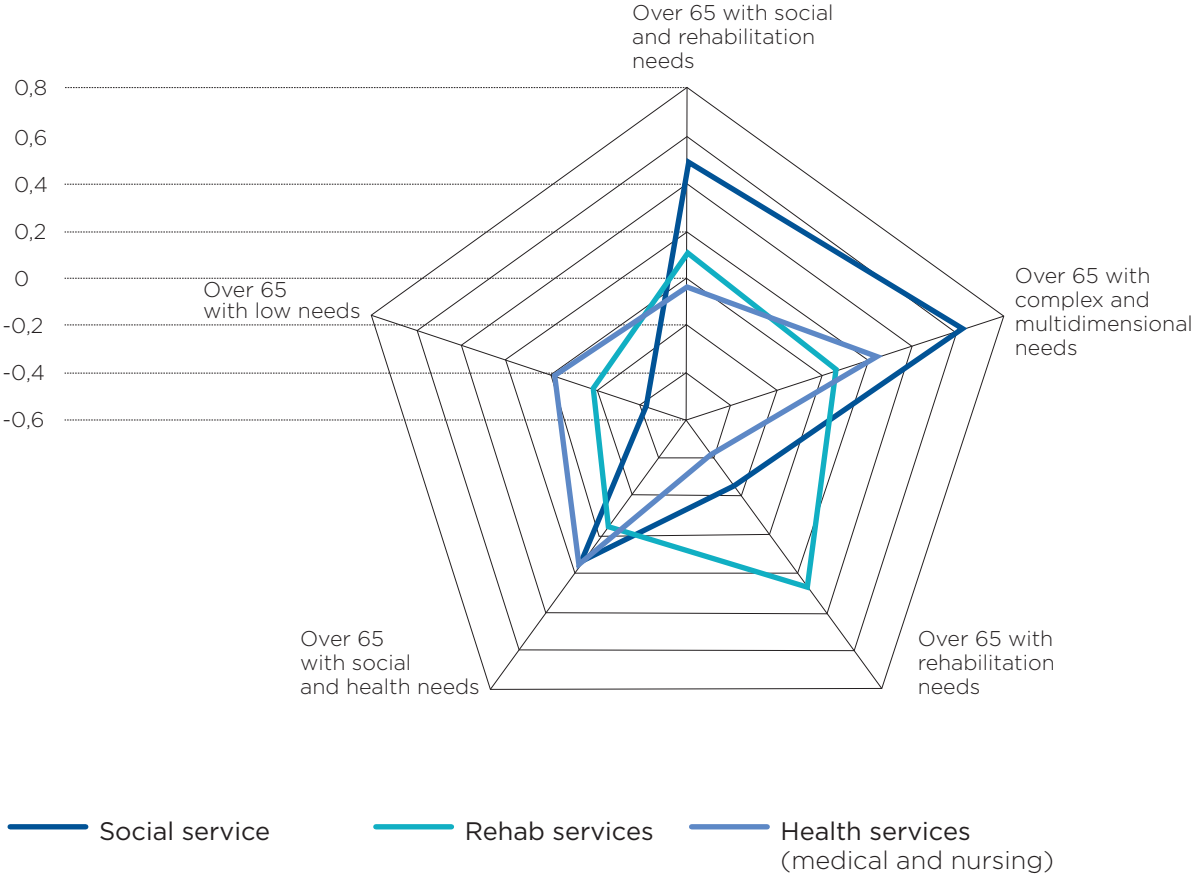
Source: OCPS-SDA Bocconi Survey "Filling the gap in LTC", 2014

There are different needs relating to various aspects of long-term care, which can vary depending on the disease stage that over 65 people and their families are facing

The need for assistance in the population eligible for LTC can be defined with three main service components: healthcare needs (medical and nursing), rehabilitation needs (including psychological support) and the social needs component (Figure 14).

