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

SDA Bocconi
SCHOOL OF MANAGEMENT

EXECUTIVE SUMMARY 2024 OASI REPORT

Observatory on Healthcare Organizations and Policies in Italy

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This summary offers a synthesis of the broader 2024 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 2024 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 2023. 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 136 billion Euros. Official estimates from national and international institutions show that private health expenditure amounts to about 46 billion Euros, evenly distributed between goods (about 34%) and services (about 66%). 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 (84 years in 2024) is among the 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. 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. Challenges and perspectives[7]

a. THE CHALLENGES OF THE ITALIAN NATIONAL HEALTH SERVICE (SSN)

Demographic Situation

Italy is the second-oldest country in the world after Japan, with over-65s making up 24% of the population—a figure rapidly climbing toward 30%. This demographic shift results in a net transfer of €165 billion per year from the state's general taxation to the national pension agency (INPS), as the contributions from the relatively small working population are insufficient to cover pensions and welfare expenses. Consequently, it is difficult to significantly increase public healthcare spending, according to the OASI Report. The key question becomes, how can good healthcare services be provided while allocating only 6.3% of GDP to public health?

Random Priorities

It is inevitable to define and select intervention priorities, such as specific disease areas, care settings, or population clusters. However, the Report notes that currently there is no deliberate process of priority selection in place, and priorities emerge randomly, without any explicit evaluation process aimed at maximizing the societal benefits achievable with the available resources. This randomness risks prioritizing responses to the first individuals who access the system, without assessing whether these cases align with genuine priorities. The entire institutional chain performs implicit and random prioritizations.

Mismatch Between Needs and Services

The OASI Report highlights discrepancies in the SSN. Comparing different types of services and regions, significant differences emerge in per capita volumes of care, which are not meaningfully related to demand or needs. Currently, production management dominates policy and managerial agendas, while demand management would be far more impactful.

Gap Between Prescriptions and Service Capacity

Additionally, the SSN's output has decreased when comparing 2023 to 2019, especially in outpatient care (-8%), despite having more personnel employed than before COVID-19 (+5%). Yet, prescriptions—such as initial visits ordered by hospital specialists and general practitioners—have

[7] The paragraph summarizes the first chapter of the OASI Report.

risen by 31%, while actual service delivery has dropped by 10%. This means many prescriptions are not fulfilled within the SSN. Meanwhile, 48% of specialist visits occur in the private sector. Regions with higher prescription rates often report higher volumes of delivered services per capita, but also longer waiting lists. Without rethinking prescriptions, this pressure on waitlists risks being counterproductive to goals of appropriateness, equity, and cost-effectiveness.

b. FOUR UNPOPULAR PROPOSALS FOR THE SSN

Managing Expectations

This entails consciously acknowledging the modest funding for the SSN and clearly defining what the public service can and cannot cover. Once enforceable rights and intervention areas are established, the SSN must outline priority targets and access criteria, moving away from models where access depends on the ability to pay exorbitant fees, as is currently the case in some segments like long-term care facilities. Greater clarity could help align public and professional expectations, gradually bridging the gap between prescribed and deliverable services.

Politically Costly Efficiency

The SSN has been on an efficiency path for 30 years, and the low-hanging fruit has largely been picked. Achieving further efficiency will require politically costly measures. For example, the SSN still has over 100 directly managed hospitals with fewer than 50 beds, and another similar number with 50-100 beds. These account for 40% of hospital facilities that are directly managed by LHA. It is unrealistic to think they all operate in isolation and that some could not reorient services and personnel toward territorial care. Similarly, despite an increase of 287 outpatient and laboratory facilities between 2019 and 2022, the system must evaluate whether their distribution remains efficient.

Small, Broad-Based Contributions

Introducing new taxes on regions or social groups already heavily supporting welfare appears economically and politically unfeasible. Instead, the Report proposes designing a system of small but widespread contributions that balances the resources provided and the benefits received between citizens-patients and the SSN.

Transforming Service Characteristics

The proposal involves a eaner, more centralized hospital system, mobile medical teams working across facilities, and widespread use of remote specialist services for patients either at home or in community hubs if they lack internet access. However, such a radical shift requires ìtransforming the necessary professional competencies, breaking down many existing professional silos, and increasing roles for service design experts and non-medical administrative case managers. Indicators of appropriateness, equity, adherence, and perceived quality must be progressively introduced at all levels.

c. THE NECESSARY AWARENESS

In conclusion, the Report seeks to raise awareness so that those who believe in the SSN do not have to accept decisions made by others. It challenges stakeholders to consider their role in revitalizing the SSN, exploring solutions for citizen health, organizational well-being, and economic, social, and institutional sustainability. Quoting Rev. L. Milani: “If you know, you belong to yourself; if you don’t, you belong to someone else.”
