10 KEY FACTS to understand the Italian Healthcare System

2017 OASI REPORT– Executive summary

English version

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This executive summary offers a synthesis of the broader 2017 OASI[1] Report for the international audience. Every year, the research carried out by OASI (Observatory on Healthcare Organizations and Policies in Italy) aims at offering a detailed analysis of the Italian healthcare system, outlining its future evolution.

The OASI Observatory is promoted by CERGAS - SDA Bocconi. CERGAS (Centre for Research on Health and Social Care Management) is part of the SDA Bocconi School of Management, the top School of Management in Italy and one of the highest-ranking in the world[2]. CERGAS researchers apply principles, instruments and techniques from policy analysis and management to support public institutions, not-for profit organizations and enterprises targeting collective needs for health and social care.

This executive summary is divided into four sections. The ***Key facts*** section (p. 3) presents 10 main policy and managerial trends described and interpreted in the OASI Report. Relevant figures and concepts are integrated with reference to the corresponding chapters of the 2017 OASI Report and to external sources. The **Index** (p. 9) reports the 2017 OASI Report table of contents, giving the reader the opportunity to retrieve the original research reports. ***Appendix* I** (p. 10) outlines the main features of the Italian Health System within a country overview, while **Appendix II** (p. 13) reports a list of useful data sources related the Italian healthcare sector.

The contents of the OASI Reports from 2000 to 2017 are fully available in Italian on the CERGAS website: www.cergas.unibocconi.it. The abstract of all chapters of the 2017 OASI Report are also available in English.

[1] Observatory on Healthcare Organizations and Policies in Italy.
[2] SDA Bocconi is ranked 6th in Europe according to the Financial Times.

10 KEY FACTS to understand the Italian Healthcare System

#1 Contained healthcare expenditure

- In 2015, total health expenditure in Italy was about 9% of GDP, while in the United Kingdom it was approximately 9.9%, 11.1% in France, 11.2% in Germany and 16.9% in the USA (2015). In 2016, the Italian National Health Service (INHS), a tax-funded, Beveridge-type public insurance scheme, covered about 75% of total healthcare expenditure (please see the *Appendix* for more details on the governance of the INHS). Private, out-of-pocket (OOP) expenditure accounted for 23% of healthcare expenditure, and the remaining 2% pertained to voluntary schemes like private insurance and mutual funds ⟶ *for further detail, please see chapters 3 and 8 of the Report.*
- Between 2010 and 2016, INHS expenditure grew, on average, by 0.7% per year in nominal terms, which is lower than the average annual inflation rate of 1.1%. In 2016, total expenditure grew approximately 0.1% compared to 2015, reaching 115.8 billion Euros ⟶ *chapter 5*.
- The quota of Welfare expenditure devoted to healthcare decreased from 24% in 2010 to 21.9% in 2016. In the meantime, expenditure on the pension system remained stable at 68%, and social care expenditure (disability and caregivers' allowance) rose from 8% to 10% ⟶ *chapter 5*.

#2 The Italian NHS balances its accounts

- In 2016, the INHS registered a surplus of 329 million Euros, including funds obtained from additional regional taxes. The INHS reached financial and economic equilibrium at the national level ⟶ *chapter 5*.
- Since Italy has a decentralized NHS, it is important to assess the sustainability of the single regional systems (Regional Healthcare Services, RHS). The majority of the RHS were essentially in equilibrium in 2016, with a relevant deficit only in Sardinia[3] ⟶ *chapter 5*.

[3] The calculation includes, as before, the resources obtained from additional regional taxes.

#3 Appropriateness of care and excellent health outcomes, with margins for improvement

- Italy registered (i) a lower level of inappropriate hospitalizations[4] than the UK, the USA, Spain, Germany and France, (ii) a reduction in the number of caesarean sections, though Italy still ranks among the highest users of this practice internationally, and (iii) high levels of antibiotic use ⟶ *chapter 5*.
- Italy boasts excellent life expectancy and healthy life expectancy rates, 82.7 and 72.5 years, respectively. Life expectancy is the third highest in Europe, after Switzerland and Spain ⟶ *chapter 2.*
- There are margins for improvement with respect to avoidable death rates and recommended vaccination rates, which fell below the recommended threshold of 95% ⟶ *chapter 2.*

#4 Public supply in progressive decrease

- Total hospital admissions continued to decrease, to 9 million in 2016, registering a 25% reduction over the 2008-2016 period → *chapter 4.*
- In 2015, 7.9% of Italy's residents declared an episode of healthcare renunciation. The main justification for this is the cost exceeding the family's budget → *chapters 3 and 4*.
- Public resources cover 95% of total hospital expenditure, but only 65% of residential long term care (LTC) expenditures and 60% of outpatient services outlays → *chapter* 8 *and Italian National Institute of Statistics - ISTAT, 2017 (a)*[5].

