How does Italy’s health sector contribute to the economy?
Health matters. The health sector is an important and innovative industry, as well as a source of stable employment for many people. Health systems support active and productive populations, reduce inequities and poverty, and promote social cohesion. A strong health system makes good economic sense and underpins the overall sustainable development agenda.

Countries around the world are grappling with the health, economic and fiscal implications of the COVID-19 pandemic. As they begin to recover from the crisis, difficult decisions will need to be made about how to allocate scarce resources. These snapshots share valuable evidence for policy-makers on how investing in health sectors and health systems helps to achieve national economic objectives.
How does Italy’s health sector contribute to the economy?

Although the health sector makes up a relatively moderate share of the Italian economy, a range of health-related industries provide opportunities for growth.

Spending on health is lower in Italy compared to many neighbouring western European Union (EU) countries. In 2019, overall health spending accounted for 8.7% of total gross domestic product (GDP), well below France (11.1%) and Germany (11.7%), slightly below Spain (9.1%) and Finland (9.2%), but above the EU average of 8.3% (Fig. 1) (WHO, 2021).

The health share of the government budget, reflecting the priority given to health, has gradually decreased since the 2008 economic crisis. From its peak of 14% in 2010, it fell to 13.2% in 2019, on a par with Lithuania (13.2%) and Portugal (13.6%), but behind 12 of the EU28, as seen in Fig. 1. In terms of current health expenditure per person, at US$ 3998 purchasing power parity (PPP), Italy spends less than Germany (US$ 6739 PPP) and France (US$ 5493 PPP) but is comparable to the EU average (US$ 3971 PPP) (WHO, 2021).

Public spending on health has been reinforced in response to the COVID-19 pandemic. For example, €25 billion of emergency funds were allocated to health in the 2020–2021 budget to support service delivery. In May 2020, the government adopted a “Relaunch” package with a further €3.3 billion for the health system to pay for additional equipment, health workers and intensive care unit beds (European Observatory on Health Systems and Policies, 2020).

Health-related industries play an important role in the economy. Italy is among the largest manufacturers of pharmaceuticals in Europe:

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Fig 1 Despite being above the European Union average, current spending on health as a share of gross domestic product (GDP) and public spending on health in Italy are lower than other neighbouring western European countries, including Germany and France.


Note: Gross National Income is used in place of GDP for Ireland.
pharmaceutical products figure among its top export categories and are the source of a €3.9 billion trade surplus (EFPIA, 2021). Italy produces and exports comparable levels of pharmaceutical products with other top European exporters in the sector, such as France and the United Kingdom. It also reaches comparable employment levels, with 66,500 people employed in the sector in 2020, well above other southern European countries. Medical devices are another burgeoning health-related industry, with private spending on medical devices growing (Corte dei Conti, 2021).

Digital advancements position Italy as one of the leaders in innovative health technologies, particularly related to digitalization and the development of e-health. Health information systems (Nuovo Sistema Informativo Sanitaria, or NSIS, and Sistema Tessera) are being implemented to build a universal system of patient electronic health records and track e-Prescriptions to monitor pharmaceutical expenditure and prescribing behaviour (Ferré et al., 2014; OECD and the European Observatory on Health Systems and Policies, 2019; Tikkanen et al., 2020). The Strategy for Digital Growth and Triennial Plan for Public Administration Informatics (2019–2021) was also established to further guide the digitalization of the health system, by promoting the use of electronic health records, e-Prescriptions and telemedicine across all regions (OECD and the European Observatory on Health Systems and Policies, 2019; Bobini et al., 2021). A major boost to digital health is expected as a result of the Italian Recovery Plan funded by the EU to boost growth in Europe after the pandemic (European Observatory on Health Systems and Policies, 2020). Digital health has also been a key element in the management of the COVID-19 crisis. The Italian health-care system has experienced an unprecedented use of new technologies to cope with delivery of care at a distance, to increase professional capacity and to perform contact tracing to cope with the pandemic.

Health-related research and development (R&D), vital to innovation, also supports economic growth. In 2019, around 10% of the Italian Government’s R&D budget was allocated to health, in line with 2018 levels despite the COVID-19 crisis. This is more than Germany (5.1%) but a small share when compared with Norway (15.6%) and the United Kingdom (21.5%) (OECD, 2020). During the pandemic, Italy has actively been participating in the R&D efforts supporting the COVID-19 vaccine in collaboration with France, Germany and the Netherlands.

