



# Italy

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## Health Care & Long-Term Care Systems

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## Italy

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Health care systems

## 1.15. ITALY

### General context: Expenditure, fiscal sustainability and demographic trends

*General country statistics: GDP, GDP per capita; population*

GDP per capita (25,158 PPS in 2013) is slightly under the EU average (27,900 PPS in 2013) slightly down from 26,067 in 2012. After a moderate growth in 2015 (0.8%), Italy's economic growth is expected to pick-up in 2016, with a projected rate of 1.4%, and in 2017, roughly stable at 1.3%<sup>(147)</sup>.

Population, estimated as 59.7 million in 2013, is projected to increase to 66.3 million in 2060, which at 10.1%<sup>(148)</sup> represents a higher growth rate with respect to the average for the EU (3.1% over the same period).

*Total and public expenditure on health as % of GDP*

Total (public plus private) expenditure<sup>(149)</sup> on health as a percentage of GDP (9.1% in 2013) is below the EU average<sup>(150)</sup> (10.1% in 2013). It has increased from 8.2% in 2003. Public expenditure on health as a percentage of GDP is also slightly below the EU average (7.1% vs. 7.8% in 2013), up from 6.2% in 2003. Total (2394 PPS) and public (1868 PPS in 2013) per capita expenditure were below the EU average (2988 PPS and 2208 PPS in 2013), having consistently increased since 2003 (1934 PPS and 1412 PPS).

The significant slowdown of the increase in the public health care expenditure has been achieved due to the governance regulations and procedures implemented in the last years, namely the Health Pact between State and Regions, the monitoring of the fulfilment of the budget objectives and the activation of the Deficit Reduction Plan procedure for those regions not complying with the agreed budget rules. As a result, public health care

<sup>(147)</sup> European Commission (2016), European Economic Forecast - Winter 2016.

<sup>(148)</sup> The increase rate is calculated using value of 60.2 as a starting level for 2013.

<sup>(149)</sup> Data on expenditure is taken from WHO HFA DB 2015..

<sup>(150)</sup> The EU averages are weighted averages using GDP, population, expenditure or current expenditure on health in millions of units or units of staff where relevant. The EU average for each year is based on all the available information in each year.

expenditure has grown by an annual average of 1.0 % in nominal terms over the period 2006-2014, against the 7.1% of the period 2000-2006<sup>(151)</sup>.

*Expenditure projections and fiscal sustainability*

As a result of ageing, health care expenditure is projected to increase by 0.7 pps of GDP until 2060 (below the average change in the EU of 0.9 pps)<sup>(152)</sup>. When taking into account the impact of non-demographic drivers on future spending growth (AWG risk scenario), health care expenditure is expected to increase by 1.2 pps of GDP from now until 2060 (EU: 1.6).

Medium term sustainability risks for Italy mainly derive from the high debt-to-GDP ratio and do not stem from health care expenditure and the projected cost of ageing<sup>(153)</sup>.

*Health status*

Life expectancy at birth (85.2 years for women and 80.3 years for men in 2013) is above the EU average (83.3 and 77.6 years in 2013). Healthy life years at birth are for men (61.8 in 2013) and for women (60.9 in 2013) similar, though the first higher and the second lower, to the EU average (respectively 61.4. and 61.5).

### System characteristics

*System financing: taxed-based or insurance-based*

A regionally based National Health Service (NHS), with a division of responsibilities between the central government and the regional governments (set by the 2001 Constitutional Amendment), and funded mainly by taxation, provides full coverage of resident population<sup>(154)</sup>.

<sup>(151)</sup> Ministero dell'economia e delle finanze – RGS (2015), *Il monitoraggio del sistema sanitario*, Report no.2. [http://www.rgs.mef.gov.it/\\_Documenti/VERSIONE-I/Attivit-i/Spesa-soci/Attivit-monitoraggio-RGS/2015/IMDSS-RS02\\_15\\_09\\_2015.pdf](http://www.rgs.mef.gov.it/_Documenti/VERSIONE-I/Attivit-i/Spesa-soci/Attivit-monitoraggio-RGS/2015/IMDSS-RS02_15_09_2015.pdf).

<sup>(152)</sup> I.e. considering the "reference scenario" of the projections (see the 2015 Ageing Report: [http://europa.eu/epc/pdf/ageing\\_report\\_2015\\_en.pdf](http://europa.eu/epc/pdf/ageing_report_2015_en.pdf)).

<sup>(153)</sup> Fiscal Sustainability Report 2015: [http://ec.europa.eu/economy\\_finance/publications/eeip/pdf/ip018\\_en.pdf](http://ec.europa.eu/economy_finance/publications/eeip/pdf/ip018_en.pdf).

<sup>(154)</sup> Including foreign citizens, and their dependent relatives, who are in one of the following positions: a) employed; b)

Starting from 2013, a new mechanism has been set for the distribution of financial resources among regions, according to the procedure envisaged in legislative decree 68/2011, which may be summarised as follows:

1. each year, the total amount of resources addressed to the financing of health system (according to the evolution of macroeconomic variables and budget constraint) is defined (so called “*fabbisogno nazionale standard*”);
2. 5 benchmark regions are identified, among regions which:
  - have guaranteed the delivery of health services efficiently and appropriately ensuring, at the same time, a budget balance position;
  - have fulfilled the achievements (“*Adempimenti*”) foreseen by law, according to the assessment of the relevant Committee (so-called “*Tavolo degli Adempimenti*”);
  - have reached a high score in health quality ranking, according to the set of indicators envisaged in the Health Pact;
3. three regions out of the 5 benchmark ones are selected by the Conference of regions, being fixed the top ranked region;
4. the average regional standard costs are computed on the basis of the actual costs of the three reference regions;
5. standard costs are applied to the regional population, weighted with regional age structure;
6. the resulting distribution is applied to the *fabbisogno nazionale standard*, obtaining the *fabbisogno sanitario* of each region (“*fabbisogno regionale standard*”).

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enrolled in the employment lists; c) had applied for a renewal of the permit of stay. As for dispositions concerning non- EU citizens, see law 40/1998, articles 32-34.

The financial coverage of the regional *fabbisogno sanitario* is guaranteed through a mix of financial resources:

1. the regional tax on production activities (IRAP);
2. the surcharge on personal income tax;
3. revenues of the ASL/AO (Local Health Bodies/Hospital Bodies - *Aziende Sanitarie Locali/Aziende Ospedaliere*) from either sale of services or fees paid by citizens (so-called “*tickets*”);
4. as for Regions with ordinary institutional status (*regioni a statuto ordinario*), a share of VAT revenue is granted to cover the difference between their *fabbisogno sanitario* and the resources obtained through the financial channels under points a)-c);
5. as for Regions with special institutional status (*regioni a statuto speciale*), the quota of their *fabbisogno sanitario* not covered by the financial channels under points a)-c) is to be financed through their own resources (additional contribution) <sup>(155)</sup>.

Regions are required to ensure a budget balance position. If they fail to comply with this requirement, a set of automatic measures is foreseen in order to restore the budget balance position (mainly the increase of regional taxes). In case of a deficit exceeding the 5% threshold (computed as a ratio between the value of regional deficit in nominal terms and the financial resources assigned to regions to finance health expenditure), regions are obliged to present a 'Deficit Reduction Plan' (*Piano di Rientro*). The latter has a time horizon of three years and lays down all the necessary measures to be taken by the region concerned to achieve the budgetary balance.

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<sup>(155)</sup> For region Sicily only, this additional contribution accounts for at maximum 49.11% of its *fabbisogno sanitario*. The remaining part is financed by the National Health Fund (Fondo Sanitario Nazionale).

