Italy
Health System Review 2022

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Key messages

- Italy has one of the highest life expectancies at birth in Europe and the COVID-19 pandemic is likely to have been a temporary setback.
- The National Health Service (SSN) provides universal coverage largely free of charge at the point of delivery, but regional differences in health indicators are marked, as well as differences in per capita spending, distribution of health professionals, access, and the quality of health services..
- Health spending per capita is lower than the EU average and is among the lowest in western European countries. Private spending has increased in recent years, although this trend was halted in 2020 during the COVID-19 pandemic.
- One major challenge for the future of the SSN is the need to invest in the health workforce, particularly to secure additional numbers of GPs and nurses in order to staff the planned new or upgraded primary and community care facilities.
- Other challenges for the health system are linked to modernizing outdated building stock and equipment, and enhancing information infrastructure.
- The National Recovery and Resilience Plan contains specific health sector priorities that can reinforce the SSN, such as strengthening the country's primary and community care, boosting capital investment and funding the digitalization of the health care system.

1. Introduction

- Italy is a **high-income country in southern Europe** with a population of 60 million in 2021.
- It is a **parliamentary republic** with a president who serves as the formal head of state, a bicameral parliament and a prime minister and cabinet which exercise executive powers.
- The country is made up of **20 regions** (with one region divided into two autonomous provinces) which are extremely varied in size, population and levels of economic development. Regions have considerable powers, particularly in health care financing and delivery.
- **Average life expectancy at birth** declined temporarily **in 2020 to 82.4 years** due to the impact of the COVID-19 pandemic but was still the third-highest in the EU.
- The main diseases affecting the population are **cardiovascular diseases, cancers** and, as a result of the COVID-19 pandemic in 2020, also **infectious respiratory diseases**.

TABLE 1.3 Mortality and health indicators, 2020 or latest available year

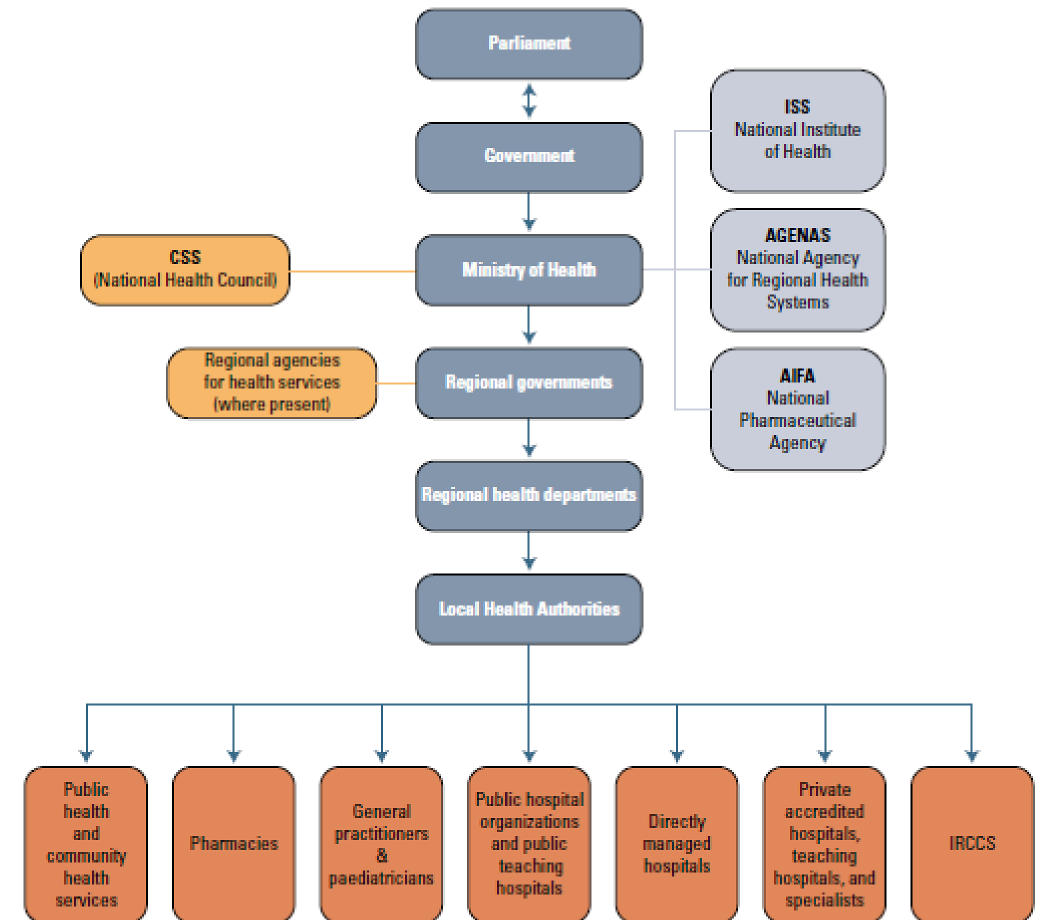
	1995	2000	2005	2010	2015	2020
LIFE EXPECTANCY (YEARS)						
Life expectancy at birth, total	78.3	79.9	80.9	82.2	82.7	82.4[a]
Life expectancy at birth, male	75	76.9	78.1	79.5	80.3	80.1[a]
Life expectancy at birth, female	81.5	82.8	83.6	84.7	84.9	84.7[a]
Life expectancy at 65 years, male	15.8	16.7	17.3	18.3	18.9	18.5[a]
Life expectancy at 65 years, female	19.9	20.7	21.1	22.1	22.2	21.8[a]
MORTALITY						
Mortality, SDR per 100 000 population						
Circulatory diseases	278	238	202	160	152	142[b]
Malignant neoplasms	192	180	168	157	146	142[b]
Communicable diseases	3.6	5.8	7.7	8.6	11.8	9.7[b]
External causes of death	39	34	30	25	23	23[b]
All causes	680.78	603.61	549.84	478.11	467.98	452.92[b]
Infant mortality rate (per 1 000)	6.1	4.3	3.3	3	2.9	2.5[c]
Maternal mortality rate (per 1 000)	3.2	3	2.6	2.9	3.4	2.5[d]