Although the health sector in Italy is a stable source of jobs, workforce retention is a major challenge

Health sector employment in Italy has remained largely stable over the past decade despite broader labour market fluctuations. The health sector accounted for 5.7% of the economically active population in 2019, slightly above the EU28 average (5.3%) and its southern neighbours but lower than France (6.6% in 2018) and Germany (7.7% in 2018). The health share of the economically active population has been growing slightly since 2008, remaining stable even after the financial and economic crisis when unemployment peaked at 12.7% in 2014 (Fig. 2) (Eurostat, 2020a; International Monetary Fund, 2020). The pharmaceutical industry, in particular, creates many job opportunities, with an estimate of 66,500 people employed in 2020 (EFPIA, 2021).

The COVID-19 crisis seems unlikely to substantially alter the stable trend of health employment, as health professionals continue to be in high demand due to an ageing population (Eurostat, 2020a). Measures to maintain an adequate supply of health workers during the pandemic have included financial bonuses, adopting faster recruitment tracks and allowing freelance workers, retired doctors and nurses as well as military health personnel to work on the COVID-19 response.

The health sector in Italy will nevertheless need to address considerable challenges when it comes to retaining workers. New medical graduates are needed to replace retirees, yet bottlenecks in training are aggravating the shortage and
prompting large migration outflows (Ferré et al., 2014; OECD and the European Observatory on Health Systems and Policies, 2019). The outflow of health workers can also be explained by unsuitable working conditions and low pay rates (OECD and the European Observatory on Health Systems and Policies, 2019). In addition, initiatives expanding the role of nurses in the health workforce remain very limited.

Regarding the number of physicians, Italy is above the EU average of 3.6 medical doctors per 1000 population, with 4 medical doctors per 1000 population in 2017 (OECD and the European Observatory on Health Systems and Policies, 2017, 2019). Nonetheless, half of these doctors are over 55 years of age and many will retire in the coming years (OECD and the European Observatory on Health Systems and Policies, 2019). The number of practicing nurses in Italy is low, 5.8 nurses per 1000 population, which is below most of western Europe and below the EU average of 8.5 (Ferré et al. 2014; OECD and the European Observatory on Health Systems and Policies, 2019).

Italy achieves good health outcomes overall given its health spending level, but geographic and socioeconomic disparities hamper progress

Italy achieves good health outcomes overall while spending less on health than many other western European countries (Fig. 3). In 2017, treatable mortality was lower than the EU average: 67 deaths per 100 000 people could have been avoided through access to quality health care, compared with 109 on average in the EU (OECD, 2020). Italy also had among the highest life expectancies in Europe, at 83.2 years in 2019 (World Bank, 2020), though life expectancy fell as a result of the COVID-19 pandemic to 82.4 years in 2020 (OECD, 2021). Preventable mortality is among the lowest in the EU in part thanks to a range of public health policies implemented in the last two decades (OECD and the European Observatory on Health Systems and Policies, 2019). Italy has also made progress with the infant mortality rate at 2.8 per 1000 in 2018, down from 4.3 per 1000 in 2000.
Taken together, this suggests that the Italian health system is fairly efficient. Despite relatively low health spending levels compared with neighbouring countries, resources are put to good use: 10 countries spent more on health in 2017 but only three attained a lower level of treatable mortality than Italy (Fig. 3). This has important implications for enhancing labour force participation and productivity, as well as decreasing vulnerability to COVID-19.

There is, however, room for improvement. According to the World Bank’s Human Capital Index, as a result of investments in health care and education, a child born in Italy today can expect to be 73% as productive by age 18 relative to a child with a complete education and full health, equivalent to Spain and the EU average but behind the United Kingdom (78%) and France (76%) (World Bank, 2020). If behavioural risk factors such as smoking and binge drinking are less prevalent than in many other EU countries, obesity and excess weight problems have increased (Ferré et al., 2014; OECD and the European Observatory on Health Systems and Policies, 2019), indicating scope for further improvement.

In general, vaccination coverage in Italy is lower than in the rest of the EU. Italy especially lags behind when it comes to measles (88% of children were immunized with two doses of measles-containing vaccine in 2019) (WHO, 2020). This can be explained by misinformation and low public trust in vaccination benefits (OECD and the European Observatory on Health Systems and Policies, 2019). In the face of rising infectious diseases and vaccine objectors, the parliament imposed mandatory vaccinations for infants and children up to age 16 years in 2017, with the aim of enhancing immunization coverage (Tikkanen et al., 2020), but more can be done. Italy has achieved high COVID-19 vaccination rates: in March 2022, 89.5% of the population over 12 years old had received two doses (Ministerio della Salute, 2022) after being severely hit by the pandemic.

Keeping people healthy across the life course contributes to a healthy and productive workforce, enabling people to participate in the labour market for longer. Labour force participation among older workers remains low in Italy: the proportion of the population aged 55–64 years old working in Italy was 57.4% in 2019, on a par with France (57%) but below Denmark (73%), Germany (74%), the Netherlands (72%) and the EU average (63%) (Eurostat, 2020b). This is mainly due to low salaries and labour productivity, the rigidity of the labour market and early retirement policies endorsed by the government in the past, as well as to low employment rates among women in general.

