The Application of Private Healthcare Strategies within a Universal Healthcare System

2014 Italy Study Tour Report

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Acknowledgements

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As well, it has been a fantastic opportunity to learn from and discuss healthcare strategy with leaders from both sides of the Atlantic. Thank you to leaders of the tour, the Canadian participants, AIOP and our new Italian network.

Canadian Participants: Frank Florio, Gino Picciano, Cal Crocker, Debra McPherson, Scott McIntaggart, John King, Sean Gehring, Anne Marquis, Vanessa Burkoski, Marilyn Rook, Keith Kerr and Linda McCurdy. Absent: Claudia Barbiero. (San Giovanni Battista Hospital, Torino, 2014)
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Executive Summary

In discussions regarding the creation of a more financially sustainable healthcare system the concept of integration of private sector strategies into the universal healthcare model is increasingly being raised. This report will assess components of the Italian healthcare system that may be considered as we move forward.

On the Italian study tour 7 healthcare facilities were toured, visiting facilities along the full spectrum of the continuum of care over the course of the 5 ½ day study tour. The group was introduced to the healthcare delivery system and its challenges across 3 different regions of Italy, and through this gained an appreciation for the various ways in which private sector strategies were applied within a universal healthcare system to increase efficiency.

Bloomberg and the EuroHealth Consumer Index, two different recent healthcare rankings reports, presented contrasting assessments of the Italian healthcare system highlighting what the group experienced on the study tour. We witnessed tremendous innovation and efficiency in several of the privately operated hospitals providing publicly funded and privately funded services. Unfortunately we also saw inequity in the healthcare system, a lack of available outcome/quality data and uncoordinated services beyond the walls of the hospital.

The Italian healthcare system has allowed private sector investment in infrastructure and the involvement in the provision of publicly funded services since the late 1970’s. As part of the Italy study tour we visited 4 privately operated facilities that provided both publicly funded and privately funded services which were key to our understanding of how the private strategies could be implemented successfully in a universal healthcare model. Two sets of takeaways were identified following visiting these facilities:

1. Strategies to enhance the patient experience:
   a. Self check-in kiosks
   b. Wayfinding strategies
   c. Patient experience data collection and reporting

2. Strategies that will require additional analysis:
   a. Fee-for-service programs
   b. On-site hospital operated hotel
   c. International patient care
   d. Co-pay fees
   e. Parallel private in-patient services
1.0 Introduction

In September 2014 leaders from the Canadian healthcare system set off to Italy to explore current developments in health services policy and organization of the Italian health system. The tour provided a rich forum for the exchange of information, ideas and experiences between the Canadians and their Italian counterparts. Our group was comprised of a diverse group of leaders from both the hospital sector and industry. With our very ambitious objective in hand we started the tour in Milan. Over the course of the 5 ½ days on the Italian study tour:

- We toured 7 healthcare facilities along the full spectrum of the continuum of care.
- Were introduced to the healthcare delivery and its challenges in 3 different regions of Italy.
- Traveling 1,100 km by bus and train.
- Met and discussed healthcare (and hockey) with the Canadian Ambassador to Italy.
- And gained an appreciation of the various ways in which private sector strategies were applied within a universal healthcare system.

It is this last bullet that will be the focus of this report. In the subsequent sections of this report I will provide a brief overview of the Italian Healthcare system, compare and contrast the efficiency of the Italian system versus the Canadian system and other EU comparators, and highlight various strategies implemented within privately operated healthcare facilities providing government funded services while offering a private healthcare option.

2.0 Overview of Italian Healthcare System

It is the intention of this section of the report to provide the reader with a brief overview of the Italian healthcare system. As part of the 2013 Italian Study Tour report a thorough overview of the Italian healthcare system was completed. This report was completed by Joanne Greco and can be found on the CCHL website (http://cchl.in1touch.org/site/italy_tour).

2.1 National Government

In 1978 Italy replaced its Bismarckian system of health insurance funding with an objective of providing uniform and comprehensive care, financed by general taxation. This newly created national health service, modeled on the British National Health Service (NHS), was named Servizio Sanitario Nazionale (SSN) (France, Taroni and Donatini, 2005). In Italy, the main role of the National government in healthcare is the distribution of tax revenue, defining the “essential levels of care” (minimum
statutory benefits package to be offered to all residents in each region) and designing the National Health Service plan. The SSN coverage is automatic, universal and all citizens and legal foreign residents are eligible to receive healthcare services. The scope of coverage was expanded in the late 1990’s to grant access and services to illegal immigrants (Donatini, 2012). Although healthcare is primarily delivered at a regional level there are 6 national agencies which provide governance over certain aspects of the healthcare system, such as Italian Medicines Agency (AIFA), whose mission is to regulate the value and cost of medicines and promote pharmaceutical research and development (AIFA, 2014).

