Presidency of the Council of Ministers

# ON THE NATIONAL HEALTH SERVICE'S COMMUNICATION TO PATIENTS OF HEALTHCARE COSTS

**28th of September 2012**

**INDEX**

Presentation ........................................................................................ 3

1. Premise ........................................................................................ 5

2. The different reasonings ........................................................................................ 6

3. The considerations of the NBC ........................................................................................ 8

ATTACHMENTS: ........................................................................................ 11

Letter of request from the Minister Balduzzi to the National Bioethics Committee; ........................................................................................ 11

Communication to citizens of the value of services reimbursement – Lombardy Region 24 February 2012 Prot. No. 2012 0006242 .................. 14

**Presentation**

In reply to a question raised by the Health Minister Prof. Balduzzi, the NBC dealt with and debated the issue of the communication to patients by the National Health Service of the average costs of healthcare services.

In the premise the text introduces the context of the problem, including it in the broad issue of the distribution of healthcare resources (at macro and micro-allocation levels) and analyses the main arguments in favour of and against the mandatory communication of costs to the patient.

Most of the NBC members considered the mandatory communication not ethically justified and imposed on the patient, granting it only in the case of authorisation given by the latter at the moment of being discharged from hospital or after receiving treatment.

On the other hand, some members of the NBC declared themselves in favour of the mandatory communication of costs, managed with due attention, as an instrument of transparency in a liberal democratic society.

Despite this divergence, the NBC was unanimous on the modalities of the communication (for some possible, for others mandatory), above all with the recommendation to avoid patients being made to feel guilty and discriminated against and to respect the need for privacy of personal details on their state of health. The communication of costs – the Committee goes on to recommend – must not be considered the only instrument for the citizens' awareness of healthcare costs, but must be included in the context of an overall social education to increase awareness of the close connection between individual health and social health, stimulating consciousness/knowledge and the assuming of responsibility by citizens with respect to the prevention of pathologies and risky behaviour and the curb on and proportionality of the demands made on the healthcare system. Once again the Committee hopes that citizens/patients are guaranteed, in the respect of the wish of whoever wants to know, the access to both general and more detailed information with regard to the costs sustained by the NHS for treatment received or to be given.

The document, edited by the Vice Presidents Profs. Lorenzo d'Avack and Laura Palazzani and written with the contribution of all the NBC members in the plenary session of 28 September 2012, was unanimously approved by the following: Profs. Amato, Battaglia, Bompiani, Canestrari, Caporale, D'Agostino, Da Re, d'Avack, Di Segni, Flamigni, Forleo, Garattini, Guidoni, Palazzani, Proietti, Toraldo di Francia, Umani Ronchi, Zuffa. Absent in the plenary session the following later expressed their

approval: Profs. Dallapiccola, Di Pietro, Gensabella, Morresi, Possenti and Scaraffia.

The President
Prof. *Francesco Paolo Casavola*

## 1. Premise

There is a more and more visible gap between the increase in healthcare costs and the decrease in the available healthcare resources.

The increase in healthcare costs is due to various factors: the development of medicine permits the population to live longer, but at the same time this makes the percentage of citizens with chronic and disabling illness increase and therefore with serious healthcare problems; the tendency to no longer accept illness as an inescapable fate but to experience it as an event to be faced in all ways possible; technological progress, in the diagnostic and therapeutic fields, with the offer of new costly intervention possibilities in favour of the ill and last but not least, the inefficiencies, the useless interventions, the waste and corruption that have had repercussions on the capacity of the NHS to satisfy the growing demand, optimising the use of the existing resources.

The decrease in the available resources has been caused by the economic crisis and by a need to curb even healthcare costs by means of the planning and rationalisation of healthcare policies, an abolition/reduction of waste and an optimisation of the use of the available resources.

The gap between the increase in costs and reduction of available resources makes the choices which have always been faced in healthcare increasingly more difficult in the relationship between state/healthcare, facility/doctor-healthcare, operator/patient. In healthcare policy the question of macro-allocation (choice of how much to invest in health and in its various sectors) and micro-allocation (choice between alternative treatment for a patient or selection of patients for the same treatment) constitutes an important and consolidated chapter of bioethical reflection.

In Italy the problem arises with specific reference to a public health system that recognises each citizen the right to health protection, healthcare and medical assistance (art. 32 Const.). With the collection of resources by means of the proportional income contribution, the state is guarantor of equal access to healthcare resources, at least for basic needs.

