Università Bocconi
CERGAS
Centro di Ricerche sulla Gestione dell'Assistenza Sanitaria e Sociale

SDA Bocconi
SCHOOL OF MANAGEMENT

EXECUTIVE SUMMARY 2023 OASI REPORT

Observatory on Healthcare Organizations and Policies in Italy

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This summary offers a synthesis of the broader 2023 OASI Report for the international audience.

Every year, the research carried out by OASI (Observatory on Healthcare Organizations and Policies in Italy) aims to offer a detailed analysis of the Italian healthcare system and outline its future evolution.

The OASI Observatory is a CERGAS - SDA Bocconi initiative. 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[1]*. 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.*

The full contents of the OASI Reports from 2000 to 2023 are available in Italian on the CERGAS website: www.cergas.unibocconi.eu → Observatories → OASI.

[1] SDA Bocconi is ranked 1st in Europe according to Bloomberg and 5th according to the the Financial Times.

An overview of Italian Healthcare

1. Country profile[2]

With a population of 59 million inhabitants and a GDP of €2 trillion, Italy is one of the four largest European countries, alongside Germany, France, and the UK. At the forefront of European economic and political integration, Italy joined the Economic and Monetary Union in 1999. It is the second largest manufacuturer and exporter in the EU, after Germany. The Purchasing power adjusted GDP per capita is € 34,400, slightly below the EU 27 (35,500)[3]. However, the North-South economic divide remains pronounced, with the affluent North enjoying higher GDP per capita, robust industrialization, and advanced infrastructure compared to the economically lagging South. In 2022, Southern regions account for 34% of the population but contribute only 22% to the GDP.

2. Healthcare System profile[4]

The Italian National Health Service (INHS), a Beveridge-type tax-funded public healthcare system, covered about 76% of total healthcare expenditure in 2022. Private, out-of-pocket (OOP) expenditure accounted for 22%, and voluntary schemes like private insurance and mutual funds account for the remaining 2%. At the national level, current healthcare expenditure financed through the NHS amounts to around 134 billion Euros. Official estimates from national and international institutions show that private health expenditure amounts to about 41 billion Euros, evenly distributed between goods (about 35%) and services (about 65%). On the international stage, however, Italy's per capita total health expenditure appears relatively limited, that is, Italy's figures for public per capita expenditure and private voluntary insurance (PVI) per capita expenditure are significantly lower than other European countries. On the other hand, per capita out-of-pocket expenditure is more aligned. Indeed, unlike what happens in most of European countries, the private component is predominantly out-of-pocket, while the use of complementary insurance is still marginal.

The INHS was introduced in 1978 with Law No. 833/1978, which founded a universal healthcare system for Italian citizens and foreigners legally residing in Italy. Decree 502/1992 introduced managerial principles into the INHS and marked the start of concerted efforts to devolve healthcare

[2] Source: Italian National Institute of Statistics (ISTAT), 2022 (or most recent year): https://www.istat.it/it/files/2023/04/indicatori-anno-2022.pdf. Last access February 2024.
[3] 36.931 USD (exchange rate February 2024). Source: Eurostat, https://ec.europa.eu/eurostat/databrowser/view/sdg_10_10/default/table?lang=en. Last access January 2024.
[4] Source: 2023 OASI Report, chapters 2, 3 and 7.

powers to the regions. The national government is responsible for setting general objectives and the fundamental principles of the INHS, while the 21 regions are responsible for ensuring the delivery of a health basket of services through a network of population-based "local health authorities" (LHAs) and public and private, accredited hospitals. The overall budget allocated by the national government and Parliament is allocated to regions according to their demographic profiles (mainly defined by age and gender). Regions can add to their share of the National Health Fund through their own discretionary funds. Regions are responsible for guaranteeing financial equilibrium as well as minimum standards of care. Serious deficits can result in mandatory Recovery Plan ("Piani di Rientro") status for a region. This kind of compulsory administration entails an automatic increase in regional taxation, while key policy choices are placed under the strict monitoring of the national government. Today, seven regions are under Recovery Plan schemes; they are all located in the south of the country[5].

Over the last 20 years, the need to contain costs and requalify services has driven a nationwide rationalization of service provision, especially in hospitals. Bed capacity has decreased by 40%, reaching 3.5 beds per 1000 inhabitants before the Covid-19 pandemic, then rising to 3.9 in 2021. Italy, therefore, aligns with levels comparable to other major Western countries, except for Germany and France, which have significantly higher capacity. Concurrently, hospital discharges have consistently decreased, with the number of potentially inappropriate admissions[6] being the lowest among major Western healthcare systems.

