Health policy 2023/2024
Charles University, Prague

The Italian healthcare system and the human resource issue

Stefano Neri
Department of Social and Political Sciences
University of Milan

The Italian healthcare system (and its doctors)

1) 1860-1942 = only (voluntary) mutual funds and corporate health insurances in big firms (coverage: 35% in 1940)

- **very high number of doctors** (1876: 6.0 per 10,000 inhabitants, FR = 2.9; GER = 3.2)
- 1911: institution of the Professional Chamber of Physicians (legal recognition of the profession)

2) 1942-1978: Social Health Insurance system (95% of population in 1975)

- **highly fragmented doctors**, with very relevant internal inequalities
- 1950-1970: **high medical dominance**

The Italian healthcare system

1978: shift to a National Health Service (NHS), because of:

- high level of disparities in access and provision
- huge debts in health funds and hospitals

Initial opposition by doctors because of the fear of control

Then they found «mutual accomodation» within the systems

The Italian healthcare system

Strong inheritage

1) healthcare debt assumed by the state

- public debt as constant issue in health policy

2) relevant share of **private expenditure** (20-25% of total expenditure) and of **private providers** (both for-profit and non-profit)

3) Mixed **public-private regulation** by doctors

- GPs as independent professionals contracted by the NHS
- Private practice by NHS hospital doctors

Main NHS reforms

1) 1992-93

- managerialisation and managed competition
- regionalisation

2) 1999

- private practice regulation

3) 2001: strong regionalisation

- management and organization of the healthcare system devolved to the 20 Italian Regions
- central control of most financial resources

Then: no formal relevant changes, but **many substantial changes**

The Italian NHS before the Covid emergency (2009-2019)

1) Strong impact **of economic crisis**, with a sovereign debt crisis in 2010-11 (**huge public debt**)

2) Subsequent harsh **austerity policies** in the public sector, including the NHS

«TINA (There Is No Alternative) solution»

3) **a new emerging governance** in the NHS (despite the absence of formal changes)

Government consolidated debt (percentage of GDP)
EU; Italy and Mediterranean countries

Source: Eurostat datawarehouse

NHS governance in the decade before the pandemic

1) A significant influence by EU institutions

- **EU as an external constraint** in welfare reforms

  «rescued by Europe?»

2) a strong **centralisation** in policy making, with

- a prominent role played by the Ministry of Economy and Finance
- a significant **weakening** of Parliament, Regions and **traditional interest groups (such as doctors)**

3) a strong request for more «**differentiated autonomy**» by Regions without serious financial problems raised

The Italian NHS and the 2008-09 economic crisis

Austerity policies aggravated some critical factors in the Italian healthcare system

1) a remarkable **public under-financing and slowdown in public expenditure**, with a limited expansion of private health expenditure