*Revenue collection mechanism (tax/social security contributions/premium)*

In 2013, 78% of total health expenditure funding came from earmarked public sources, including regional tax on production activities (corporation tax on the value added of companies and on the salaries of public sector workers - IRAP), regional surcharge on income tax and a share of VAT revenue (see §. 1).

*Administrative organisation: levels of government, levels and types of social security settings involved, Ministries involved, other institutions*

According to the organisational setting of the Italian Health Care System, the Ministry of Health, in agreement with the Ministry of Economy and Finance, defines general objectives and national policy priorities, as well as the basic levels of health care treatments which are provided for free over the national territory (so called *Livelli Essenziali di Assistenza-LEA*); regions are in charge with planning, coordinating and providing health services (including primary, specialist outpatient and hospital care, health promotion, disease prevention and rehabilitation, long-term nursing and psychiatric care) for their residents. They have large autonomy in the way they organise care delivery, within the general framework designed at national level. The funds to be allocated to each type of care are somewhat determined by both the central government and regions.

A committee (so-called *Comitato LEA*) is in charge of monitoring the provision of LEAs in each region; the committee is composed of representatives of the ministries concerned (Health and Economy and Finance), the Department of Regional Affairs (within the Presidency of the Council of Ministers) and Regions<sup>(156)</sup>.

Regions may choose to provide extra LEA benefits, and some do, but the relative costs should be covered through their own financial resources.

<sup>(156)</sup> Such a committee was first established in 2005, according to article 9 of the Health Pact of 23rd March 2005.

Recently, the budget law for 2016, has foreseen the establishment of the National Committee for the updating of LEA.

*Coverage (population)*

Health services are provided for free to all citizens; however, a fee (co-payment) may be requested for the provision of some health services (e.g. specialist health services) depending on income and age requirements.

*Treatment options, covered health services*

Primary care and hospital inpatient care are free at the point of use. Outpatient specialist consultations that follow a referral from a general practitioner (GP - family doctor) and diagnostic procedures involve a small fee as do pharmaceuticals prescribed by a physician in those regions who have chosen to use a fee. Unwarranted visits to emergency departments also involve a fee. Dental care is guaranteed for specific groups of the populations (children, vulnerable groups such as disabled, people with HIV and those with rare diseases) and in emergency cases, while others purchase dental care are out-of-pocket. Eyeglasses and contact lenses and dental prostheses are not funded or provided by regions. Patients visiting a physician without a referral or buying over-the-counter medicines have to pay for the full cost of care out of their pockets. Children below 6, and elderly (65+) individuals with an income below a certain threshold, pregnant women and people with certain medical conditions are exempted from cost-sharing. According to the OECD (2010) 15.6% of the population buys duplicative private insurance (to cover for the same services covered by public provision/ funding).

Waiting times and lists for specialist consultation and hospital surgery are considered long by the population and there are important regional variations in the waiting time, which are seen as a problem in Italy. To reduce waiting times, the 28<sup>th</sup> of October 2010 the Agreement between the Government, the Regions and Autonomous Provinces on the Government National Plan of waiting lists ( PNGLA ) for 2010-2012 was signed

<sup>(157)</sup>. In addition, patients are allowed to obtain hospital care in other regions and there is a system of interregional compensation whereby regions paid for the patients they send away and receive the payments of those who come into the region to receive treatment. The interregional mobility is directly related to the right of citizens to choose health care treatments, for example by accessing high specialised health structures located out of their own region.

#### *Role of private insurance and out of pocket co-payments*

In 2013, 18% of total (public and private) health care expenditure came from out-of-pocket payments and 4 % from private insurance. The remaining 78% was publicly funded. Out-of-pocket payments in Italy are currently above EU average (14.1 in 2013).

#### *Types of providers, referral systems and patient choice*

As the responsibility for care delivery has been delegated to the regions, there may be differences in the way the various types of care are organised/delivered.

In general, health care services are provided for free through public providers (ASLs, public hospitals, university public hospitals) as well as private accredited providers. Health services can be delivered also by private non-accredited providers but the relative costs are fully charged on the users.

Primary care is provided by independent general practitioners (GPs) and paediatricians acting on the basis of a contract with the NHS, and running their activities in single practices or in joint practices (for which a financial incentive is provided).

Outpatient specialist care is provided by specialist doctors in outpatient departments in hospitals as well as in private ambulatories (both accredited and not accredited). A decree of Ministry of health (issued according to Decree law 78/2015, converted into Law 125/2015) has recently laid

down supplying conditions and appropriateness indications, which doctors must report in their prescriptions. In case doctors do not comply with this obligation, the additional part of their compensation is reduced and any specialist care provided in contrast with the decree is charged to patients.

Day case and inpatient care also take part in hospitals. Provision has traditionally been public but currently health services are provided also by private providers. According to the OECD (2012), about 68% of all acute hospital beds are public, 4% are private not-for-profit and 28% is private for profit. Some public hospitals (*Aziende Ospedaliere*) have also been given financial and technical autonomy (contracting with the ASLs), while others remain under the direct management of the ASLs.

The ASLs oversee also health promotion, disease prevention and occupational diseases activities.

The number of practising physicians per 100 000 inhabitants (390 in 2013) is above the EU average (344 in 2013). The number of GPs per 100 000 inhabitants (75 in 2013) is in line with the EU average (78.3 in 2013). The number of nurses per 100 000 inhabitants (614 in 2013) is below the EU average of 837.

Authorities' efforts to encourage the use of primary care vis-à-vis specialist and hospital care include compulsory registration with a GP and a compulsory referral system from primary to secondary care (i.e. GPs act like gatekeepers to specialist and hospital care), while allowing patient choice of GP, specialist and hospital <sup>(158)</sup>. The coverage of primary care services in health centres is guaranteed over 24 hours, through the primary care out of hours (so called *guardia medica*). Over time there has been a strong emphasis on primary care as the first point of access to care, emphasis that is to continue to ensure quality and efficiency of care. Patient satisfaction with primary care GPs and paediatricians is high. Moreover, authorities have been introducing a number of ICT and eHealth solutions to allow for nationwide electronic exchange of medical data (including patient electronic medical records and patient e-

<sup>(157)</sup> For further information, see: [http://www.salute.gov.it/portale/temi/p2\\_5.jsp?area=qualita&menu=liste](http://www.salute.gov.it/portale/temi/p2_5.jsp?area=qualita&menu=liste).

<sup>(158)</sup> Indeed, according to the OECD, the level of choice of provider and gatekeeping in Italy both score of 6 out of 6.

card) to support care coordination, reduce medical errors and increase cost-efficiency as well as monitoring activity and consumption.

The number of acute care beds per 100 000 inhabitants (275 in 2012) is below the EU average (360 in 2012; 356 in 2013). In line with the EU trend, the number of acute beds in Italy has been decreasing over the last decade (351 in 2003), as a result of the policies run over the last years aimed at reducing the rate of acute beds towards the standard levels set by the current legislation <sup>(159)</sup>. In some areas there may be a shortage of follow-up/long-term care beds/ facilities which might create bed-blockages in acute care. It is regional government to plan for the number of hospitals and the provision of specific specialised services.

#### *Pricing, purchasing and contracting of healthcare services and remuneration mechanisms*

Primary care physicians are paid on a capitation basis, while outpatient and inpatient specialists acting in public structures are paid by a salary. The pay scale is determined at national level. Primary care physicians appear to be eligible to receive bonuses regarding preventive care or disease management activities <sup>(160)</sup>. Private sector doctors are paid a fee-for-service.

