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Le spese inutili dei sistemi sanitari europei ed il costo della corruzione

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Tackling Wasteful Spending on Health

OECD

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"A significant share of health spending in OECD countries is at best ineffective and at worst, wasteful. **One in ten patients is adversely affected during treatment** by preventable errors, and more than **10% of hospital expenditure** is allocated to correcting such harm."

"Many more patients receive **unnecessary or low-value care**. A sizable proportion of emergency hospital admissions could have been equally well addressed or better treated in a primary care setting or even managed by patients themselves, with **appropriate education**."

"Large cross-country variations in **antibiotic** prescriptions reveal **excessive consumption**, leading to wasted financial resources and contributing to the development of antimicrobial resistance."

"The potential for **generic medicines** remains underexploited."

"Finally, a number of administrative processes add no value, and money is lost to **fraud and corruption**."

"Overall, existing estimates suggest that **one-fifth** of health spending could be channelled towards better use."

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Esiste una curva di Laffer nei sistemi sanitari europei?

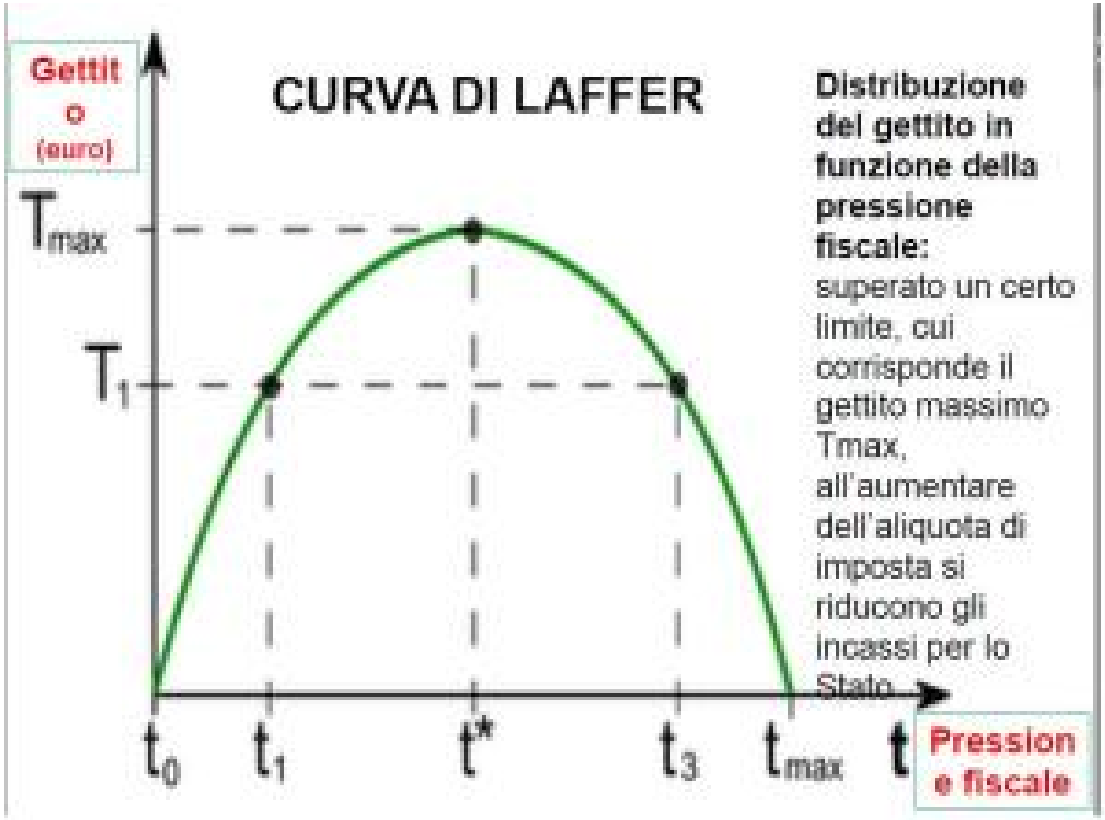

Figure 1.1. **Three categories of waste mapped to actors involved and drivers**

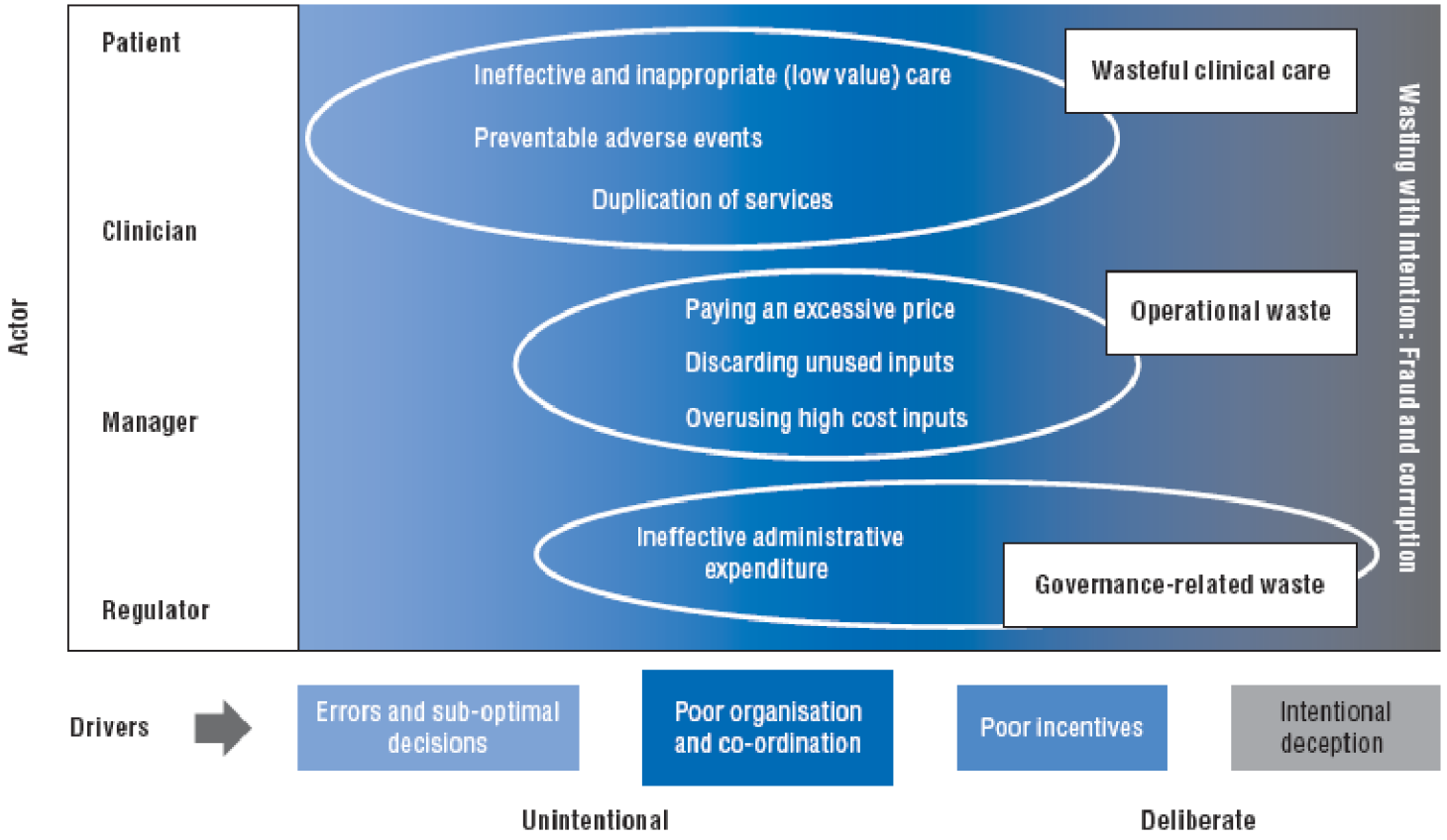

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Table 1.1. **Who, why and what to do? Summary of findings on wasteful clinical care**

Category of waste	Actors	Main drivers	Information systems required	Policy levers	Policy impact	Country examples
Preventable adverse events		Organisational shortcomings, suboptimal decisions, poor incentives		**Behaviour change:** clinical guidelines, checklists, standards of practice, safety campaigns	+	**Spain:** A five-point checklist is used in intensive care units to reduce catheter-related bloodstream infections
				Organisational change: improved	+	**Germany, Denmark and Sweden:**

Table 1.1. **Who, why and what to do? Summary of findings on wasteful clinical care**