2.2 Regional Government

Italy has 19 regions and 2 autonomous provinces (Donatini, 2012). There are socio-economic differences between the northern and southern regions of Italy and between the individual regions. For example, in the Lombardy (Milan/North) and Lazio (Rome/South) regions the annually public health-care spending per capita ranged from $1,972 in Lombary to $2,324 in Lazio. In addition, the Northern region of Italy has a GDP per capital of approximately $31,400 versus approximately $17,000 in the Southern region. Even with the guarantee of universal healthcare the contrasting differences between the cost of providing healthcare and the financial health of the region have led to a clear north-south divide (Schnackenberg, 2011).

In 1997 there was a significant shift towards the decentralization in the organizing and delivery of healthcare services to the regional governments and the Local Health Authorities (LHA). Regional governments have legislative, executive, technical and evaluative functions. The regional governments draw up regional health plans every 3 years, which include financial distribution strategies to the LHA or hospitals. Each region is also responsible for any deficit that it may incur through provision of health services. In addition, they are to ensure that the delivery of the benefits packages occurs through the local health units, and public and privately accredited hospitals (Donatini, 2012; Schnackenberg, 2011).

2.3 Local Health Authorities

In Italy the LHAs are called Unita Santarire Lokale (USL) with whom every citizen must register. Each USL has between 50,000 and 200,000 citizens in its catchment area and it is through the USLs that citizens both receive their health card and chose a general practitioner (ESS-Europe.de, 2013). Operationally the USLs are self-governing, and led by a CEO who is appointed by the region. USLs are responsible for the delivery of primary care, hospital care, public health, occupational health and social health (Commonwealth Fund, 2015). Italians can seek medical care in any region they chose, and the
onus is on the patient to pay the cost of travel, the home region pays their medical bills. This creates a competitive environment of sorts, where private and public hospitals are expected to compete on both cost and quality of service. The hospitals in the Lombardy region have been particularly successful in this regard, with San Raffaele Hospital, a privately run hospital included as part of the study tour, reportedly earning 70 million euros in 2009 from out of region patients (Stancati, 2010).

2.4 Healthcare Funding

2.4.1 Publicly funded healthcare

Publicly funded healthcare accounted for approximately 80% of the total healthcare spending in 2010. The public system is primarily funded through corporate taxes pooled nationally and a fixed proportion of national value-added tax (VAT) revenue, collected by the national government and redistributed to the regions and LHAs (Donatini, 2012).

2.4.2 Privately funded healthcare

Privately funded healthcare accounted for approximately 17.8% of the total health spending. This was mainly related to the expense of over-the-counter drugs and dental care. Approximately 15% of the population has some form of private insurance which is mainly used to cover services not included in the SSN such as better accommodations during your inpatient stay in the hospital, unrestricted choice of specialist, shorter wait times and covering co-payments for services (Donatini, 2012).

3.0 The Italian Healthcare System – How it Stacks Up

Now that a brief overview of the structure of the system has been provided, the next question that needs to be addressed is how ‘good’ is the Italian Healthcare system? This question can be approached from several different directions. By examining recent reports by Bloomberg and the European Health Consumer Index (ECHI) the key metrics can be highlighted and we can move towards answering the question.

3.1 Bloomberg – Most Efficient Health Care 2014: Countries

In 2014 Bloomberg released its annual report on the most efficient healthcare rankings. Bloomberg’s metrics were life expectancy, healthcare as a percentage of gross domestic product, and
total expenditures. It looked at 51 countries with a population of at least 5 million people, a per capita gross domestic product of $5,000, and a life expectancy of at least 70 years old. Although there has been some criticism of the report that it uses life expectancy as the only health outcome measure, the ranking is meant to employ a simple approach and life expectancy is a reflection of how well the healthcare system works (Edney, 2014). Table 1.0 provides a comparison between the efficiency of the Canadian healthcare system and the Italian healthcare system. In addition, I have included the Holland and France in order for the reader to create links between the Bloomberg and ECHI reports.