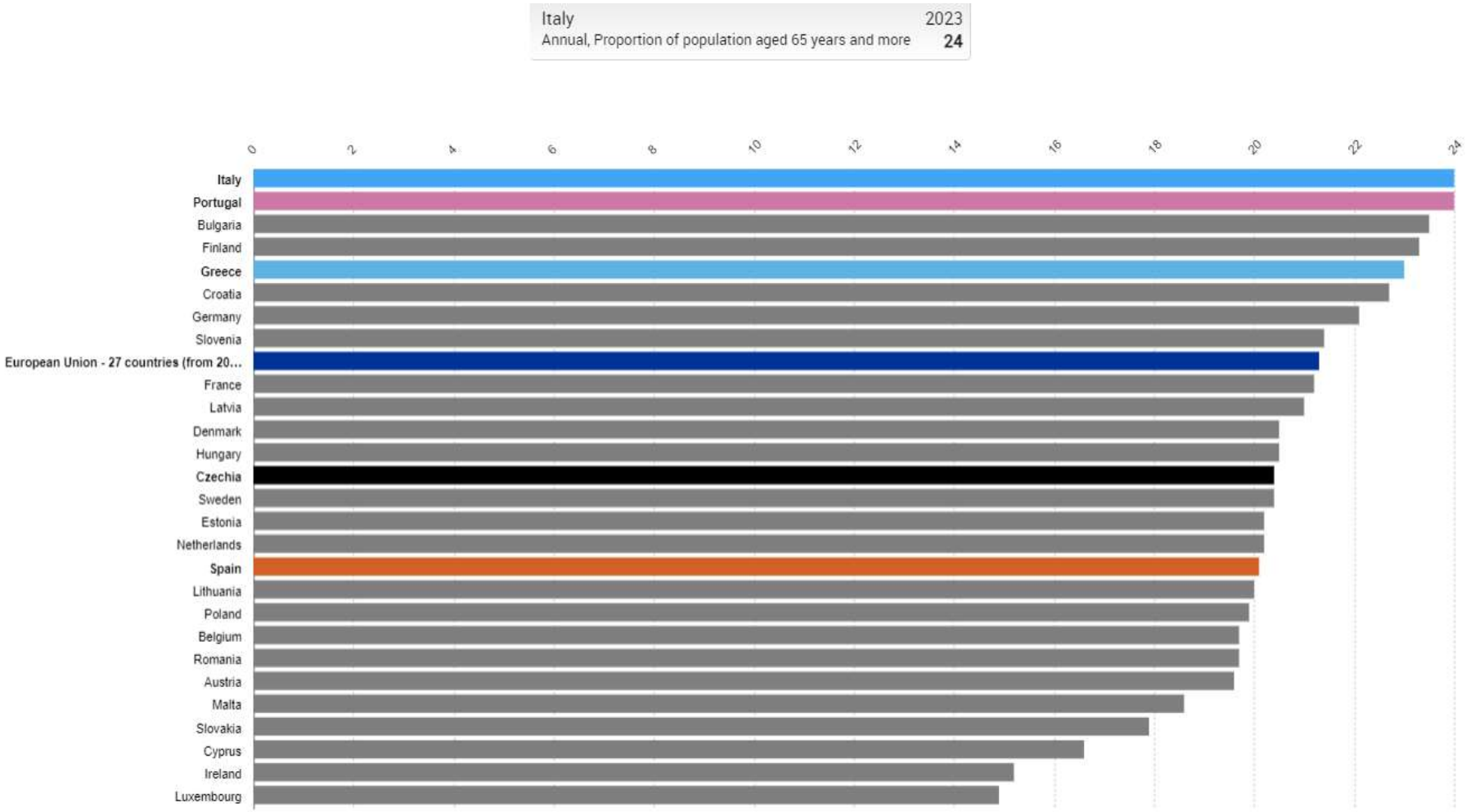
2) a **shortage** of structural resources, with a very low hospital bed rate

3) **an increasing shortage of human resources**, with **NHS staff decreasing** from 693.600 to 648.507 employees between 2009 and 2018 **(-6.5%)**