Category of waste	Actors	Main drivers	Information systems required	Policy levers	Policy impact	Country examples
Preventable adverse events		Organisational shortcomings, suboptimal decisions, poor incentives	Adverse event reporting systems, PRIMs	**Behaviour change:** clinical guidelines, checklists, standards of practice, safety campaigns	+	**Spain:** A five-point checklist is used in intensive care units to reduce catheter-related bloodstream infections
				Organisational change: improved co-ordination and use of ICT	+	**Germany, Denmark and Sweden:** More targeted information-sharing systems focused on medications or specific diseases
		Organisational shortcomings, poor incentives		**Incentives:** financial penalties for "never events", change in tort law towards no-fault systems	+	**Israel:** The Ministry of Health defined four "never events" in which hospitals cannot bill health insurers
				Regulation: mandatory accreditation of providers	+	**Australia:** All hospitals must meet ten national standards as part of mandatory accreditation
Overprescription of antimicrobials		Suboptimal decisions, organisational shortcomings, poor incentives		**Behaviour change: guidelines,** campaigns	+	**France** implemented a continuing medical education (CME) programme for communicable diseases
		Suboptimal decisions, poor incentives	Prescription monitoring systems	**Organisational change:** rapid diagnostic tools, stewardship programmes	++	**Belgium** one of the few countries to carry out a full cost-benefit analysis of its mass media campaign
				Incentives: performance-based payments, patient co-payments	+	Stewardship programmes were widely implemented and proved to be effective in the **United States, France** and other countries

 Manager;  Clinician;  Patient.

+ Some evidence of positive impact but limited and system-dependent; ++ Positive impact; ? Impact so far unknown.

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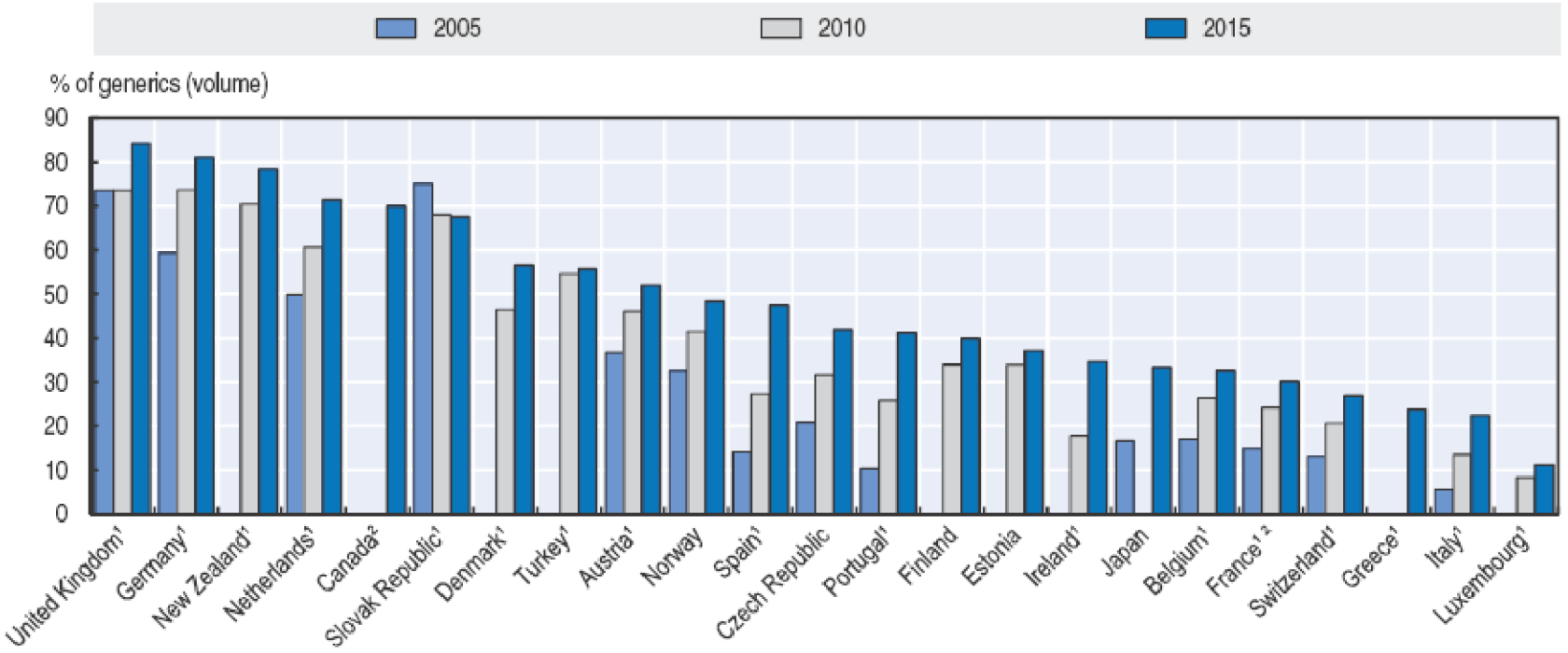