Note: [a] 2020, estimate, provisional; [b] 2017; [c] 2019; [d] 2018.

Sources: Eurostat, 2022c; OECD, 2022c; WHO Regional Office for Europe, 2021a.

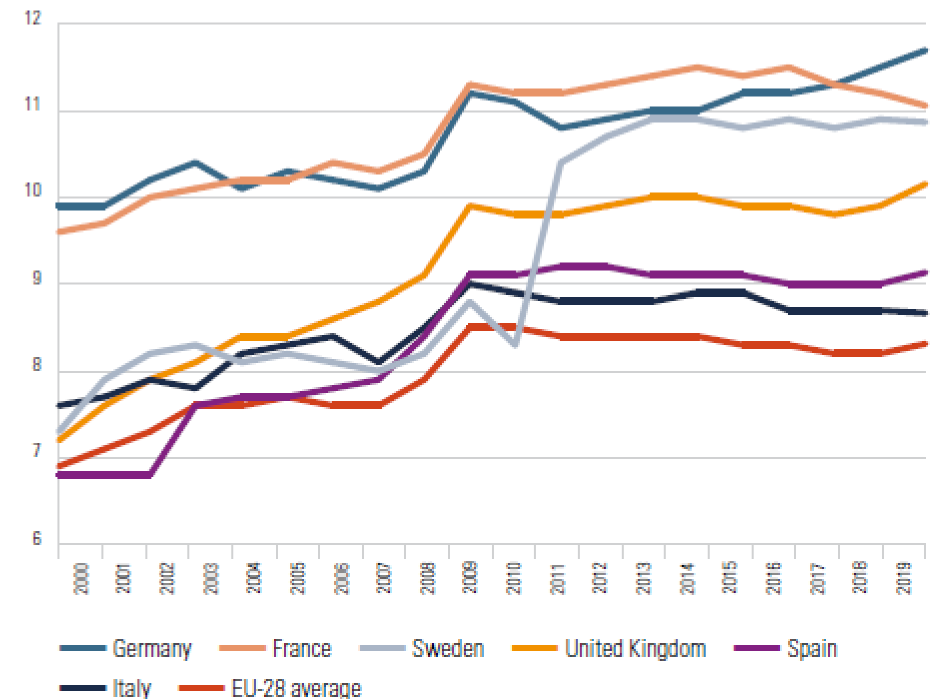
2. Organization and Governance

- The **Italian National Health Service (*Servizio Sanitario Nazionale,* SSN)** provides universal coverage to all citizens and legal foreign residents.
- The **national benefits package** is established by the central government, which also oversees and allocates funding for regional health systems.
- The regions, through **Local Health Authorities**, are in charge of financing, planning and provision of services at the local level.
- GPs and paediatricians, who are independent contractors, **act as gatekeepers** to higher levels of care.
- **Hospital and specialist ambulatory services** can be provided by the local health authorities through directly-managed hospitals, semi-independent public hospitals ("hospital trusts") or accredited private providers.
- National-level planning instruments include **3-year health plans, pacts between regions and the central government, and national programmes** addressing specific health issues.
