ESPN Thematic Report on Inequalities in access to healthcare

Italy

2018

Jessoula, Pavolini, Raitano, Natili
May 2018

EUROPEAN COMMISSION

Directorate-General for Employment, Social Affairs and Inclusion
Directorate C — Social Affairs
Unit C.2 — Modernisation of social protection systems

Contact: Giulia Pagliani

E-mail: Giulia.PAGLIANI@ec.europa.eu

European Commission
B-1049 Brussels

EUROPEAN COMMISSION

European Social Policy Network (ESPN)

ESPN Thematic Report on Inequalities in access to healthcare

Italy

2018

Jessoula Matteo, Pavolini Emmanuele and Raitano Michele with Marcello Natili

Directorate-General for Employment, Social Affairs and Inclusion

2018

The European Social Policy Network (ESPN) was established in July 2014 on the initiative of the European Commission to provide high-quality and timely independent information, advice, analysis and expertise on social policy issues in the European Union and neighbouring countries.

The ESPN brings together into a single network the work that used to be carried out by the European Network of Independent Experts on Social Inclusion, the Network for the Analytical Support on the Socio-Economic Impact of Social Protection Reforms (ASISP) and the MISSOC (Mutual Information Systems on Social Protection) secretariat.

The ESPN is managed by the Luxembourg Institute of Socio-Economic Research (LISER) and APPLICA, together with the European Social Observatory (OSE).

For more information on the ESPN, see:
http:ec.europa.eusocialmain.jsp?catId=1135&langId=en

Europe Direct is a service to help you find answers to your questions about the European Union.

Freephone number (*):

00 800 6 7 8 9 10 11

(*) The information given is free, as are most calls (though some operators, phone boxes or hotels may charge you).

LEGAL NOTICE

This document has been prepared for the European Commission, however it reflects the views only of the authors, and the Commission cannot be held responsible for any use which may be made of the information contained therein.

More information on the European Union is available on the Internet (http:www.europa.eu).

© European Union, 2018
Reproduction is authorised provided the source is acknowledged

Contents

SUMMARY/HIGHLIGHTS 4

1. DESCRIPTION OF THE FUNCTIONING OF THE COUNTRY'S HEALTHCARE SYSTEM FOR ACCESS 5
2. ANALYSIS OF THE CHALLENGES IN INEQUALITIES IN ACCESS TO HEALTHCARE IN THE COUNTRY AND THE WAY THEY ARE TACKLED 8
3. DISCUSSION OF THE MEASUREMENT OF INEQUALITIES IN ACCESS TO HEALTHCARE IN THE COUNTRY 11

ANNEX: TABLES, GRAPHS AND BOXES 12

REFERENCES 18

Summary/Highlights

From an international comparative perspective, the Italian national health system (NHS) can be defined as a well performing healthcare system in terms of health status and healthcare quality, presenting at the same time high levels of inequality in access to care. Therefore, inequalities in access to healthcare (and the reasons behind them) are nowadays one of the most important and urgent problems of the Italian NHS.

The Italian NHS is mostly tax-funded. Although in theory it offers universal coverage, there are problems in providing such coverage effectively. From a legal point of view, universal access to public healthcare is offered to all residents in Italy, including foreign nationals – even undocumented migrants. The central government sets a list detailing the healthcare goods and services available to the population through public funding, known as 'essential levels of care'. Apart from dental care and orthodontics, which are not included in the national benefits package and are mostly covered by the private market, the main health needs are covered by NHS services.

However, the problems are not connected to formal rights, but instead arise for four different reasons: the inadequacy of healthcare funding; the level of co-payments and out-of-pocket (OOP) expenditure; unmet needs and waiting lists for access to healthcare provision; and strong social differences in access to healthcare.

In particular, there are four main types of social inequalities in the Italian NHS, related to: income; geographical location; age; and employment status.

Around 12.6% of those belonging to the first income quintile (the lowest one) in Italy declared in 2016 unmet needs for healthcare (this percentage was much lower - 5.0% - in the EU-28). If the lowest income quintile suffered the most, the second lowest income quintile also showed a worrisome percentage – 6.4% declared unmet needs (2.9% in the EU-28).

Social inequalities in access to healthcare are not only related to income levels but also to geography. Contrary to what happens in other countries, the main territorial divide in Italy is not between rural and urban areas, but between macro-regions – in particular, between northern and southern Italy.

Although there are no significant differences in Italy in access to healthcare on a gender basis, a third type of access inequality is represented by age. The elderly population (aged at least 65) more often encounters problems of access than the younger population. Moreover, the Italian healthcare system has problems in adequately covering chronic and long-term care needs, which mostly affect the elderly population.

Being unemployed exposes people to a higher risk of declaring unmet medical needs in all the EU (5.3% of unemployed vs 1.6% of employed people), but this risk is much higher in the Italian case (11.2% vs 3.4%). The risk of rising inequalities in access also stems from a relatively recent phenomenon: the growth of occupational healthcare, created by social partners' agreements or companies' own decisions. The generosity of occupational healthcare depends strongly on companies' characteristics (size, productivity level, etc.): the growth of occupational funds therefore increases, not reduces, inequalities in access to healthcare.

Although the Italian situation is characterised by severe problems of inequality in access to healthcare, the attempts of national and regional governments to tackle the issue have been limited so far.

A report on the sustainability of the NHS was recently delivered by the Italian Senate. The conclusions of the report underline many of the problems described in these pages.