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Table 1.2. **Who, why and what to do? Summary of findings on operational waste**

Category of waste	Actors	Main driver	Information systems required	Policy levers	Policy impact	Good practice examples
Discarded pharmaceuticals and other medical supplies		Suboptimal decisions		**Behaviour change:** guidelines, training and campaigns	+	**England:** Pharmacists provide face-to-face or telephone support to patients starting new treatments
		Organisational shortcomings	Monitoring of patient adherence to medication	**Organisational change:** e-prescription systems, improved management of stocks in health care facilities	?	**Denmark, United Kingdom:** Physicians receive periodical reviews of prescriptions
		Organisational shortcomings	Monitoring of prescriptions			
Expensive originator drugs used instead of generics		Inadequate regulation	Monitoring of prescriptions and the use of generics	**Regulation:** prescription by INN, early-entry legislation, mandatory substitution of a prescribed medicine with the cheapest generic	?	**Denmark, Finland, Spain, Sweden:** Mandatory generics substitution by pharmacists
		Inadequate regulation, poor incentives		**Incentives:** P4P, patient co-payments, internal reference pricing	?	**France, Japan:** P4P for prescribers based on share of generics in prescribed medicines
		Suboptimal decisions, poor incentives		**Behaviour change:** guidelines, campaigns	?	**Denmark, France, Portugal, Spain:** Information campaigns on generics for patients
		Organisational shortcomings	programmes Market intelligence	analysis of price variations		**Denmark, Norway:** Pooled procurement through voluntary collaboration of purchasers
High-cost hospital care used where less expensive alternatives exist		Organisational shortcomings, poor incentives		**Organisational change:** development of OOH primary care, community and intermediate care services, improved co-ordination of services, better hospital discharge management	++	**Norway:** Larger primary care centres (intermediate care facilities) with 24-hour, 7-day a week access
		Suboptimal decisions	Monitoring of inappropriate and avoidable hospital admissions	**Incentives:** bundled and performance-based payments, payments encouraging same-day surgery, co-payments (removing outpatient co-payments, charging for unnecessary use of emergency)	++	**United States:** Stronger community care centres
		Poor incentives, suboptimal decisions	Monitoring of variations in primary care practice			**France, United Kingdom, United States, Canada:** Fast-track systems for emergency services
		Inadequate regulation		**Behaviour change:** guidelines, patients' education and campaigns	++	**Hungary:** Removed budget caps for same-day surgery

Regulator; Manager; Clinician; Patient.
+ Some evidence of positive impact but limited and system-dependent; ++ Positive impact; ? Impact so far unknown.

Table 1.4. **Who, why and what to do? Summary of findings on governance-related waste**

Category of waste	Actors	Main driver	Information systems required	Policy levers	Policy impact	Good practice examples
Administrative waste		Organisational shortcomings, inadequate regulation	Evaluation of costs and benefits of administrative activities	**Organisational change:** merging/ separating/sharing among administrative institutions; improved co-ordination of administrative activities within and between institutions; user guides and protocols, improving management quality; improved use of ICT **Regulation:** removal of administrative tasks; legislative principles; budget ceilings; simplification of procedures; standardisation of forms and reporting requirements	?	**Australia:** Functional and efficiency review of the Commonwealth Department of Health assessing the efficiency and effectiveness of the Department's operations, programmes and administrations **Estonia:** Introduction of paperless e-prescription, reducing time spent to issue prescriptions and medication and for verification by provider and insurers
		Organisational shortcomings, inadequate regulation	Collection and disclosure of information on administrative performance		+	**Germany, Netherlands:** Collaborative efforts of all stakeholders to quantify and agree on reduction of administrative reporting requirements that add little value
		Organisational shortcomings, inadequate regulation			?	**United States:** Stipulating the share of premiums that private insurers have to spend on medical claims
Integrity violations in service delivery and payment				**Organisational change:** setting up/empowering dedicated institutions/programmes; data mining	+	**Belgium:** INAMI (the National Institute for Health and Disability Insurance) uses data mining to detect integrity violations and a step-wise strategy to deal with integrity violations, and can take administrative sanctions (fines)
	 	Intentional deception	Publication of estimates; large-scale collection of treatment and billing data	**Behaviour change:** reporting hotlines, feed-back to outliers	?	**United Sates:** CMS uses contractors to detect error and possible fraud. Zone Program Integrity Contractors are authorised to conduct investigations and co-ordinate with law enforcement
				**Regulation:** administrative and legal sanctions	?	The **European Healthcare Fraud and Corruption Network** (EHFCN) serves as a knowledge exchange platform for countries interested in tackling these integrity violations
Inappropriate business practices	   	Intentional deception	Disclosure of information on potential for conflict of interests Disclosure of clinical trial data	**Regulation:** setting limits or banning specific practices (direct to consumer marketing, gifts and hospitality, self-interested referrals, etc.)	?	Countries with comprehensive and well-established Sunshine regulations include **Australia, France, Portugal, the Slovak Republic and the United States**