Hospitals remuneration is on a payment per case basis using DRGs <sup>(161)</sup>. Hospital remuneration methods are defined at central level with the DRG weights and other service rates negotiated at regional level.

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<sup>(159)</sup> According to law decree 65/2012, the standard rate for acute care beds is set at 300 per 100 000 inhabitants.

<sup>(160)</sup> It is foreseen by article 8 of the National General Agreement (Accordo nazionale collettivo) concerning the discipline of GP.

<sup>(161)</sup> The OECD score for remuneration incentives to raise the volume of care in Italy is a bit more than 3 out of 6 as a result of the use of activity related payment in hospital remuneration though not in other areas. The OECD overall efficiency score for Italy is slightly higher than its group average (about 1.8 years potential gain to be made through greater efficiency in the sector compared to the group average of 2.6 years) and above the OECD average (2.3 years). There are nevertheless areas for improvement including: continue to improve efficiency in the hospital sector notably through the publication of comparable information on activity and quality and/or through an element of activity related payment of physicians; increasing consistency in the allocation of resources across levels of government.

When looking at hospital activity, inpatient discharges per 100 inhabitants are below the EU average (11.8 vs. 16.5 in 2013). As day case discharges have, similar to inpatient discharges, been decreasing (contrary to the EU <sup>(162)</sup> trend), also day cases discharges per 100.000 inhabitants is now below the EU average (4070 in Italy and 7031 as EU average in 2013). Overall acute hospital average length of stay (6.8 days in 2013) <sup>(163)</sup> is slightly above the EU average (6.3 days in 2013).

#### *The market for pharmaceutical products*

Total (1.6%) and public (0.8%) expenditure on pharmaceuticals as a percentage of GDP was about and below the EU average (respectively 1.4% and 1%) in 2013. Total (18.2 %) and public (11.9%) pharmaceutical expenditure as a percentage of total current health expenditure is respectively above and slightly below the EU average (14.9% and 12.5% in 2013). The policy priority is to keep under control the dynamics of public pharmaceutical expenditure by fixing appropriate ceilings as a share of the financing level of the National Health Service (*Servizio Sanitario Nazionale* - SSN) contributed by the State <sup>(164)</sup>.

The authorities have implemented a number of policies to control expenditure on pharmaceuticals, based on (i) limits to expenditure dynamics and (ii) control of pharmaceuticals prices. Expenditure rules on pharmaceutical products exist since 2001; however, since 2008, a new rule was introduced, foreseeing thresholds for pharmaceutical products supplied by pharmacies or, directly, by the ASLs. The rule establishes two expenditures ceilings for pharmaceutical products (including patient co-payments) expressed as a percentage of the financing level for the National Health Service contributed by the State. Starting from 2013, the thresholds are set as follows:

- 11.35% for pharmaceutical products supplied by pharmacies;
- 3.5% for pharmaceutical products supplied by hospitals.

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<sup>(162)</sup> This refers to the aggregate EU-28.

<sup>(163)</sup> Eurostat, Last update 10.07.15, In-patient average length of stay (in days), Services of curative care.

<sup>(164)</sup> For the details, see section 6.

The expenditure ceilings must be respected both at regional and national levels.

As for the latter expenditure item, since 2008 an automatic procedure (so-called pay-back) is in place to compensate for possible overruns.

Concerning price control policies, the initial price of a new pharmaceutical product is based on clinical performance, economic evaluation, on the cost of existing treatments. There are controlled price updates. Price setting involves important negotiations between the Italian Pharmaceutical Agency (*Agenzia Italiana del Farmaco* - AIFA) and the pharmaceutical companies and negotiations take into consideration the social relevance of the disease, the effect of the medicines, the expected utilisation and financial impact, prices in other countries, prices of similar products in Italy. Discounts, payback and price freezes and cuts are some of the mechanisms used to directly control expenditure. There is a positive list of reimbursed products which is based on health technology assessment information/economic evaluation. Reference pricing for reimbursement purposes is also applied. For medicines for which generics are available the reimbursement level is set at the lowest price of the drugs in a group (defined as drugs with same active ingredient, bioequivalent form and therapeutic indications), and the cheapest price must be at least 20% lower than the originator product. For those without generics, the reimbursement level of a new drug is based on a sort of average cost of a defined group of medicines that are related but slightly different chemically.

Authorities promote rational prescribing of physicians through treatment and prescription guidelines complemented with education and information campaigns on the prescription and use of medicines and the monitoring of prescribing behaviour (by regions and ASLs). GPs receive some kind of feedback on their prescription patterns. Authorities also pursue information and education campaigns directed at patients and some regions have introduced a small fee for either pack or receipt to make patients more sensitive to the cost of medicines and encourage a rational use of medicines on the patients' side. There is an explicit generics policy. Generic sales targets are set by the Italian Pharmaceutical Agency. Generic

substitution takes place i.e. pharmacies are obliged to offer the generic medicine when available. If patients refuse a generic, they will have to pay the difference between the reimbursement price of the branded drug and the pharmacy retail price of the cheapest available generic. Generics are exempted from the mandatory discount of pharmacies to the NHS so as to encourage pharmacies to hold and sell generics.

In order to monitor and keep under control the dynamics of pharmaceutical expenditure and GPs prescriptions, a comprehensive information system called "*Sistema Tessera sanitaria*" has been implemented.

#### *Use of Health Technology Assessments and cost-benefit analysis*

Health Technology Assessment is undertaken at various levels although there is no national structure responsible for conducting, promoting, coordinating or financing HTA. There are clinical guidelines for medical interventions and medicines established through the National Programme on Clinical Guidelines.

#### *eHealth (e-prescription, e-medical records)*

Starting from 2003, the "*Tessera Sanitaria*" information system (herehence "*TS*") has been gradually implemented under the supervision and management of the Ministry of Economy and Finance - Department of General Accounts. In 2009, such a system was fully implemented in all regions and since then it has been regularly utilised for the monitoring of the full procedure for pharmaceutical and specialist care provisions, from the prescription to the delivery. Besides, through a set of performance indicators, the *Tessera Sanitaria* system allows to make cross-regional comparative analysis on the efficiency and appropriateness of prescriptions.

Since 2013, the *TS* has also been utilised for the gradual implementation of the electronic medical prescription (*ricetta elettronica*) over the entire national territory, in line with the programme of the Italian Digital Agenda (*Agenda Digitale Italiana*) which foresees the full dematerialisation of medical prescriptions. In this regards, the *TS* has implemented a technological infrastructure for electronic interconnection with doctors,



pharmacies, hospitals and other public health body, or private health body accredited by the National Health System <sup>(165)</sup>.

Since 2015, *TS* also allows patients to check online their own health care expenses, made available to the Fiscal Agency (*Agencia delle entrate*) for the pre-filled income tax statement (*730-precompilato*).

Finally, according to law decree 179/2012, article 12, a project concerning the implementation of the patient's electronic health record (*Fascicolo Sanitario Elettronico*) has been started.

#### *Health and health-system information and reporting mechanisms*

Following a pilot period, a comprehensive information and monitoring system (National Healthcare Information System) - using 130 indicators and covering population health status, budgetary and economic efficiency, organisation climate and staff satisfaction, patient satisfaction, performance indicators (appropriateness, quality) and effectiveness in reaching regional targets - is now fully operational. A comprehensive set of indicators has been introduced by the Health Pact 2010-2012, for evaluating the performance of regional health services.