In order to tackle the problems Italy faces in terms of social inequalities, three recommendations can be put forward. First, there is a need for more economic resources to be poured into the NHS. Second, there is also a need to tackle the problem of governance and the effective use of spending. Third, there is a need for a new policy dealing with NHS personnel.

1. Description of the functioning of the country's healthcare system for access

The Italian healthcare system is a tax-funded national healthcare system (NHS), introduced in 1978, which replaced the previous social insurance healthcare model. Since the 1990s, Italy has strongly decentralised its NHS, organising it around the country's 19 regions and two autonomous provinces. At the national level, the government exercises a stewardship role, controls and distributes the tax-financed health budget, and defines the essential levels of care. Regions are responsible for the organisation, planning and delivery of health services through two different kinds of agencies (local health authorities – *aziende sanitarie locali*, and hospital trusts – *aziende ospedaliere*), and they enjoy substantial autonomy in how they structure their health systems within the general framework established nationally. The coordination of 21 different regional/provincial public healthcare systems has required increasing effort by central and regional governments to improve NHS governance: regional financial coordination and responsibility have both been important achievements of the last decade (CREA, 2016). Regions are financed by the state on a per capita basis, corrected for the age structure of the regional population (given the fact that healthcare expenditure increases on average with individuals' age). At the same time regions have a duty to cover possible healthcare deficits with their own additional taxation.

The organisation of the NHS follows partially different rules in primary care and secondary care. Primary care is mostly provided by self-employed physicians, paid mostly through capitation. Individuals are required to register with a general practitioner (GP), or a paediatrician up to the age of 14, who receives financial incentives to act as a gatekeeper. Specialist and hospital care are predominantly delivered by public providers and partly by accredited private providers.

From an international comparative perspective, what it striking about the Italian NHS is the fact that it can be defined as a well performing healthcare system in terms of health status and healthcare quality (Table 1 – all tables and figures are presented in the Annex), at the same time presenting high levels of inequality in access to care. The core issue discussed in the present thematic report is therefore of fundamental importance to an understanding of the Italian healthcare system and how to improve it. In other terms, inequalities in access to healthcare (and the reasons behind them) are nowadays one of the most important and urgent problems of the Italian NHS.

On the one hand, the Italian Senate (2018), the OECD (OECD-MH, 2016) and the World Health Organization (WHO, 2016) have all underlined the fact that Italy is among the top world performers in terms of years of life expectancy (only second to Japan), years of health living (only second to Singapore), low adult mortality rates for all causes, and neonatal mortality rates. Moreover, the same studies underline that there have been major improvements in these indicators since the early 1990s. Italian national monitoring systems provide a similar picture: the 'healthcare outputs and outcomes programme' ('*piano nazionale esiti*') has been implemented, and the yearly results are published in a transparent way on the website of the health ministry in order to allow patients, professionals and policy makers to have a clearer view of their local healthcare system[1]. This programme monitors how a whole range of healthcare provision functions in terms of timing, waiting times, appropriateness and efficacy: the results of the latest monitoring results showed a significant improvement for most indicators (e.g. caesarean birth rates and survival rates for myocardial infarction) between 2010 and 2017 (Ministry of Health, 2017).

[1] The website is: http://www.salute.gov.it/portale/temi/p2_6.jsp?lingua=italiano&id=2905&area=programmazioneSanitariaLea&menu=vuoto.

On the other hand, although in theory the Italian NHS offers universal coverage, a series of indicators and phenomena show that there are problems in providing such coverage effectively. From a legal point of view, universal access to public healthcare is offered to all residents in Italy, including foreign nationals. Refugees and undocumented migrants have the same right to access to healthcare services as everyone else: the Italian constitution (art. 32) as well as the Law n° 286/1998 (art. 34 and art. 35) recognise health as a fundamental individual right not bound to citizenship or residence (regular or irregular).

The central government sets a list detailing the healthcare goods and services available to the population through public funding known as 'essential levels of care' (*livelli essenziali di assistenza*). Services not included in the essential levels of care can be provided if financed by regions. Apart from dental care and orthodontics, which are not included in the national benefits package and are mostly covered by the private market, the main health needs are covered by NHS services. The NHS only offers partial coverage in dental care for children under 15 years and vulnerable groups (mostly low-income patients).

However, the problems are not connected to what is legally prescribed by NHS legislation, but instead arise for four different reasons: the inadequacy of healthcare funding; the level of co-payments and out-of-pocket (OOP) expenditure; unmet needs and waiting lists for access to healthcare provision; and strong differences in access to healthcare. The first three issues are discussed in the present section. The last one is discussed in more detail in the next one.

Before discussing these topics, it is important to draw attention to an important, potentially far-reaching, change that has started to take place in Italy in the last decade: the growth of a second pillar of protection in healthcare, created by social partners' agreements or companies' own decisions. So-called 'occupational welfare', as Titmuss (1958) defined it 60 years ago, has become increasingly important in the Italian healthcare system. Occupational healthcare funds were almost non-existent in the 1990s: but they have since increased dramatically, especially since the mid-2000s, covering around 43% of total employees in 2018 (Ascoli et al., 2018). Such a figure is not only high compared with Italian occupational pensions coverage, but also when compared with the role occupational schemes have in healthcare in other European countries (Natali and Pavolini, 2018). The expansion of occupational healthcare funds can be explained on different grounds: among the main reasons are the cuts to NHS expenditure during the last decade, the relatively low level of public expenditure compared with other western European countries, and the high share of OOP expenditure (see Tables 2 and 3, and Figure 1). In such a situation, many workers, trade unions and employers have agreed to create and to foster their own healthcare funds in order to substitute for public healthcare funding and provision.