 Industry;  Regulator;  Manager;  Clinician;  Patient.

+ Some evidence of positive impact but limited and system-dependent; ? Impact so far unknown.

Wasting with intention: Fraud, abuse, corruption and other integrity violations in the health sector

- a vast array of transactions involving providers of health services, payers of these services, and/or recipients/consumers
- the procurement and distribution of medical goods and services
- the promotion of corporate/industrial interests in the health sector.

Savedoff and Hussmann (2006) detail how the high prevalence of uncertainty and asymmetry of information, as well as the number and variety of actors with diverging interests involved in the system, create opportunities for integrity violations in health.

The combination of uncertainty, asymmetric information and fragmentation. Economists label these situations "**agency relationships**"
"principal" who has a direct stake in the result delegates a task to an "agent".

These relationships are often imperfect in the sense that agents can choose not to act in the best interests of the principal, attributing suboptimal results to uncertainty or information that the principal cannot verify.

Portugal's General Inspectorate of Health (IGAS, *Inspeçâo Geral das Actividades em Saúde*) reported EUR 4.6 million of fraud detected in 2014.

In Spain between 10% and 25% of public procurement expenditure for the provision of sanitary technologies and pharmaceuticals was lost in corrupt practices (OECD - Study on Corruption in the Healthcare Sector – 2013)

Figure 7.2. **Corruption perception across sectors in EU OECD countries versus EU non-OECD countries**