**Table 1.0 - Bloomberg – Most efficient Health Care 2014: Italy, Canada, Netherlands and France**

<table>
<thead>
<tr>
<th>Country</th>
<th>2014 Ranking</th>
<th>Efficiency Score</th>
<th>Life Expect.</th>
<th>Healthcare cost as a %'age of GDP</th>
<th>Healthcare costs per capita (US$)</th>
<th>Change in life expect. (years)</th>
<th>Change in healthcare cost per capita (US$)</th>
<th>Change in healthcare cost per capita (%)</th>
<th>Change in GDP per capita (%)</th>
<th>Inflation (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Italy</td>
<td>3</td>
<td>76.3</td>
<td>82.9</td>
<td>9</td>
<td>$3,032</td>
<td>0.3</td>
<td>-306.64</td>
<td>-9.2</td>
<td>-8.6</td>
<td>3.0</td>
</tr>
<tr>
<td>Canada</td>
<td>21</td>
<td>52.9</td>
<td>81.2</td>
<td>11</td>
<td>$5,741</td>
<td>0.17</td>
<td>84.32</td>
<td>1.5</td>
<td>1.2</td>
<td>1.5</td>
</tr>
<tr>
<td>Holland</td>
<td>40</td>
<td>41.1</td>
<td>81.1</td>
<td>12.5</td>
<td>$5,737</td>
<td>-0.1</td>
<td>-260.38</td>
<td>-4.3</td>
<td>-7.9</td>
<td>2.0</td>
</tr>
<tr>
<td>France</td>
<td>8</td>
<td>64.6</td>
<td>82.6</td>
<td>11.8</td>
<td>$4,690</td>
<td>0.45</td>
<td>-278.26</td>
<td>-5.6</td>
<td>-6.6</td>
<td>2.5</td>
</tr>
</tbody>
</table>

(Bloomberg.com, 2014)


For the purpose of this report I’d like to highlight 3 key items:

1. Italy spends $2,709 per capita less than Canada on healthcare. What is staggering is to calculate what this equates to: Canada spends 20 billion dollars more on healthcare then Italy and has 25 million less people.

2. Despite the budget reductions and cost savings strategies implemented in an ever-changing Canadian healthcare system, healthcare costs in Canada have risen year-on-year. In contrast, the Italian system has successfully implemented efficiency strategies and continued to decrease the cost per capita by over $300.

3. Inflationary pressures do not present as a strong factor in the expense of the Canadian or Italian healthcare systems. Although the inflation rate is higher in Italy, Italy’s healthcare cost per capita decreased while Canada’s increased. Interestingly, Canada is the outlier as the two other European comparators also decreased healthcare costs per capita. The impact of inflation
could be damped by all 4 countries healthcare workers being heavily unionized or other mechanisms to shield year-on-year cost increases through contracts with suppliers.

These key items paint a picture of the Canadian and Italian healthcare systems going in different directions. It also highlights that there may be an opportunity to learn from a country that operates a very similar system to our own, while spending less and ranking higher in efficiency.

3.2 EuroHealth Consumer Index 2012

The EuroHealth Consumer Index (EHC1) produces a report that evaluates the 34 countries in the European Union (EU) across 41 patient metrics divided into 5 categories. It gives each country an overall score per category and creates the ranking based on the aggregate total. Based on this evaluative criteria Italy comes in 21st amongst EU countries. As stated above France and Holland have also been included to create additional points of comparison. Located in the table below is a comparison of the total score for each category including the overall ranking of each country. Several metrics are also included within each category that were identified as areas that required improvement in the Italian healthcare system.