1.1 Adequacy of healthcare funding

Italy has been able to obtain the performance results described above despite the fact that it has a public healthcare model which is less expensive than the average one found in western Europe. Looking at the amount of public resources devoted to the healthcare system, Italy spends less than the EU average, especially compared with the 'old' EU-15. Per capita public expenditure on health (at purchasing power parity, PPP) was in 2016 equal to 1,952 euros – around 32% lower than the EU-15 average (Table 2). At the beginning of the 2000s the gap was more limited, at around 13%. Italy is one of the few EU countries where between 2005 and 2016 the average annual growth rate of public expenditure on health in real terms was negative (-0.2%): in the rest of western Europe it increased yearly by 1.8% (Table 3). Cuts in healthcare public expenditure were visible in the period between 2008 and 2014, especially after 2010: the annual growth rate of expenditure on public healthcare in real terms was on average -2.4% between 2010 and 2014. Cuts affected mostly hospital care expenditure and personnel costs (thanks to the stop on new hiring since 2010).

It is hard to foresee the NHS being able to maintain the good levels of performance it has reached (see Table 1) with such limited resources, unless the high level of inequalities in access to healthcare can be considered an acceptable feature of its functioning.

1.2 Affordability of health expenditure and depth of coverage

The relatively low level of public expenditure on healthcare in Italy is linked to the fact that the country has the highest share of OOP in total health expenditure in Western Europe. Cost-sharing applies to some services. In particular, co-payments are levied on outpatient specialist visits, on diagnostic procedures, and on medicines with full or partial reimbursement[2], in all those cases when referred by a GP. Regions determine the levels of co-payments. Specific groups, such as people over 65, pregnant women or individuals on low income, are exempted from these user fees or pay reduced fees.

In 2016 OOP expenditure accounted for 22.7% of total current health expenditure (Figure 1). This was higher than in all other NHS systems in western Europe, except for Spain, and started to increase again from the mid-2000s.

As stated above, co-payments are mainly used in outpatient care. In relation to inpatient care, the share of co-payment is extremely low (below 1% of expenditure) and among the lowest found in the EU. Conversely, the share of expenditure in outpatient care through co-payments is among the highest found in the EU-15 (together with the other southern European countries) (EC, 2017).

Italy increased co-payments during the austerity years (CREA, 2016; AGENAS, 2017). However, the situation has improved in recent years in this respect: the Italian Court of Auditors (Corte dei Conti, 2018) has shown that between 2012 and 2016 overall expenditure on co-payments decreased by 13% (from around 1.5 billion euros to 1.3 billion – in 2016 co-payments represented the equivalent of 1.1% of total healthcare public expenditure). What happened was a strong initial increase in 2012 and 2014 and then a drop afterwards. Most co-payments are paid directly OOP by individuals and households.

There is no evidence of a serious problem in Italy of *informal, under-the-table payments*, based on data from the recent Eurobarometer survey (Eurobarometer, 2017). Just 4% of respondents said that they had given an additional payment or valuable gift to a nurse or doctor, or make a hospital donation, in the previous 12 months, the same as the EU-28 average, and this figure is stable over time (it was the same as that for 2013).

The main weaknesses of the public healthcare basket are related to pharmaceuticals and dental care. As Table 4 shows, in 2015 almost 8% of individuals reported an unmet need for dental care on grounds of cost in the previous 12 months, and 4.4% in the case of pharmaceutical products. At the same time, only around 46% of individuals declared in 2015 they went to a dental care visit – around 15 points below the EU-28 average (60.1%) (Table 5). Most dental care is offered by private providers (around 87% of individuals) and in most cases such care is covered entirely through OOP expenditure (80%) (Table 7).

1.3 Unmet needs and waiting lists in access to healthcare provision

Eurostat's latest available estimations for 2016 show that 5.5% of Italians reported an unmet need for medical care, either for economic reasons (too high co-payments and fees), waiting lists or travel distance (Figure 2). This share is more than twice as high as the EU average, and since 2007 the gap has increased considerably (data not shown in the figure).

[2] The majority of regions introduced or, more often, increased co-payments on pharmaceuticals in 2012, as well as user fees for emergency services that are deemed inappropriate.

The only good news about the Italian situation is that the share of Italians with unmet needs fell in 2016 to levels similar to those for 2008-2012, whereas between 2013 and 2015 it had reached 7%.

If we use Eurostat EU-SILC data, the reasons for unmet medical need are mostly connected to costs and not to travel distances and waiting lists (Table 8). In respect of travel distance and waiting lists, the results for Italy are practically the same as those for the EU as a whole.

However, if we examine other national data (ISTAT, 2018), neither waiting lists (Table 10) nor, to some extent, travel distances (Table 11) seem to be non-negligible problems, especially the former. Around 30% of those who accessed medical care services in 2015 in Italy declared they had problems with waiting lists (Table 10) and 10% reported unmet needs due to travel distances (Table 11). Although it is not possible to explain the differences between the EU data and the ISTAT data, the latter seem more in line with the expected impact of austerity policies and cuts on personnel in the last ten years.

2. Analysis of the challenges in inequalities in access to healthcare in the country and the way they are tackled

The NHS presents four main types and forms of inequality in access to care, as follows.