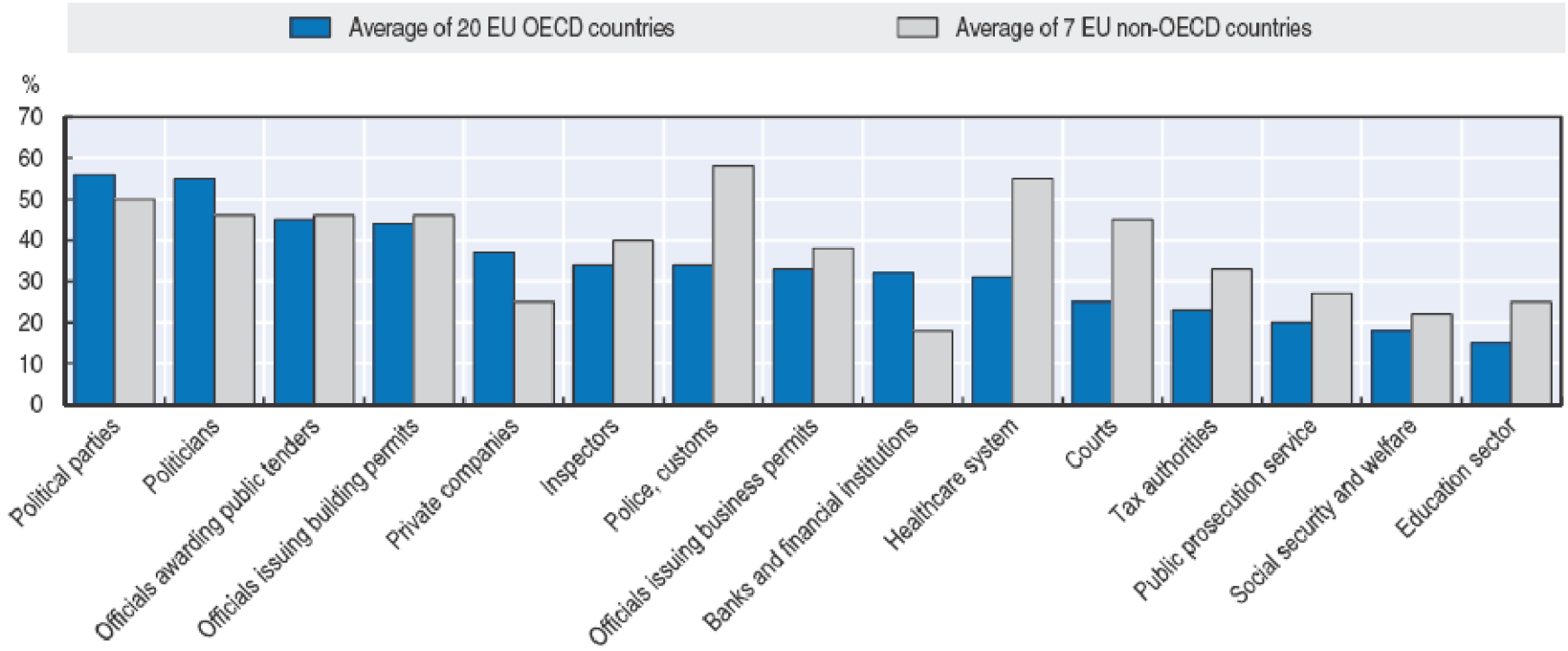
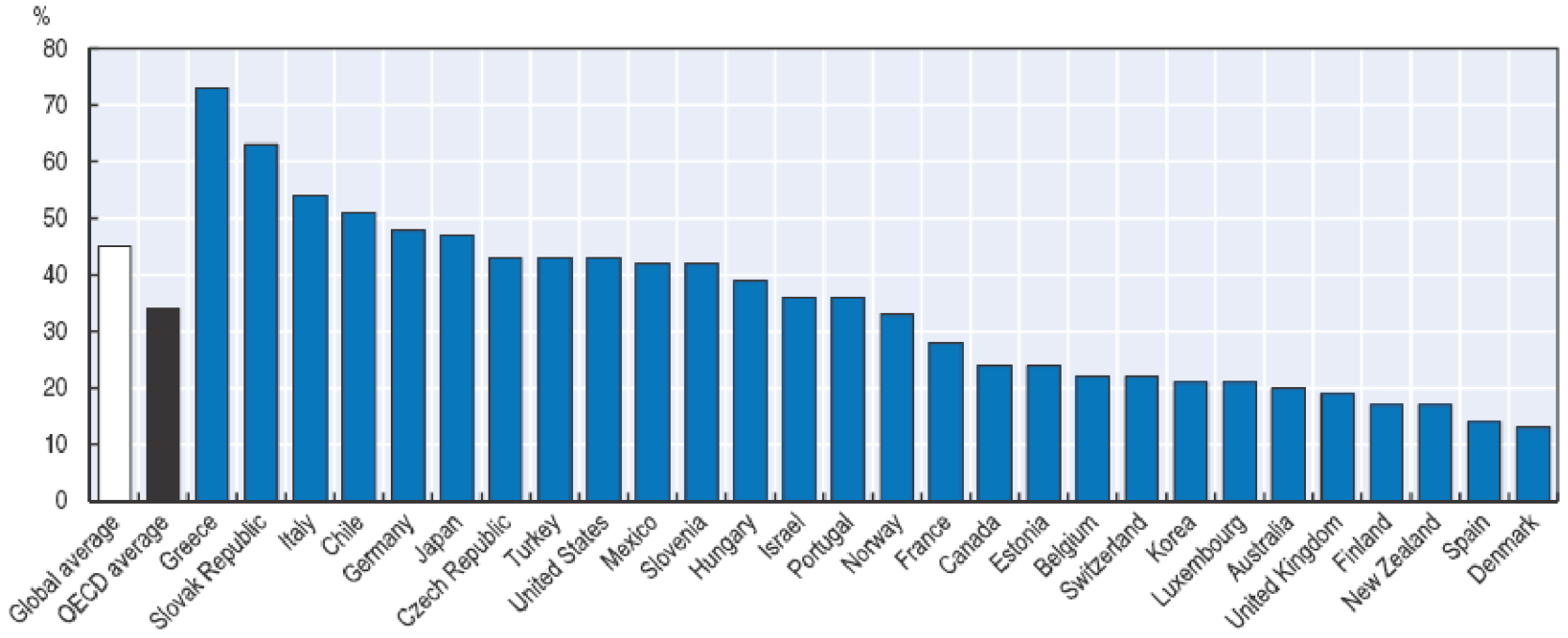