Table 2 - EuroHealth Consumer index 2012

<table>
<thead>
<tr>
<th>Category</th>
<th>France</th>
<th>Holland</th>
<th>Italy</th>
<th>Italy Rank</th>
<th>Italian System Areas for Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Patient Rights and Information</td>
<td>136</td>
<td>170</td>
<td>131</td>
<td>14</td>
<td>e-Prescriptions, no fault malpractice insurance, provider catalogue with quality ranking</td>
</tr>
<tr>
<td>2. Accessibility (wait times)</td>
<td>167</td>
<td>200</td>
<td>133</td>
<td>26</td>
<td>CT scan and cancer therapy wait times</td>
</tr>
<tr>
<td>3. Outcomes</td>
<td>238</td>
<td>263</td>
<td>270</td>
<td>15</td>
<td>MRSA infections, undiagnosed diabetes, heart infarct case fatality</td>
</tr>
<tr>
<td>4. Prevention/Range and reach of services</td>
<td>140</td>
<td>163</td>
<td>93</td>
<td>25</td>
<td>Long term care for the elderly, informal payment to doctors, equity in healthcare system</td>
</tr>
<tr>
<td>5. Pharmaceuticals</td>
<td>86</td>
<td>76</td>
<td>52</td>
<td>24</td>
<td>Timely access to new drugs, treatment subsidy</td>
</tr>
<tr>
<td>Overall Ranking</td>
<td>8</td>
<td>1</td>
<td>21</td>
<td></td>
<td>(ECHI, 2013)</td>
</tr>
</tbody>
</table>

(ECHI, 2013)


Perhaps we can draw some conclusions from these 2 reports of the Italian Healthcare system. The Bloomberg report highlighted the efficiency of the Italian healthcare system and the ECHI report identified operational gaps in services and processes. These assessments capture what the group
reported experiencing on the study tour. We witnessed tremendous innovation and efficiency in several of the privately operated hospitals providing publicly funded and privately funded services. Unfortunately we also saw inequity in the healthcare system, a lack of available outcome/quality data and uncoordinated services beyond the walls of the hospital.

In considering the potential to implement some of the efficiencies of the Italian healthcare system into our Canadian system section 4.0 of this report will highlight several of the innovation and efficiency strategies that the group learned about while on the study tour.

4.0 Italian Study Tour – “Items to Declare”

Between 2000 and 2012 the percentage of Canadian national GDP dedicated to healthcare increased from 8.7% to 10.9%. During that same period health expenditure per capita increased by 82%. We are at a period of time in healthcare where we have to look to other healthcare systems to understand some of their successful operational strategies in order to create a more financially sustainable healthcare system going forward in Canada. In contrast to our predominately publicly funded system the Italian healthcare system has allowed private sector investment in infrastructure and involvement in the provision of publicly funded services since the late 1970’s. As part of the Italy study tour we visited 4 privately operated facilities that provided both publicly funded and privately funded services and were key to our understanding of how the private strategies could be implemented successfully in a universal healthcare model. The first part of this section will highlight several strategies that are directed to enhance the patient experience. The second part will provide an overview of successful strategies that we saw on the tour that would require further evaluation and dialogue to determine the merits and feasibility of implementation within our healthcare system.

4.1 Patient Experience

4.1.1 Ambulatory Care Kiosks

When a patient enters the ambulatory care area of San Raffaele hospital the first point of interaction is with a self-check kiosk (picture 1.1 below).
The patient proceeds with entering their health card number and additional demographic data to confirm their identity into the kiosk. They receive a small ticket with a number on it then proceed to wait in a large open concept waiting area filled with natural light resembling a passport office, with numerous teller windows around the periphery of the room. There are a number of display screens continually refreshing the expected wait time based on their number. This is the first step in setting the expectation for the patient about their journey on that visit. This area also serves two other functions which benefit the hospital. First, the kiosk decreases the number of clerks/tellers required to admit the patient into the system, thus decrease the HR expense the hospital will incur. Second, in order for the patient to proceed to see the physician they are required to check in with the teller to pay all co-pay fees prior to their appointment.

4.1.2 Wayfinding Strategies

At Humanitas Research Hospital they also implemented check-in kiosks with an additional function. Once you checked-in for your appointment the kiosk provides the patient a printout similar to the one below (see picture 1.2), including information about:

**Picture 1.2 - Wayfinding Printout**
1. Number of patients in the queue ahead of them
2. Patient tracking number so they can follow the expected wait time on the display screen in the lounge
3. Hours of operations for the clinic
4. Scheduled clinic appointment time
5. Map describing route to get to the clinic from the check-in kiosk
6. Ground transportation number
7. Hospital phone number and address

This strategy can decrease the patient’s anxiety in locating their appointment within a large facility, set the expectations early in the experience around wait times and can ensure the patient has all the information they would typically need up front.

4.1.3 Data Collection and Reporting

At Humanitas Research Hospital they have set up the physical environment so patients will walk by an area featuring their “Help Us Improve” campaign (see picture 1.3 below) at the end of their appointment. There are a series of question regarding their patient visit that starts with identifying which of the 4 expressions best represent their visit. The patient inputs their responses on a touch screen tablet (see picture 1.4 below) allowing them to give immediate feedback in a semi-private area directly after their appointment.

