



State of Health in the EU Italy

Country Health Profile 2017

The Country Health Profile series

The *State of Health in the EU* profiles provide a concise and policy-relevant overview of health and health systems in the EU Member States, emphasising the particular characteristics and challenges in each country. They are designed to support the efforts of Member States in their evidence-based policy making.

The Country Health Profiles are the joint work of the OECD and the European Observatory on Health Systems and Policies, in cooperation with the European Commission. The team is grateful for the valuable comments and suggestions provided by Member States and the Health Systems and Policy Monitor network.

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Data and information sources

The data and information in these Country Health Profiles are based mainly on national official statistics provided to Eurostat and the OECD, which were validated in June 2017 to ensure the highest standards of data comparability. The sources and methods underlying these data are available in the Eurostat Database and the OECD health database. Some additional data also come from the Institute for Health Metrics and Evaluation (IHME), the European Centre for Disease Prevention and Control (ECDC), the Health Behaviour in School-Aged Children (HBSC) surveys and the World Health Organization (WHO), as well as other national sources.

The calculated EU averages are weighted averages of the 28 Member States unless otherwise noted.

To download the Excel spreadsheet matching all the tables and graphs in this profile, just type the following StatLinks into your Internet browser:
<http://dx.doi.org/10.1787/888933593627>

Demographic and socioeconomic context in Italy, 2015

	Italy	EU
Demographic factors	Population size (thousands)	60 731
	Share of population over age 65 (%)	21.7
	Fertility rate ¹	1.3
Socioeconomic factors	GDP per capita (EUR PPP ²)	27 800
	Relative poverty rate ³ (%)	13.4
	Unemployment rate (%)	11.9

1. Number of children born per woman aged 15–49.

2. Purchasing power parity (PPP) is defined as the rate of currency conversion that equalises the purchasing power of different currencies by eliminating the differences in price levels between countries.

3. Percentage of persons living with less than 50% of median equivalised disposable income.

Source: Eurostat Database.

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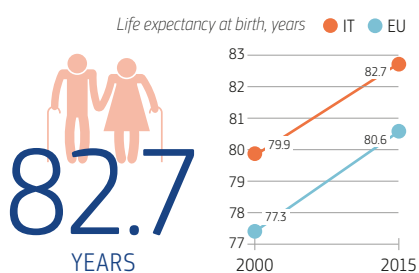
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1 Highlights

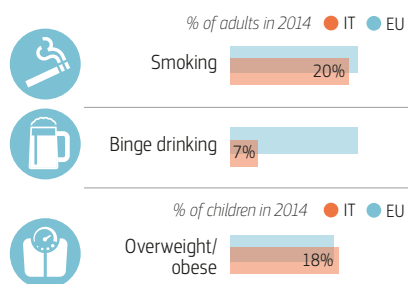
The life expectancy of Italian people is among the highest in Europe, although disparities exist across regions and socioeconomic groups. Under tight budget constraints, Italy has managed to reform and expand the national health benefit basket. The central government is also fostering a recentralisation of funding and designing a new system to allocate resources among regions to achieve the ambitious objective of providing access to this expanded benefit basket to all residents.

Health status



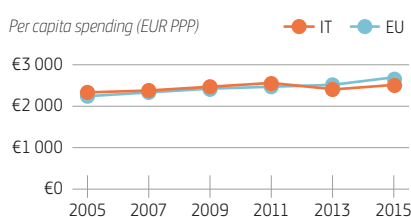
Life expectancy at birth in Italy reached 82.7 years in 2015, up from 79.9 years in 2000, which is the second highest in the EU after Spain. Life expectancy gains were driven mainly by reductions in mortality from cardiovascular diseases. However, substantial gender and socioeconomic status gaps persist.

Risk factors



In 2014, 20% of adults in Italy smoked tobacco every day, slightly below the EU average and down from 25% in 2000. Overall alcohol consumption per adult also fell and is well below the EU average. The proportion of adults reporting regular heavy alcohol consumption is also much lower than in most other EU countries. On the other hand, in contrast to low levels in adults, overweight or obesity problems among children have grown and are now above the EU average.

Health system

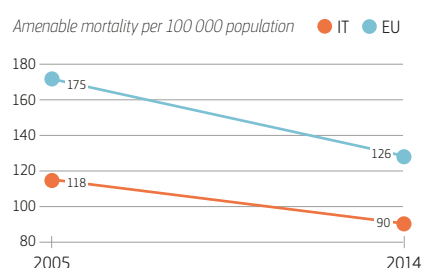


Health spending in Italy, at EUR 2 502 per capita in 2015, is 10% lower than the EU average of EUR 2 797. This equals 9.1% of GDP, also below the EU average of 9.9%. Although a core set of essential services are free, out-of-pocket spending is relatively high (23% compared to the EU average of 15% in 2015) and are mainly used to pay for pharmaceuticals and dental care.

Health system performance

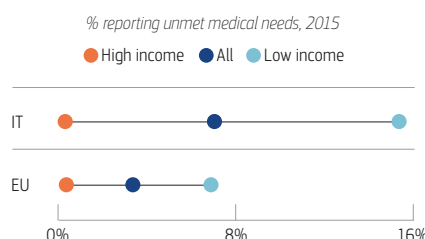
Effectiveness

Amenable mortality in Italy remains one of the lowest in EU countries, suggesting that the health care system is effective in treating people with life-threatening conditions.



Access

The Italian National Health Service automatically covers all citizens and foreign residents. However, access to health care in Italy varies largely by region and income group.



Resilience

A new system to increase equity in regional health spending has been designed. More nurses are being trained to tackle population ageing. New national performance measurements are being implemented to increase accountability and improve quality of care.



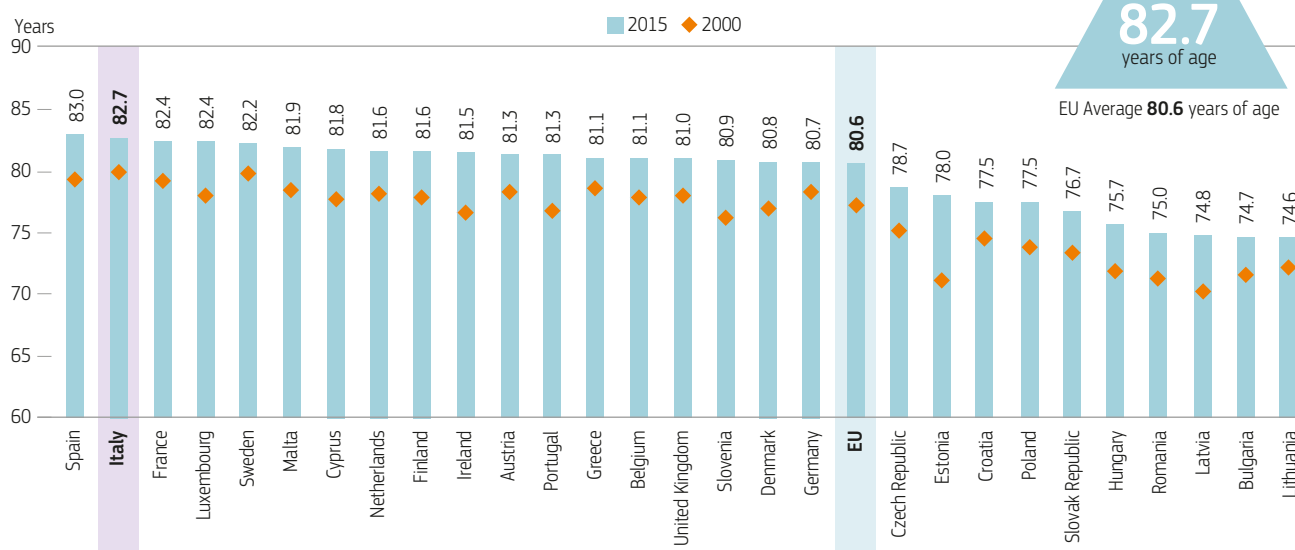
2 Health in Italy

Life expectancy at birth in Italy is the second highest among EU countries

At 82.7 years, life expectancy at birth in Italy is the second highest in the EU (after Spain) and two years longer than the EU average (Figure 1). Life expectancy at birth increased by 2.8 years between 2000 and 2015. As in other EU countries, a substantial gender gap remains, with life expectancy for women about five years higher than for men. Disparities by socioeconomic status also persist. Highly educated Italians have a life expectancy at birth that is four years higher than Italians who have not completed their secondary education.¹

Most of the life expectancy gains in Italy since 2000 were driven by reduced mortality rates after the age of 65. Italians at age 65 can expect to live longer but with less disability-free years than other EU people at age 65. In 2015, an Italian woman at the age of 65 has a life expectancy of 22.2 years, while the life expectancy of a man at the same age is 18.9 years. At age 65, women can expect to live only about one-third (7.5 years) of their remaining life free of disability, while men can expect to live about 40% (7.8 years) of the rest of their life disability-free.²

Figure 1. Life expectancy at birth in Italy is two years above the EU average



Source: Eurostat Database.

Mortality continues to be driven by cardiovascular diseases and cancer

Close to two-thirds of all deaths in Italy were attributable to either cardiovascular diseases or cancer in 2014 (Figure 2). Cardiovascular diseases represent the main causes of death among women (40%) followed by cancer (24%), while for men one-third of deaths are related to cardiovascular diseases and another one-third to cancer.