FIGURE 14

OVER 65 PERCEIVED NEEDS: FIVE CLUSTERS



Source: OCPS-SDA Bocconi Survey "Filling the gap in LTC", 2014

A deep and widespread gap emerges between people's needs and the LTC services provided by the public system or available for a fee

Survey respondents usually assign high degrees of importance to various types of assistance (with scores >5/7), while indicating poor levels of perceived coverage for the same types of assistance (with a score between 3 and 4). In fact, public or private services are not used because they are considered inadequate, unable to meet requirements or inaccessible. The level of importance attributed to the information components of the services is even higher and relatively less covered. A substantial absence of "reference figures/institutions" is reported by almost all respondents (nearly 90%). Only a few respondents, less than 7%, indicate the family doctor as a reference figure for "help, advice and to guide choices."

PRIVATE VOLUNTARY HEALTH INSURANCE IN ITALY: A GROWING PHENOMENON

Voluntary health insurance (VHI) covers only around the 13% of total private healthcare expenditure. However, several changes have been taking place in the last ten years both in terms of population enrolled and strategies of the actors involved.

The VHI market is composed by different segments: the individual insurance market and the corporate insurance market

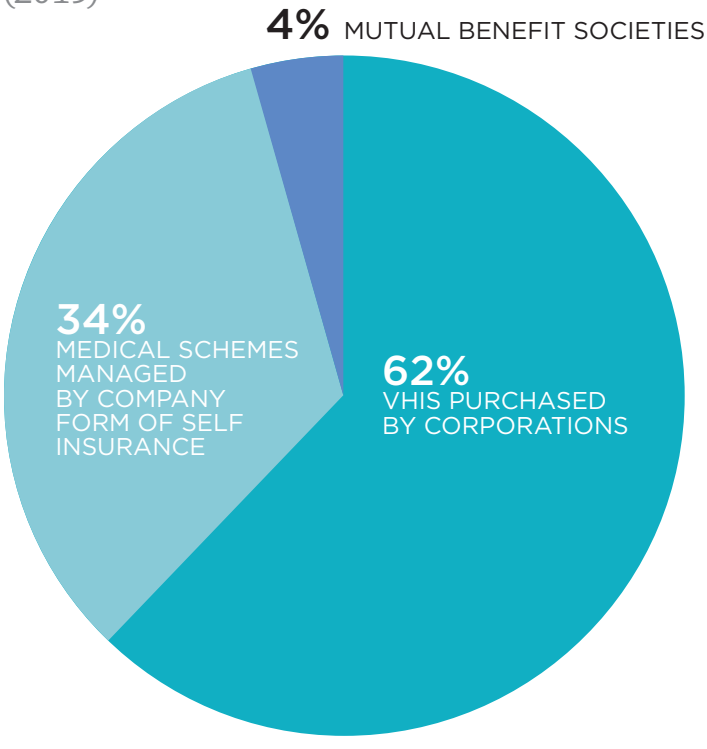
In the latter, the VHI policies are employer-purchased and they are provided to employees as a work-related benefit. The individual market is poorly developed; therefore it is the corporate insurance market that provides for the majority of VHIs. Employers can purchase collective policies on the market or they can have a sort of company self-insurance (i.e. they are similar to British NIMES).

In the year 2015, 34% of premia belonged to these last-mentioned private medical schemes, whereas 62% of collective premia were paid by corporations; mutual benefit societies managed the 4% of collective premia (Figure 15).

FIGURE 15

DISTRIBUTION OF PREMIUMS BY TYPE OF COLLECTIVE INSURANCE

(2015)