- At regional level, planning is based on **regional health plans**, **financing and allocation of funds**, and adapting national goals to local socio-epidemiological contexts.



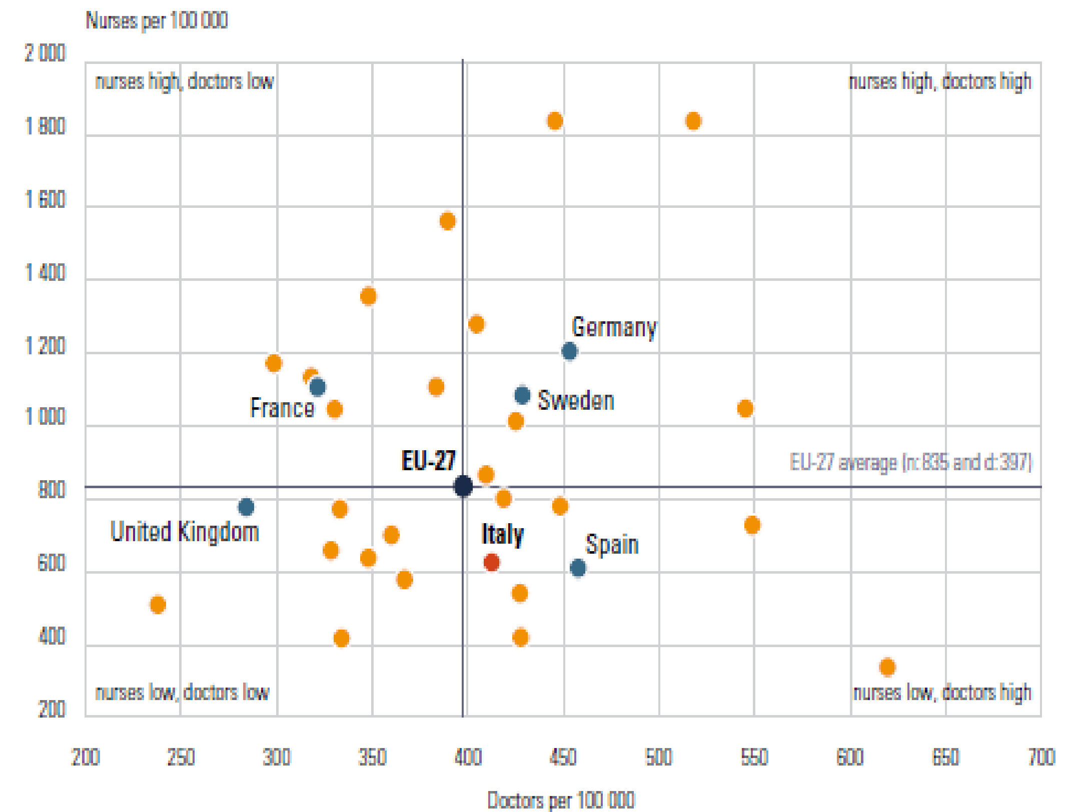
3. Financing

- In total, 8.7% of Italy's GDP was spent on health in 2019. **Health expenditure per capita is below the EU average**: in 2019 it amounted to US$ 3998 PPP.
- The **share of public spending on health stood at 74%** in 2019 but increased sharply in 2020 in response to the COVID-19 pandemic.
- The **private share of health spending reached over 26%** of current health expenditure in 2019, most of which is represented by out-of-pocket (OOP) expenses, including co-payments and direct payments by households.
- **OOP payments** are mainly spent on dental care, OTC medicines and specialist outpatient services.
- **Voluntary health insurance** accounted for just over 2% of health expenditure (2019).
- Payment of primary care providers is based on **capitation** in all regions, while **fee for service and diagnosis-related groups (DRGs)** are the main methods of paying independent providers (both public and private accredited). **Local health authorities are mainly paid according to capitation** formulae that vary region by region.