When looking at trends in more specific causes of death, heart diseases and stroke continue to be the leading causes in 2014 (Figure 3). Lung cancer is still the leading cause of cancer mortality, followed by colorectal cancer, breast cancer and pancreatic cancer.

Deaths from Alzheimer's disease and other dementias have increased substantially since 2000, due to population ageing, but also as a result of better diagnosis and an improved recording of different forms of dementia as the primary cause of death.

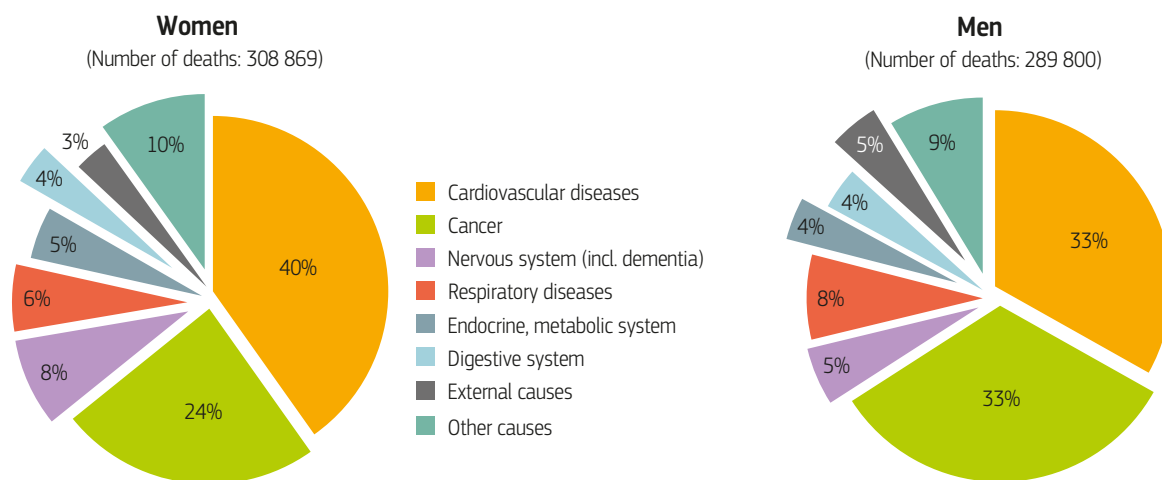
Italy is facing a high burden of chronic conditions mainly related to population ageing ...

In addition to the high burden of disease caused by cardiovascular diseases and cancer, musculoskeletal conditions (including low back and neck pain), diabetes and ageing-related conditions, including falls and Alzheimer's diseases and other dementias, are major

1. Lower education levels refer to people with less than primary, primary or lower secondary education (ISCED levels 0–2) while higher education levels refer to people with tertiary education (ISCED levels 5–8).

2. These are based on the indicator of 'healthy life years', which measures the number of years that people can expect to live free of disability at different ages.

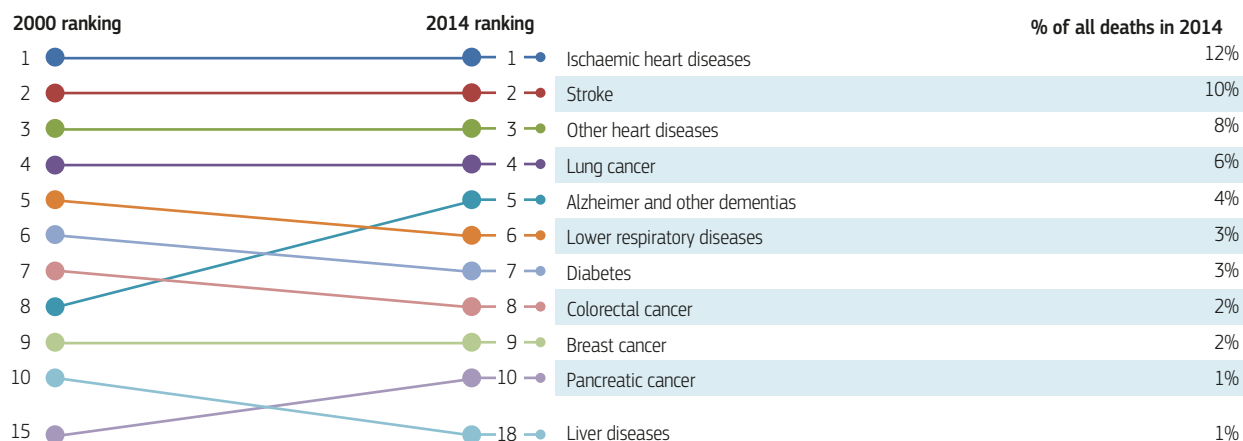
Figure 2. Cardiovascular diseases and cancer cause nearly two in every three deaths in Italy



Note: The data are presented by broad ICD chapter. Dementia was added to the nervous system diseases' chapter to include it with Alzheimer's disease (the main form of dementia).

Source: Eurostat Database (data refer to 2014).

Figure 3. Cardiovascular diseases remain the leading cause of death, but death from dementias is rising



Source: Eurostat Database.

determinants of disability-adjusted life years³ (DALYs) (IHME, 2016). Data from the European Health Interview Survey (EHIS) report that around 5% of Italians live with asthma, more than 20% live with hypertension, and around 6.5% have diabetes. Wide inequalities exist in the prevalence of these chronic diseases depending on individuals' level of education. People with the lowest level of education are almost four times as likely to live with depression, more than three times as likely to live with diabetes, and more than twice as likely to live with hypertension as those with the highest level of education.⁴

...and a high prevalence of viral hepatitis

Data from the European Centre for Disease Prevention and Control show that Italy has the highest rate of hepatitis C virus infections in the general population, at 5.9% for first-time blood donors. Italy also reports the highest hepatitis C virus infection rate among migrants from Eastern Europe, at 7.1% (ECDC, 2016).

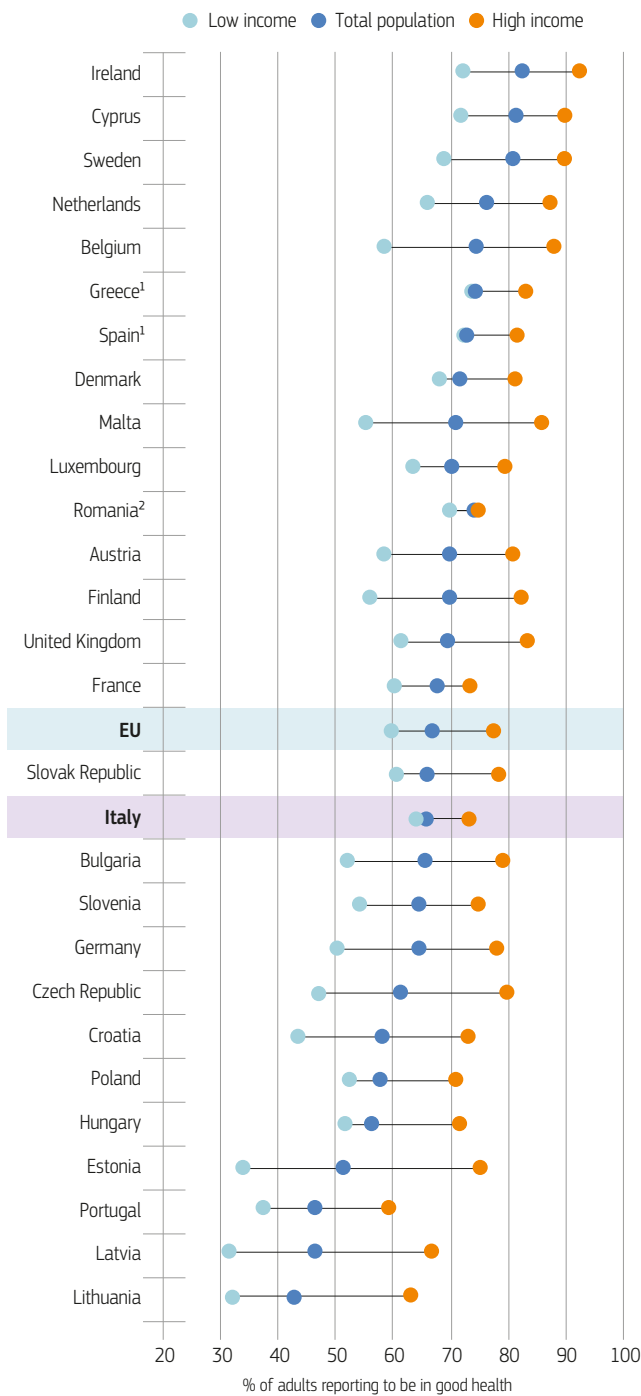
3. DALY is an indicator used to estimate the total number of years lost due to specific diseases and risk factors. One DALY equals one year of healthy life lost (IHME).

4. Inequalities by education may partially be attributed to the higher proportion of older people with lower educational levels; however, this alone does not account for all socioeconomic disparities.

Most Italians report being in good health

Two-thirds of the Italian population report being in good health, a rate close to the EU average (Figure 4). A gap in self-rated health exists between high- and low-income groups, but this gap is smaller than in other countries: 73% of people in the highest income quintile consider their health to be good, compared to 64% of people in the lowest income quintile.

Figure 4. Two-thirds of Italians report being in good health



1. The shares for the total population and the low-income population are roughly the same.
 2. The shares for the total population and the high-income population are roughly the same.
Source: Eurostat Database, based on EU-SILC (data refer to 2015).