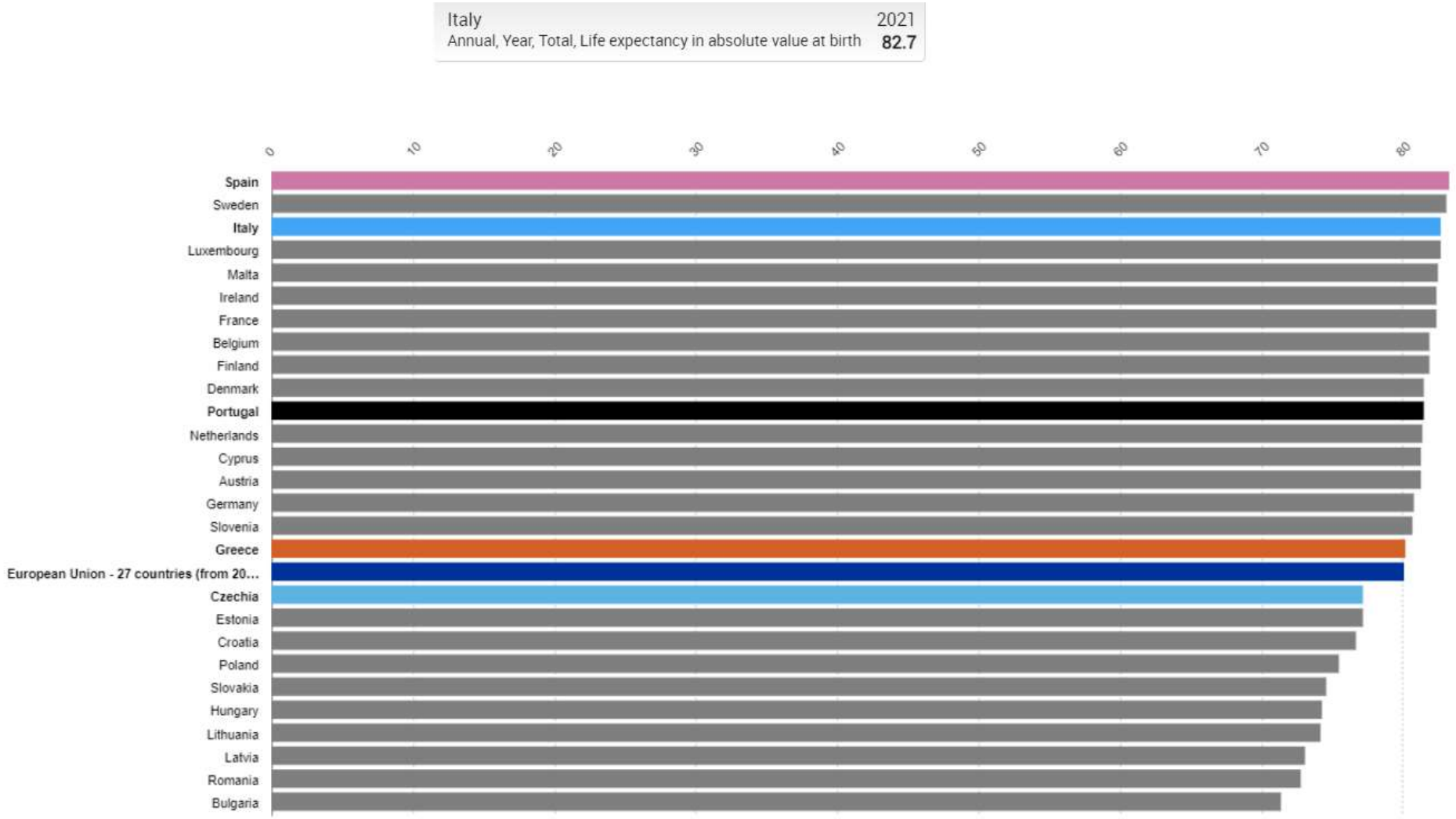
Health expenditure 2009-2019

Public expenditure on health: government schemes and compulsory contributory healthcare funding schemes					
	Share of gross domestic product (%)		Per capita, constant prices, constant PPPs, OECD base year (US dollars)		Per capita expenditure growth rate (%)
	2009	2019	2009	2019	2009-2019
Italy	**7.0**	**6.4**	**2300**	**2629**	**12.5%**
France	8.6	9.3	2969	4314	31.2%
Germany	9.4	9.8	3465	5390	35.7%
UK	8.1	7.9	2689	3480	22.7%
Spain	6.8	6.5	2060	2489	17.3%
Source: OECD Health data 2024					

Proportion of population aged 65 years or more – EU countries (2022)