Several regions have adopted the system which uses standard codes. As a result, Italy will be able to gather extensive information at regional and sub-regional levels, which is publicly available on a website allowing for public comparisons. Such a system, allows regions to identify good practices as well as areas for improvement. Physicians are being monitored in terms of their activity and compliance with guidelines as well as their prescription behaviour. They receive feedback on their prescription patterns.

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<sup>(165)</sup> All this further strengthens the accuracy and timeliness in checking prescription appropriateness and requirements for co-payment exemptions. In 2015, about 350 million of dematerialised prescriptions were issued. Thanks to the e-prescription system, since 1st March 2016 the validity of prescriptions has been extended also to regions other than that of residence.

#### *Health promotion and disease prevention policies*

The central Government through the Ministry of Health sets and monitors public health priorities in terms of process, outcomes and the reduction of health inequalities. There are some risk factors that can translate into an important burden of disease and financial costs. The latest National Health plan lists a number of priority areas for health promotion and disease prevention which is proposed as good practice across the regions. Health promotion and disease prevention activities has not historically received the same emphasis as in other countries in the EU, as seen by its pattern of expenditure and some indicators. However, in 2013, public and total expenditure on prevention and public health services as a % of GDP are in line with the EU average (0.25% and 0.25% vs. 0.24% and 0.19% in 2013), after a decade of consistently being markedly lower than average. Public and total expenditure on prevention and public health services as a % of current health expenditure (public and total, respectively) are currently both above the EU average (3.7% vs. 2.5% and 2.9% vs. 2.5% in 2013).

#### *Transparency and corruption*

In order to guarantee the full accountability and monitoring of health sector, Italy has implemented an integrated governance framework.

Health expenditure trends are analysed on a quarterly and yearly basis, relating on a set of standardised economic accounts, mainly based on a profit and losses account and a balance sheet account. These accounts are filled at the regional level and single public provider of health services, on the basis of harmonised recording criteria.

A dedicated committee (named "*Tavolo degli Adempimenti*") is in charge with the analysis of expenditure trend, the verification of the budget balance position and the fulfilment of the other requirements envisaged in the legislation.

A bonus (equal to the 3% of the regional share of national health fund) is granted to regions conditionally to a positive evaluation by the *Tavolo degli Adempimenti* about the fulfilment of all the requirements (and, firstly, the budget balance position) envisaged in the legislation.

### Recently legislated and/or planned policy reform

In July 2014, a new Health Pact was signed between central government and regions. The main issues regulated by the Pact are as follows:

- the financial framework, i. e. *the level of fabbisogno nazionale standard* for each of the years 2014-2016;
- a procedure for the revision of the current basic healthcare levels (LEA);
- a procedure for the revision of co-payment schemes, in order to make them more fair without affecting current revenues;
- a strengthening of monitoring activity, through an increased role of the National Agency for regional Health Services (*Agenzia Nazionale per i Servizi Sanitari Regionali*, AGENAS) in evaluating the quality of regional health services.

Recently, the latest budget law for 2016, introduced a Deficit Reduction Plan (*Piano di Rientro*) procedure also for hospital bodies as an additional tool to restore budget balance positions and improve an efficient use of public resources.

### Challenges

The analysis above shows that a range of reforms have been implemented in recent years, for example to strengthen primary care provision and its use, to improve efficiency, to improve data collection, information and monitoring systems and the use of ICT solutions, to control overall expenditure and pharmaceutical expenditure while delivering quality healthcare. They were to a very large extent successful and, therefore, Italy should continue to pursue them. The main challenges for the Italian health care system are as follows:

- To continue increasing the efficiency of health care spending, promoting quality and integrated care as well as a focusing on costs, to tackle the impact on spending due to population ageing and non-demographic factors.

- To extend the possibilities of hospitals to provide ambulatory and day care as well as to transfer more health care services into the ambulatory sector in order to reduce the number of inpatient care treatments, as well as to strategically direct more resources towards providers of lower levels of care, to increase efficiency.
- To tackle unwarranted regional variation in waiting times and resource distribution. In particular, monitor and correct potential uneven distribution of hospital beds (follow-up and long-term care), to free-up capacity in acute settings as a driver of lower waiting times. To the same end, further develop ICT solutions to increase service efficiency of operations
- To re-think the current mix between doctors and nurses, to favour solutions that relying less heavily on doctors, in the cases where nurses can represent a substitute, consistently with a more primary-care oriented system.
- To further the efforts in the field of pharmaceuticals by considering additional measures, both on the side of patients and of health care professionals, to improve the rational prescribing and usage of medicines. The policies could help reducing the high level of out-of-pocket payments and improving access to cost-effective new medicines by generating savings to the public payer.
- To ensure a greater and nationally coordinated use of health technology assessment to determine new high-cost equipment capacity, the benefit basket and the cost-sharing design across medical interventions.
- To implement the National Health Information System across all regions and sub-regional levels, which has a strong potential to monitor and relate expenditure with activity and with outcomes and in identifying good practices and areas for improvement. To encourage debate, information exchange, and peer reviews between regions once the system is fully implemented. In this context, the patient e-card (Tessera Sanitaria) should be fully exploited.

- To continue to monitor regional expenditure policies, making regions showing deficit in the health sector budget restore the balance, and ensure efficiency and appropriateness in the provision of LEAs. To continue to improve accountability and governance of the system and identify possible cost-savings in the health sector administration, as it currently involves national and regional institutions.
- To further the efforts to support public health priorities and enhance health promotion and disease prevention activities, i.e. promoting healthy life styles and disease screening.

Table 1.15.1: Statistical Annex – Italy

General context												EU- latest national data		
	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2009	2011	2013
<b>GDP</b>														
GDP, in billion Euro, current prices	1391	1449	1490	1549	1610	1633	1574	1606	1639	1615	1607	9289	9800	9934
GDP per capita PPS (thousands)	27.4	26.9	27.1	27.8	28.5	27.9	25.6	26.2	26.4	26.1	25.2	26.8	28.0	27.9
Real GDP growth (% year-on-year) per capita	-0.8	0.7	0.2	1.6	0.9	-1.9	-6.1	1.2	0.1	-2.7	-2.1	-4.8	1.4	-0.1
Real total health expenditure growth (% year-on-year) per capita	-2.4	4.8	3.0	2.8	-3.0	2.6	-0.7	1.3	-1.6	-3.3	-3.2	3.2	-0.2	-0.4
<b>Expenditure on health*</b>												<b>2009</b>	<b>2011</b>	<b>2013</b>
Total as % of GDP	8.2	8.5	8.7	8.8	8.5	8.9	9.4	9.4	9.3	9.2	9.1	10.4	10.1	10.1
Total current as % of GDP	7.9	8.2	8.4	8.5	8.2	8.6	9.0	8.9	8.8	8.8	8.8	9.8	9.6	9.7
Total capital investment as % of GDP	0.3	0.3	0.4	0.4	0.3	0.3	0.4	0.5	0.4	0.4	0.3	0.6	0.5	0.5
Total per capita PPS	1934	2095	2201	2307	2299	2421	2452	2497	2498	2444	2394	2828	2911	2995
Public as % of GDP	6.2	6.6	6.8	6.9	6.7	7.0	7.4	7.4	7.1	7.1	7.1	8.1	7.8	7.8
Public current as % of GDP	5.9	6.2	6.5	6.6	6.3	6.6	7.0	7.0	6.8	6.8	6.8	7.9	7.7	7.7
Public per capita PPS	1412	1556	1646	1728	1726	1844	1868	1898	1878	1877	1868	2079	2218	2208
Public capital investment as % of GDP	0.3	0.3	0.3	0.3	0.3	0.4	0.4	0.4	0.3	0.3	0.3	0.2	0.2	0.1
Public as % total expenditure on health	76.2	77.4	77.9	78.2	78.3	78.9	78.9	78.9	77.1	77.3	78.0	77.6	77.2	77.4
Public expenditure on health in % of total government expenditure	13.3	14.1	14.4	14.6	14.3	14.8	14.6	14.9	14.7	14.4	:	14.8	14.9	:
Proportion of the population covered by public or primary private health insurance	100.0	100.0	100.0	100.0	:	:	:	:	100.0	100.0	100.0	99.7	99.7	98.7
Out-of-pocket expenditure on health as % of total expenditure on health	20.8	20.1	19.0	18.7	18.8	18.5	17.7	17.5	18.8	18.8	18.0	14.1	14.4	14.1

Note: \*Including also expenditure on medical long-term care component, as reported in standard international databases, such as in the System of Health Accounts. Total expenditure includes current expenditure plus capital investment.