- Inequalities related to income
- Inequalities related to geographical location
- Inequalities related to age
- Inequalities related to position in the labour market

2.4 Inequalities related to income

Eurostat's latest available estimations (EU-SILC for 2016) show that the percentage of Italians reporting unmet medical need for economic reasons (too high co-payments and fees) was particularly high for lower-income households and individuals (Table 9): around 12.6% of those belonging to the first income quintile in Italy declared unmet need (this percentage was much lower - 5.0% - in the EU-28). If the lowest income quintile suffered the most, the second-lowest income quintile also showed worrisome data: 6.4% (2.9% in the EU-28) declared unmet need. Only for the highest quintile was the figure in line with the EU-28 average. The CREA report (2016) describes this situation as the 'crisis of the (NHS) universalism', with the middle classes paying the highest price for austerity policies in healthcare.

Other data contained in various tables in the appendix confirm the role of personal and household income in influencing ease of access to healthcare. Table 4 shows that 12% of Italians reported in 2015 unmet healthcare needs of various kinds in the previous year (from medical care to dental care to pharmaceutical products): this percentage reached 20.3 in the first income quintile and it was still as high as 15% in the second one. Income strongly affects the likelihood of accessing dental care services (Table 6).

2.5 Inequalities related to the geographical dimension

Social inequalities in access to healthcare are related not only to income levels but also to geography. Contrary to what happens in other countries, the main territorial divide in Italy is not between rural and urban areas, but between macro-regions – in particular, northern and southern Italy.

All studies quoted so far report that southern Italian regions do less well in terms of healthcare performance, and tend to impose higher co-payments on their residents. The latest 'Osservasalute Report' (2018) shows that health and healthcare differences are particularly strong between southern and northern Italy. For example, there is a two-

years gap in terms of life expectancy between Campania (south) and Trentino-Alto-Adige (north). It is hard to provide an explanation for such a wide gap. It is not simply related to public healthcare per capita spending: several analyses have shown that even if the expenditure were exactly the same, the performance of most southern Italian regions in healthcare would still be worse than northern Italian ones. What seems to explain a good part of the north-south difference is the worse administrative and organisational capacities of southern regional and local administrations compared with the northern ones, in terms of their ability to manage healthcare efficiently and effectively (Pavolini, 2011).

The data shown in several tables illustrate the magnitude of this north-south gap. The ISTAT (2017) survey on health conditions and use of healthcare in Italy underlines that the number of individuals in southern Italy declaring unmet healthcare needs in 2015 was double than in northern Italy (Table 4). In particular, whereas 4.7% of individuals living in northern Italy declared unmet medical care needs, 9.4% of individuals living in southern Italy declared the same problem. In relative terms, the gap in unmet needs is even more evident for pharmaceutical products (2.5% versus 6.8%). Overall, 16.2% of southern Italians declared at least one type of unmet healthcare need, whereas this percentage was 8.4% in northern Italy. Central Italy found itself in-between, closer to southern Italy – a relatively new phenomenon, given that it has traditionally been closer to northern Italy (Pavolini, 2011).

There was also a wide gap in 2015 between the share of Italians accessing dental care by macro-region: around 52% in northern Italy and around 36% in southern Italy (Table 6). Waiting lists and problems of travel distance to healthcare centres were also more prevalent in southern (and central) Italy than in northern Italy (respectively Tables 10 and 11).

The healthcare access problems of the Italian NHS that are highlighted in this report have become quite common knowledge. Findings by the Parliament (Senate, 2018) as well as research institutes (e.g. Osservasalute, 2018) all point in the same direction of a gap between northern and southern Italy. The size of this territorial gap between macro-regions within the same country is not found in any other demographically large country in the EU (Pavolini, 2016).

In relation to this last point, it is important to look at Tables 12 and 13, which show territorial differences in relation to secondary prevention (Table 12) and cancer survival rates (Table 13) in the three main Italian macro-regions. Three main observations can be deduced from the information included in the two tables. First, they confirm that the gap is wide between northern and southern Italy. Second, inequalities in access to healthcare by geographical location can intertwine with inequalities based on social class, as shown by the higher disparity in southern Italy between the share of highly educated women receiving mammography and that of low-educated women. Third, some indicators, but not all of them (especially in secondary prevention), show that a reduction of the territorial gap in access to healthcare took place between 2005 and 2015.

2.6 Inequalities related to age

While there are no significant differences in Italy in access to healthcare based on gender, a third type of access inequality is represented by age. Information contained in several tables show that the elderly population (aged at least 65) encounters problems of access slightly more often than the younger population. This is the case for: unmet needs for medical care and, especially, pharmaceutical products (Tables 4 and 9); the costs for accessing dental care (Table 7); the presence of waiting lists problems and travel distance problems (respectively Tables 10 and 11.

Moreover, what these data do not show is the fact that the Italian healthcare system has problems in adequately covering chronic and long-term care needs, which affect mostly the elderly population. Information on this specific issue is available in a previous ESPN thematic report on long-term care (Jessoula et al., 2018).

2.7 Inequalities related to position in the labour market

Given the fact that the Italian healthcare system is a national one, based on the principle of universal coverage for all residents, independent of their specific socio-economic characteristics, we should theoretically expect that inequalities in access to healthcare should not be related to the position of individuals in the labour market. The strength of income inequalities described above has already proven that this theoretical assumption does not totally hold. Table 9 shows that being unemployed in Italy exposes people to a higher risk of unmet medical needs than that of people in employment – at 11.2%, it is four times higher (the EU average is 5.3%, versus 1.6% among employed persons).