**Picture 1.3 - The “Help Us Improve” Campaign**
The kiosks and the tablets were 2 ways that the private hospitals were using technology to improve the patient experience.

4.2 Strategies That Will Require Further Analysis

4.2.1 Hospital Responsibility for 30 Days Post Discharge

As part of the SSN the funding follows the patient, so when a patient is discharged from the hospital, the discharging hospital is identified as being responsible for that patient for 30 days post-discharge. In this model the medications for the first 30 days are managed and dispensed by the pharmacy on-site. If the patient is readmitted within 30 days the hospital does not receive funding for that patient’s previous stay in hospital. The physicians at San Raffaele hospital have reported that this has kept down their readmission rates, however this could also have the potential in turn to extend the length of the inpatient stay (note: length of stay data was unavailable). Given the environment where care in the community, i.e. post hospital care, was reported by healthcare workers at several different facilities as lacking coordination, perhaps this strategy makes sense in Italy. In Canada many hospitals carry a readmission metric on their corporate scorecards. It would be beneficial to have further dialogue
with several of the privately operated hospitals on the impact of responsibility over the patient for 30
days post-discharge and what tactics they have implemented to improve in this area.

4.2.2 Fee-for-Service Wellness and Prevention Programs
At Humanitas Research Hospital they have identified certain 3rd tier patient needs and created programs to address those needs. However, wellness and prevention services are not always fully covered by the SSN, therefore they are fee-for-service programs. These programs include senior’s exercise programs, healthy living education classes and smoking cessation programs. All funds generated through these programs go towards supporting patient care activities in other areas of the hospital.

4.2.3 Hospital Operated Hotel
On the grounds of the San Raffaele Hospital there is hotel that is operated by the hospital corporation. As mentioned previously, San Raffaele is estimated to have generated 70 million euros from out of region patients in 2009. Having amenities such as a full service hotel on the grounds where your loved one is receiving service has been integral in supporting this ‘out of region’ business model. As Canadian hospitals further consolidate specialization of services at fewer locations and given the distance patients are required to travel within our provinces to receive care at times it would be beneficial to gain a better understand of the cost/benefit of the availability of this type of amenity and services.

4.2.4 International Patient Care
At Ospedale Pediatrico Bambino Gesu, as part of strategy to ensure the long term financial health of the organization, they have developed an International Patient Care program. This hospital is world renowned for its pediatric care, especially their transplant services. Through leveraging the existing expertise and infrastructure they have created a successful model where the revenue generated within the International Program goes toward supporting patient care activities within the hospital. Hospital Administration reported that 1 in 10 patients is not from Italy. Moving to a model where 10% of your patient services are dedicated to International patients in Canada would be challenging. However, moving to a central in-take and triage point at a provincial level for International patient requesting services, along with creating the downstream policies and procedures would allow hospital to more efficiently utilize their infrastructure and generate revenue to support patient care.
4.2.5 Co-Pay Fees

Primary and in-patient care is free at the point of care. Since 1993 the patients have paid for the cost of treatment up to a ceiling as determined by law. The ceiling currently stands at €36.15 per prescription. Therefore, if there is a prescription for an MRI test and a lab test, the patient is required to pay €36.15 for each prescription. Prescriptions for services must come from a GP or a specialist. In addition, at a regional level an additional €10 fee is added to each prescription (Commonwealth, 2012).

Since 2007 an additional co-pay fee of €25 euros has been implemented to address non-urgent patients usage of emergency services. Upon arrival at the emergency department the patient will be triaged and placed in 1 of 4 color categories based on the urgency of care required. Red, yellow and green categories are for patients who require care of the emergency services. Patients who are categorized as code white are deemed non-urgent and must pay the €25 fee to be seen by the physician. In 2013 Humanitas received 55,000 patient visits in its Emergency Department. It was reported that 88% of these visits were triaged as code white. This translates to an addition €1.2 million euros in revenue for the hospital. The rationale behind the emergency services co-pay fee is that every citizen of Italy is assigned a physician from the time they are born. There is also a physician available to them 24/7 through the Guardia medica program. Therefore the patient should be seeking medical attention through either of these avenues prior to presenting to emergency department (Donatini, 2012).