Population and health status												2009	2011	2013
Population, current (millions)	57.5	57.5	57.9	58.1	58.2	58.7	59.0	59.2	59.4	59.4	59.7	502.1	504.5	506.6
Life expectancy at birth for females	82.8	83.7	83.6	84.1	84.2	84.2	84.3	84.7	84.8	84.8	85.2	82.6	83.1	83.3
Life expectancy at birth for males	77.3	78.0	78.1	78.6	78.8	78.9	79.1	79.5	79.7	79.8	80.3	76.6	77.3	77.8
Healthy life years at birth females	74.4	71.0	67.8	64.7	62.6	61.8	62.6	:	62.7	61.5	60.9	:	62.1	61.5
Healthy life years at birth males	70.9	68.7	66.6	65.2	63.4	62.9	63.4	:	63.5	62.1	61.8	:	61.7	61.4
Amenable mortality rates per 100 000 inhabitants*	74	:	:	62	61	61	59	55	123	121	:	64.4	128.4	:
Infant mortality rate per 1 000 life births	3.9	3.9	3.8	3.6	3.5	3.3	3.4	3.2	2.9	2.9	2.9	4.2	3.9	3.9

Notes: Amenable mortality rates break in series in 2011.

System characteristics												EU- latest national data		
	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2009	2011	2013
<b>Composition of total current expenditure as % of GDP</b>														
Inpatient curative and rehabilitative care	3.60	3.80	3.89	3.99	3.86	4.10	4.29	4.31	4.21	4.23	4.21	3.13	2.99	3.01
Day cases curative and rehabilitative care	:	:	:	:	:	:	:	:	:	:	:	0.18	0.18	0.19
Out-patient curative and rehabilitative care	2.76	2.87	2.99	3.01	2.93	3.09	3.30	3.33	3.32	3.40	3.39	2.29	2.25	2.24
Pharmaceuticals and other medical non-durables	1.70	1.70	1.70	1.70	1.60	1.60	1.70	1.70	1.60	1.60	1.60	1.60	1.55	1.44
Therapeutic appliances and other medical durables	:	:	:	:	:	:	:	:	:	:	:	0.31	0.31	0.32
Prevention and public health services	0.03	0.04	0.03	0.04	0.04	0.04	0.04	0.04	0.04	0.04	0.25	0.25	0.25	0.24
Health administration and health insurance	0.05	0.04	0.05	0.05	0.05	0.06	0.06	0.06	0.06	0.06	:	0.42	0.41	0.47
<b>Composition of public current expenditure as % of GDP</b>														
Inpatient curative and rehabilitative care	:	:	:	:	:	:	:	:	:	:	:	2.73	2.61	2.62
Day cases curative and rehabilitative care	:	:	:	:	:	:	:	:	:	:	:	0.16	0.16	0.18
Out-patient curative and rehabilitative care	1.89	1.98	2.15	2.16	2.09	2.21	2.42	2.46	2.40	2.47	2.52	1.74	1.71	1.80
Pharmaceuticals and other medical non-durables	0.87	0.91	0.91	0.91	0.86	0.85	0.90	0.90	0.84	0.81	0.81	0.79	1.07	0.96
Therapeutic appliances and other medical durables	:	:	:	:	:	:	:	:	:	:	:	0.13	0.12	0.13
Prevention and public health services	0.03	0.04	0.03	0.04	0.04	0.04	0.04	0.04	0.04	0.04	0.25	0.25	0.20	0.19
Health administration and health insurance	0.07	0.07	0.07	0.08	0.08	0.08	0.09	0.09	0.09	0.12	0.11	0.11	0.27	0.27