The risk of rising inequalities in access to healthcare related to labour market position depends also on the growth of the second pillar of protection in healthcare: 'occupational welfare'. The generosity of occupational welfare schemes, with large companies in high-productivity economic sectors (finance, export-oriented manufacturing industries, etc.) more likely to offer generous healthcare plans to their (skilled) workers than small or medium-sized companies in economic sectors with lower productivity levels (Natali and Pavolini, 2018). The growth of such funds in Italy is therefore increasing, not reducing, socio-occupational inequalities in access to healthcare.

Although the Italian situation is characterised by severe problems of inequality in access to healthcare (by social class, geographical location, age, and employment status), the attempts by national and regional governments to tackle the issue have so far been limited. In January 2017, the government approved an updated version of the publicly financed benefit package – the essential levels of care – based on epidemiological and demographic needs. The list of services was extended to include new vaccinations and neonatal screenings. An updated list has been produced of chronic and rare diseases that are exempt from cost-sharing. Whether the essential levels of care are actually being delivered to the population is also monitored more closely than in the past following a strengthening of the 'eHealth' and health information infrastructure in recent years.

The 2014 'pact for health' went a step further towards care integration, requiring regions to establish 'primary care complex units' comprising GPs, specialists, nurses and social workers.

However, the overall conclusion is that Italy has not so far given itself a specific and detailed plan for tackling social inequalities in access to healthcare, either in general or in relation to specific types of social inequality (income, age, etc.). The issue does not seem high on the public agenda and it is often masked by more general problems of either fiscal austerity in the public sector (cuts to expenditure, including healthcare) or social inclusion (rising poverty problems in Italian society).

At the same time, it must be underlined that an important report was recently delivered by an institutional commission of the Italian Senate on the sustainability of the NHS, which had a 'particular focus on how to ensure the principles of universality, solidarity and equity' (Italian Senate, 2018). The conclusions of the Report are important because, on the one hand, they practically underline many of the problems for a universal NHS described in these pages, and on the other, they offer valuable policy recommendations.

The Senate report was delivered just a few weeks before the end of the parliamentary mandate, and the new parliament has a totally different composition in terms of political parties. It will be important to see if the new government intends to use the report to start a new discussion on what has to be done in order to tackle inequalities in access to healthcare in Italy more effectively.

In order to tackle the problems Italy faces in terms of social inequalities in access to healthcare, at least three recommendations can be formulated, mostly in line with the Italian Senate report.

First, there is a need for more economic resources to be poured into the NHS. This could help to reduce the pressure on individuals (with a decrease of OOP expenditure and co-payments) and social partners (with a less central role for occupational healthcare), and

reduce inequalities in access. The expenditure cuts and the slow growth registered in recent years (see Tables 2 and 3) risk increasing inequalities in the Italian NHS, and jeopardising in the short and medium term not just the principle of universality but also the stability and functioning of the whole system. Italy is losing ground compared with its main EU partners in this respect.

Second, it is not just an issue of investing more resources. There is also a problem of governance and spending in a more effective way. Part of the gap between southern and northern Italy described in the present section is not simply generated by lower expenditure in the south but by more complex problems related to how the NHS is run at the regional level. Southern regions often have public healthcare systems that are less efficient and effective than northern ones (Pavolini, 2011). Within a quasi-federalist institutional framework, the central government should strengthen its capacity to support and to guide those regional healthcare systems that have more problems in being effective.

Third, there is a need for a new policy dealing with NHS personnel. Italy has a major problem of an ageing workforce in healthcare (please also see on this issue the ESPN country profiles on Italy). The limited number of new professionals entering the NHS in recent years, as a consequence of the austerity measures, is creating an NHS workforce shortage, which in turn leads to problems in terms of waiting lists and increasing difficulties in tackling healthcare needs. A massive recruitment plan for healthcare professionals is much needed.

3. Discussion of the measurement of inequalities in access to healthcare in the country

As this report shows, there are already enough available data in order to provide an in-depth assessment of inequalities in access to healthcare in Italy. Combining different sources (Eurostat, ISTAT, OECD, Ministry of Health, etc.) can offer a good view of what is happening and where the main problems lie in relation to inequalities in access.

The Ministry of Health has also been improving the flows of administrative data that can be used in order to analyse and to tackle inequalities.

The main indicator used by Eurostat for international comparison (the EU-SILC set of questions on perceived unmet personal needs) is important and valuable because it ensures comparative information over time and across countries. However, as the comparison with similar data provided by ISTAT shows, there are issues as to how the questions are framed, and there is a possibility that the issue of waiting lists might be underestimated.

It is important for Eurostat to improve the gathering and coordination of national statistical offices (and Ministries of Health) in order to collect more administrative comparative data (not only survey ones) on different types of inequality, starting with information on waiting lists and co-payments.