#5 Growing demand for chronic care and elderly assistance

- Multi-morbid, chronic patients represent 21% of the entire population. These patients tend to saturate the supply of the NHS, pushing acute "occasional" patients towards private assistance → *chapter 4*.
- Dependent or disabled elderly persons number 2.8 million, but only 270,000 beds in public and private accredited nursing homes are available, i.e., there is a lack of resources and fragmentation within institutional capacity

[4] The calculation includes admissions for asthma, COPD and diabetes.

[5] Please see the report: "Il Sistema dei conti della Sanità per l'Italia", available at the following link: https://www.istat.it/it/files/2017/07/CS-Sistema-dei-conti-della-sanit%C3%A0-anni-2012-2016.pdf?title=Conti+della+sanit%C3%A0+-+04%2Flug%2F2017+-+Testo+integrale.pdf.

(which are shared across the INHS, the National Institute for Social Security, and Municipalities). Often, families are forced to self-manage the situation either through the direct care of their relatives, through an informal caregiver, or by paying for nursing homes out-of-pocket → *chapter 7 and Bank of Italy, 2015*[6].

- The equilibrium of the welfare system is getting precarious. Demographic trends will not reverse, due to the low fertility rate: the average number of children per woman was 1.34 in 2017, showing a sharp decrease from 2010 (1.46). Demographic projections estimate that the aging rate (the elderly/total population) will reach 60% in 2065, and spending power for future retired people will decrease progressively → *chapter* 2 *and ISTAT, 2017 (b)*[7].
- Insufficient supply of elderly care has an impact on the functioning of healthcare services. Repeat admissions (same type of care, same Major Diagnostic Category) amount to 55% of ordinary admissions for people over 65 → *chapter 7.*

#6 Excellent health outcomes, with persistant inequalities

- In 2016, life expectancy at birth was 82.8 years. In 2015, Italy's life expectancy was the third highest in Europe, outdone only by Switzerland and Spain→ *chapter 2*.
- Life expectancy in good health shows sharp variation across the country. In 2015, the indicator reached 60 years in the North of Italy and 56 years in the South. The greatest difference was between Calabria and the Autonomous Province of Bolzano: 50 years and 70 years, respectively → *chapter 4.*
- In 2016, in the North, 49.6% of chronic patients reported being in "good health", while in the South the analogous group accounted for only 36.6% → *chapter 4.*

[6] Please see the report: "I bilanci delle famiglie italiane dell'anno 2014", available at the following link: ttps://www.bancaditalia.it/pubblicazioni/indagine-famiglie/bil-fam2014/index.html
[7] Please see the report: "Previsioni demografiche 2016-2065" available at the following link: https://www.istat.it/it/files/2017/04/previsioni-demografiche.pdf

- The extra-regional admission quota for acute hospitalization in the inpatient setting increased from 7.4% in 2010 to 8.2% in 2016 → *chapter 4 and Ministry of Health, 2017*[8].
- The percentage of dependent elderly persons assisted in nursing homes, which is low in the North (maximum 40%), is worringly close to zero in Central and Southern regions → *chapter 7.*
- Out-of-pocket (OOP) household expenditure for health is skewed towards the richest regions of the North. For example, during the 2014-16 period, the most populous region in the North, Lombardy, had double the OOP expenditure compared to Campania: 752 Euros per person compared to 303 Euros → *chapter 8*.

#7 Regional governance evolving towards integration. Regions as "parent companies"?