Sources: EUROSTAT, OECD and WHO

Table 1.15.2: Statistical Annex - continued – Italy

Composition of total as % of total current health expenditure												EU- latest national data		
	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2009	2011	2013
Inpatient curative and rehabilitative care	45.8%	46.4%	46.5%	47.1%	47.3%	47.9%	47.8%	48.1%	47.7%	47.9%	48.0%	31.8%	31.3%	31.1%
Day cases curative and rehabilitative care	:	:	:	:	:	:	:	:	:	:	:	1.8%	1.9%	1.9%
Out-patient curative and rehabilitative care	35.1%	35.1%	35.8%	35.6%	35.9%	36.1%	36.8%	37.3%	37.7%	38.5%	38.6%	23.3%	23.5%	23.2%
Pharmaceuticals and other medical non-durables	21.7%	20.8%	20.3%	20.1%	19.6%	18.7%	18.9%	19.0%	18.1%	18.1%	18.2%	16.3%	16.2%	14.9%
Therapeutic appliances and other medical durables	:	:	:	:	:	:	:	:	:	:	:	3.2%	3.3%	3.3%
Prevention and public health services	0.4%	0.4%	0.4%	0.4%	0.4%	0.5%	0.5%	0.5%	0.5%	0.5%	2.9%	2.6%	2.6%	2.5%
Health administration and health insurance	0.6%	0.5%	0.6%	0.6%	0.6%	0.7%	0.6%	0.6%	0.7%	0.7%	:	4.2%	4.3%	4.9%
<b>Composition of public as % of public current health expenditure</b>														
Inpatient curative and rehabilitative care	:	:	:	:	:	:	:	:	:	:	:	34.6%	34.1%	34.0%
Day cases curative and rehabilitative care	:	:	:	:	:	:	:	:	:	:	:	2.0%	2.1%	2.3%
Out-patient curative and rehabilitative care	32.0%	31.7%	33.1%	32.8%	33.1%	33.3%	34.4%	35.1%	35.4%	36.3%	37.1%	22.0%	22.3%	23.4%
Pharmaceuticals and other medical non-durables	14.6%	14.7%	14.0%	13.9%	13.6%	12.8%	12.9%	12.8%	12.3%	11.9%	11.9%	10.0%	13.9%	12.5%
Therapeutic appliances and other medical durables	:	:	:	:	:	:	:	:	:	:	:	1.6%	1.6%	1.6%
Prevention and public health services	0.6%	0.6%	0.5%	0.5%	0.6%	0.6%	0.6%	0.6%	0.6%	0.6%	3.7%	3.2%	2.7%	2.5%
Health administration and health insurance	1.2%	1.1%	1.1%	1.1%	1.2%	1.2%	1.2%	1.3%	1.4%	1.7%	1.6%	1.4%	3.5%	3.5%
<b>Expenditure drivers (technology, life style)</b>														
MRI units per 100 000 inhabitants	1.18	1.40	1.48	1.67	1.85	1.97	2.12	2.20	2.36	2.46	:	1.0	1.1	1.0
Angiography units per 100 000 inhabitants	:	:	:	:	1.0	1.1	1.2	1.2	1.2	1.3	:	0.9	0.9	0.8
CTS per 100 000 inhabitants	2.4	2.6	2.8	2.9	3.0	3.0	3.1	3.2	3.2	3.3	:	1.8	1.7	1.6
PET scanners per 100 000 inhabitants	:	:	:	:	0.2	0.2	0.2	0.2	0.2	0.3	:	0.1	0.1	0.1
Proportion of the population that is obese	9.0	:	9.9	10.2	9.9	9.9	10.3	10.3	10.0	:	:	14.9	15.4	15.5
Proportion of the population that is a regular smoker	24.2	:	22.3	23.0	22.4	22.4	23.3	23.1	22.5	22.1	21.1	23.2	22.4	22.0
Alcohol consumption litres per capita	8.6	8.3	7.4	7.3	7.2	6.8	6.4	6.1	:	:	:	10.3	10.0	9.8
<b>Providers</b>														
Practising physicians per 100 000 inhabitants	:	:	:	:	:	:	374	:	:	387	390	329	335	344
Practising nurses per 100 000 inhabitants	:	:	:	:	:	:	:	:	634	641	614	840	812	837
General practitioners per 100 000 inhabitants	82	82	81	80	80	79	78	76	76	76	75	:	78	78.3
Acute hospital beds per 100 000 inhabitants	351	333	331	323	313	302	292	287	276	275	:	373	360	356
<b>Outputs</b>														
Doctors consultations per capita	:	:	6.1	:	:	:	:	:	:	:	6.8	6.3	6.2	6.2
Hospital inpatient discharges per 100 inhabitants	15.2	14.9	14.6	14.4	13.9	13.5	13.2	12.8	12.2	12.1	11.8	16.6	16.4	16.5
Day cases discharges per 100 000 inhabitants	6,309	6,677	6,803	6,649	6,156	5,958	5,414	5,097	4,757	4,350	4,070	6368	6530	7031
Acute care bed occupancy rates	76.0	76.0	77.0	78.0	78.0	78.8	79.4	78.7	78.5	77.5	:	72.0	73.1	70.2
Hospital curative average length of stay	6.7	6.7	6.7	6.7	6.7	6.8	6.7	6.7	6.8	6.8	6.8	6.5	6.3	6.3
Day cases as % of all hospital discharges	29.3	30.9	31.8	31.5	30.7	:	29.0	28.5	28.0	26.4	25.6	27.8	28.7	30.4
<b>Population and Expenditure projections</b>														
<b>Projected public expenditure on healthcare as % of GDP*</b>	2013	2020	2030	2040	2050	2060	Change 2013 - 2060				EU Change 2013 - 2060			
AWG reference scenario	6.1	6.2	6.4	6.6	6.8	6.7	0.7				0.9			
AWG risk scenario	6.1	6.2	6.6	7.0	7.2	7.2	1.2				1.6			
Note: *Excluding expenditure on medical long-term care component.														
<b>Population projections</b>	2013	2020	2030	2040	2050	2060	Change 2013 - 2060, in %				EU - Change 2013 - 2060, in %			
Population projections until 2060 (millions)	60.2	62.1	64.2	66.3	67.0	66.3	10.1				3.1			

Sources: EUROSTAT, OECD and WHO

## Italy

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Long-term care systems

## 2.15. ITALY

### General context: Expenditure, fiscal sustainability and demographic trends

Italy, one of the six founding fathers of the European Union, has a population of almost 60 million inhabitants, which is almost 12% of the total EU population. It makes it the fourth largest country in terms of population, after Germany, France and the United Kingdom. During the coming decades the population of Italy will steadily grow, from 59.7 million inhabitants in 2013 to 66.3 million inhabitants in 2060. This 11% increase is higher than the EU average of 3%.

With a GDP of some EUR 1600 bn (16% of the EU's total GDP), or 25,200 PPS per capita it is lower, though similar, to the EU average of 27,900. Total public expenditure on long-term care is with 1.8% in 2013 <sup>(399)</sup> higher than the EU average of 1.0% in 2012.

### Health status

Life expectancy at birth for both women and men is in 2013 respectively 85.2 years and 80.3 years and is above the EU average (83.3 and 77.8 years respectively). The healthy life years at birth for both sexes are with 60.9 years (women) and 61.8 years (men) similar to the EU average (61.5 and 61.4 respectively). The percentage of the population having a long-standing illness has been increasing through the decade going from 21.6% (2004) to 25.4%, in 2013, and is well below the EU average (32.5% in 2013). On the other hand, the percentage of the population indicating a self-perceived severe limitation in its daily activities has been steadily increasing from 5.6% (2004) to 9.7% (2013), and is above the EU-average (8.7% in 2013).

### Dependency trends

The number of people depending on others to carry out activities of daily living increases significantly over the coming 50 years. From 4.57 million residents living with strong limitations due to health problems in 2013, an increase of 51% is envisaged until 2060 to around 6.89 million. That is a steeper increase than in the EU as a whole (40%). Also as a share of the population, the

dependents are becoming a bigger group, from 7.6% to 10.4%, an increase of 37%, though in line with the EU average (EU: 36%) <sup>(400)</sup>.

### Expenditure projections and fiscal sustainability

With the demographic changes, the projected public expenditure on long-term care as a percentage of GDP is steadily increasing. In the AWG reference scenario, public long-term expenditure is driven by the combination of changes in the population structure and a moderately positive evolution of the health (non-disability) status. The joint impact of those factors is a projected increase in spending of about 0.9 pps of GDP, from 1.8% to 2.7%, by 2060 <sup>(401)</sup>. The "AWG risk scenario", which in comparison to the "AWG reference scenario" captures the impact of additional cost drivers to demography and health status, i.e. the possible effect of a cost and coverage convergence, projects an increase in spending of 1.1 pps of GDP by 2060, from 1.8% to 2.9%. Overall, the projected long-term care expenditure increase is expected to add to budgetary pressure. However, no sustainability risks appear over the long run assuming full implementation of the legislated pension reforms and the structural primary balance <sup>(402)</sup>.

### System Characteristics

Public expenditure on Long Term Care (LTC) basically includes three components: i) LTC services to dependent people provided by the public health care system, ii) the social component of LTC provisions provided by municipalities and iii) attendance allowances (*indennità di accompagnamento*) <sup>(403)</sup>.

The overall expenditure accounts for 1.8 percentage points of GDP in 2013 and refers to all LTC provisions financed by public resources,

<sup>(400)</sup> The 2015 Ageing Report.

<sup>(401)</sup> The 2015 Ageing Report.

<sup>(402)</sup> Fiscal Sustainability Report 2015: [http://ec.europa.eu/economy\\_finance/publications/eeip/pdf/ip018\\_en.pdf](http://ec.europa.eu/economy_finance/publications/eeip/pdf/ip018_en.pdf).

<sup>(403)</sup> Ministero dell'economia e delle finanze - RGS (2015), Le tendenze di medio-lungo periodo del sistema pensionistico e socio-sanitario (Mid-long term trends for the pension, health and long term care systems), Report no. 16. [http://www.rgs.mef.gov.it/\\_Documenti/VERSIONE-I/Attivit-i/Spesa-soci/Attivita\\_di\\_previsione\\_RGS/2015/Rapporto\\_n\\_16\\_10-07-2015.pdf](http://www.rgs.mef.gov.it/_Documenti/VERSIONE-I/Attivit-i/Spesa-soci/Attivita_di_previsione_RGS/2015/Rapporto_n_16_10-07-2015.pdf).