Annex: Tables, graphs and boxes

Table 1: Health status and healthcare in Italy in comparison with EU-15 countries over time (2000 and 2016 or most recent year)

	Italy		EU-15 (unweighted average)	
Health status	2000	2015-16	2000	2015-16
Life expectancy at birth – females (years)	82.8	85.6	81.2	84.3
Life expectancy at birth – males (years)	76.9	80.7	75.1	79.3
Life expectancy at 65 – females (years)	20.7	22.8	19.7	22.0
Life expectancy at 65 – males (years)	16.7	19.2	15.8	18.6
All causes of death – deaths per 100,000 population (standardised rates)	870.3	708.9	963.5	744.8
Infant mortality - deaths per 1,000 live births	4.1	2.8	4.4	3.2
Healthcare expenditure (2016 data)				
Public expenditure on health, per capita, US$ purchasing power parities, constant prices	1,949	2,248	2,132	3,151
Out-of-pocket expenditure on health, % of current expenditure on health	26.5	22.7	16.4	17.6
Healthcare activities				
Average length of stay in hospital, all causes, days	7.5	7.8	8.1	7.1
Discharge rates - all causes, per 1,000 population	173	120	161	158
Healthcare quality indicators				
Thirty-day mortality after admission to hospital for acute myocardial infraction (AMI)	9.1	5.5	n.a.	7.2
Thirty-day mortality after admission to hospital for hemorrhagic stroke	21.0	19.6	n.a.	22.9
Thirty-day mortality after admission to hospital for ischemic stroke	8.3	6.2	n.a.	8.0

n.a.: not available. Based on OECD Health Statistics online database (2018).

Table 2: Public health expenditure per capita in Italy as a percentage of the average EU-15 public health expenditure per capita over time, in PPP (2000-2016)

2000	2005	2010	2016
91%	90%	83%	69%

Based on OECD Health Statistics online database (2018). PPP = purchasing power parity.

Table 3: Annual growth rate of public expenditure on health, in real terms, in Italy in a comparative perspective (2005-2016, %)

	2005-2008	2008-2009	2009-2010	2010-2011	2011-2012	2012-2013	2013-2014	2014-15	2015-16	2005-2016
Italy	+1.2	-0.6	+1.3	-2.8	-3.0	-3.1	-0.9	+0.3	+0.6	-0.2
EU-14	+3.3	+4.3	+0.3	-0.7	0.0	-0.3	+0.9	+1.0	+1.5	+1.8

EU-14: Greece excluded. Based on OECD Health Statistics online database (2018).

Table 4: Self-reported unmet need for medical and dental care due to costs by type of provision in Italy (2015, %)

	Medical care	Dental care	Pharmaceutical products	A least one type of need
Total	7.0	7.9	4.4	12.0
Individuals aged 65+	7.7	7.0	6.1	12.8
Northern Italy	4.7	5.7	2.5	8.4
Central Italy	9.8	7.6	6.7	15.8
Southern Italy	9.4	11.0	6.8	16.2
First quintile	12.2	13.9	7.1	20.3
Second quintile	9.2	9.7	5.6	15.0
Third quintile	5.9	6.1	3.6	10.2
Fourth quintile	4.1	5.7	3.0	7.8
Fifth quintile	4.2	4.8	3.1	7.6

Source: Based on ISTAT (2017).

Table 5: Individuals declaring they went to a dental care visit in the previous 12 months by age (2015, %)

	15-64	65+	Total
Italy	49.0	36.1	45.8
EU-28	62.5	51.5	60.1

Source: Based on ISTAT (2017).

Table 6: Individuals declaring they went to a dental care visit in the previous 12 months by geographical location and income quintile in Italy (2015, %)

	Total
Northern Italy	52.1
Central Italy	45.3
Southern Italy	36.3
First quintile	34.2
Second quintile	39.0
Third quintile	43.8
Fourth quintile	51.9
Fifth quintile	55.8

Source: Based on ISTAT (2017).

Table 7: Individuals declaring they went to a dental care visit in the previous 12 months by age and type of provider (2015, %)

	Public provider	Private provider	Share of individuals who have paid dental care entirely out-of-pocket
Total	11.7	86.9	80.0
Individuals aged 65+	9.5	88.8	81.6

Source: Based on ISTAT (2017).

Table 8: Self-reported unmet need for medical care by specific reason (2016, %)

	Too expensive	Too far to travel	Waiting lists	Total
Italy	4.9	0.1	0.5	5.5
EU-28	1.6	0.1	0.8	2.5

Source: Based on Eurostat online database (2018).

Table 9: Self-reported unmet needs for medical examination for reasons related to costs, distance or waiting times by income quintile, age and labour market participation (2016, %)

	EU-28	Italy
First quintile	5.0	12.6
Second quintile	2.9	6.4
Third quintile	2.3	5.5
Fourth quintile	1.5	2.8
Fifth quintile	1.1	1.1
Individuals aged 15-64	2.2	5.1
Individuals aged 65+	3.3	6.6
Employed person	1.6	3.4
Unemployed	5.3	11.2

Based on Eurostat EU-SILC online database (2018).

Table 10: Self-reported unmet need for medical care due to waiting lists in Italy by age and geographical location (2015, %)

	Yes, waiting list	No waiting list	No unmet need	No answer	Total
Total	15.9	37.4	45.2	1.5	100.0
Individuals aged 65+	22.2	51.9	25.0	0.9	100.0
Northern Italy	13.3	42.0	43.4	1.3	100.0
Central Italy	19.2	34.8	44.7	1.2	100.0
Southern Italy	16.8	31.1	50.3	1.8	100.0

Source: Based on ISTAT (2017).

Table 11: Self-reported unmet need for medical care due to travel distance in Italy by age and geographical location (2015, %)

	Yes, travel distance problems	No travel distance problems	No unmet need	No answer	Total
Total	5.0	47.5	46.2	1.3	100.0
Individuals aged 65+	8.1	65.0	25.9	1.0	100.0
Northern Italy	2.5	52.0	44.3	1.2	100.0
Central Italy	7.1	45.6	46.1	1.2	100.0
Southern Italy	6.6	40.4	51.4	1.6	100.0

Source: Based on ISTAT (2017).