Health status is a deciding factor in exiting the labour force early. For example, in 2012 (the latest...
year for which data are available), 12.5% of 50- to 69-year olds who were in receipt of a pension reported that they stopped working due to poor health or disability (Eurostat, 2019). Although it is a low proportion compared with the rest of the EU, about 50% of Italians report having at least one chronic condition or suffer from disabilities and health conditions after age 65 years (OECD and the European Observatory on Health Systems and Policies, 2019).

Health inequalities by socioeconomic status and region affect labour force participation. There is a roughly 3-year longevity gap between people living in affluent regions in the north, like Trentino- Alto-Adige, in comparison to those living in the south, such as in Campania (Ferré et al., 2014; OECD and the European Observatory on Health Systems and Policies, 2019). Additionally, unmet need for medical care in Italy is concentrated among people on low-income, mainly because of long waiting times and travel distances (Ferré et al., 2014). In response to these inequities, the Ministry of Health adopted a 3-year national plan in 2019 requiring regions to set and monitor a maximum wait time for all health services (OECD and the European Observatory on Health Systems and Policies, 2019), but the outbreak of the pandemic has hampered the full implementation of the plan.

Co-payment policies vary across the country due to the regional delivery of care, exacerbating socioeconomic inequalities

The goals of universal health coverage are to ensure that everyone can use the quality health services they need without experiencing financial hardship (United Nations, 2015). Universal health coverage is central to health and well-being, alleviates poverty, reduces socioeconomic inequalities, contributes to health security and boosts economic growth (Cylus, Govin & Smith, 2018). Financial protection, which is central to universal health coverage and health system performance, is measured using two indicators: catastrophic health spending and impoverishing health spending.

Although the Italian national health system (Servizio Sanitario Nazionale; SSN) automatically covers all residents, there are gaps in coverage for some services, which are paid for with out-of-pocket payments (OOPs). Spending on OOPs as a share of current health spending in Italy is high compared with the rest of Europe. It accounted for 23.3% in 2019, above the EU average (21.6%), and higher than Germany (12.8%), the United Kingdom (17.1%) and Spain (21.8%) (WHO, 2021). Spending on OOP is also driven by user charges, which are applied to outpatient care, dental care, laboratory and diagnostic tests, non-urgent visits to emergency departments and outpatient medicines. The use of co-payments varies across regions. Some regions have increased co-payments on pharmaceutical products with the aim of containing public expenditure, notably in order to face growing deficits (Ferré et al., 2014), while others have introduced user fees for inappropriate use of emergency services (OECD and the European Observatory on Health Systems and Policies, 2019).

Rates of catastrophic and impoverishing health spending have been increasing (Fig. 4). In 2019, 1.4% of households were impoverished and 2.8% were further impoverished because of OOP spending. The percentage of households who experienced catastrophic health spending doubled between 2004 and 2019, reaching 9.4% in 2019. This is a sizeable proportion compared with other EU countries. The risk of catastrophic health spending as well as the risk of forgoing care for financial reasons is concentrated among the poorest households. Dental care and outpatient medicines are the main drivers of catastrophic spending. Although fiscal incentives have been introduced to encourage the use of complementary health insurance (voluntary health insurance) to address coverage gaps, take-up remains limited, covering only 2% of total health expenditure (Ferré et al., 2014; OECD and the European Observatory on Health Systems and Policies, 2017).

Some protection mechanisms are in place to alleviate the impact of co-payments and improve financial protection, including:
• Exemptions from user charges are granted for low-income people, pregnant women and patients suffering from disabilities, chronic conditions and rare diseases as well as people in early diagnosis for some types of cancers (OECD and the European Observatory on Health Systems and Policies, 2019; Tikkanen et al., 2020).

• All OOPs (including user charges for medicines and outpatient services) exceeding an annual deductible of €129 are eligible for the 19% income tax credit (OECD and the European Observatory on Health Systems and Policies, 2019; Tikkanen et al., 2020). This measure does not benefit the very poor (who do not pay taxes).

These protection mechanisms vary by region, but national requirements need to be fulfilled.

Fig 4 The share of households experiencing catastrophic health spending as a result of out-of-pocket payments has increased

Source: Fattore & Preti (in press).
Key lessons

A stronger role for national NHS institutions can help address regional health and socioeconomic inequalities

The north–south gradient in socioeconomic development is a root cause of the large disparities in health care quality and health outcomes in Italy. This is made worse by the decentralized nature of the National Health Service (SSN). At the national level, the SSN should increase its institutional capacity and be empowered to intervene when regions cannot achieve national standards. A more equitable resource-allocation formula, plus other mechanisms such as special funding administered centrally to finance new investments, centralization of critical functions (e.g. purchasing) and investments to build social and human capital, would benefit the most disadvantaged regions in particular.