Source: RBM Assicurazione Salute & OCPS-SDA Bocconi Report, 2017

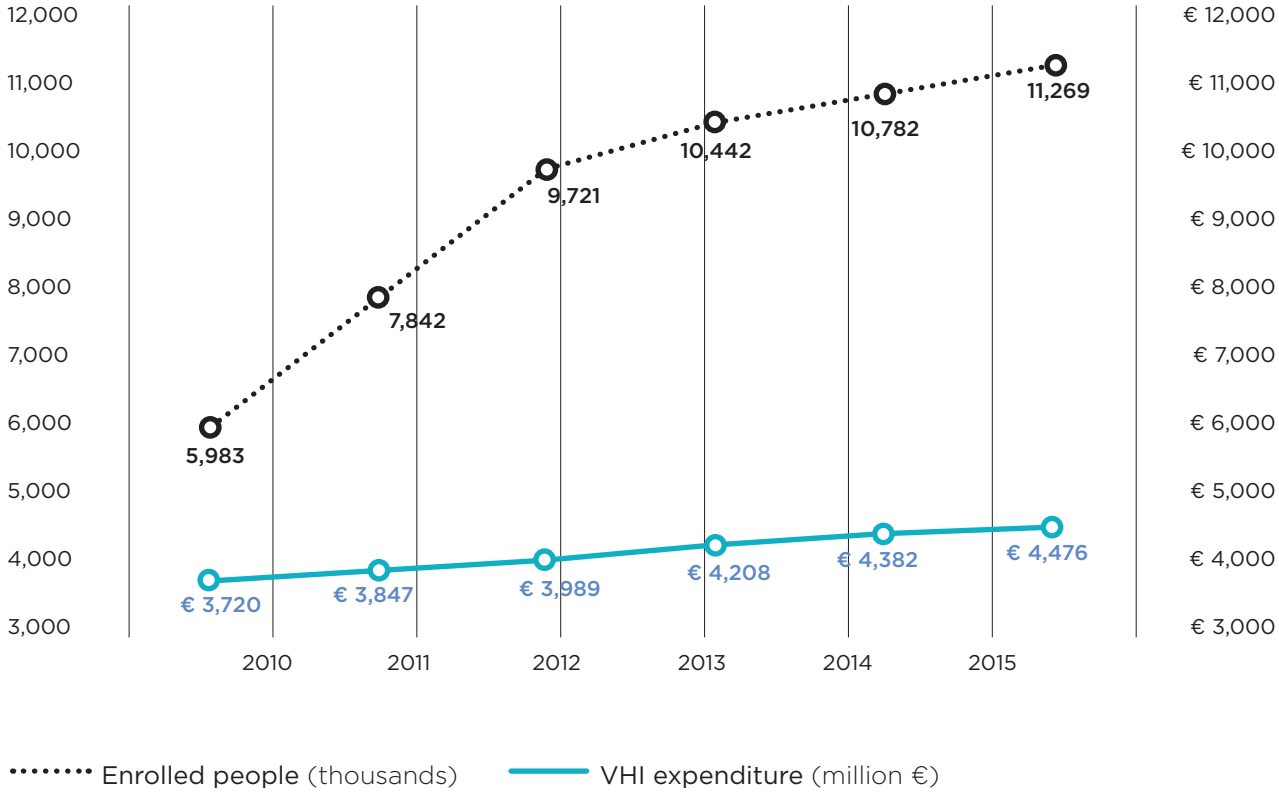
A rapid increase in the population enrolled with declining per capita premiums

Two intertwined trends can be observed: on the one hand, the number of enrolled people has nearly doubled in just five years, and on the other, there has been a much slower increase in the corresponding insurance expenses (Figure 16). Such clear divergence between the two trends is due to the strong increase in the number of collective labour agreements that include VHI as employees' benefit: indeed these insurance policies require very low premiums and they consequently guarantee a narrow coverage.

FIGURE 16

TREND OF ENROLLED PEOPLE AND VHI EXPENDITURE

(2010- 2015)



Source: RBM Assicurazione Salute & OCPS-SDA Bocconi Report, 2017

A changing business

According to the innovative trends occurring in Europe (Table 13) even Italian insurance companies working in the health insurance sector have modified their business model to provide corporations not only with insurance policies but also with several other services often through their third-party administrator (TPA). Table 14 shows the combination of internalized and externalized activities by corporation and category associations in their VHI management. Such a change has allowed insurance companies to lower premiums, and small-medium firms and national trade associations to guarantee these benefits to their employees/affiliated members. The latter specifically include, besides the collective insurance coverage, the access to preferred provider networks and the management of administrative activities, via TPAs.