Table 12: Share of individuals accessing several types of healthcare prevention examinations by geographical location (1994 and 2013)

	Share of women 40+ doing mammography (%)		Ratio of women with tertiary education receiving mammography to women with low education doing mammography		Share of individuals 50% undergoing tests for hidden blood in faeces (%)	Share of individuals 50% undergoing colorectal examinations (%)
	1994	2013	1994	2013	2013	2013
Northern Italy	43.5	76.1	2.44	1.32	31.1	17.5
Central Italy	42.8	71.9	2.68	1.63	21.1	15.6
Southern Italy	25.1	52.1	3.01	2.09	6.7	7.8
Difference, north-south	+18.4	+24.0	-0.57	-0.77	+24.4	+9.6
Difference, north-centre	+0.7	+4.2	-0.24	-0.32	+10.0	+1.9

Source: Based on ISTAT Health for All online database (2018).

Table 13.1: Cancer survival rates after 5 years of the diagnosis by geographical location (2005 and 2015, %)

	Lungs - Male		Lungs - Female		Cervix	
	2005	2015	2005	2015	2005	2015
Northern Italy	15.0	20.5	19.0	27.7	69.4	71.7
Central Italy	13.3	15.7	19.7	25.9	67.5	69.5
Southern Italy	13.6	21.2	16.3	17.3	60.2	62.7
Difference, north-south	+1.4	-0.7	+2.7	+10.4	+9.2	+9.0
Difference, north-centre	+1.7	+4.8	-0.7	+1.8	+1.9	+2.2

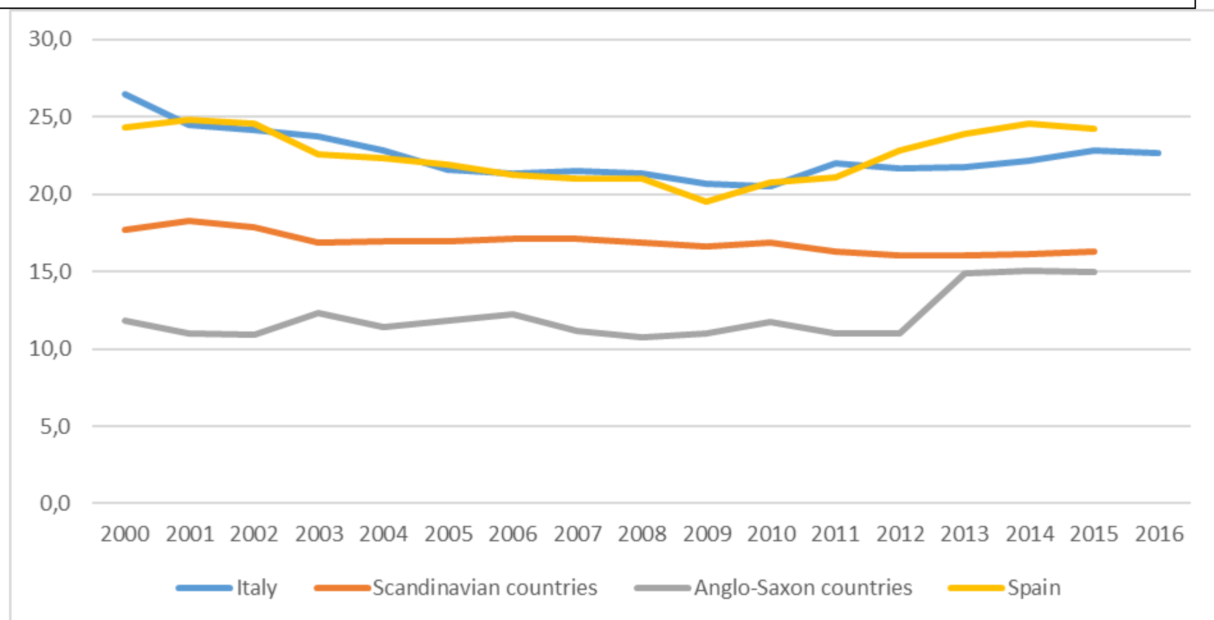
Source: Osservasalute (2018).

Table 13.2: Cancer survival rates after 5 years of the diagnosis by geographical location (2005 and 2015, %)

	Colorectal - Female		Colorectal - Male		Breast	
	2005	2015	2005	2015	2005	2015
Northern Italy	65.6	73.7	64.9	73.3	87.4	90.9
Central Italy	66.7	74.7	66.6	74.4	89.0	92.7
Southern Italy	59.6	68.5	58.1	67.6	85.2	90.5
Difference, north-south	+6.0	+5.2	+6.8	+5.7	+2.2	+0.4
Difference, north-centre	-1.1	-1.0	-1.7	-1.1	-1.6	-1.8

Source: Osservasalute (2018).