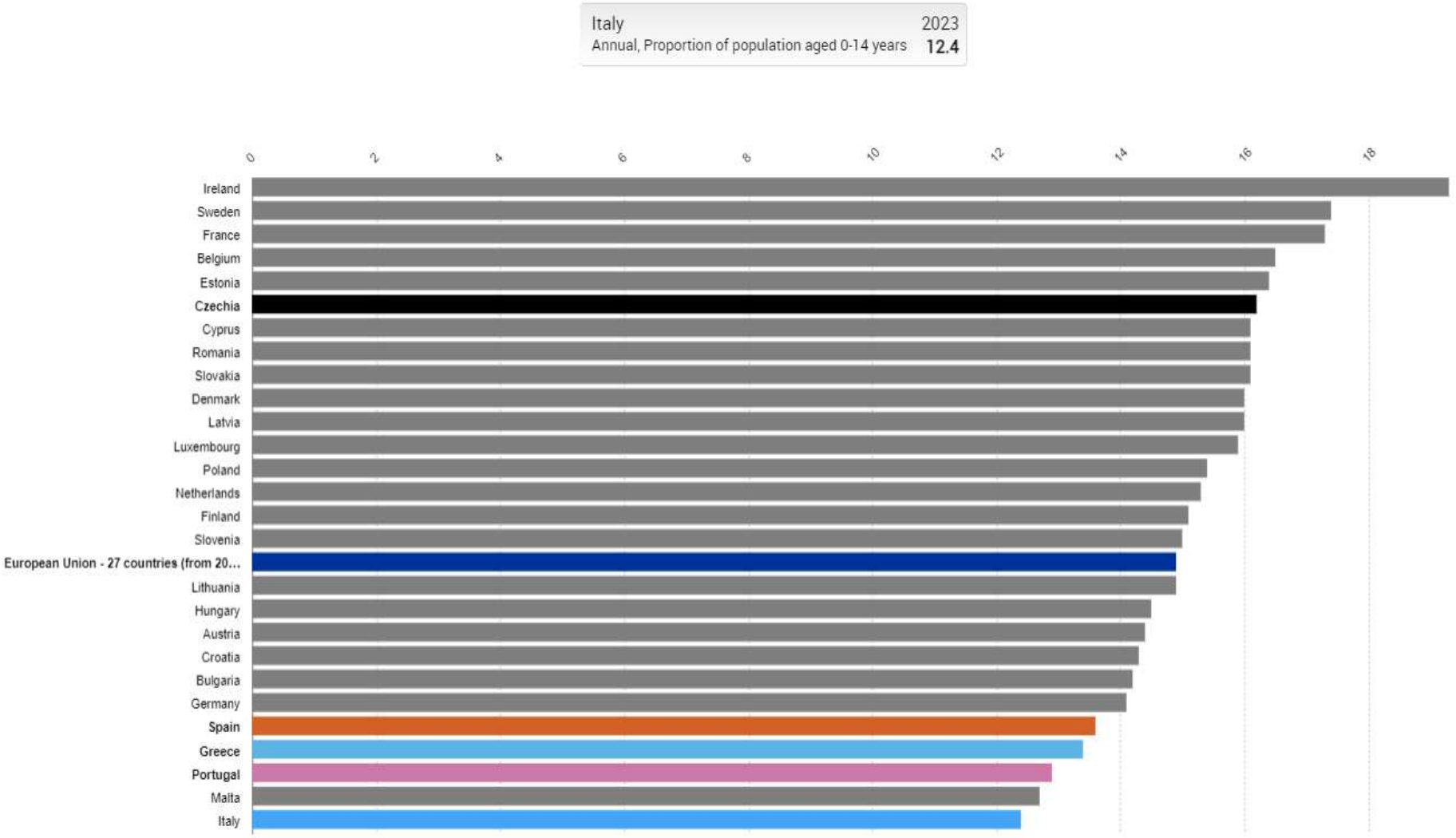


Life expectancy in absolute value at birth – EU countries (2021)