3 Risk factors

The main behavioural risk factors have a considerable impact on health

Estimates from the Institute for Health Metrics and Evaluation (IHME) show that a large percentage of the burden of disease (measured in DALYs) in Italy in 2015 was due to behavioural risk factors, with dietary risks (11.2%), tobacco smoking (9.5%), high body mass index (6.1%), alcohol use (4.2%) and low physical activity (2.5%) contributing the most (IHME, 2016).

Smoking among adults has decreased, but progress in reducing smoking among adolescents remains limited

The proportion of adults who smoke regularly in Italy has reduced substantially, with the rate now slightly below the EU average; however, one in five adults in Italy are still regular smokers. Smoking remains much more common among men than women: 25% of men, compared with just 15% of women, are daily smokers. Of greater concern, the prevalence of smoking among



adolescents has not reduced much, with a rate among the highest in the EU: 22% of 15-year-old girls (the second highest prevalence in the EU) and 20% of 15-year-old boys (the third highest) reported regular smoking in 2013–14. This is despite a series of public health measures put in place to combat smoking, such as the ban on smoking in public places and the introduction of pictorial warnings in late 2016 (see Section 5.1).

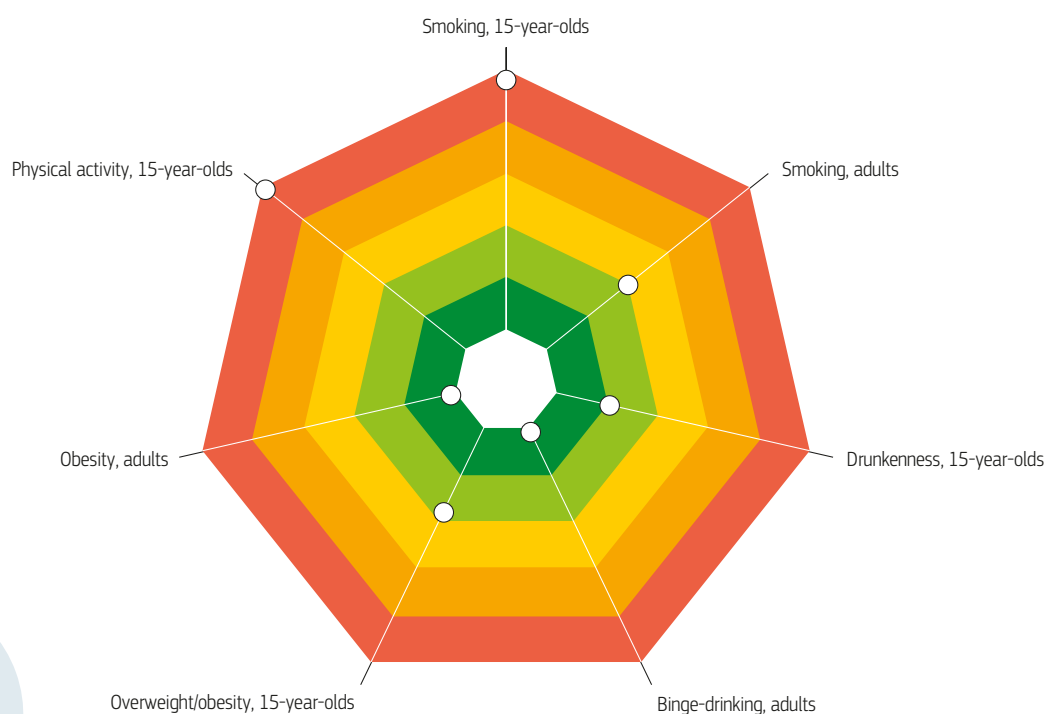
Alcohol consumption is relatively low

Compared with other EU countries, the proportion of Italian adults reporting regular heavy alcohol consumption (binge drinking⁵) is very low – just 7% of adults reported such excessive consumption, the second lowest proportion (after Cyprus) in the EU. Overall alcohol consumption (measured by sales) is also low, with Italy having the third lowest consumption per capita (after Greece and Sweden). Alcohol consumption among adolescents is also stable and relatively low: 14% of 15-year-old girls and 19% of 15-year-old boys reported having been drunk more than once in their life, a lower proportion than in most other EU countries.

Obesity rates are relatively low among adults, but high and rising among adolescents

Just over 10% of Italian adults are obese, the second lowest obesity prevalence in the EU. Though obesity has increased, it has done so more slowly than in other EU countries. But a particular concern is that the proportion of adolescents who are overweight or obese has gone up quite rapidly and now equals the EU average (18%). The proportion of 15-year-old boys in Italy who are overweight or obese is particularly high (26%), the fourth highest prevalence among all EU countries. This high and rising overweight and obesity rate among adolescents in Italy is linked, at least partly, to low levels of physical activity (Figure 5). This is particularly concerning, since being overweight or obese in childhood or adolescence is a strong predictor of becoming overweight or obese in adulthood.

Figure 5. Smoking and overweight problems among adolescents are important public health issues



5. Binge drinking behaviour is defined as consuming six or more alcoholic drinks on a single occasion, at least once a month over the past year.

Note: The closer the dot is to the centre the better the country performs compared to other EU countries. No country is in the white 'target area' as there is room for progress in all countries in all areas. Comparable data on a comprehensive measure of physical activity among adults are not available for Italy.

Source: OECD calculations based on Eurostat Database (EHIS in or around 2014), OECD Health Statistics and HBSC survey in 2013–14. (Chart design: Laboratorio MeS).

4 The health system

A highly decentralised National Health Service results in different organisational models and outcomes across regions

Italy's National Health Service is regionally based, with the central government sharing responsibility for health care with the country's 19 regions and two autonomous provinces. At the national level, the government exercises a stewardship role, controls and distributes the tax-financed health budget, and defines the national benefits package (known as the 'Essential Levels of Care') that must be guaranteed to all citizens and foreign residents. Regions are responsible for the organisation, planning and delivery of health services through local health authorities. Public hospital-based physicians are salaried employees.

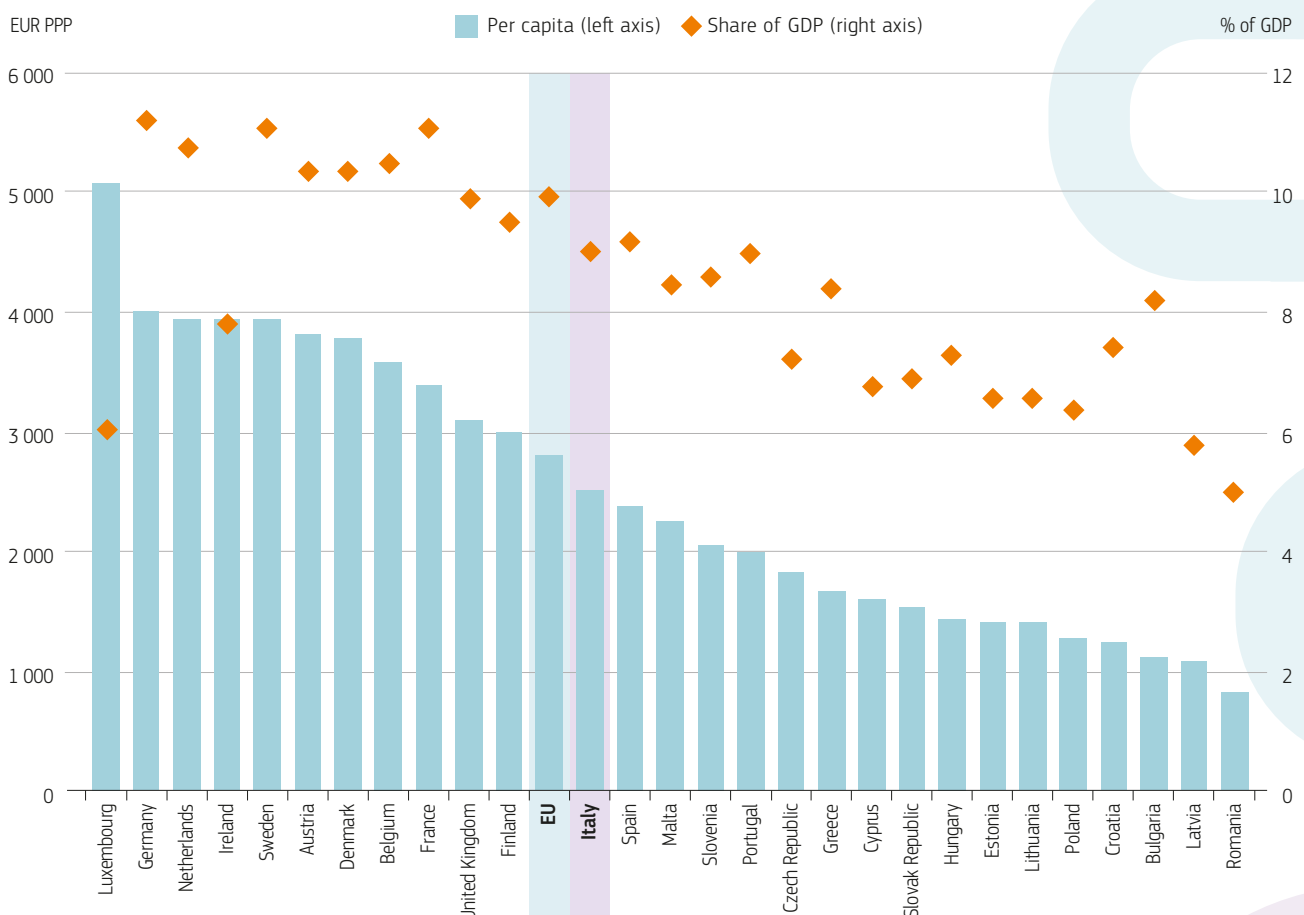
Regions enjoy substantial autonomy in how they structure their health systems within the general framework established nationally (building on previous decentralisation efforts and incomplete

market-oriented reforms). Since 2016, several regions have merged local health authorities into larger entities to achieve efficiency gains and improve quality of care through economies of scale and better organizational integration. Despite the commitment to the Health System being legally enforced, policy concerns have been raised over regional differences in population health status, and access and quality of health services (OASI, 2016). This calls for an effective performance management of hospitals, clinics and professionals at regional level (OECD 2014).