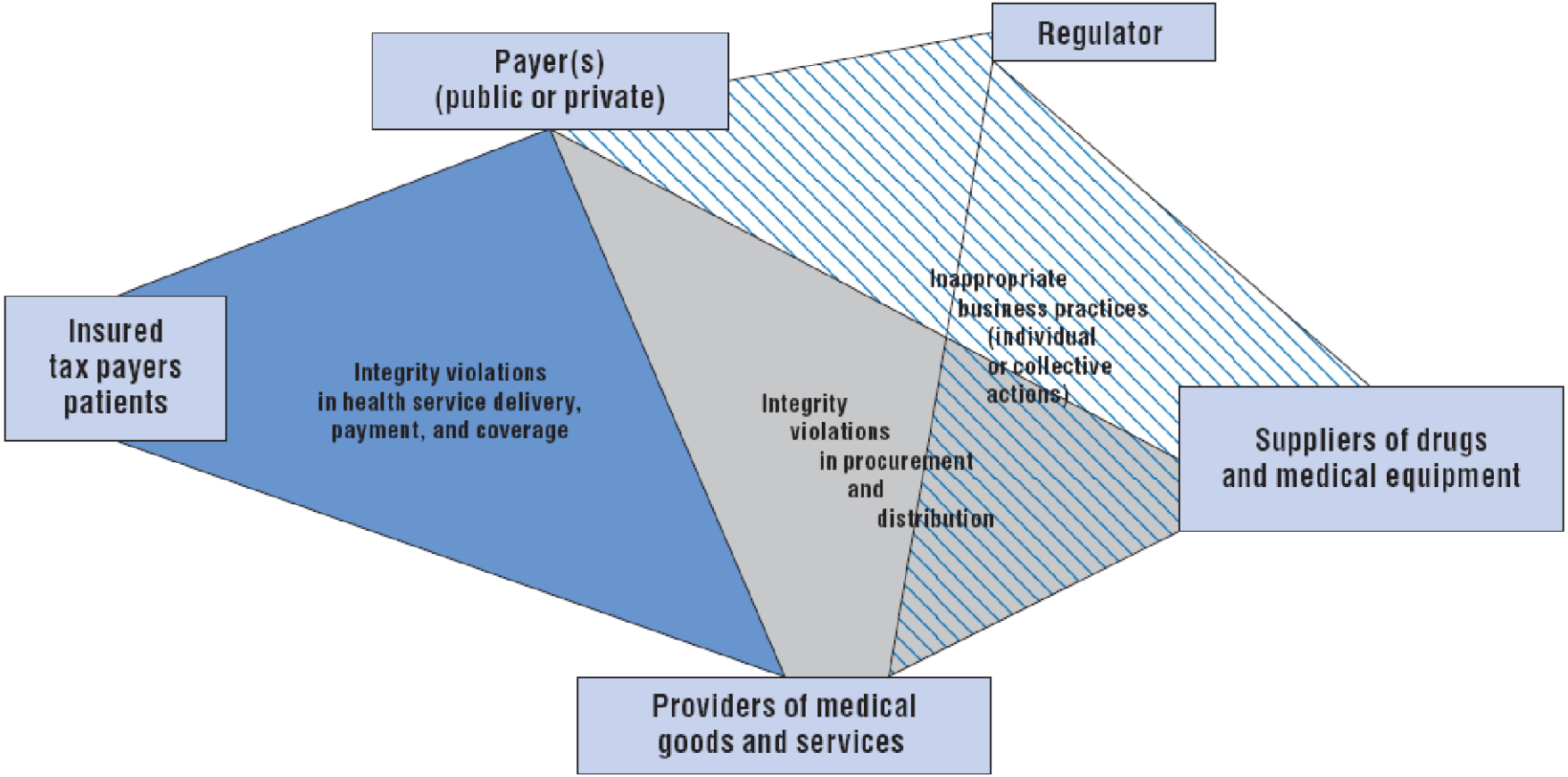
Figure 7.3. **Percentage of the population that considers the health sector corrupt or very corrupt in OECD countries**



Note: The global average includes 103 countries. The OECD average includes 28 countries.
Source: Transparency International (2013), *Global Corruption Barometer Report and Data*, *www.transparency.org/gcb2013*.