Until today the healthcare costs sustained by the state for treatment and assistance were not made known to citizens. The Lombardy Region, with select committee resolution No. IX/2733 of 6 December 2011, bearing “Decisions concerning the management of the Regional Socio-Healthcare Service for the year 2012” foresaw that citizens be informed of the costs, as of 1 March 2012, by this meaning the reimbursements made to

the healthcare facilities, that the Regional Healthcare Service sustains for hospitalisation and consultancies enjoyed by the citizens[1].

This initiative by the Lombardy Region focussed the attention on a number of problems that require both an ethical and juridical reflection, insofar as they relate the question of the value of health and the economic costs to guarantee it, in the context of the relationship between individual and social wellbeing.

The Health Minister, Prof. Renato Balduzzi, asked the National Bioethics Committee "to consider whether the introduction of such obligation of transparency might not have prejudicial effects on the actions that the National Health Service must bring about to correspond to the duty of improving the patient's wellbeing, above all when suffering from serious illnesses and whether the just economic reasons are not in this case unbalanced with respect to those of humanity and solidarity"[2].

Different standpoints arise with regard to this, on the basis of the arguments that are compared.

## 2. The different reasonings

Among the reasons justifying the direct communication of the costs of healthcare treatment and public assistance to the patient, the following can be considered:

1. The need to show the costs of healthcare in the notifications to the patient relative to hospital admittance and specialist treatment, according to the criteria mentioned above, permits the citizen to know how much the community in which he or she lives contributes with taxes, the modalities of the use of public resources by the state and the regions and the extent of personal contribution with regard to the services received.

2. The patient's knowledge of the costs fosters an awareness process of the close connection between individual and social health and the assuming of responsibility in the use of healthcare resources, with possible positive consequences in terms of the rationalisation of expenses and reduction of waste.

3. The transparency in public healthcare costs financed by the National Health Service in the different regions can allow the citizen to

[1] See attachment No. 2.
[2] See attachment No. 1

compare and judge the efficiency of the structures involved, relating them also to private costs.

4. The availability of economic data becomes an opportunity for public debate with the participation of the media and social networks, resulting in greater transparency and better control of expenses.

Among the reasons against the compulsory and direct communication of the costs of the healthcare services to the patient, the following can be considered:

1. In the Italian health service the protection of health forms part of a solidarity concept of the division of the expenses among those with the most and least benefits. Healthcare and medical assistance for basic needs are due actions towards every citizen regardless of the costs sustained.

2. The communication of information on costs to the patient expresses an economic 'calculating' logic in healthcare that can encourage choices (collective and individual) that introduce the reference (at times even as priority) to costs into the risks/benefits balance, risking making the premises of the justification of the non giving of care/medical assistance considered inefficacious insofar as too expensive compared with the poor therapeutic relevance. Such logic impoverishes the medical principle of beneficence, the very sense of medicine as 'taking care' of the ill person and mortifies the social concern towards those who are in need.

3. The communication of the costs to chronic patients, subject to repeated hospital stays, can increase their distress. Hospital admittance itself usually creates a state of identity disorientation and greater psychological fragility (especially in more serious cases or those with an uncertain diagnosis), which create the need for an empathetic welcome and not one of making them feel guilty, even indirectly.

4. Awareness of the costs can have serious outcomes on patients who can be led to decrease the ethical perception of the dignity of their own life, considering their life condition as not worthy of being lived and perceiving their existence as a burdensome and 'costly' (in terms of individual suffering and economic family and social costs) biological process. In this sense the information of the costs could urge the patient to refuse further treatment, or contribute to this.

### 3. The considerations of the NBC

Before the hypothesis that the Lombardy Region should keep the resolution in question, and other regions opt for an analogous communication of information, the analysis of the arguments in favour and against the communication of the costs of the medical record to the patient, the Committee replies to the question with the following observations:

1. The majority of the Committee[3] considers that:

a) the mandatory communication to the patient of the costs of medical treatment received is not ethically justified, in consideration that the protection of health is a citizen's fundamental right and a duty by state and society.

It is important that the state and regions formulate homogenous measures and strategies aimed at rationalising the use of healthcare resources, but the curbing of expenses in the administration of public healthcare funds must not lapse into forms of bureaucracy or business-making of healthcare, lacking in respect for the dignity of the patient as a person;

b) the communication of costs, to the extent in which it is considered relevant, must take place when requested by the patient, at the moment of being discharged from hospital or during treatment or should the patient be incapable, by his or her legal representative at the time of discharge or medical treatment;

c) the non mandatory communication of costs to the patient must not however mean absence of knowledge. On the contrary, should they wish so, it is important that all citizens be able to have general and individual information on healthcare expenses.