- The number of Local health Authorities (LHAs), the territorial public organization responsible for healthcare commissioning and provision, decreased to 120 from 146 in 2016. As a consequence, the average size of LHAs has grown (504,000 residents in 2017 compared to 413,000 in 2010). In some Regions, among which Lombardy stands out, the reorganization of the SSR saw the reintegration of the hospital network or at least of a part of it. For this reason, the number of Independent Hospitals (IHs) fell from 75 in 2015 to 43 at the end of 2017 → *chapter 4.*
- In many Regional Health Services (RHS), LHAs, IHs and other public providers are uniting in a sort of regional technostructure, assuming the features of a "parent company". The regional technostructure, in some contexts, defines the strategic orientation of the "controlled" public providers; moreover, the regional technostructure has frequently centralized operational functions, like purchasing, logistics, IT management, recruiting. → *chapter 9*.
- Within these new, more integrated RHS, public providers are therefore becoming more heterogeneous with respect to vertical dimensions (independence in carrying out strategic planning), and to horizontal

[8] Please see the report "Rapporto SDO 2016" , available at the following link: http://www.salute.gov.it/portale/documentazione/p6_2_8_3_1.jsp?lingua=italiano&id=28

dimensions (mission orientation and services provided). Growing heterogeneity across providers will require more diverse governance configurations, organizational models and managerial competencies → *chapter 9*.

#8 Pivotal role of private accredited providers, with strong path dependencies in commissioning

- Private accredited providers supply 30% of hospital beds, 59% of outpatient facilities and 78% of nursing homes in the INHS → *chapter 6*.
- Public and private accredited providers are strongly complementary within the publicly-funded system, especially because private entities offer services in many areas where the demand is growing and the public supply is limited (elderly care, rehabilitation, etc.) → *chapter 6*.
- With respect to service provision, many RHSs should be less complacent in externalizing services to private accredited organizations. Moreover, Regions should guarantee more regulatory stability and favor programming and evaluation metrics based on performance → *chapter 6*.

#9 An urgent need for HR policies consistent with epidemiological trends

- Nursing staff ratios are less than half those observed in Germany: 6 nurses per 1,000 residents compared to 13, even though the population makeup of the two countries is comparable. Generally speaking, Italy reports a number of medical doctors comparable to other developed countries, but lower numbers of nurses and other health care workers → *chapter 3*.
- Among physicians, 52% are more than 55 years old. However, there are twice as many young physicians on waiting lists for the compulsory, 5-year, paid training programs: 13,802 candidates vs. 6,725 scholarships in 2016). Therefore, the crucial problem is the scarcity of resources to train and hire new medical staff, while the number of doctors themselves is, paradoxically, overabundant → *chapter 3 and Ministry of University and Research, 2017*[9].
- Given the persistent scarcity of resources, along with the increase in chronic diseases and the need for LTC, the system should increase the

[9] Please refer to: http://hubmiur.pubblica.istruzione.it/web/ministero/cs180716. Last access: February 27, 2018.

quota of healthcare assistants, keeping in mind that the average cost for a physician equals that of two nurses. However, deep shifts in the normative framework and managerial habits are needed → *chapter 11*.

#10 The ongoing development of intermediate care services and facilities

- There are about 300 Intermediate Care Facilities (ICF) across Italy, with differing characteristics, services and denominations. Within and outside ICF, especially in Northern Italy, new forms of transitional care are increasingly common: for example, nurse-led teams working to strengthen the continuity of care and the appropriateness of the setting → *chapter 12 and 13*.
- 93% of ICFs were created through reconversion of existing healthcare structures. Frequently, ICFs replace former small-size hospitals, by now unfit for emerging health care demand (rehabilitation, chronic care, elderly care). In other cases, ICFs integrate outpatient facilities and primary care. ICFs are increasing throughout the country, but they usually face the challenge of delivering innovative, patient-centered care with decreasing financial resources and unvaried staff → *chapter 13*.
- Even though 81% of ICFs claim to supply proactive, personalized medicine for chronic patients, only half of them provide *ad hoc* reporting. Only 8% of ICFs are able to monitor compliance with clinical pathways for their patients. These figures testify that awareness of the chronic care model across Italy is increasing, but managerial tools should be enhanced→ *chapter 13*.

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Please note that the OASI Report chapters are in Italian. English abstracts are available at www.cergas.unibocconi.it

Appendix I - an overview of Italy and Italian Healthcare

Demographic profile

Italy is the sixth most populous country in Europe, with 60.6 million inhabitants in 2017[10]. The population growth rate is slightly negative (-1.6% in 2017, -0.1% in 2016 and -0.2% in 2015), one of the worst in the EU. On one hand, immigration, with 292,000 foreign newcomers in 2017, plays a key role in maintaining the population decrease close to zero. On the other hand, the balance of the resident population is deeply negative, (-184,000), mainly due to a low fertility rate (1.34 children per woman).