4. Physical and Human Resources

- Overall **numbers of health care professionals have only modestly increased**, resulting from cost-containment choices over the past decade.
- With **412 practising physicians per 100 000 population**, Italy's ratio is above the EU average (393) but there are growing shortages of doctors in public hospitals and within primary care.
- With **626 nurses per 100 000 population**, the density of nurses in Italy is considerably lower than the EU average (835), especially in lower-income regions. The country is experiencing an acute shortage of nurses.
- There are **large regional differences in the distribution of health care personnel and infrastructure**.
- **Acute hospital capacity** has decreased over the last two decades, from 422 beds per 100 000 population in 2000 to 260 in 2019 (but rose again during the pandemic).
- Since 2015, the national government has encouraged regions to implement new standards to **rationalize, reorganize and decrease the number of hospital facilities** and in parallel increase outpatient facilities; also aiming to promote greater integration and continuity of care.



5. Provision of Services

- **Public health** in Italy is well established as part of SSN activities through local health authorities.
- **Primary care** is provided by GPs and paediatricians, who provide ambulatory or home visits, prescriptions for medications, referrals to specialists and for laboratory or diagnostic tests.
- **Most GPs still work in solo practices** with limited opportunities to share knowledge with other colleagues and no access to diagnostic technologies. Attempts to incentivize different forms of group practice have only taken hold in a handful of regions.
- **Hospital and outpatient specialist care** is provided by SSN facilities (independent hospitals or local health authorities) and private-accredited providers. Patients are free to choose providers, resulting in high levels of cross-regional mobility, mainly from patients residing in southern regions seeking care in central and northern regions.
- **Hospital emergency departments** provide care for urgent and critical situations but are often overutilized by patients who wish to access care outside the normal working hours of primary care and for minor conditions.
- In 1978 Italy was the first country in Europe to close psychiatric hospitals to manage acute patients in psychiatric wards within general hospitals and various other community-based facilities. **Mental health care** is delivered by multi-professional units with defined catchment areas.
- Most **long-term care for the elderly** is provided informally within families. The growing number of residential health facilities are mainly private; access to public facilities is regulated by local authorities and the SSN covers only health-related medical costs. The SSN covers a range of home care services for eligible non-self sufficient individuals.
- Publicly funded **dental care** is very limited and patients mostly rely on their own resources to receive services from private dentists.

6. Principal health reforms

Although **no major structural changes** have occurred in the SSN over the last 15 years, the government has brought about important changes through specific measures in the areas of:

- prevention
- hospital care
- redefining the national benefits package
- introducing a special regime for regions that overshoot their budget and/or do not deliver on the benefits package.

Priority areas under the EU-funded **National Recovery and Resilience Plan** include:

- strengthening primary and community care by investing in infrastructural facilities and telemedicine
- improving the SSN digital infrastructure
- investing in upgrading medical equipment and training for human capital

Key health system reforms over the last 10 years

- **Recovery plans for underperforming regional health systems** (2005): addresses overspending and guaranteeing the national benefits package
- **Ministerial decree 70/2015** (2015)**:** sets standards for planning of hospital care and setting up hospital networks
- **Law 24/2017 "Gelli Law"** (2017): sets out patient safety measures
- **National Vaccination Plan** (2017-2019): expands vaccination coverage
- **Ministerial decree 77/2022** (2022): strengthens primary and community care services