In terms of outcome, life expectancy in Italy (82.7 years) is the sixth highest in the world, and it has grown steadily since 2000, with the exception of the pandemic period. Also looking at health life expectancy at birth, Italy registered high performance level compared with other countries (71.9 years; fifth-highest in the world). The percentage of premature deaths due to non-communicable diseases is lower than in the United Kingdom, Spain, USA, Germany and France. However, when considering the internal Italian context, a strong inter-regional gap clearly emerges: healthy life expectancy at birth is relatively higher in northern regions as opposed to southern regions.

[5] https://www.salute.gov.it/portale/pianiRientro/dettaglioContenutiPianiRientro.jsp?lingua=italiano&id=5022&area=pianiRientro&menu=vuoto. Last access February 2024.
[6] Asthma, COPD, diabetes.

3. Key trends and open questions regarding the Italian healthcare system

a. *Demographic imbalance and the displacement effect of pension spending. The economic difficulties at the regional level*[7]

The Italian population is one of the oldest in the world, with the number of individuals over 65 (potential pensioners) double the number under 15 (14.1 million versus 7.3 million) in 2023. Apart from declining fertility (among the lowest globally, at 1.2 children per woman), this scenario also stems from relevant improvements in life expectancy (see previous section).

While increased life expectancy is certainly positive, it exacerbates tensions within the national welfare system. The most recent forecasts anticipate growth in the population over 65 from 14 to 19 million in the next 20 years, of which 6 million will live alone. As the healthcare needs of an aging population rise, the number of tax-base contributors decreases, and the number of pensions to be disbursed grows. The October 2023 National Economic and Financial Document (NADEF) predicts a €64 billion automatic increase in pension spending only between 2022 and 2026, a 22% rise for an expenditure item that already absorbs 15% of GDP, more than double the 6.7% allocated to public healthcare. The latter is expected to grow by €8 billion by 2026 compared to 2022, a 6% increase, well below the expected economic and inflationary trend. This will result in a decline in the nominal and real impact of healthcare spending on GDP from 6.7% to 6.1%, a much lower figure compared to France, Germany, and the United Kingdom, where healthcare spending represents 10-11% of GDP. Despite recent funding increases approved by the Budget Law (€3 billion for 2024, €4 billion for 2025 and 2026), the gap with other major European countries is expected to persist.

The above-described situation poses challenges not only for the state, but also for the regions. Regions, especially in the north-central part of the country with higher productivity and a more robust public service delivery network, face economic and financial difficulties. Examples include the Emilia-Romagna and Tuscany regions, known for their excellent services but recording negative financial results in 2022. In fact, most central-northern regions, which provide a good level of service albeit insufficient in order to cover fast-increasing needs, struggle due to limited resources allocated to healthcare spending. In contrast, southern regions manage to achieve financially balanced budgets by adhering to the confines of the strictly-enforced recovery plan controls, but offer relatively modest service levels. A notable example is the Calabria region, with fewer healthcare services, lower life expectancy, and lower healthy life expectancy, yet it recorded a budget surplus in 2022.

[7] Sources: 2023 OASI Report, chapters 1 and 3.

The scarcity of public resources for healthcare is not an easily resolvable issue and can be considered as a context constraint that regional policymakers and sector managers have limited possibility to modify.

b. *Universal coverage, but quite selective and fortuitous access to outpatient services. The need for a radical change in service logics*[8].

Inevitably, limited funding affects actual coverage rates. In the supposedly universal Italian NHS, public funding covers over 90% of inpatient services, while 50% of outpatient specialist visits are privately paid, along with 33% of diagnostic outpatient tests[9]. Home and outpatient rehabilitation, as well as odontoiatric care, are mostly financed out-of pocket. Thus, the universality of the healthcare system is practically selective, especially outside hospitals. Overall, there is high variability in the levels of service provision for outpatient care covered by the National Health Service among regions and territories, even considering similar demographic and socio-economic contexts. Take, for example, the regions of Emilia Romagna and Lombardy. The former records twice as many diagnostic services as the latter, but the latter provides 50% more clinical services (visits, outpatient surgery and rehabilitation). Consequently, those who can access services are not necessarily those who need them the most. Given the increasing scarcity of resources, the question arises whether to establish specific priorities aimed at maximizing collective benefit or to continue with emerging and non-transparent prioritizations.