Socio-economic profile

After years of recession, Italy has seen a slight recovery since 2014, with annual GDP growth rates remaining below 1%. In addition to stagnation, public finances are constrained by the high levels of government debt (133% of the GDP) [11] and tax evasion. Consequently, resources available for welfare expenditure are considerably lower than in other large European countries. According to Eurostat[12], in 2015 Italian expenditure on social protection was about €8,200, while Germany and France reached €10,800 at PPS[13] and UK €8,500 at PPS.

Italy is a decentralized state, with a significant quota of public expenditure managed by the Regions. Italian territory is made up of 20 administrative Regions, which are extremely varied in size, population and levels of socio-economic development. The well-known divide between Northern and Southern areas is still relevant. Italian per capita GDP is €27,700 overall, while North West regions reach €34,200 (+23% with respect to the national average) and €18,200

[10] The Source of the demographic data is the Italian National Institute of Statistics (ISTAT). Last access 02.26.2018.
[11] While primary surplus been positive since 2009, the relevant debt service results in a negative fiscal balance (-2.4 in 2016).
[12]Please see the Eurostat newsreleas 188/2017 – 12.8.2017.
[13] Parity purchase power.

(-34%) in the South. According to EUROSTAT (2016)[14], the Italian Gini Index is 33.1, slightly above the EU-28 value of 30.8 and many European countries: France is 29.3, Germany 29.5, UK 31.5, while Spain register 34.6. In addition to the Southern regions, socio-economic hardship affects younger people and families with children, since the Welfare State considerably reduces poverty risk only for retired people (ISTAT, 2017)[15]

Healthcare System profile

In 2016, the Italian National Health Service (INHS), a tax-funded, Beveridge-type public insurance scheme, covered about 75% of total healthcare expenditure (please see the *Appendix* for more details on the governance of the INHS). Private, out-of-pocket (OOP) expenditure accounted for 23%, and the remaining 2% pertained to voluntary schemes like private insurance and mutual funds.

The INHS was introduced in 1978 with Law No. 833/1978, which defined a universal healthcare system for Italian citizens and foreigners legally residing in Italy. The Decree 502/1992 introduced managerial principles into the INHS and marked the start of concerted efforts to devolve healthcare powers to the Regions. Nowadays, Italy's healthcare system is a regionally-based, National Health Service that provides universal coverage, largely free of charge at the point of service. The national level is in charge of general objectives and the fundamental principles of the INHS. Regions are responsible for ensuring the delivery of a package of services through a network of population-based "local health authorities" (LHAs) and public and private, accredited hospitals. The national level defines the total amount of public resources for health expenditure. This amount is allocated among regions according to their demographic profiles (mainly, age structure and sex ratio). Regions can integrate the National Health Fund with their own additional resources.

[14] Please consult the EUROSTAT database: http://appsso.eurostat.ec.europa.eu/nui/show.do?dataset=ilc_di12. Last access 02.28.2018.
[15] Please see the report "La redistribuzione del reddito in Italia", http://www.istat.it/it/files/2017/06/CS_-Redistribuzione-reddito-in-Italia_2016.pdf.

Regions are responsible for guaranteeing financial equilibrium as well as minimum standards of care. Serious deficits can result in Recovery Plans (“Piani di Rientro”). This kind of compulsory administration entails an automatic increase in regional taxation, while key policy choices are under the strict monitoring of the national government. Today, 8 Regions are under Recovery Plan Schemes; six of which are located in the south of the country.

Appendix II - Selected data sources for the Italian Healthcare System

- Italian Ministry of Health, Open Database
  http://www.salute.gov.it/portale/documentazione/p6_2_8.jsp?lingua=italiano

- Italian Ministry of Health, Report on Hospital Admissions (Rapporto SDO)
  http://www.salute.gov.it/portale/temi/p2_4.jsp?lingua=italiano&area=ricoveriOspedalieri

- Italian Ministry of Health & National Agency for Regional Health Systems, National Outcomes Program
  http://pne2017.agenas.it/

- Italian National Institute of Statistics, Health statistics,
  http://www.istat.it/it/salute-e-sanit%C3%A0