<sup>(399)</sup> The 2015 Ageing Report: [http://europa.eu/epc/pdf/ageing\\_report\\_2015\\_en.pdf](http://europa.eu/epc/pdf/ageing_report_2015_en.pdf).

regardless of the age of recipients. Since the incidence of dependency is strongly linked to age, about 2/3 of the expenditure is directed at the elderly over 65.

The health component of LTC is provided by Regions through the local health authorities (Aziende Sanitarie Locali, ASLs) and accounts for about 45% of the total public expenditure on LTC.

The social component of LTC services includes a heterogeneous group of benefits, largely in kind, mainly provided at a local level by municipalities, directly or in association. These provisions are generally means-tested.

Both health and social LTC provisions include home and residential care services. The admission to LTC services is based on needs but also on income levels: co-payments may play a relevant role and together with the waiting lists tend to shape the users' profile.

Investment in home care is average compared to other countries, although this type of service is fundamentally and informally supported by migrant care workers that are paid directly by families, also through the use of the attendance allowance. This partly explains the fact that investment in residential care is, on the contrary, relatively weak. Nevertheless, the relatively low coverage of residential care may create tensions on public home care provision insofar as severe cases, that could be treated through different forms of residential care (last stages of Alzheimer or other forms of dementia, etc.), might be left at home.

Attendance allowances are based on cash allowance programme for individuals with very severe disability. They are not means-tested. They are run by the *National Institute of Social Security* – *INPS* and financed through general taxation. The attendance allowance accounts for about EUR 500 per month (for 12 months) and is provided directly to the dependent person. Different amounts are foreseen for particular categories of disability such as the blind or the deaf-mute. Italy spent in 2014 the equivalent of 0.90% of its GDP in LTC cash benefits, of which 0.83% of GDP for attendance allowances alone<sup>(404)</sup>. The share of this type of

care was in 2014 about 47% (43% of GDP spent on attendance allowances) of total LTC expenditure<sup>(405)</sup>, nearly 4/5 of which covers the frail elderly over 65.

#### *Administrative organisation*

The actors directly involved in the organisation of LTC services are municipalities, local health authorities - ASLs), nursing homes (*residenza sanitarie assistenziali* - RSAs) and the National Institute of Social Security (*INPS*), but other players are involved in planning and funding these services – i.e. the central state, regions and provinces. Additionally, in Italy individual households play an important role in the organisation and provision of long-term care.

#### *Types of care*

In Italy, public long-term care for older persons includes three main kinds of formal assistance: community care, residential care and cash benefits. The Italian National Health Service (*Servizio Sanitario Nazionale, SSN*) plans and manages, through local health units (*aziende Sanitarie locali*), home health-care services – the so-called 'integrated domiciliary care' (by the *Assistenza domiciliare integrata, ADI*) – and other health services provided in residential settings. Personal social services, both domestic and personal care tasks provided at home (by the *servizi di assistenza domiciliare, SAD*) and institutional social care are managed at a local level by municipalities, although this should be planned in coordination with the ADI. In practice there may be significant differences between different municipalities in terms of spending on care provided. Levels of institutionalisation of patients differs also between regions. Long-term care is delivered by both public and accredited private providers of health and personal social care.

#### *Eligibility criteria*

In Italy there is not a single, national legal definition of persons in need of care to which one can refer.

<sup>(404)</sup> Ministero dell'economia e delle finanze - RGS (2015), Le tendenze di medio-lungo periodo del sistema pensionistico

e socio-sanitario (Mid-long term trends for the pension, health and long term care systems), Report no. 16.  
<sup>(405)</sup> Ministero dell'economia e delle finanze - RGS (2015).



To obtain services in kind for LTC, there is not the same unique system. Indeed, ASLs of the Italian National Health Service are responsible for assessing the degree of disability of citizens living in their catchment area, but their criteria are not homogeneous. For most health and social services, the needs assessments are carried out by a multidisciplinary team of the ASL – in most of them by the geriatric evaluation units (Unità di Valutazione Geriatrica), which include doctors, nurses, social workers and sometimes administrative employees. This team in some cases classifies the claimants into categories of need, sets out the care plan and chooses the type of provider.

However, to obtain the cash benefits provided by the *INPS*, each region refers to the same classification system: a claimant must apply to the Local Health Authority Service (ASL) in charge of deciding whether the health requirements (in terms of disability and dependence) are present, through its medical commission. If this is the case, the claimant is referred to an *INPS* commission, which makes the final decision.

#### *Co-payments, out of the pocket expenses and private insurance*

Neither the access nor the amount of social transfers related to the cash benefits programme (the “Attendance Allowances”) are means-tested. The Attendance Allowance is provided only on the base of needs. The criteria of access to residential and home care are somewhat differentiated in the country as well as the criteria of co-payment. Practically in the whole country means-testing is applied to define the amount of economic resources households have to provide in order to receive the service.

#### *Role of the private sector*

Private providers of long-term care (both for-profit and not-for-profit) have a share of 65% of all institutional long-term care beds.

Private home care is increasingly important in the Italian LTC system, although there are no official data on this aspect. According to the little data available, 6.6% of those aged over 65 (NNA, 2009) received home care privately. Private home care is provided mainly by migrant workers on individual basis: in 2008 it was estimated that

around 700 000 migrant workers were employed to provide home care to elderly persons (NNA, 2009).

#### *Formal/informal caregiving*

Informal care is extremely important in the Italian social protection system, but the data available are limited.

Generally speaking, in northern Italy the culture of public (formal) service in LTC is rather widespread, partly owing to the high level of participation by women in the labour market. These regions – and municipalities – have been making an effort to improve their LTC system, thanks also to their more developed management capabilities and their larger economic resources. In the south, by contrast, the care burden rests mostly on families (informal caregiving), with poor public (formal) support.

#### *Prevention and rehabilitation policies/measures*

Rehabilitative health care services, included in the LTC definition, are provided to disabled people at home or in residences, generally as a part of more general assistance programmes related to dependency.

#### *Recently legislated and/or planned policy reforms*

The Stability law for 2015 (Law 190/2014) and the Stability law for 2016 (Law 208/2015) have increased the Fund for dependents in the State budget (*Fondo per la non autosufficienza*) up to 400 million euro per year and made it permanent as of 2015. Resources in the Fund are transferred to Regions to finance services and benefits in kind for people with severe disabilities.

Furthermore, with the Stability law for 2016 (Law 208/2015), a new Fund (90 million euro per year from 2016) has been set up in the State budget to finance interventions in favour of heavily disabled persons who have no family support. The law which regulates the measures of assistance, care and protection of the disabled is in the process of approval in Parliament.