The above-described scenario calls for a shift from the predominant focus on supply to demand management. It requires more transversal processes between organizational silos with a care management focus as opposed to volume-oriented logic. In detail, four points provide a basis for structuring interventions for service analysis and transformation.

- Patient needs must be accurately assessed in terms of the urgency and intensity of required care, and the most appropriate response setting must be identified.
- Access and consumption among homogeneous patients in terms of diseases and staging should be convergent;
- The volumes and mix of prescribed services should be consistent with what can be effectively delivered;
- Appropriate services that are actually available in a reasonable territorial and temporal scope should be directly indicated to the citizen when prescribing.

[8] Sources: 2023 OASI Report, chapters 1, 4 and 6.
[9] Reference year: 2021.

c. *The National Recovery and Resilience Plan: an opportunity to redesign healthcare supply*[10]

In February 2020, Italy was the first European country to be dramatically affected by Covid-19. As of January 2024, the epidemic has been responsible for 195,000 deaths: Italy is the 8th hardest hit country in the world in terms of fatalities, and the second in Europe after the UK.

To address the dramatic consequences of the pandemic and to boost the economic development of member states, within the framework of the 2021-27 Budget programming, the European Commission has launched the "Next Generation EU" (NGEU) program, supported by the allocation of approximately 750 billion Euros. Of these, a significant portion, surpassing 190 billion Euros net of complementary funds, are dedicated to Italy, which has defined a National Recovery and Resilience Plan (PNRR). Almost 16 billion are expressly allocated to investments in the healthcare system. In particular, Mission 6 - Health foresees, on one hand, 7 billion for enhancing territorial assistance through improved home care, telemedicine, and the creation of new facilities: Community Hospitals and Community Homes, that are, *de facto*, integrated outpatient centres. On the other hand, 8.6 billion are allocated to the infrastructural and technological renewal of hospitals and to strengthening the human capital of the NHS through the enhancement of research and training.

This important and necessary process will be sustainable if investments sustain service reorganization and redesign, as outlined in the previous paragraph. For example, new facilities would require massive digitalization, a transfer of hospital services instead of creating duplication, a real integration among different professional profiles. Generally speaking, a comprehensive rethink of management control systems in a process-oriented logic is needed, using global metrics of sustainability, appropriateness, overall effectiveness, and quality of care, instead of mono-dimensional measurement based on service volumes and fee-for service tariffs.

d. *Healthcare professionals between ageing and skill mix imbalances*[11]

Concerning medical and nursing professionals, seniority and skill mix imbalances have emerged as crucial factors. Seniority affects all professional areas: the average age of doctors is 51, nurses 47, and general directors of LHA and public hospitals, 60. The quantitative shortage, though mitigated during the pandemic biennium (+3% of new employees between 2019 and 2021), is exacerbated by some internal imbalances for which no trend reversals are foreseeable. Italy has medical staff levels fairly in line with those of other major Western countries, and is growing following the recent

[10] Source: National Recovery and Resilience Plan; 2023 OASI Report, chapter 1.
[11] 2023 OASI Report, chapters 2 and 11.

expansion of available slots for university education. Some significant shortages concern specific disciplines such as emergency care, anesthesia, or laboratory medicine. Another critical issue is the imbalance in medical resources between urban and rural areas, generally to the disadvantage of the latter. However, the most glaring critical issue to date is the reduced provision of nurses: 62 per 1,000 inhabitants, comparable to Spain (63) but far from France (85), the United Kingdom (87), and Germany (121). The problem here is the increasing shortage of "vocations": in the academic year 2023-24, nursing faculties recorded an average of 1.2 applications per place. In 2012-13, the value was 2.7. As a result of these dynamics, in 2023, medical faculties contributed as many doctors to the sector as nurses (approximately 10,000), whereas the need for the latter is about 2.5-3 times that of the former, even considering only the need for replacement of current employees.

Personnel management issues are at least partially beyond the scope of healthcare organizations. However, managers can adopt some strategies to correct, or limit, imbalances in staff distribution. The evidence gathered indicates professional factors as the main drivers of workplace choice. Therefore, for example, the attractiveness of peripheral facilities depends greatly on the ability to develop skills, autonomy, and reputation among colleagues and patients.