In most local health units (ASLs) the doctors of the area periodically receive the list of the services carried out with the expenses variance for each with respect to the average. In the hospitals the doctors and managers receive adequate information on the DRGs (Diagnosis Related Groups) that correspond to their interventions. It is therefore opportune to also allow citizens/patients to access information of both a general and specific nature with regard to the costs sustained by the NHS or regional body for the services to be allocated or received. It is to be hoped, for the very reason that the objectives are those of transparency and the assuming of

[3] Bompiani, Canestrari, D'Agostino, Da Re, d'Avack, Di Segni, Flamigni, Forleo, Guidoni, Palazzani, Proietti, Toraldo di Francia, Umani Ronchi, Zuffa. Absent in the plenary session the following later expressed their approval: Profs. Dallapiccola, Di Pietro, Possenti and Scaraffia.

responsibility, that the possibility of knowing the average costs regards all the services and does not concern only a part of these, in particular the ones whose costs to the citizen are below those reimbursed by the region, and not those on the contrary that are above. More generally, a website could be foreseen, at regional and national level, which all taxpayers can access in order to check the macro and micro allocation of the resources and above all to compare the healthcare costs. This could curb costs, avoid a lot of waste and produce a qualitative improvement in the healthcare organisation.

2. Some members of the NBC[4] share the opportunity by citizens to also access information of a general nature and on unitary costs, and consider however that the mandatory communication kept separate from the medical record, if managed with due attention out of sensitivity for the individual, is not only bioethically legitimate, but constitutes an important instrument in the growth of a liberal democracy. A liberal democracy manages its service transparently, informing citizens who must never be considered paternalistically, in this case only as patients to be taken care of (sensitive, incompetent, fragile). The citizen is and must remain, despite his or her illness, an active and responsible part in the running of public affairs, capable of exercising a control on the services given insofar as part of the community, which transparency contributes to strengthening.

3. The Committee is unanimous in considering that the communication of costs (prior consent for some; mandatory for others):

a) be given with an ad hoc document and not in the medical record, an obligatory document at least in the case of admittance to hospital and reserved for keeping clinical records relative to the genesis of the illness;

b) be given with suitable criteria and modalities to avoid a sense of guilt and the mortification of the patient, with fitting reassurance on the care of the illness and any need for assistance due;

c) must in any case be founded on the recognition of equality and non-discrimination of sick persons; a differentiation in treatment by reason of the patient's age, his or her capacity to understand, state of health (more or less serious pathologies) is not to be considered ethically legitimate and – lastly – the costs themselves (more or less onerous pathologies): it would be like clearly expressing and stressing – more or less indirectly – the seriousness of their condition, of which they may not be aware;

[4] Amato, Battaglia, Caporale, Garattini, Neri.

d) respect the need for the confidential nature of the personal data relative to the patient's state of health and of any activity concerning the latter;

e) must not be considered the only instrument to foster citizens' awareness of healthcare costs, but must be included in the context of an overall social education to increase awareness of the close connection between individual health and social health, stimulating awareness/knowledge and the assuming of responsibility on the part of the citizen with respect to the prevention of pathologies and risky behaviour and the curb on and proportionality of the demands made on the healthcare system.

The Committee furthermore hopes that:

f) citizens/patients are guaranteed, in the respect of the wish of whoever wants to know, the access to both general and more detailed information with regard to the costs sustained by the NHS for services received or to be given.

g) the transparency on economic costs pursues the objective of making not only patients/citizens responsible but above all the health service administration and the doctors, for the purpose of leading them to more rational choices in the use of resources, considering the appropriateness of treatment and the compatibility with the funds available.

The evaluation of treatment and its compatibility with the resources available is above all left to the doctors, considering both the clinical and organisational appropriateness of the chosen diagnostic therapeutic course, where the patient can only propose or refuse. The evaluation of the appropriateness of the interventions, together with quality, and the definition of the levels of essential assistance are central arguments in the activity of the NHS and the Health Ministry, besides being professional constraints and internationally recognised rules of conduct[5].

[5] Oviedo Convention, Art. 4.

**ATTACHMENTS:**

**Letter of request of Minister Balduzzi to the National Bioethics Committee;**

**Communication to citizens of the value of services reimbursement – Lombardy Region 24 February 2012 Prot. No. 2012 0006242.**

Dear President,

the Lombardy Region, with select committee resolution No. IX/2633 of the 6th of December 2001 bearing "Decisions concerning the management of the Regional Socio-Healthcare services for the year 2012" defined and approved healthcare and socio-healthcare planning guidelines, the system framework, plans and regional development programs for the year 2012, identifying as basic requirements, the integration between healthcare authorities and innovation in technical-healthcare and administrative processes. Measures able to improve access to services, the appropriateness/effectiveness of surgeries and the continuity of treatment, as well as organizational and managerial solutions in order to integrate the activities of the healthcare authorities, have been indicated as key priorities.