Source: Eurostat datawarehouse

Proportion of population aged 0-14 years – EU countries (2022)



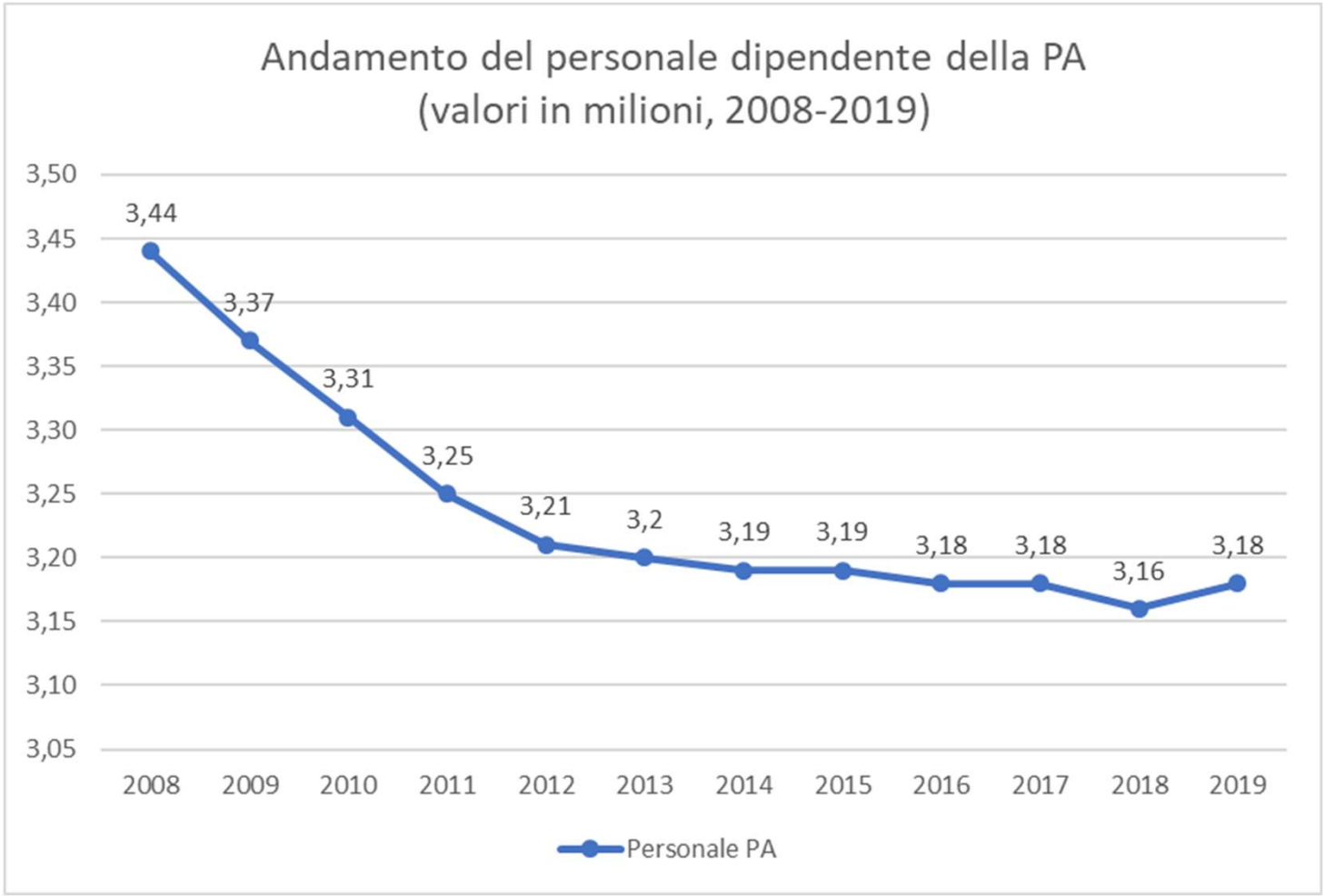
Source: Eurostat datawarehouse

Structural resources: hospital beds
(Oecd Health Data, various years and WHO, 2020)