Total health spending declined following the 2008 economic crisis but is now rising again

Italy spent 9.1% of its GDP on health in 2015. This translated to EUR 2 502 per capita (adjusted for differences in purchasing power), which was 10% below the EU average (Figure 6). Following the economic crisis of 2008, total health spending per capita in real terms remained flat or decreased, but it has started to increase

Figure 6. Italy spends 10% less than the EU average on health care



Source: OECD Health Statistics, Eurostat Database, WHO Global Health Expenditure Database (data refer to 2015).

again since 2014. Public sources account for 76% of total health spending, while private sources make up the remaining 24%, mostly direct out-of-pocket payments, as voluntary private health insurance plays only a marginal role.

Containing health care costs has been a major priority

In Italy, containing the cost of health care has been a major concern for many years and forms part of wider efforts to reduce high public debt. A Spending Review in 2012 led to decreased funding for the National Health Service by between EUR 900 million and EUR 2.1 billion annually between 2012 and 2015 and introduced new health services standards and regulations, such as further promoting the prescription of generic drugs. Also in 2012, the government's Balduzzi Decree introduced a series of measures, including restructuring local health units and hospitals, revising copayment levels and the list of reimbursable pharmaceuticals, as part of a cost-containment and efficiency-promoting package. Not all of these measures have been uniformly implemented though. Regions with health budget deficits are also targeted via the imposition of regional 'recovery plans', which comprise various instruments to foster a reduction in expenditure and balance budgets. Most recently, in 2016, the central government introduced compulsory Deficit Reduction Plans for hospitals as an additional tool to induce hospitals to balance their accounts.

Despite some exclusion from the benefits package, exemptions protect vulnerable groups

Italy's health care system provides universal coverage, largely free of charge at the point of service. Among the services not included in the benefit package is dental care (except for specific population groups⁶), which has to be paid for by households either out of pocket or by subscribing to private insurance. Similarly, services such as orthodontics are not covered. Moreover, the package identifies a positive list of services for people suffering from chronic diseases, which are fully covered.

6. Children up to 16 years old, people over 65 years old, vulnerable populations, and people in economic or emergency need.

Variations in available resources and perceived quality of care result in significant regional disparities and mobility of patients

The important differences in health care resources across regions pose a challenge for access to services. Generally speaking, northern and central regions have higher capacity, more advanced technology and better perceived quality of care than southern regions, leading to flows of patients to north-central regions to obtain care. Data from the Ministry of Health show the southern regions of Campania, Calabria and Sicily lose at least 30 000 patients a year in search of health care (and attract far fewer). It is widely accepted that the main reason why patients move from south to north is to seek better quality care (Ministry of Health, 2011).

Overall, the number of acute care hospital beds has declined rapidly since 2000 (from 4.2 beds per 1 000 population in 2000 to 2.8 beds in 2013) in response to national targets to reduce all bed numbers and the transformation of some acute care facilities into other types of services to meet changing needs (e.g. to care for those with chronic conditions or frail elderly).

The ratio of nurses per doctor is very low

The health workforce grew steadily over the past decade. Figure 7 shows that the ratio of doctors to population (3.8 per 1 000 population) is higher than the EU average (3.6). In contrast, the density of nurses is relatively low (6.1 per 1 000 population compared with an EU average of 8.4). Consequently, the ratio of nurses per doctor (1.5) is among the lowest in the EU (EU average of 2.3).

The role of nurses is currently being strengthened in Italy, especially with regard to the management of chronic care patients and the introduction of nurse-led professional groups in primary care.

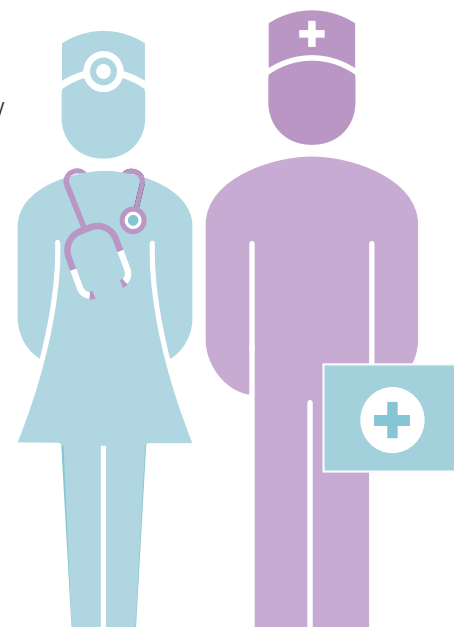
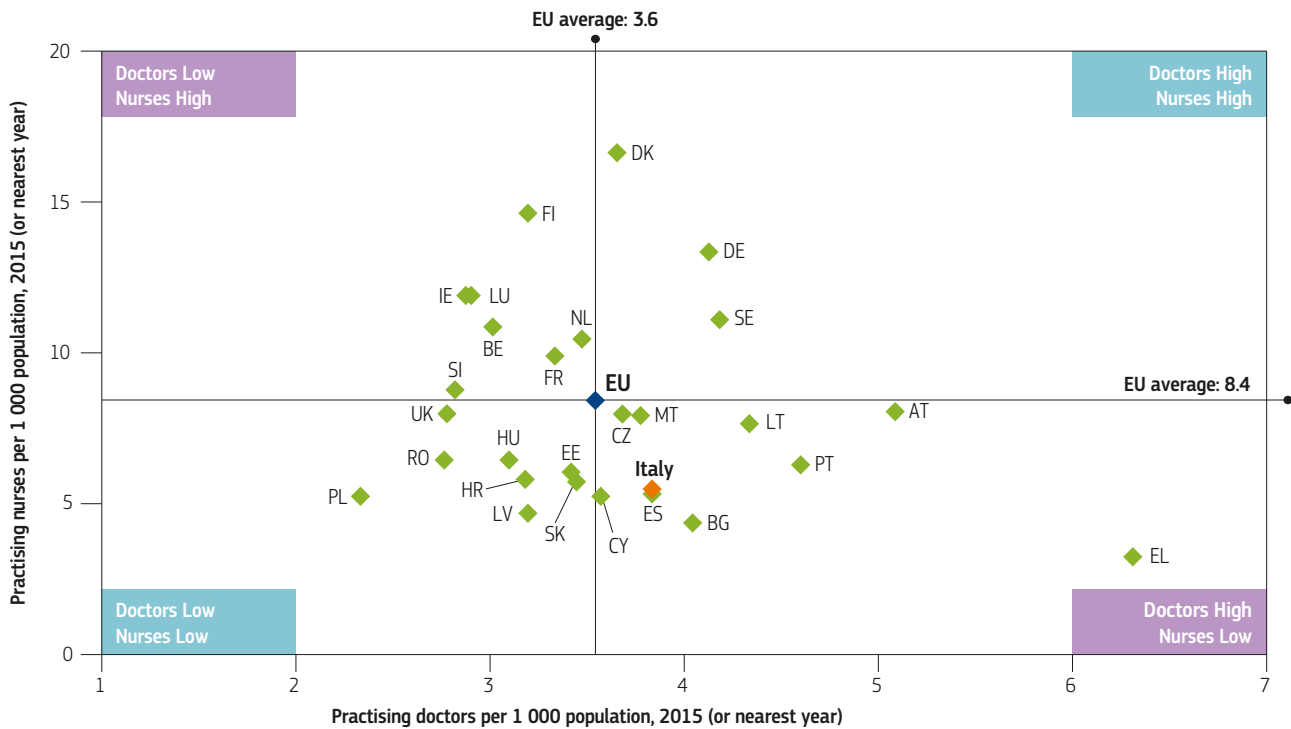


Figure 7. Italy has a relatively high density of doctors and a low density of nurses



Note: In Portugal and Greece, data refer to all doctors licensed to practice, resulting in a large overestimation of the number of practising doctors (e.g. of around 30% in Portugal). In Austria and Greece, the number of nurses is underestimated as it only includes those working in hospital.

Source: Eurostat Database.

Strong primary care with a focus on better coordination of care

Health care services are delivered through public providers (such as district and regional hospitals and university hospitals) as well as private accredited providers. Great emphasis is placed on primary care, and people are required to register with a General Practitioner (GP) (or a paediatrician up to the age of 14), who has financial incentives to act as a gatekeeper and care coordinator and to prescribe and refer only as appropriate. Primary care services in health centres are guaranteed 24 hours a day/7 days a week through the primary care out-of-hours service (called the *guardia medica*). Moreover, financial incentives have been provided in recent years for GPs to move towards various models of group practice with fellow GPs and/or other health professionals, following a multidisciplinary and multiprofessional approach. Furthermore, in an effort to improve the coordination of care, some regions also introduced chronic disease management programmes, focusing on conditions such as diabetes, congestive heart failure (CHF) and respiratory diseases.