7. Assessment of the health system

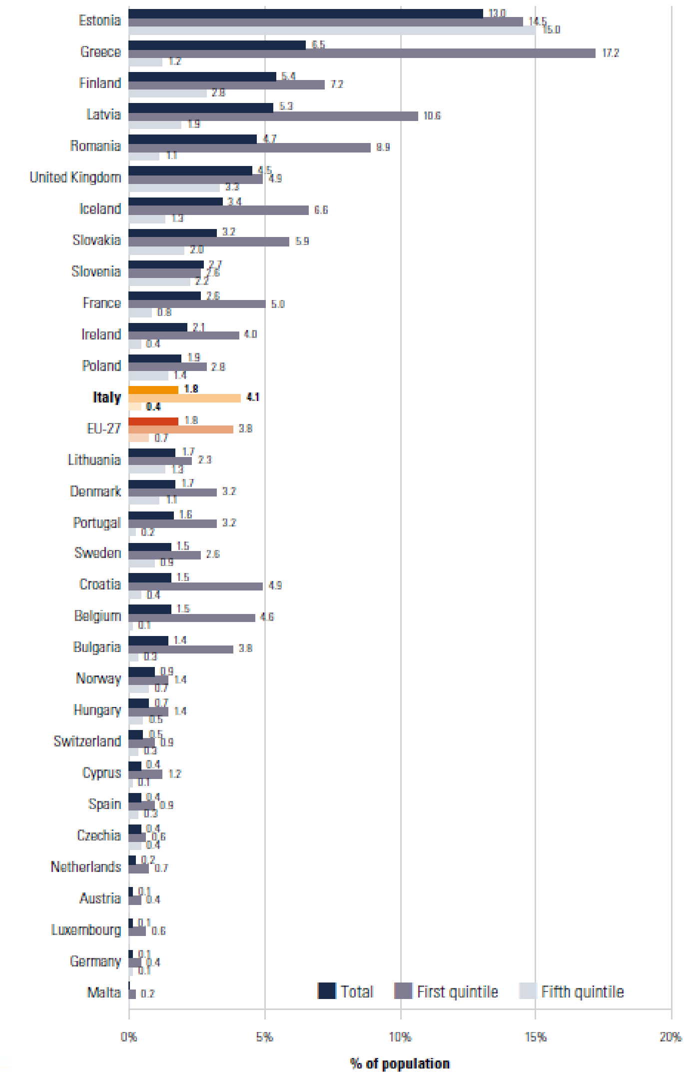
- **Performance monitoring and information systems:** Health system performance measurement strongly relies on both the **National Outcomes Programme and the New Guarantee System**, which is complemented by quarterly monitoring and evaluation of the adequate delivery of the national benefits package.

- **Accessibility:** Access to services is generally high but varies according to region. **Primary and inpatient care are free** at the point of use. Although **the level of unmet needs is similar to the EU average,** citizens from poorer southern regions are more likely to report unmet medical care needs than those living in wealthier regions in the north.

- **Financial protection: OOP spending on health is high** (23% in 2019). There are several exemption categories (e.g. by age or income level) for services that do incur cost-sharing but most OOP spending is due to direct payments to private providers rather than co-payments. Excessive waiting times are one of the reasons citizens use their savings or incur debts to cover private health care expenses.

In 2019, **a high proportion of Italian households experienced catastrophic health expenditure** (9.4%).

FIG. 7.1 Unmet needs for a medical examination (due to cost, waiting time, or travel distance), by income quintile, EU/EEA countries, 2020 or nearest available year



7. Assessment of the health system

- **Quality:** Key indicators of the **quality of primary care**, such as avoidable hospital admissions for chronic conditions, including chronic obstructive pulmonary disease (COPD) and asthma, congestive heart failure and diabetes **show good results** for Italy. The country also **performs well in terms of the effectiveness of secondary care,** with 30-day mortality after admission from acute myocardial infarction among the lowest in Europe.
- **Outcomes:** Prior to the COVID-19 pandemic, Italy's rates of **mortality from preventable and treatable causes** were among the lowest in the EU, reflecting the effectiveness of the health system. Several **national screening plans** promote screening for common types of cancer while strong public health measures, such as **tobacco and alcohol control policies**, partly explain Italy's low rate of preventable deaths.
- **Efficiency:** Measures aimed at **enhancing technical efficiency** in the hospital sector include incentives to promote appropriateness of care; reductions in hospital beds (by 30% since 2000) and number of discharges; an increase in day surgery and better purchasing. New standards that require minimum capacity volumes of care for hospitals have led to mergers, closures or repurposing of small hospitals.