Both of these co-pay strategies were born as a result of large operational deficits in the healthcare system. It would be a worthwhile exercise to evaluate the cost/benefit of both approaches, and what model for GPs in the community would be required to support the later co-pay strategies.

4.2.6 Medical University and Hospital as a Single Entity

Two of the privately operated hospitals, Humanitas and Biomedico, have developed their own Medical schools. Within the medical school other healthcare professions are educated, such as nurse and biomedical engineers. This is very interesting approach as it takes the strategy of affiliation between large academic health centers and Universities that we have in Canada one step further. It allows the facility to create a perfect environment of HR supply and demand. It ensures that the facility will have an appropriate supply of well-educated healthcare workers and that the healthcare workers education can be tailored to meet the needs to the specific hospital. In addition, one of the facilities had
a goal of targeting 50% of the medical school class in-coming class as international students, which on a per student basis generates more revenue than an Italian student for the hospital.

4.2.7 Parallel Private In-Patient Services

Privately funded inpatient services were implemented in a variety of different ways within the privately operated hospitals, from 70 beds spread throughout the 1,100 bed Humanitas Research Hospital to 3 sets of parallel public-private units at Campus Biomedico. At Campus Biomedico the main differences between the private and public units was the private rooms, comfort level within the rooms (personal couch, fridge, etc.), standardized uniforms and the ability to choose your physician. At San Raffaele Hospital there were patient suites, which included kitchenette, dining room, private bath, separate hospital room, private bathroom in the hospital room and a place for additional individuals to sleep, specifically built for VIP patients.

5.0 Summary

In discussions regarding the creation of a more financially sustainable healthcare system the concept of integration of private sector strategies into the universal healthcare model is increasingly being raised. This report assessed components of the privately operated Italian healthcare system that may be considered as we move forward.

Section 4.0 of the report reviewed several strategies that have been successful implemented in the Italian Healthcare system. These strategies are meant to be presented to give the reader insight into both what the group experienced on the study tour and to start the discussion about how the leaders of the Canadian healthcare system can create a system that will be financially viable well into the future. In my relatively brief experience as both a healthcare provider and administrator I am quite confident we have the creative minds and leaders to make this a reality.

As a follow-up to the CCHL study tour, in November a group of under 40 health leaders from the private sector hospital association (AIOP), came for a 4 day study tour of the Canadian healthcare system. They toured hospitals in Toronto and Ottawa, including UHN, SickKids, TOH and CHEO. Located in appendix A and B are articles posted on the AIOP website about our study tour in Italy and their Canadian visit to our centres, respectively. I hope they learned as much on their study tour to Canada as much as we learned during our study tour to Italy.
Memento presented to the Emerging Health Leader for participation on the 2014 CCHL Italy Study Tour.

Appendix A – Article from AIOPL website regarding CCHL Study Tour of the Italian Healthcare System (http://www.aioplombardia.it/AIoPLombardia/News/TabId/314/ArtMID/1029/ArticleID/76133/La-sanit224-italiana-per-una-settimana-parler224-canadese.aspx)
La sanità italiana per una settimana parlerà "canadese"