5 Performance of the health system

5.1 EFFECTIVENESS

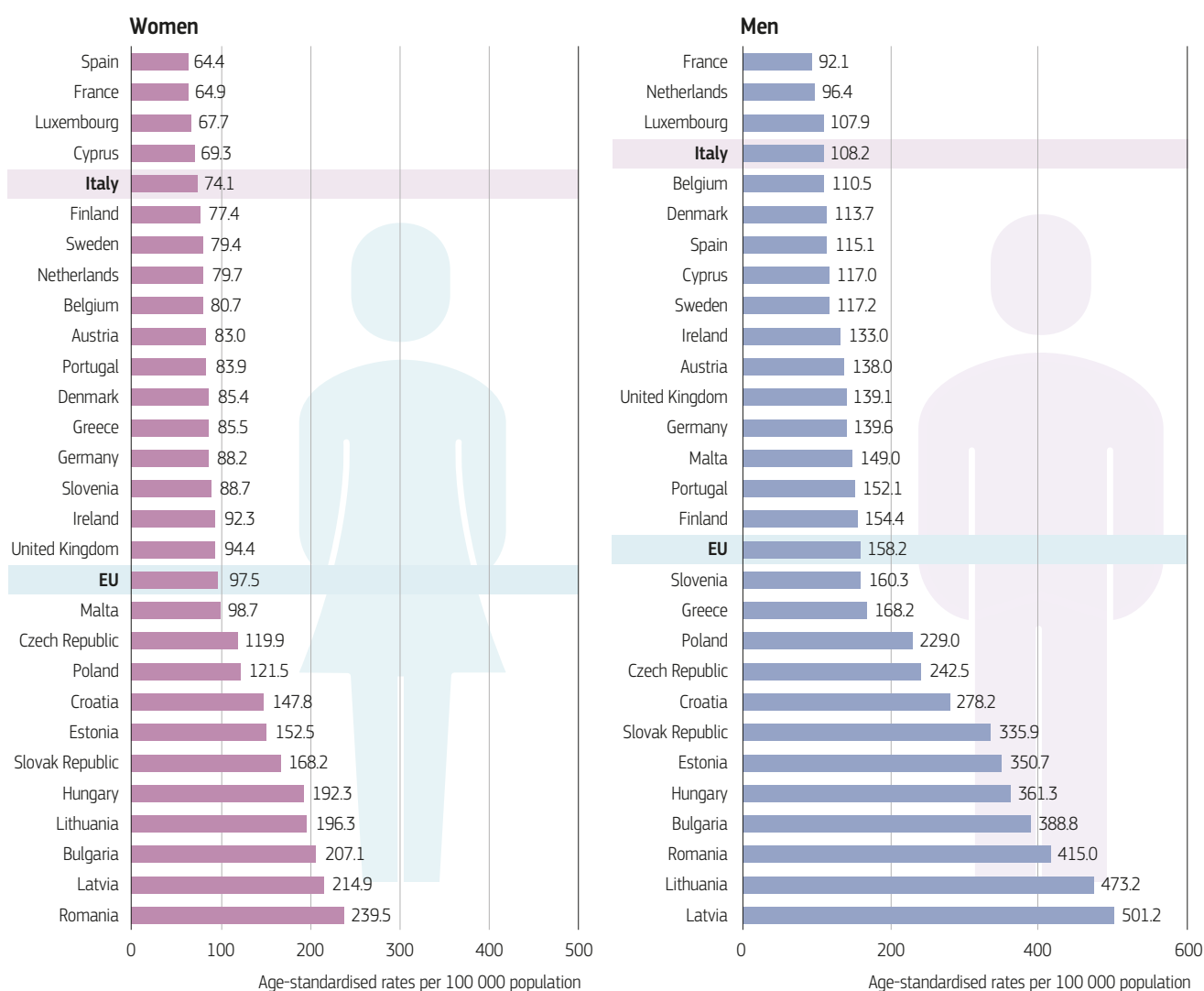
Low amenable mortality rates suggest that the Italian health care system is generally effective

Mortality from conditions that are considered amenable to medical treatment can be used as a general measure of health care system performance⁷. The relatively low rates of amenable mortality in Italy suggest that the Italian health care system is effective in dealing with life-threatening conditions, such as ischaemic heart disease, stroke and breast, cervical and other treatable cancers, with relatively low mortality rates for both men and women (Figure 8). Moreover, amenable mortality rates trended downward over the past decade.

A strong acute care sector contributes to low death rates from cardiovascular diseases

Indicators of quality of care suggest a generally good performance of hospitals in saving the lives of people, although variations arise across regions and hospitals. Deaths following admission for acute myocardial infarction (AMI, the main form of ischaemic heart diseases) are the lowest among EU countries reporting these data, with only 7.6 deaths per 100 admissions in 2015 (Figure 9). This progress in reducing mortality reflects a range of factors, such as more timely transportation to hospital and more effective medical interventions. Similarly, mortality rates from stroke came down and were among the lowest in Europe in 2015.

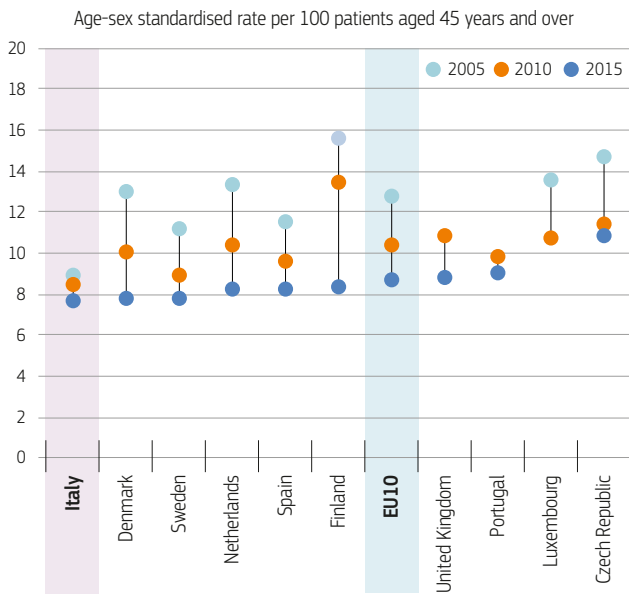
Figure 8. Amenable mortality rates in Italy are among the lowest in Europe



7. Amenable mortality is defined as premature deaths that could have been avoided through timely and effective health care.

Source: Eurostat Database (data refer to 2014).

Figure 9. In-hospital case-fatality rates following AMI decreased and are very low in Italy



Note: This indicator is based on patient-level data. Three-year average for Luxembourg. The EU average is unweighted.

Source: OECD Health Statistics 2017.

Primary care is generally of good quality

Primary care's ability to serve patients with chronic conditions is often used as an indicator of primary care performance. Ambulatory (or outpatient) care-sensitive conditions, such as asthma, chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF) and diabetes, are conditions for which accessible and effective primary care can generally reduce the risk of complications and

prevent the need for hospitalisation. The Italian health care system generally provides good-quality primary care for people with such chronic conditions, which is indicated by relatively low admission rates for such ambulatory care-sensitive conditions (Figure 10).

Despite low screening rates, cancer survival is among the highest in the EU

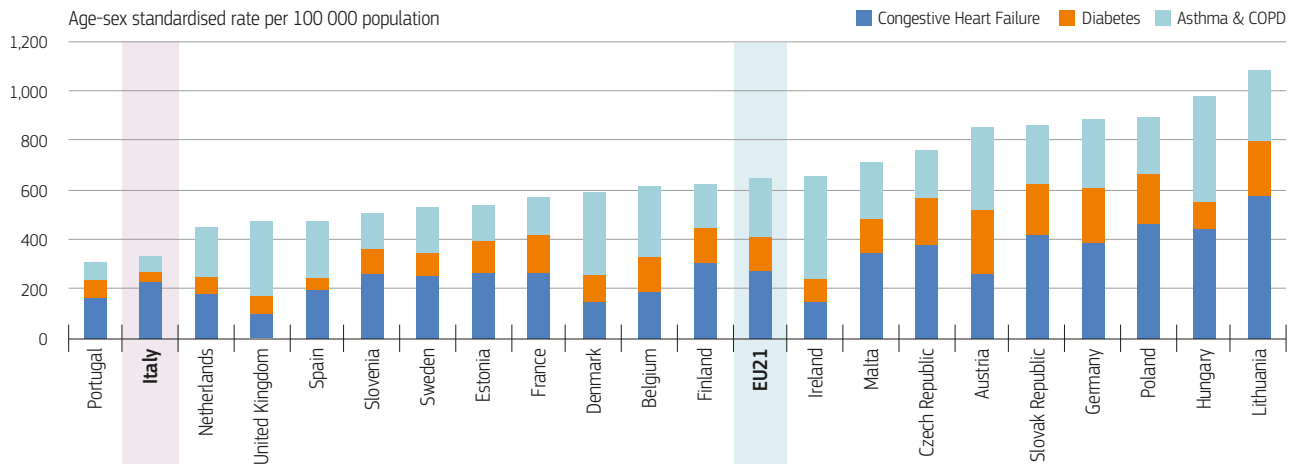
In recent years, several National Screening Plans were implemented to strengthen monitoring and screening for the most common types of cancer – colorectal, breast and cervical. Following EU guidelines, population-based screening programmes are offered free of charge at regional level for target populations.