The Lombardy Region stressed the central role of local healthcare authorities in protecting the citizens' health, in particular as regards to healthcare and socio-healthcare needs; even through differentiated means of access to care procedures.

Specifically, from the 1st of March 2012, it has been made mandatory (see attachment 1, "planning guidelines") for physicians and hospitals to indicate in the medical records related to hospital admittances and consultancies, the costs of healthcare services, including any extra costs the patient is charged with. Both the above, to be indicated in the letters of release from the hospital and in all communications to the patient. This procedure is carried out in order to make the citizen aware of how the community in which he or she lives finances, through taxes, health services he or she receives and the extent of his or her personal contribution.

The Committee is required to express an opinion on the compatibility of the provisions of the above-mentioned resolution of the Lombardy Region with the principles of our legal order, in that, from March 1st 2012,it bears "an obligation for both public and private authorities whether they are admittance or consultancy units to communicate to the citizen, the cost of the health service divided between the cost sustained by the Region and if necessary that of the citizen".

In particular, it is required to consider whether the introduction of such obligation of transparency, regarding the cost of the services sustained by the Region, could have prejudicial effects on the actions that the National Health Service must bring about to correspond to the duty of improving the patient's wellbeing, above all when suffering from serious illness and whether the just

economic reasons are not in this case unbalanced with respect to those of humanity and solidarity.

Best regards.

Renato Balduzzi

-------------------

Prof. Francesco Paolo Casavola
President of the National Bioethics Committee
Via della Mercede n. 96
ROMA

RegioneLombardia

Giunta Regionale
Direzione Generale Sanità
U.O. Governo dei servizi sanitari territoriali e politiche di appropriatezza e controllo

Piazza Città di Lombardia, 1
20124 Milano
tel 02 6765 3061
fax 02 3936097
www.regione.lombardia.it

Data 24 FEB. 2012

Protocollo H1.2012.0006242

Ai Direttori Generali
delle Aziende Sanitarie Locali
delle Aziende Ospedaliere
delle Fondazioni IRCCS di diritto pubblico

Al Direttore Generale
dell'IRCCS di diritto pubblico INRCA

Via email

Ai Legali Rappresentanti
degli IRCCS di diritto privato
degli Ospedali Religiosi Classificati
delle Case di Cura private accreditate

**Oggetto: Comunicazione ai cittadini del valore di rimborso delle prestazioni**

**Riferimenti**

Le regole di sistema 2012 hanno previsto che i cittadini siano informati, a partire dal 1° marzo 2012, sui costi che il Servizio Sanitario Regionale sostiene per le attività di ricovero e di specialistica ambulatoriale di cui hanno usufruito.

**Come fare?**

I costi del sistema sono i rimborsi corrisposti alle strutture e quindi sono questi i valori da comunicare ai cittadini. È infatti inopportuno che ogni struttura cerchi di stimare i propri costi di produzione con l'esito di avere una grande eterogeneità di informazioni, poco verificabili, fornite ai cittadini con il risultato di generare confusione.

**Ricovero**

Per i ricoveri, con l'obiettivo di avere delle informazioni univoche date ai cittadini su tutto il territorio regionale, la DG Sanità fornisce alle Asl ed ai soggetti erogatori pubblici e privati accreditati un file nel quale per gli interventi e per le diagnosi principali vengono specificati i valori medi dei rimborsi corrisposti nel 2011, anno nel quale vigevano tariffe uguali a quelle del 2012.

**In fase di implementazione di questa nuova attività si dispone che vengano notificati i rimborsi medi solo per le diagnosi, gli interventi e le classi di ricovero che si trovano nel foglio denominato ricovero della cartella excel allegata.**

**Costruzione e contenuti del file allegato**

Il DRG non è quasi mai calcolabile al momento della dimissione. Al momento della dimissione sono altresì disponibili per i ricoveri chirurgici gli interventi principali effettuati e per i ricoveri non chirurgici le diagnosi principali trattate a livello diagnostico e/o terapeutico.