## Challenges

Italy has a system of LTC that focuses on cash benefits as much as on residential and home care. Based on the current features, the main challenges of the system appear to be:

- **Improving the governance framework:** to establish a coherent and integrated legal and governance framework for a clear delineation of responsibilities of state authorities concerning the provision of long-term care services; to strategically integrate medical and social services via such a legal framework; to define a comprehensive approach covering both policies for informal (family and friends) carers, and policies on the formal provision of LTC services and its financing; to establish good information platforms for LTC users and providers; to deal with cost-shifting incentives across health and care.
- **Improving financing arrangements:** to determine the extent of user cost-sharing on LTC benefits; to include assets in the means-test used to determine individual cost-sharing (or entitlement to public support) for board and lodging costs to better reflect the distribution of economic welfare among individuals.
- **Providing adequate levels of care to those in need of care:** to adapt and improve LTC coverage schemes, setting a homogenous need-level triggering entitlement to coverage; the depth of coverage, that is, setting the extent of user cost-sharing on LTC benefits; to provide targeted benefits to those with highest LTC needs.
- **Supporting family carers:** to establish policies for supporting informal carers, such as through flexible working conditions, respite care, carer's allowances replacing lost wages or covering expenses incurred due to caring, cash benefits paid to the care recipients, while ensuring that incentives for employment of carers are not diminished and women are not encouraged to withdraw from the labour market for caring reasons.
- **Ensuring coordination and continuity of care:** to establish better co-ordination of care pathways and along the care continuum, such as through a single point of access to information, the allocation of care co-ordination responsibilities to providers or to care managers, via dedicated governance structures for care co-ordination and the integration of health and care to facilitate care co-ordination.
- **To facilitate appropriate utilisation across health and long-term care:** to arrange for adequate supply of services and support outside hospitals, changing payment systems and financial incentives to discourage acute care use for LTC; to create better rules, improving (and securing) safe care pathways and information delivered to chronically-ill people or circulated through the system; to steer LTC users towards appropriate settings.
- **Improving value for money:** to invest in ICT as an important source of information, care management and coordination; to invest in assistive devices, which for example, facilitate self-care, patient centeredness, and co-ordination between health and care services.
- **Prevention:** to promote healthy ageing and preventing physical and mental deterioration of people with chronic care; to employ prevention and health-promotion policies and identify risk groups and detect morbidity patterns earlier.
- **Improving administrative efficiency.**

Table 2.15.1: Statistical Annex – Italy

GENERAL CONTEXT																
GDP and Population	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	EU 2009	EU 2010	EU 2011	EU 2012	EU 2013
GDP, in billion euro, current prices	1,391	1,449	1,490	1,549	1,610	1,633	1,574	1,606	1,639	1,615	1,607	9,289	9,545	9,800	9,835	9,934
GDP per capita, PPS	27.4	26.9	27.1	27.8	28.5	27.9	25.6	26.2	26.4	26.1	25.2	26.8	27.6	28.0	28.1	27.9
Population, in millions	57.1	57.5	57.9	58.1	58.2	58.7	59.0	59.2	59.4	59.4	59.7	502	503	504	506	507
Public expenditure on long-term care																
As % of GDP	:	:	:	:	:	:	:	:	:	:	:	1.0	1.0	1.0	1.0	:
Per capita PPS	:	:	:	:	:	:	:	:	:	:	:	297.1	316.7	328.5	317.8	:
As % of total government expenditure	:	:	:	:	:	:	:	:	:	:	:	2.1	2.2	2.2	2.1	:
Note: Based on OECD, Eurostat - System of Health Accounts																
Health status																
Life expectancy at birth for females	82.8	83.7	83.6	84.1	84.2	84.2	84.3	84.7	84.8	84.8	85.2	82.6	82.8	83.1	83.1	83.3
Life expectancy at birth for males	77.3	78.0	78.1	78.6	78.8	78.9	79.1	79.5	79.7	79.8	80.3	76.6	76.9	77.3	77.4	77.8
Healthy life years at birth for females	74.4	71.0	67.8	64.7	62.6	61.8	62.6	:	62.7	61.5	60.9	:	62.6	62.1	62.1	61.5
Healthy life years at birth for males	70.9	68.7	66.6	65.2	63.4	62.9	63.4	:	63.5	62.1	61.8	:	61.8	61.7	61.5	61.4
People having a long-standing illness or health problem, in % of pop.	:	21.6	22.1	21.6	21.2	22.6	21.8	22.5	26.6	24.5	25.4	:	31.4	31.8	31.5	32.5
People having self-perceived severe limitations in daily activities (% of pop.)	:	5.6	6.3	7.1	7.6	8.2	7.9	:	8.8	9.5	9.7	:	8.1	8.3	8.6	8.7
SYSTEM CHARACTERISTICS																
Coverage (Based on data from Ageing Reports)	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	EU 2009	EU 2010	EU 2011	EU 2012	EU 2013
Number of people receiving care in an institution, in thousands	:	:	:	:	165	201	237	273	276	280	294	3,433	3,771	3,851	3,931	4,183
Number of people receiving care at home, in thousands	:	:	:	:	359	498	637	775	782	791	754	6,442	7,296	7,444	7,569	6,700
% of pop. receiving formal LTC in-kind	:	:	:	:	0.9	1.2	1.5	1.8	1.8	1.8	1.8	2.0	2.2	2.2	2.3	2.1
Note: Break in series in 2010 and 2013 due to methodological changes in estimating number of care recipients																
Providers																
Number of informal carers, in thousands	4,035	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:
Number of formal carers, in thousands	407	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:

Source: EUROSTAT, OECD and WHO

Table 2.15.2: Statistical Annex - continued – Italy

PROJECTIONS								
	2013	2020	2030	2040	2050	2060	MS Change 2013-2060	EU Change 2013-2060
<b>Population</b>								
Population projection in millions	59.7	62.1	64.2	66.3	67.0	66.3	11%	3%
<b>Dependency</b>								
Number of dependents in millions	4.57	4.96	5.52	6.17	6.76	6.89	51%	40%
Share of dependents, in %	7.6	8.0	8.6	9.3	10.1	10.4	37%	36%
<b>Projected public expenditure on LTC as % of GDP</b>								
AWG reference scenario	1.8	1.9	2.0	2.2	2.5	2.7	50%	40%
AWG risk scenario	1.8	1.9	2.0	2.3	2.7	2.9	64%	149%
<b>Coverage</b>								
Number of people receiving care in an institution	293,848	319,265	353,596	404,173	471,412	503,845	71%	79%
Number of people receiving care at home	753,533	822,153	915,927	1,042,981	1,197,286	1,258,118	67%	78%
Number of people receiving cash benefits	1,822,500	2,001,718	2,237,299	2,566,758	2,989,562	3,189,472	75%	68%
% of pop. receiving formal LTC in-kind and/or cash benefits	4.8	5.1	5.5	6.1	6.9	7.5	57%	68%
% of dependents receiving formal LTC in-kind and/or cash benefits	62.9	63.4	63.6	65.1	68.9	71.9	14%	23%
<b>Composition of public expenditure and unit costs</b>								
Public spending on formal LTC in-kind ( % of tot. publ. spending LTC)	52.5	51.3	49.7	49.8	49.5	48.6	-8%	1%
Public spending on LTC related cash benefits ( % of tot. publ. spending LTC)	47.5	48.7	50.3	50.2	50.5	51.4	8%	-5%
Public spending on institutional care ( % of tot. publ. spending LTC)	45.1	45.7	46.1	46.8	47.6	48.2	7%	1%
Public spending on home care ( % of tot. publ. spending LTC in-kind)	54.9	54.3	53.9	53.2	52.4	51.8	-6%	-1%
Unit costs of institutional care per recipient, as % of GDP per capita	87.1	85.5	82.4	84.0	84.3	82.8	-5%	-2%
Unit costs of home care per recipient, as % of GDP per capita	41.4	39.4	37.2	37.1	36.5	35.7	-14%	-3%
Unit costs of cash benefits per recipient, as % of GDP per capita	28.1	28.3	28.5	28.6	28.4	28.8	2%	-2%

Source: Based on the European Commission (DG ECFIN)-EPC (AWG), "The 2015 Ageing Report – Economic and budgetary projections for the 28 EU Member States (2013-2060).