CONCORD Programme data show that five-year survival rates following a diagnosis for several types of cancers increased in Italy between 2000–04 and 2010–14 and remain higher than in most EU countries for breast cancer (86%), colon cancer (64%) and cervical cancer (67%) in 2010–14.

Preventable mortality has been reduced through public health policies targeted at tackling risky behaviours

Death rates from many preventable causes of mortality have also reduced in Italy, due, at least partly, to public health policies aimed at reducing these risk factors. The number of deaths from alcohol-related diseases (excluding external causes) is very low – Italy had the fourth lowest rate (5.9 per 100 000 population compared to an EU average rate of 15.7) in 2014. Italy reports a rate of deaths from road transport accidents of 5.9 per 100 000 population, similar to the EU average.

Figure 10. Low hospitalisation rates point towards good-quality care for chronic conditions



Note: Rates are not adjusted by health care needs or health risk factors.

Source: OECD Health Statistics 2017 (data refer to 2015).

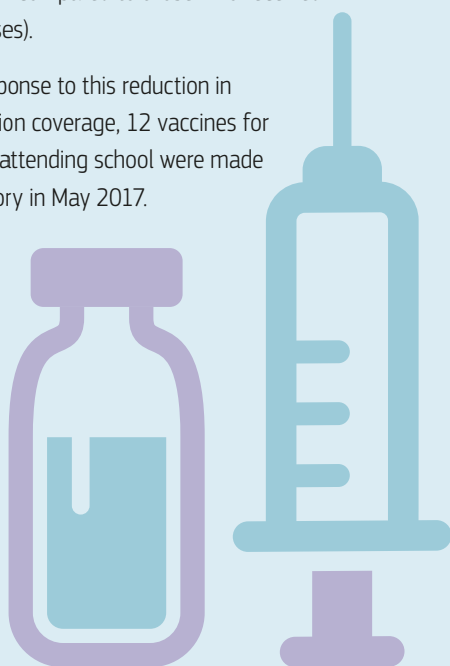
Deaths from lung cancer were lower than the EU average, at 60.2 deaths per 100 000 population in 2014 compared with 82.5. Policies have targeted smoking for the past 15 years, including the 2012 ban on smoking in all public and work places, and stronger restrictions on consumption for minors. However, smoking rates among teenagers remain too high (see Section 3). A recent European policy introduced pictorial warnings on packs in late 2016, targeting teenagers in particular. However, its effect might be diminished by the simultaneous release, in tobacco shops, of 'pack covers' made specifically to hide the unsettling images on the new packaging.

BOX 1. A DECREASE OF VACCINATION COVERAGE IS THE MAIN CAUSE OF A 2016–17 MEASLES OUTBREAK

To meet the target of 95% vaccination coverage set by WHO guidelines, a National Vaccination Plan was approved in 2012, stressing the right to vaccination, which is compulsory and included in the benefits package. Although vaccination coverage rates were mostly above the 95% target around the year 2012, the recent trend is downward, with rates for specific individual vaccines (DTP3, MCV, HepB3) down by 3 to 5 percentage points in 2015.

The reduction in vaccination led to a worrisome measles cases outbreak in 2016 and 2017, with a total of 865 cases in 2016 and 2 851 cases up to June 2017 (ECDC, 2017). Of the cases reported in 2017, 89% of people (mainly children) were not vaccinated, and 6% had received only the first dose of the vaccine (thereby increasing the likelihood of contagion compared to those who received both doses).

As a response to this reduction in vaccination coverage, 12 vaccines for children attending school were made mandatory in May 2017.



Italy recently introduced new measures to increase vaccination coverage among children to reduce the risk of epidemics of infectious diseases (Box 1).

Efforts to reduce childhood obesity seem to be working, although regional disparities persist

The Italian government has taken steps to monitor and reduce the prevalence of overweight and obesity rates among children. The surveillance system 'Okkio alla salute' has monitored children in elementary schools throughout Italy since 2008. The latest report (Nardone *et al.* 2016) shows that these rates, at the national level, went down from 23% in 2008 to 20.9% for overweight, and from 12% to 9.8% for obesity among children aged 8–9. The trend of the prevalence of overweight is almost stable, with a slight decrease in 2014 and 2016 with respect to the previous rounds; the prevalence of obesity shows, instead, a steadily decreasing trend. However, profound regional differences still remain, with southern regions such as Calabria, Campania and Molise showing rates of overweight and obesity above 40%, while northern regions remain below 25%. The Okkio report identifies large regional differences in the availability of gyms in schools, initiatives for the promotion of healthier eating habits, and the percentage of schools that offer lunch, which is generally thought to result in healthier meals (below 50% in the south compared to 90% in the north).

Antimicrobial resistance is a major threat to population health, the health system and the economy

Italy is particularly exposed to antimicrobial resistance (AMR), as it reports some of the highest levels of resistance in the EU for most pathogens under surveillance by the European Centre for Disease Prevention and Control (ECDC, 2017). In 2014, Italy introduced a four-year national prevention plan for AMR based on a One-Health approach (i.e. a cross-sectoral approach to address health hazards based on the idea that the health of humans, animals and ecosystems is interconnected). The current plan relies mainly on regions to implement monitoring systems, conservation and prevention strategies, and educational campaigns to promote the appropriate use of antibiotics. A new integrated plan – including many of the priorities highlighted in the WHO global action plan for AMR – is currently being developed and should be launched in 2018. Italy is also engaged in the fight against AMR through its participation in international initiatives such as the Global Health Security Agenda, which aims to coordinate efforts at the global level to establish comprehensive AMR national plans, strengthen surveillance systems and promote antibiotic stewardship.

5.2 ACCESSIBILITY

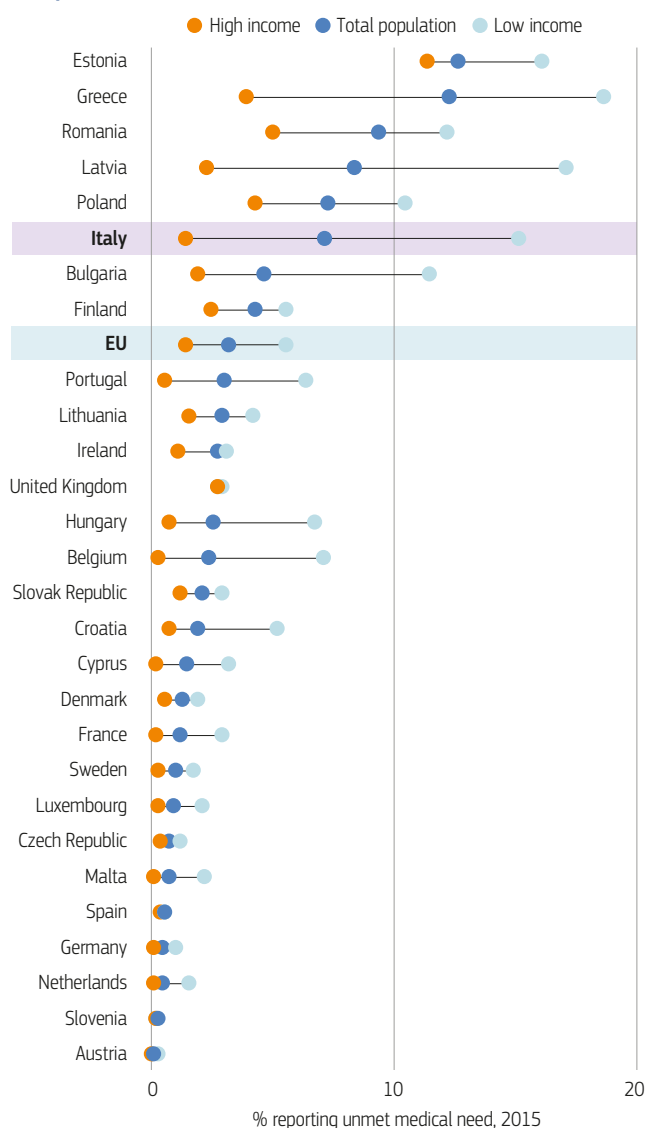
Despite universal coverage, a relatively high share of people reports unmet needs for medical care

The Italian National Health Service covers all citizens and foreign residents, making the health system theoretically universal in terms of population coverage. It also gives access to basic services – such as emergency care – to people without a residence permit without the need for registration within the national health system. Other health care services for persons without a residence permit are increasingly covered by nongovernmental organisations, but the costs outside of basic services are covered mainly through out-of-pocket payments. The market for voluntary health insurance is quite limited (0.9% of total health expenditure in 2012). Voluntary health insurance is taken either as complementary insurance to reduce copayments, or as supplementary insurance to cover services such as dental care (which are partially outside the benefits basket) or to obtain access to *intra-moenia*⁸ services that guarantee faster treatment. In recent years, governmental measures in the form of financial incentives (tax exemptions) were introduced to enhance complementary insurance.

Despite full coverage for basic medical services, 7% of Italians reported some unmet needs for medical care in 2015 either for financial reasons, geographic reasons (having to travel too far) or waiting times. This is a higher proportion than the EU average (less than 4%) and has grown in recent years. The proportion of people in the lowest income group reporting some unmet needs for medical care is particularly high (over 15.0% in 2015), compared to less than 1.5% among people in the highest income group (Figure 11). Most of the unmet medical needs are attributable to care being too expensive, with waiting lists and geographic barriers accounting for a relatively small share.