	Total hospital beds per 1,000 inhabitants							
	2018	2015	2010	2005	2000	1995	1990	1980
Italy	**3.1**	**3.2**	**3.6**	**3.8**	**4,7**	**6,3**	**7,2**	**9,6**
France	6,0	6,1	6,4	6,9	8	8,5 (1997)	=	=
Germany	8,0	8,1	8,3	8,2	9,1	9,7	10,1 (1991)	=
UK	2,5	2,6	2,9	3,3	4,1	=	=	=
Spain	3,0	3,0	3,1	3,2	3,7	3,9	4,3	5,4
	Acute hospital beds per 1,000 inhabitants							
	2018	2015	2010	2005	2000	1995	1990	1980
Italy	**2,6**	**2,6**	**3,0**	**3,5**	**4,2**	**6,1**	**7,0**	**9,3**
France	3,0	3,2	3,5	3,7	4,1	4,3 (1997)	=	=
Germany	6,0	6,1	6,2	6,4	6,8	7,5	8,3 (1991)	=
UK	=	2,2	2,4	3,0	3,2	=	=	=
Spain	2,5	2,5	2,5	2,7	2,9	3	3,3	3,5 (1985)

Staff in Italian public administration from 2008 to the pandemic (in millions)

Source: elaborations from M*EF. (2022)*



Healthcare staff in the decade before the pandemic

NHS Staff declined from 693.600 to 648.507 employees, between 2009 and 2018 (-45,093 employees; 21,813 of them were doctors, nurses and other health professionals)

In %: **-6.5%** (-4.5% in PA as a whole)

In general terms (not only in the NHS), from 2010 to 2017:

1) **doctors decreased** from 1,82 per 1,000 inhabitants to 1,67 per 1,000 inhabitants
2) **nurses decreased** from 4,46 per 1,000 inhabitants to 4,18 per inahabitants

Human resources: doctors and nurses

	No. of doctors per 1,000 inhabitants (2019)	No. of nurses per 1,000 inhabitants (2019)
Italy	**4.0 (4.05)**	**6.2 (6.16)**
France	3.2	8.5 (2021)
Germany	4.4	11.8
UK	2.9	8.2
Spain	4.4	5.9

Sources: OECD Health Data, 2024

Female doctors: % of total doctors

	% of total doctors (2009)	% of total doctors (2019)
Italy	**36.7%**	**43.8%**
France	40.2%	46.1%
Germany	41.6%	47.8%
UK	42.9%	48.6%
Spain	49.2%	56.6%

Italy: 45.6% in 2022

Sources: OECD Health Data, 2024

Is there a shortage of Italian doctors?

While there is an evident shortage of nurses, there doesn't seem to be a shortage of doctors.

However

1) Italian healthcare is highly **«doctor-centered»** (large jurisdiction by doctors)

2) **Lack of doctors in some medical specialties** such as anestethists, internists, GPs, emergency areas (all crucial during the Covid emergency)

3) **Aging doctors.** About 50% of Italian doctors are 55 years old or over = increasing shortage in future years

Shortage of doctors
Medical specialties with the greatest shortages

Specialties	No. of further doctors needed according to planned needs 2018-2025
A&E doctors	4,241
Pediatricians	3,394
Internists	1,878
Anesthetists	1,523
Surgeons	1,301