TABLE 13

PRIVATE HEALTH INSURANCE IN FIVE EUROPEAN COUNTRIES

France	Great Britain	Spain	Portugal	Italy
Nature of the public system				
Bismarck System	Beveridge System with clear definition of public boundaries	Beveridge System with wide regional differences and opting-out option for public servants	Beveridge System coexisting with two mutual aid subsystems	Beveridge System with wide regional differences
Population covered by PHIs				
93% (12% of which financed by the State)	16%	22.5% (4.1% of which from opting-out)	About 25% from public and private subsystems; 17% individual VHIs	18.6%
Characteristics and trends of the market				
Standardization of coverage solutions in a mass market	Variety of products and solutions available in a market with a high degree of concentration	Standard and low cost solutions in a concentrated market	Standard and low cost solutions in a concentrated market	Growth of collective coverage in a concentrated market
Main features of innovation				
Industrialisation of administrative solutions	Customization of the coverage solutions to reduce risk premia	Development of managed care solutions via vertical integration	Development of managed care solutions and networks of preferred providers	Efforts to stimulate individual VHI and process of commissioning of preferred providers

Source: RBM Assicurazione Salute & OCPS-SDA Bocconi Report, 2017

TABLE 14

VHI: INTERNALIZED VS. EXTERNALIZED ACTIVITIES

Types of activities	Internalized activities	Externalized activities
Risk management	Forms of company self-insurance and corporations purchase only policies for the greatest risks	Corporations purchase collective insurance policies from insurance companies
Preferred providers network	A few corporations or category associations can set up a preferred providers network	TPAs set up preferred providers network where enrolled patients can access affordably
Administrative management	Corporations or category associations can manage entire long administrative process or only some parts of it	TPAs manage entire long administrative process or some parts of it

Source: RBM Assicurazione Salute & OCPS-SDA Bocconi Report, 2017

What is lacking in the VHI sector

The VHI sector is becoming increasingly more relevant in the Italian healthcare system, however, proper regulation is still lacking. In particular, interventions are required regarding the fiscal regime, transparency and the relationship with the National Healthcare Service (NHS). Such steps would prove crucial to support further development of the sector.

MEDICAL TOURISM IN ITALY: SOMETHING IS MOVING

The rise of many international hospital groups over the past decades (i.e. Tokuda Hospital, Acibadem Group, Bumrungrad Hospital) and the steady engagement of some countries in the sector (i.e. Thailand, Hungary, Croatia) prove that medical tourism is still a promising sector.

Global medical tourism market: up to 100 billion dollars

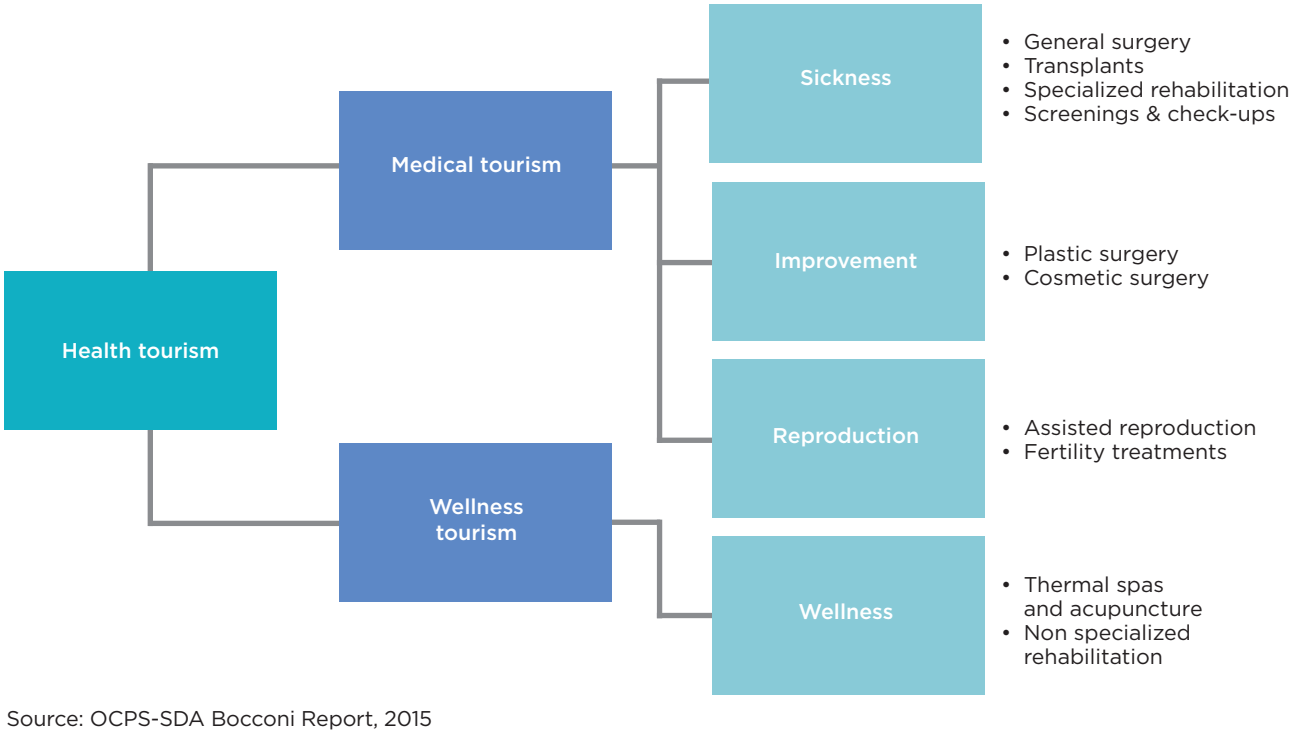
"Medical tourism occurs when consumers decide to travel across international borders with the intention of receiving some form of medical treatment" (Green et al., OECD 2011). The market is estimated to be worth between 45 and 72 billion dollars according to Patient Beyond Borders and up to 100 billion dollars according to Medical Tourism Association.