National studies have found a substantial amount of inequity in health service use by socioeconomic status, with a significant amount of pro-rich inequity in specialist care, diagnostic services and basic medical tests, and pro-poor inequity in the use of primary care (Glorioso and Subramanian, 2014). Disparities in the use of specialist care, diagnostic services and basic medical tests are largely connected to higher health literacy of the well-off (affecting the utilisation rates of preventive services and screening), flat-rate copayments (limiting access to mainly specialist outpatient care for low-income people) and low-quality services and long waiting lists (particularly in the southern regions) that lead citizens to turn to private health care, with ability to pay for those services positively associated with socioeconomic status.

Figure 11. Italians' unmet needs for medical care are among the highest in the EU, particularly for the poorest



Note: The data refer to unmet needs for a medical examination or treatment due to costs, distance to travel or waiting times. Caution is required in comparing the data across countries as there are some variations in the survey instrument used.

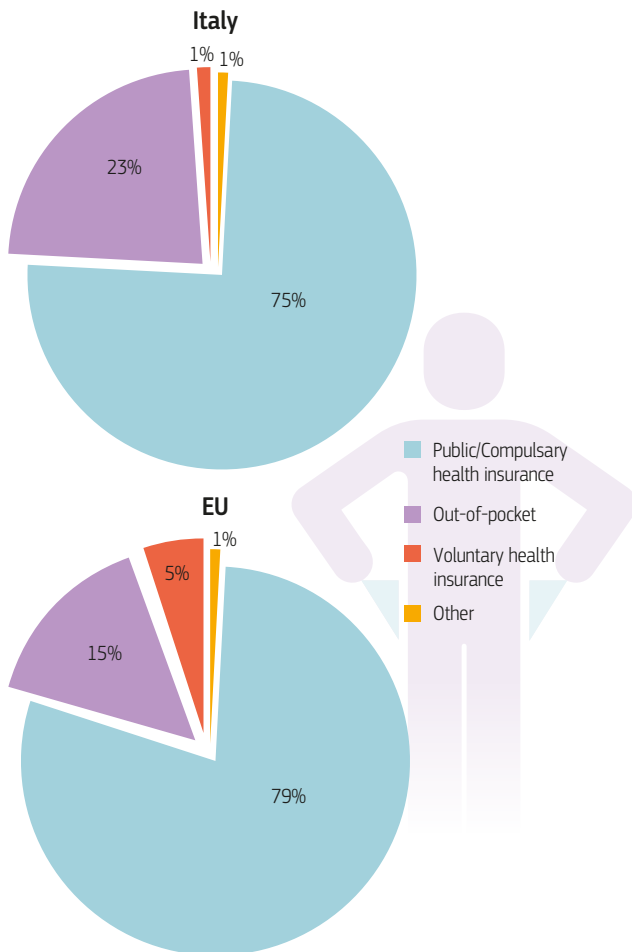
Source: Eurostat Database, based on EU-SILC (data refer to 2015).

Out-of-pocket spending increased after the economic crisis

Some 23% of health expenditure in Italy is paid out of pocket, compared to the EU average of 15% (Figure 12). While primary and hospital inpatient care are free at the point of service, flat copayments are levied on outpatient specialist visits (with a GP referral, otherwise the full cost is paid), on diagnostic procedures, and on medicines with full or partial reimbursement (within national limits).

8. Public physicians who see private patients in public hospitals.

Figure 12. More than one-fifth of health expenditure is paid directly by households



Source: OECD Health Statistics, Eurostat Database (data refer to 2015).

Increasing copayment for medicines has become a frequently used policy tool to contain public spending in many regions and to reach better appropriateness in prescription. The majority of regions have implemented or increased different levels of copayments on pharmaceuticals. Some regions have also implemented user fees for the inappropriate use of emergency services. Nevertheless, some groups are exempted from these user fees, such as children under the age of 6 and people over the age of 65, low-income groups, pregnant women, people with severe disabilities and people with many different medical conditions.

Interregional differences in the ability to provide services comprised in the benefit package may persist

In 2016, the depth of coverage was revised and expanded (see Box 2).

Concerns are growing regarding individual regions' ability to provide the services that the benefit package defines at the national level. Overall, the resources allocated to regions – mainly on the basis of

BOX 2. THE NEW BENEFIT PACKAGE RATIONALISES AND EXPANDS THE LIST OF AVAILABLE HEALTH SERVICES

In 2016, the government approved a revised list of health services guaranteed to all Italian residents. When the first Essential Levels of Care were published in 2001, the legislation only provided a general description of the sublevels of care that regions had to provide. In contrast, the new benefits package was developed on the basis of current epidemiological and demographic needs and defines in detail the health services available to the population through public resources. Expanded benefits include: additional ambulatory specialist services, with particular emphasis on clinical effectiveness; new vaccinations and neonatal screenings; and new measures of innovative technologies, such as prostheses, to replace old procedures. Moreover, there is an expanded list of chronic diseases for which services are fully covered by the National Health Service.

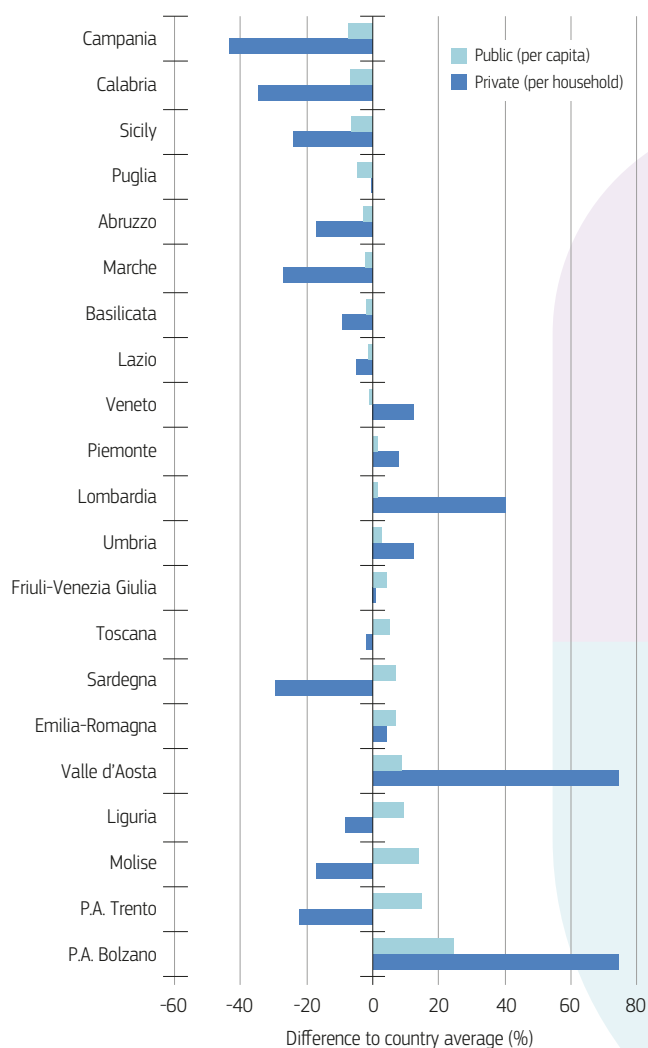
demographic factors – do not match the resources required to fund the expanded benefit package. In accordance with the regulations of the Deficit Budget Plans, regions that do not consistently reach the funding level required to fund the Essential Levels of Care will have to individually provide the additional funds to match the budget required to serve their population. Depending on the extent to which additional funds are available, interregional differences in access to the defined benefit package may persist and increase.

5.3 RESILIENCE

A recentralisation process is underway

In 2001, Italy introduced a major decentralisation of fiscal, financial and managerial responsibilities to regions. In particular, financial transfers from the central government to regions were replaced by regional taxes on businesses and by a national solidarity fund financed by value-added taxes. However, several regions experienced financial and service shortfalls, mainly due to weak managerial capacity and lower productivity, which in turn also affected perceived quality of care (Fattore, Petrarca, and Torbica 2014), leading to calls for (re)centralisation of the system. As a consequence, half of the regions reported substantial deficits in the health sector. Also following the 2009 economic crisis, the central government imposed an obligation to adopt regional recovery plans in regions with the largest deficits (*Piani di Rientro*), which have proven to be effective in reducing deficits.

Figure 13. Southern regions spend less on health compared to the national average



Source: Ministero dell'Economia e delle Finanze and Istat (data refer to 2016).

Providing services to an ageing population poses a threat to financial sustainability

Private health expenditure per household in richer regions – i.e. the autonomous province (P.A.) of Bolzano, Lombardia and Valle d'Aosta – is two times that of poorer regions – Campania and Calabria (Figure 13). Southern poorer regions also report lower public health spending, even if the variation across regions is lower than that of private spending.⁹

With 22% of the population aged 65 and over in 2015, Italy has the oldest population in Europe. In this context, and under a set of assumptions regarding the health of the population and future economic growth, Italy's public spending on health care as a share of GDP is projected to rise modestly to 6.7% of GDP in 2060. In

addition, public spending on long-term care is projected to rise to 2.7% of GDP in 2060, reflecting the greater long-term care needs of ageing populations (European Commission and European Policy Committee, 2015).

The focus on care integration and coordination is increasing

The Balduzzi Decree, adopted in 2012, promoted the formation of voluntary group practices in primary care: while GPs still primarily work in solo practice, the evolution is towards group practice and team-working models to better address patients with complex needs. More recently, the 2014 Pact for Health went a step further towards care integration, requiring regions to establish 'primary care complex units' comprising GPs, specialists, nurses and social workers. This new organisational model aims at improving continuity of care while reducing the inappropriate use of emergency services.