StatLink http://dx.doi.org/10.1787/888933444316

Figure 7.5. **Three main types of integrity violations in health care systems**



Attori	Descrizione
Sistema Sanitario-Paziente	Corruzione per una migliore assitenza sanitaria
Industria - Sistema Sanitario	Influenza nell'acquisto di tecnologie e medicine da parte delle istituzioni
	Relazioni commerciali improprie
Industria - Regolatori	Relazioni commerciali improprie
Tutti gli attori (tranne i pazienti)	Abuso di potere
Sistema Sanitario - Utenti	Rimborsi impropri
Sistema sanitario	Frode e appropriazione indebita

Table 7.1. **Who commits which type of integrity violation in health care service delivery and financing?**

Who commits the fraud?	In relation to	Type of fraud
Patient	Payer	In the process of obtaining and paying for coverage: • coverage obtained on the basis of a false identify, or misrepresentation of characteristics (e.g. labour status, income, etc.) • fraud to avoid or reduce/avoid insurance premiums, or contributions (or taxes) Wrongful claims (misrepresenting the cost of care, lying to provider to obtain unwarranted benefits, multiple prescription requests) Claiming reimbursements from multiple insurers
	Provider	Bribery (for access to care, referrals, shortening of waiting time, priority on waiting lists, uninsured care, privileged treatment, etc.)
Payer	Patient	Unjustified denial of coverage Unjustified denial of benefits to patients
	Payer	Misuse of resources (embezzlement of funds)[1]
	Provider	Unjustified denial of payments to health providers
Provider	Patient	Informal payments (under-the-table payments, gratuity, "black medicine", "fakelaki")[2]
	Payer	Overprovision/overuse of services Overbilling (upcoding, sidecoding, debundling, double defrayment, billing for higher-qualified personnel than those involved in performing the services) Charging for phantom care (charging for care that is not provided, use of false patient identity) Misuse of resources (embezzlement of funds, pilferage of medicines, misuse of medical equipment, including the use of public equipment for private/commercial use) Absenteeism and other payroll fraud

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Table 7.4. **Levers used to manage inappropriate practices: Examples from OECD countries** *(cont.)*

Activity	Banned	Severely restricted	Authorised and regulated	No specific law	Self-regulated
Gifts and advantages[2]	**France:** 1993 "Anti-gift" law prohibits health professionals from receiving gift in cash or in kind, direct or indirect (with a few exceptions linked to research activities or attendance of scientific conferences) **Germany** has a similar law	**Japan** (2016 effectiveness) **EU Directive 2001/83/CE:** gifts must be limited to inexpensive and related to the practice of medicine **Norway** (2005), **Sweden** (2004), **Poland, Slovenia** **Switzerland** (2016): Art. 55 of Therapeutic Product Act)		**Japan, Poland, Sweden, United Kingdom**	
Disclosure of financial relationships and transfers of value (Sunshine Act or transparency)[2]			Comprehensive laws: **United States** (2010), **France** (2011 website open to the public), **Portugal** (2013), **Slovak Republic** (2011) Some mandated disclosure (limited): **Australia** (industry-sponsored events), **Belgium, Denmark, Germany, Italy** (hospitality), Slovenia (public servants), **Spain** **Switzerland** (on rebates as of 2016)		**Netherlands** (2012): Health professionals and pharma industries jointly decided to disclose relationships Disclosure by pharma industry required by **EFPIA** (2016) and **Japan's** pharmaceutical association
Sponsorship of individuals to attend medical conferences[3]	**Sweden, United States, Norway**	**Belgium, Greece, Italy, Netherlands, Turkey**	**Japan, Austria, Finland, France, Germany, Switzerland, Slovenia, Hungary, Portugal**	**Czech Republic, Ireland, Poland, Slovak Republic, Slovenia, Spain**	**Canada:** Canadian Medical Association provides guidelines for physicians in interaction with industry
Promotional meetings		EU Directive 2001/83/CE: hospitality limited to event and prescriber			
Relation with education institutions		**Germany** has in place specific rules to ensure neutrality of education and training			
Provision of free samples		Restricted by **EU Directive** 2001/83/CE	**Japan, Canada** (provincial variations)		
Provision of low-value promotional aids	**United States, United Kingdom**		**Japan**		

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