Le elaborazioni effettuate dalla DG Sanità sulle SDO del 2011 hanno raggruppato le attività di ricovero nel modo seguente **(vedi foglio denominato ricovero della cartella excel allegata che permette di effettuare delle selezioni ma che non deve essere aggiornato [non effettuare comando aggiornamento del report])**:

- per i casi chirurgici (afferenti ad un DRG chirurgico), per le procedure che il GROUPER considera principali (MPR);
- per i casi non chirurgici (afferenti ad un DRG non chirurgico), per le diagnosi principali (prima diagnosi segnalata sulla SDO).

Un ulteriore raggruppamento è stato effettuato secondo le principali tipologie di ricovero, caratterizzate da diversi profili tariffari, di seguito esposte:

| Classe | Descrizione |
|---|---|
| DD | Acuti; Degenza Ordinaria 2gg; MoDim <> "3","4"; DRG non Chirurgico con Soglia >10gg; |
| DH | Acuti; Day Hospital |
| DO | Acuti; Degenza Ordinaria |
| RG | Riabilitazione Generale e Geriatrica; Rep. "60" |
| RM | Riabilitazione di Mantenimento; Rep. "98" |
| RS | Riab. Spec.; Rep. "56", "75", "28" |
| ZU | Acuti; Degenza Ordinaria; Ricoveri 0-1gg |

Considerando poi che i medesimi interventi principali e le medesime diagnosi possono essere classificati in DRG complicati e non complicati e che in Regione Lombardia dal 2008 vige per questo tipo di DRG (coppie complicato e non complicato) un sistema di tariffazione che prevede la tariffa complicata solo al di sopra di una determinata soglia di degenza, un ulteriore raggruppamento è stato effettuato suddividendo i record in CC (complicati) ed in NC (non complicati) e quindi classificando l'intervento o la diagnosi in un DRG complicato quando il ricovero dura più di una determinata soglia di degenza o in un DRG non complicato quando il ricovero dura meno della predetta soglia. Nei casi in cui al medesimo intervento o alla medesima diagnosi possono corrispondere sia la tariffa non complicata che la tariffa complicata, nel file allegato vengono esposte le due degenze di riferimento per definire il rimborso medio da comunicare al paziente.

**In sintesi, la procedura da seguire utilizzando il file allegato è la seguente**:

1. selezione della classe di ricovero (CP, DD, DH, DO ecc.) dal menù del filtro posto in corrispondenza della voce "CLASSE";
2. selezione del tipo di ricovero (C, chirurgico o M, medico) dal menù del filtro posto in corrispondenza della voce "TIPO";
3. individuazione della diagnosi principale di dimissione (tipo M) o della procedura principale eseguita (tipo C) a livello della colonna "etichette di riga";
4. individuazione del valore di degenza media (colonna "deg_media") entro il quale ricade il ricovero di proprio interesse;

5. individuazione tariffa "cc" o "nc" di proprio interesse (colonna "media_valore") come da attribuzione di cui alla degenza media.

**Specialistica ambulatoriale**

Vengono comunicati ai cittadini esenti e non esenti i rimborsi corrisposti alle strutture dettagliando separatamente il ticket tradizionale ed il superticket nazionale.

**In fase di implementazione di questa nuova attività si dispone che vengano notificati i rimborsi medi solo per impegnative che contengono almeno una delle prestazioni elencate nel foglio denominato ambulatoriale della cartella excel allegata.**

**Contenuti della comunicazione che deve essere utilizzata come spiegazione del valore del rimborso:**

**Ricovero:**

Egregia Signora/e, il valore di seguito esposto, espresso in euro, rappresenta il rimborso corrisposto mediamente agli ospedali della Lombardia per il costo sostenuto per tipologie di attività e di prestazioni simili a quelle da Lei usufruite nel corso del Suo ricovero.

**Ambulatoriale:**

Egregia Signora/e, di seguito trova esposto il valore complessivo del rimborso corrisposto alle strutture ambulatoriali della Lombardia per il costo sostenuto per tipologie di attività e di prestazioni simili a quelle da Lei usufruite, che risulta costituito dalle seguenti voci:

a. La quota di ticket da lei eventualmente pagata.
b. La quota di eventuale ulteriore partecipazione alla spesa da lei pagata (quota fissa per ricetta) stabilita dalla Legge Nazionale n. 111/2011.
c. La quota eventualmente riconosciuta dal Servizio Sanitario Regionale alla struttura ambulatoriale a saldo / completamento di quanto da lei eventualmente già corrisposto come ticket.

**Le ASL sono pregate di comunicare tempestivamente la nota ed il file allegato a tutti i soggetti interessati dalla presente disposizione ubicati sul proprio territorio di competenza e non presenti in indirizzo.**

Cordiali Saluti

Il Direttore Generale
Carlo Lucchina

Allegato: file excel