Study Tour degli imprenditori canadesi in Italia

mercoledì 17 settembre 2014

di Claudia Barbiero, Rappresentante dell'Italian Chamber of Commerce of Ontario

La Camera di Commercio Italiana dell'Ontario, il Canadian College of Health Leaders e Aiop Giovani hanno collaborato per il secondo anno di fila nell'organizzazione di un viaggio studi in Italia, ideato ad hoc per i dirigenti sanitari canadesi. Durante la visita, il gruppo composto da 12 dirigenti ha avuto la possibilità di visitare 7 ospedali italiani pubblici e privati situati in tre regioni, quali la Lombardia, il Piemonte e il Lazio. Dopo aver conosciuto il San Raffaele, l'Humanitas e la Residenza San Pietro, come eccellenza della sanità privata; per la sanità pubblica, i canadesi hanno voluto visitare la Città della Salute di Torino. A Roma, la delegazione si è recata presso l'Ospedale pediatrico Bambin Gesù, il Campus Biomedico e l'Ospedale Sant'Andrea. È importante per la nostra Camera di Commercio avere l'opportunità di conoscere le eccellenze italiane nel settore sanitario, la loro lunga tradizione nello svolgere attività di ricerca e nel fornire cure di alta qualità per i suoi pazienti. È altrettanto interessante notare che l'assistenza sanitaria in Canada è molto simile al "modello italiano", in quanto è espresso attraverso un sistema di assistenza sanitaria finanziata con fondi pubblici, dove il governo assicura la qualità delle cure attraverso norme federali e dove le province gestiscono la cura giorno per giorno. Nel corso di quest'esperienza, i delegati canadesi hanno potuto apprezzare anche significative differenze, come il fatto che in Italia gli ospedali di proprietà sia privata che pubblica, siano in grado di coesistere nello stesso territorio, completandosi a vicenda nell'erogazione dei servizi al cittadino. La Camera di Commercio dell'Ontario insieme con il "Canadian College of Health Leaders" per conto di Aiop Giovani, organizzerà poi un tour per garantire lo studio del sistema sanitario del nostro Paese, attraverso le visite ai principali ospedali, istituti di ricerca delle città di Toronto e Ottawa. Non possiamo che definirci entusiasti di
continuare questa collaborazione con la Sezione giovanile dell'Aiop, accogliendo i suoi giovani imprenditori in Canada, per assisterli nella promozione della loro attività e per garantirgli la comprensione delle complessità del sistema sanitario canadese.

Di seguito riportiamo la testimonianza di Sean Ghering, giovane delegato del gruppo canadese, vincitore di una borsa di studio.

The Canadian College of Health Leaders (the College) is a strong advocate of the development of young and emerging health leaders. This has been highlighted annually over the past 5 years through the Emerging Health Leader Scholarship. The College is committed to sending 1 emerging health leader to participate on their international study tour. This opportunity is sponsored by Aramark Healthcare. *For the first time, the scholarship winner part updated in the study tour of the Italian Healthcare system.* To qualify for the scholarship the applicant must be under 40, and in their first 5 years of a leadership position within a healthcare organization. In addition the applicant had to complete an essay highlighting their previous leadership experience, and noting how participating on the tour would impact their learning goals and how they could bring the learning back to their own organization. The top 3 candidates then participated in a panel interview. Of the dozen candidates who applied I was the winner of this year’s scholarship.

My current role is a Clinical Manager of the Neuromuscular and Specialized Care Steam, and the TOH Pain Clinic at the Ottawa Hospital. This portfolio include inpatient, outpatient and revenue generating services. I have also been a consultant for Royal College International and have a keen interest on international healthcare systems.

Meeting and discussing opportunities and challenges with leaders from different facilities along the full continuum of care here in Italy has been a fantastic opportunity. Of particular interest has been gaining an understanding of how in the Italian Healthcare system that private sector strategies have been applied within a universal healthcare system. This concept is still in its infancy in Canada and seeing its success and growth has provided a model to following and guide us in Canada. In addition, the networks I have developed on this tour will help continue my professional development as a leader when I return home. On a personal note I have also enjoyed the Italian culture and the people. We are welcoming a delegation of young leaders from Italy in the October of this year.

Appendix B – Article from AIOP website regarding group of under 40s young leaders from the Private Sector Hospitals Association’s Study Tour of Canadian Hospitals

(http://www.aiop.it/Aiop/AiopTV/Tabld/290/ArtMID/983/ArticleID/76302/L%e2%80%99eccellenza-del-TOHRC.aspx)
L’eccellenza del TOHRC
La riabilitazione attraverso il Caren System

di Alessandro Bonvicini*

In occasione dell’11° Study Tour la delegazione Aiop Giovani ha conosciuto il Sistema Sanitario canadese grazie ad una serie di interessanti e stimolanti visite presso numerose strutture ospedaliere presenti a Toronto ed Ottawa, accompagnati dai “Ciceroni” John King e Gino Picciano, membri del Canadian College of Health Leaders. Quest’esperienza ha permesso a tutto il gruppo di “toccare con mano” le eccellenze sanitarie di questo Paese presenti in diversi settori, basti pensare al Princess Margarthe Cancer Center dell’UHN (University Health Network) di Toronto, all’Innovation Unit del Mackenzie Health di Richmond Hill, all’area dedicata alla simulazione del The Ottawa Hospital, e ancora, all’interessante e trasparente sistema di accreditamento canadese delle strutture sanitarie (AC ed ACI).