Improving the efficiency of the hospital sector is necessary and within reach

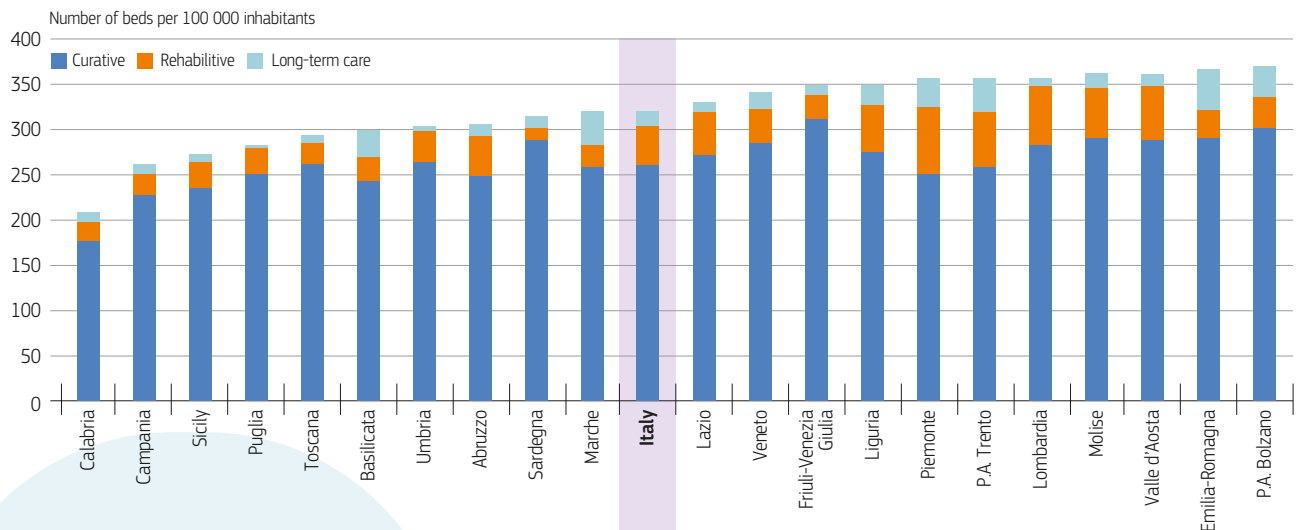
As in many other EU countries, the number of hospital beds per capita in Italy has come down since 2000 (see Section 4). The number of beds – curative, rehabilitative and long-term care – per 1 000 population was 3.2 in 2015, which is much lower than the EU average of 5.1. However, large regional differences arise, with southern regions reporting a lower capacity (Figure 14).

In contrast with other EU countries, the average length of stay in hospitals has not reduced since 2000 – it has remained constant at around eight days (equal to the EU average). The average bed occupancy rate for hospitals in 2015 was 79%, also in line with the EU average.

Generics only constitute a small share of prescribed drugs in Italy

The Spending Review of 2012, apart from including measures such as the reduction of hospital bed ratios and reduced public financing for the National Health System, made a further step to promote GPs' prescription of generics by requiring them to explicitly state the active ingredients on their prescription, in order to facilitate substitution. Despite this, the market penetration of generics in Italy is still relatively low compared to other European countries: 11% of pharmaceutical expenditure in value and 19% in volume in 2015. In this case as well, large regional differences exist in how generics are prescribed and consumed. However, the cause of these regional differences seems to be less rooted in policy variation across regions, and more in cultural preferences and local health authorities' monitoring systems.

9. This variation is even lower if financial compensation for the interregional mobility of people to seek care is taken into account.

Figure 14. Southern regions have lower hospital capacity

Source: Eurostat Database (data refer to 2015).

Preparing for the future, Italy is training more nurses and regulating the status of paid carers

The workforce witnessed a freeze in recruitment of health professionals in the public sector following the 2008 economic crisis. As already noted, the Italian health workforce is characterised by a relatively high number of doctors and a low number of nurses. In response to this imbalance, the number of students admitted to and graduating from nurse graduating programmes increased substantially over the past 15 years, and improvements were made in their curriculum. While the number of medical graduates has stayed relatively constant at around 6 500 per year, the number of nursing graduates more than quadrupled, from about 3 100 in 2000 to over 13 000 in 2014. The challenge now will be to create enough positions to absorb these growing numbers of graduates, given hiring freezes in recent times, to achieve a better balance between nurses and doctors.

While reliance on foreign nurses is low (about 5% of the total in 2015), demand for foreigners to provide care to elderly people at home (the so-called *badanti*, or paid carers) is very high. In 2015, the demand for foreign informal carers was estimated to be around three times as high as the demand for formally trained nurses to provide home care. With the ageing population, this demand is expected to increase further. As most informal carers initially enter without a residence permit, the government has taken steps to ensure the regulation of their status and eased the entry requirements for nurse training.

Stronger efforts to adopt new technologies and improve performance measurement are being made

In Italy, the National Committee for Medical Devices and the Agency for Regional Health Services contribute to promoting the adoption of new cost-effective technologies (also linked to Health Technology Assessment – HTA). Additionally, some regions established their own agencies to monitor quality of care, carry out comparative effectiveness analyses, and give scientific support to regional health departments.

By strengthening eHealth and health information infrastructure in recent years, Italy increased its focus on performance measurement. Following the structuring of the regional recovery plans, the government moved towards a better monitoring of hospital performance to ensure that the Essential Levels of Care are being delivered to the population. Public providers are obliged by law to report different performance indicators, such as waiting times and quality measures, as part of a 'health services chart' published nationally. On accreditation grounds, these reporting practices were adopted by private providers as well, enabling the public and government to closely monitor and assess the quality of services delivered to the population.

6 Key findings

- The Italian health system has made important contributions to population health and life expectancy gains. Amenable mortality rates in Italy are among the lowest in EU countries, mainly due to low and steady reductions in mortality from cardiovascular diseases. The number of alcohol-related deaths is among the lowest in the EU, reflecting generally low alcohol consumption and low levels of binge drinking. Yet further efforts are needed to reduce smoking rates among adolescents and adults, so as to reduce deaths from lung cancer and other smoking-related deaths.
- Despite steps taken by the Italian government to reduce the prevalence of overweight and obesity, southern regions such as Calabria, Campania and Molise show rates above 40% of overweight and obesity among children.
- A series of cost-containment measures in the aftermath of the 2008 economic crisis led to a reduction in public funding for health. Increased copayments for medicines and for inappropriate use of hospital emergency services were implemented in most regions following the introduction of the Deficit Reduction Plans.
- The proportion of people in the lowest income group reporting unmet needs for medical care due to costs is particularly high, suggesting a significant degree of inequality in access to care. Various vulnerable groups are nevertheless exempted from cost-sharing arrangements.
- Following the economic recovery in recent years, the health benefits package was revised and expanded in 2016, but there are concerns regarding regions' financial ability to implement this more generous benefits package, which must be provided to all residents in the country. The allocation of funds raises concerns regarding the capacity of poorer regions to fund access to these services without increasing regional taxes (or running deficits), possibly leading to growing rates of unmet needs and rising out of pocket payments.
- Despite policy efforts to improve efficiency in pharmaceutical spending, generics still constitute a small share of the overall volume of prescribed drugs. Recent policies promote the prescription of generics by requiring GPs to explicitly state the active ingredients of prescribed drugs to facilitate substitution.
- More nurses are being trained and paid carers are being regulated in an attempt to tackle the growing health and long-term care needs of an ageing population, and to achieve a more efficient use of human resources. While the country is characterised by a low ratio of nurses to doctors compared to most other EU countries, the annual number of new graduates from nursing schools quadrupled over the past 15 years. The challenge now will be to find suitable positions in the health system for all of these new graduates. The role of personal care workers, who constitute the largest share of carers providing home care for the elderly, is being regulated in an attempt to tackle the increasing demand for long-term care.



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Country abbreviations

Austria	AT	Denmark	DK	Hungary	HU	Malta	MT	Slovenia	SI
Belgium	BE	Estonia	EE	Ireland	IE	Netherlands	NL	Spain	ES
Bulgaria	BG	Finland	FI	Italy	IT	Poland	PL	Sweden	SE
Croatia	HR	France	FR	Latvia	LV	Portugal	PT	United Kingdom	UK
Cyprus	CY	Germany	DE	Lithuania	LT	Romania	RO		
Czech Republic	CZ	Greece	EL	Luxembourg	LU	Slovak Republic	SK		



State of Health in the EU

Country Health Profile 2017

The Country Health Profiles are an important step in the European Commission's two-year *State of Health in the EU* cycle and are the result of joint work between the Organisation for Economic Co-operation and Development (OECD) and the European Observatory on Health Systems and Policies. This series was co-ordinated by the Commission and produced with the financial assistance of the European Union.

The concise, policy relevant profiles are based on a transparent, consistent methodology, using both quantitative and qualitative data, yet flexibly adapted to the context of each EU Member State. The aim is to create a means for mutual learning and voluntary exchange that supports the efforts of Member States in their evidence-based policy making.

Each Country Health Profile provides a short synthesis of:

- health status
- the determinants of health, focussing on behavioural risk factors
- the organisation of the health system
- the effectiveness, accessibility and resilience of the health system

This is the first series of biennial country profiles, published in November 2017. The Commission is complementing the key findings of these country profiles with a Companion Report.

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