Medical vs. wellness or medical & wellness?

Medical tourism includes illness treatment, assisted reproductive technology, and aesthetic surgery (Figure 17) while wellness tourism is confined to thermal treatments, acupuncture, non-specialized rehabilitation and so on. Treatments may therefore comprehend the full range of medical services, but most commonly include dental care, cosmetic surgery, elective surgery, and fertility treatment. Within the realm of healthcare tourism, it is still possible to distinguish between medical tourism and wellness tourism: these markets are typically seen as separate even though there is wide room for continuity.

FIGURE 17

COMPONENTS OF HEALTHCARE TOURISM



Source: OCPS-SDA Bocconi Report, 2015

Push factors for medical tourism

Typically, the sector recognizes the following push factors that drive the patient to the choice of leaving his country to seek treatment abroad ("should I stay or should I go"):

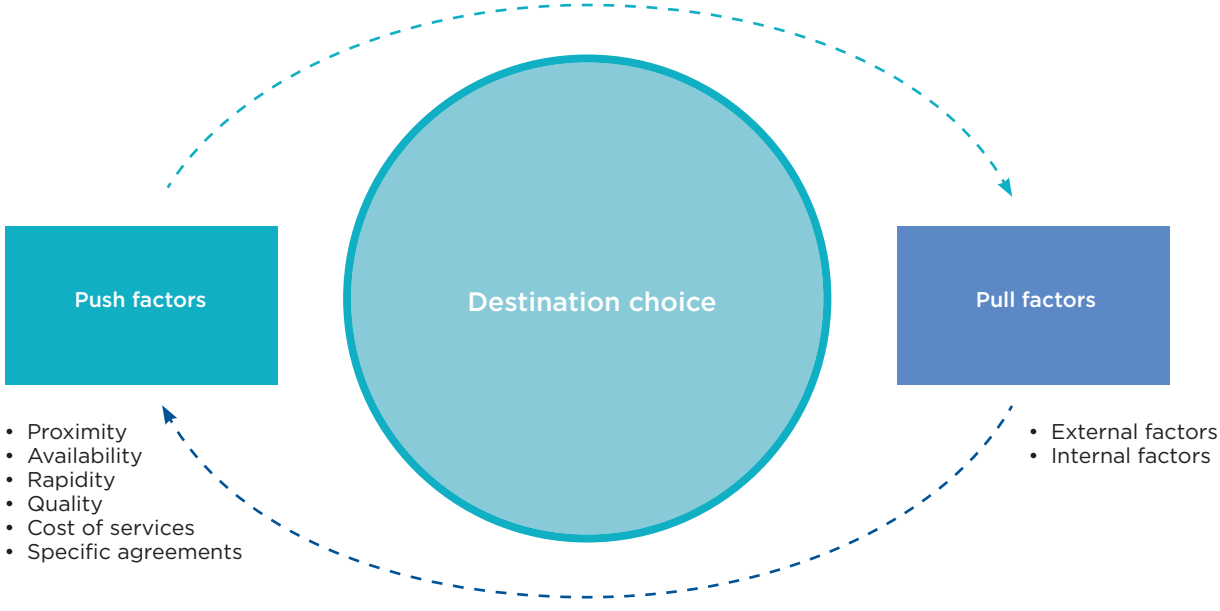
- access in terms of *proximity* (it could be more convenient to reach a hospital in the neighbouring country);
- access in terms of *availability* of the treatment (since not all healthcare systems can provide patients with the desired service);
- access in terms of access *time* (waiting times making treatment inaccessible within national borders, dramatic when a sudden intervention is needed);
- perceived *quality* of treatment (this factor has primary relevance for those looking abroad for highly specialized professionals);
- *cost* (each country conceives a range of services that are not provided through the national healthcare service and that are to be purchased on the private market);
- specific *agreements* (either bi- or multi-lateral agreements made by countries or insurance companies).