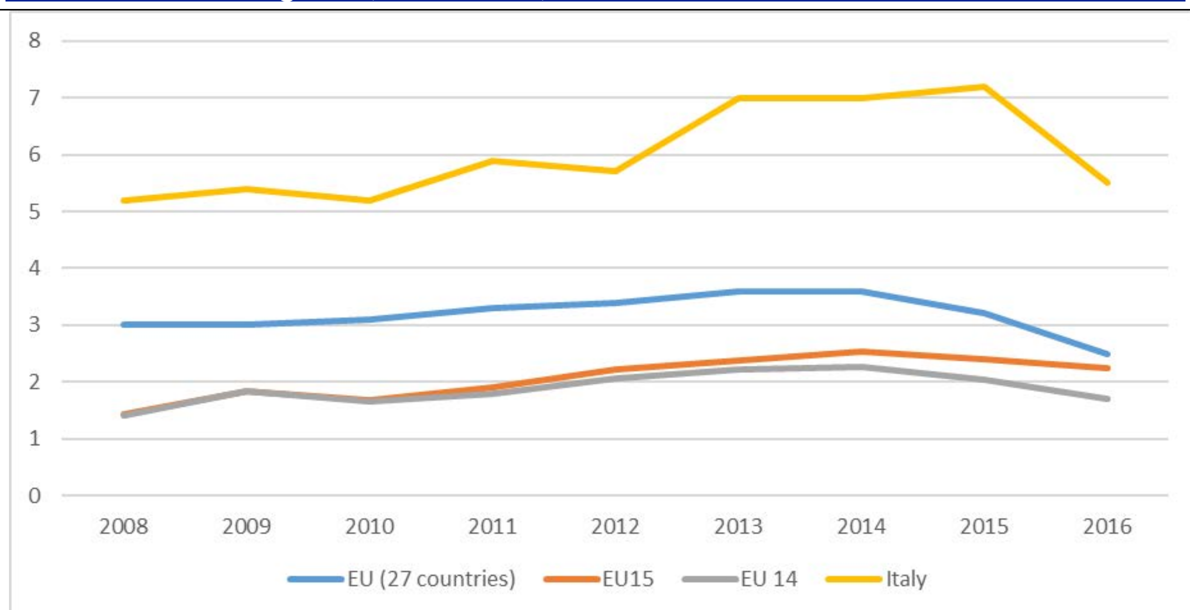
Figure 1: Out-of-pocket expenditure, % of current expenditure on health (2000-2016)



Scandinavian countries: Sweden, Finland, Denmark and Norway; Anglo-Saxon countries: the UK and Ireland

Source: Based on OECD Health Statistics online database (2018).

Figure 2: Self-reported unmet need for medical care due to costs, travel distance or waiting list (2008-2016)



Source: Based on Eurostat online database (2018).

References

AGENAS, *Andamento della spesa sanitaria. Approfondimento sul confronto delle voci di entrata riferibili a ticket ed intramoenia, anni 2012-2015* [The evolution of healthcare expenditure. A focus on co-payments, years 2012-2015], AGENAS, Rome, 2017.

Ascoli, U., Natali, D. and Pavolini, E., 'Still a weak occupational welfare in Southern Europe? Evidence from the Italian case', in *Social Policy & Administration*, DOI: 10.1111/spol.12382, 2018.

Court of Auditors [Corte dei Conti], *Referto al Parlamento sulla gestione finanziaria dei servizi sanitari regionali. Esercizio 2016* [Report to the Parliament on the financial management of the regional healthcare systems], Rome, 2018.

CREA (Consortium for economic research in healthcare), *12th Health Report*, CREA Università Tor Vergata, Roma, 2016.

EC – European Commission, *Note on out-of-pocket payments in the context of the Joint Assessment Framework in the Area of Health*, Brussels, 23 October 2017.

Eurobarometer (2017), *Special Eurobarometer 470: Report – Corruption*, Wave EB88.2.

ISTAT, *Condizioni di salute e ricorso ai servizi sanitari in Italia e nell'Unione Europea – Indagine EHIS 2015* [Health conditions and access to healthcare provision. The EHIS 2015 Survey], ISTAT, Rome, 2017.

Italian Senate (2018), *Documento conclusivo dell'indagine conoscitiva sulla sostenibilità del servizio sanitario nazionale con particolare riferimento alla garanzia dei principi di universalità, solidarietà ed equità approvato dalla Commissione* [Final Report on the Sustainability of the Italian NHS], January 2018.

Jessoula, M., Pavolini, E., Raitano, M. with Natili, M., *ESPN Thematic Report on challenges in long-term care: Italy*, 2018.

Ministry of Health (MH), *Piano Nazionale Esiti* [Healthcare Outputs and Outcomes Monitoring Programme], Roma, 2017.

Natali, D. and Pavolini, E. with Vanhercke, B. (eds), *Occupational Welfare in Europe. Risks, Opportunities and Social Partners Involvement* Brussels, European Trade Union Institute and European Social Observatory, 2018.

OECD-MH, *Revisione OCSE sulla qualità dell'assistenza sanitaria in Italia. Sintesi dei dati* [OECD review on the quality of healthcare in Italy. Data summary], 2016.

Osservasalute, *Rapporto Osservasalute 2017: Stato di salute e qualità dell'assistenza nelle regioni italiane* [Osservasalute Report 2017 on health and healthcare situation in the Italian regions], Osservasalute, Rome, 2018.

Pavolini, E. (ed.), *Il cambiamento possibile. La Sanità in Sicilia fra Nord e Sud* [The potential change. Healthcare in Sicily between Southern and Northern Italy], Roma, Donzelli, 2011.

Pavolini, E., 'How many Italian welfare states are there?', in Ascoli, U. and Pavolini, E. (eds), *The Italian Welfare State in European Perspective: A Comparative Analysis*, Bristol, Policy Press, 2016.

Titmuss, *Essays on the Welfare State*, London, Allen and Unwin, 1958.

WHO (World Health Organisation), *World Health Statistics 2016*, 2016.