Durante l’ultima giornata del tour, i giovani imprenditori della sanità privata hanno visitato il consolidato ed allo stesso tempo innovativo reparto di riabilitazione del TOHRC, The Ottawa Hospital Rehabilitation Center. La struttura in questione, di non recentissima costruzione, risalente agli anni ’80, si caratterizza per un unico obiettivo, quello di riabilitare al meglio i pazienti e di farli sentire il più possibile a proprio agio, come fossero a casa propria. Durante la consueta presentazione della struttura, a cura di Sean Gehring, Manager specializzato nei sistemi di cura, è emerso che:

- in tutto il Canada ci sono solo due strutture riabilitative di questo calibro e con questa dotazione tecnologica;
- vengono trattati pazienti complessi (spesso militari e soldati vittime di gravi infortuni ortopedici e neurologici durante
le loro missioni), che dopo un primo triage clinico sono inquadrati dai fisiatri presenti in struttura;
- il reparto è dotato di 54 posti letto di degenza per circa 400 pazienti riabilitati durante l’anno
- e sono trattati circa 100.000 pazienti a livello ambulatoriale all’anno.

La caratteristica che fa del centro un punto di riferimento per l’intera nazione è il macchinario “Caren System”
presente nel Rehabilitation Virtual Reality Laboratory.

Si tratta di un sofisticato macchinario di simulazione 3D che ricostruisce situazioni che richiedono un certo
impegno fisico e neurologico, il tutto a carattere ludico e con immediata analisi dei risultati funzionali da parte
dello staff riabilitativo. La dimostrazione a cui abbiamo potuto assistere ha visto protagonisti il Vice Presidente di
Aiop Giovani del nord Italia, Michele Nicchio e il Vice Presidente del centro, Giulia De Leo. Entrambi sono stati
coinvolti direttamente in quelle che potrebbero sembrare ai non esperti banali ricostruzioni virtuali di attività fisiche
all’aria aperta (dallo slalom con una imbarcazione attorno ad alcune boe, ad una camminata su un ponte
pericolante, a una passeggiata su terreni sconnessi e instabili) e in giochi di abilità (break out e una sorta di
bubble shooter), ma che in realtà sono funzionali alla riabilitazione fisico motoria.
La visita è proseguita poi con un tour attraverso le aree del reparto, in cui abbiamo potuto apprezzare le palestre,
piuttosto ampie ad esempio quella dedicata alla terapia occupazionale, con tanto di cucina, la piscina e i
numerosi ambulatori dedicati ai servizi di psicologia, di logopedia, sino a quello di riabilitazione alla guida col
programma “Candrive”, di dietologia, di ergoterapia.
Con convinzione posso affermare che questa struttura si sia dimostrata sicuramente stimolante per i presenti, a
tal punto da lasciare interessanti spunti che sta a noi giovani imprenditori far propri. Nonostante una notevole
differenza culturale e sociale, che sembra semplificare le spesso tortuose dinamiche socio-sanitarie italiane, le
occasioni per cercare e creare sinergie con il Sistema Sanitario Canadese ci sono e devono rappresentare
nientemeno che lo stimolo per la nostra delegazione ad impegnarsi nel futuro.

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Bolzano - http://www.gruppobonvicini.it/

Appendix C – Italy Study Tour Facilitators and Participants

Italy Study Tour Facilitators

Claudia Barbiero – Italian Office Representative, Italian Chamber of Commerce of Ontario
John A. King – International Facilitator, Canadian College of Health Leaders
Gino Picciano – Co-Director, Canadian College of Health Leaders

Italy Study Tour Participants

Vanessa Burkoski – Vice President/Chief Nursing Executive, Quality, Patient Safety and Professional Scholarly Practice, London Health Sciences Centre
Cal Crocker – Executive Vice-President and Chief Financial Officer, Royal Ottawa Health Care Group
Frank Florio – President, BD Canada
Keith V. Kerr – Vice-President Business Development, Healthcare, Sodexo
Anne Marquis - Commercial Manager, Services, GE Healthcare Canada
Linda McCurdy - President and CEO, K-Bro linen Systems Inc.
Scott McIntaggart - Senior Vice-President, University Health Network; Executive Lead, Toronto General Hospital
Debra McPherson – President, British Columbia Nurses Union
Marilyn Rook – President and CEO, Yhe Salvation Army, Toronto Grace Health Centre
Sean Gehring – Manager, Specialized and Neuromuscular Care Stream, The Ottawa Hospital

References