Pull factors for medical tourism

Once the decision of moving to another country for treatment has been made, the next step is to decide specifically on the country and location. At this level, the choice can be driven by the following pull factors, either internal or external. *Internal* factors usually represent the characteristics of the healthcare structures: for instance, short waiting times, low prices, unique treatments, perceived quality of the treatment and of the service (both of professionals and structures). Among the *external* factors the most important are socio-cultural connections with the country of origin in terms of language, religion and customs; then the socio-economic stability of the country also affects the decision as well as geographical proximity, transportation and legal protection.

FIGURE 18

INTERACTION BETWEEN PUSH AND PULL FACTORS



Source: OCPS-SDA Bocconi Report, 2015

Medical tourism means building bridges with other sectors and stakeholders

According to the literature, the provision of medical tourism services requires a wide chain of specific services that pose new strategic and managerial challenges to healthcare providers. Medical tourism is an emerging global industry, with a range of key stakeholders endowed with commercial interests such as brokers, health care providers, insurance providers, websites and media services providers.

Medical tourism in Italy: something is moving (before it is too late)

The Italian healthcare system is often recognized as one of the top healthcare systems in international rankings (WHO), not to mention the fact that the country is one of the most famous touristic destinations. Yet, Italian hospitals have only very recently started to show some interest in inbound medical tourism.

Private hospitals in Italy have already identified their potential market (with respect to medical tourism) in terms of geographical area and pathologies. However, their "fishing" strategy is still to be defined. Public hospitals have some experience with international institutional programs of inbound patients, and some are starting to be aware of the advantages that medical tourism can bring. In fact, such emerging phenomenon could guarantee a steady flow of patients with rare diseases, an alternative source of revenues to invest and the building of a powerful brand awareness.

Public hospitals, however, lack the necessary organizational flexibility and their missions are targeted only to Italian citizens. Moreover, all providers are struggling with the lack of an internationally-recognized brand for Italian healthcare, similar to what exists for fashion, design or cooking.

Together with the definition of appropriate strategies for public and private providers, medical tourism should enter the policy agenda of both the State and the Regions, that need to work on developing an effective governance approach for the sector.

ABOUT US

SDA BOCCONI

SDA Bocconi – the School of Management of Bocconi University – has been creating and sharing knowledge since 1971. The School's commitment to research and education has enabled it, over the years, to contribute significantly to the development of many industries, both in Italy and abroad. SDA Bocconi is proud to be part of a number of prestigious international associations, which benefit not only the school but also the students, businesses and institutions collaborating with SDA Bocconi. Such benefits include access to up-to-date information and an international network of contacts, as well as opportunities for debate on current management issues.

WHY AN OBSERVATORY ON PRIVATE HEALTH CONSUMPTION - OCPS

Aware of the growing interplay between public and private in the healthcare market, OCPS has been working to move beyond a simplified vision of the Italian healthcare system. **The mission of OCPS is collecting and systematically framing knowledge and information on the private healthcare market.** Since its foundation, in 2012, OCPS has become a leading platform for discussion and formulation of new ideas and opportunities for the sector. Indeed, the final aim of the Observatory is to spur policy and management innovations within the private sector and foster collaborations between public and private actors, based on data, facts and figures.

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