Improving working conditions would address health workforce shortages and benefit the labour market

COVID-19 has shown the need to address workforce shortages. Initiatives allowing greater flexibility for the regions to offer permanent contracts, improving working conditions and expanding the role of nurses in the health workforce have been put in place, but regulatory changes are required to ensure successful task-shifting (Ferré et al., 2014; OECD and the European Observatory on Health Systems and Policies, 2019).

Harmonizing and improving co-payment policies across regions would reduce financial hardship attributable to out-of-pocket payments

There is room for improving financial protection in Italy. There are no annual ceilings on co-payments, which can have an adverse impact on frequent users of health services who are not eligible for exemptions (OECD and the European Observatory on Health Systems and Policies, 2019). Additionally, as each region establishes their own co-payment policies, financial protection and unmet need vary across the country, exacerbating socioeconomic and health inequalities (Ferré et al., 2014; OECD and the European Observatory on Health Systems and Policies, 2019). A more unified national approach would reduce socioeconomic inequalities.
Description of the health system

The Italian health-care system is based on a National Health Service (Servizio Sanitario Nazionale; SSN), which provides compulsory universal coverage for all legal residents. The state defines the national benefits package to be provided by the SSN to all residents across all regions based on “Essential levels of care” (Livelli Essenziali di Assistenza, LEA), which include primary care visits, hospital inpatient care, pharmaceuticals, outpatient health services, rehabilitation and community health services. Patients are required to register with a general practitioner (Ferré et al., 2014).

Regulation, management and delivery of health services is highly decentralized. The central government is responsible for setting national health policies and priorities, regulating SSN and the regional fund allocations while the regional entities are responsible for ensuring the organization and delivery of care services through local health units and public and private hospitals. Given the reliance on regional care provision, significant variability in health system efficiency and quality exists and remains a challenge (Ferré et al., 2014; Tikkanen et al., 2020). Variations across regions are mainly due to differences in service availability, quality, waiting times and efficiency.

The compulsory SSN scheme is funded from national corporate and value-added taxes. Although the Italian health system provides a comprehensive publicly financed benefits package, patients incur co-payments to access some services including specialist outpatient services and prescribed drugs. Over-the-counter drugs are not covered by the SSN and dental care coverage is very limited (Ferré et al., 2014).

Some exemptions are in place to provide equitable access and reduce the financial burden on people with chronic conditions and disabilities, pregnant women and low-income households. Voluntary health insurance makes up 2% of total health expenditure; although both complementary and supplementary voluntary health insurance are available, they play a limited role in Italy (Tikkanen et al., 2020).
### Key indicators

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<tr>
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<th>Italy</th>
<th>EU Average</th>
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<tbody>
<tr>
<td>People aged 65 years and above (% of total)</td>
<td>23</td>
<td>20.5</td>
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<tr>
<td>Life expectancy at birth (years)</td>
<td>83.2</td>
<td>81.1</td>
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<tr>
<td>GDP per person (PPP US$)</td>
<td>46 121</td>
<td>48 340</td>
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<tr>
<td>Current health spending per person (PPP US$)</td>
<td>3998</td>
<td>4010</td>
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<tr>
<td>Health spending paid out of pocket (% of current health spending)</td>
<td>23.3</td>
<td>21.6</td>
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**Source:** World Bank World Development Indicators (2020); WHO, Global Health Expenditure Database (2021).

**Note:** Data for 2019. PPP US$, purchasing power parity in US dollars.

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The European Observatory on Health Systems and Policies is a partnership hosted by WHO that includes international agencies, national governments, decentralized authorities and academic research institutes. It supports and promotes evidence-informed policy-making, using comparative analysis of European health systems and trends to give decision-makers insights into how their own and other systems operate; what works better or worse in different contexts; and why. Ultimately the Observatory aims to help countries to strengthen their health systems to improve their peoples’ health and well-being. It engages directly with policy-makers and works with a range of experts, not least its Health Systems and Policies Network whose members provide key knowledge and insights into health systems in countries.

**WHO Barcelona Office for Health Systems Financing**

The WHO Barcelona Office is a centre of excellence in health systems financing for universal health coverage. It works with Member States across WHO’s European Region to promote evidence-informed policy-making. A key part of the work of the Office is to assess country and regional progress towards universal health coverage by monitoring financial protection – the impact of out-of-pocket payments for health on living standards and poverty. Financial protection is a core dimension of health system performance and an indicator for the Sustainable Development Goals. The Office supports countries as they develop policy, monitor progress and design reforms and is part of the Division of Country Health Policies and Systems of the WHO Regional Office for Europe.

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