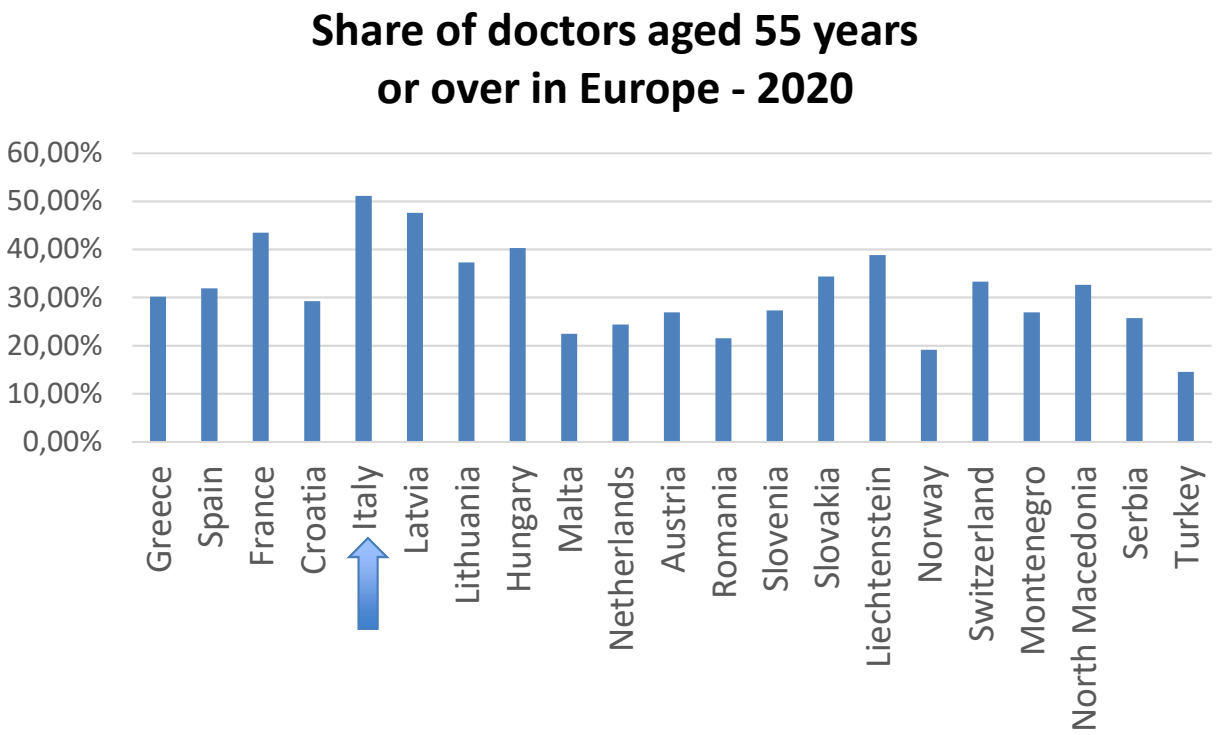
Source, Anaao, 2018; 2020

Doctors' retirements

An Anaao (the main doctors' union) study estimated:

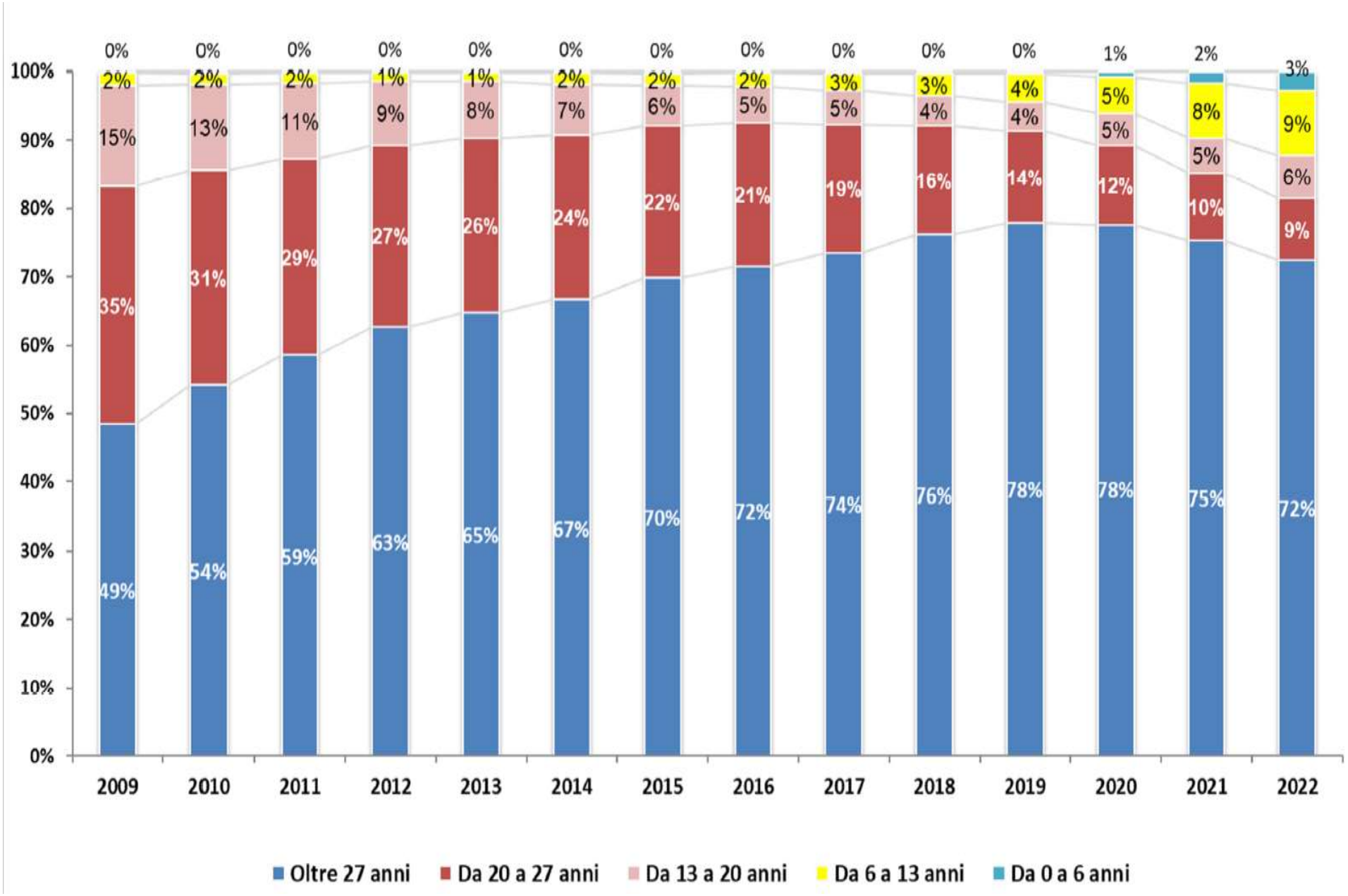
- 6-7,000 retirements a year from 2018 and 2022
- 52,000 specialty doctors retirements from 2018 to 2025 between 2018 e il 2025 (nearly 50% of NHS specialty doctors)

«Aging doctors»



Source: elaborations from Eurostat data

Distribution of GPs per seniority - no. of years («anni») from the degree – Min. of Health data



Why a doctor and staff shortage?

1) **Restrictions and blocks in recruitment** in the last decade

2) **Bad planning**:

- restricted quota in university entry
- highly restricted quota in specialty schools

Was it bad planning or an exclusion strategy?

3) **Bad distribution among specialties**, with unattractive specialties (general medicine, some surgeries) and others too attractive (dermatology, plastic surgery, ophtalomology)

Why a doctor and staff shortage?

4) **Worsening working conditions**

- **Strong wage moderation.**

From 2009 to 2018 (as a whole), salary increased of 2.7% in the NHS (4.3% in PA), while inflation increased of 12.5%

- Increasing workload
- Stress and burnout
- Worsening in the relationships with patients (disputes and aggressive behaviours)

5) Worsening in the social status (**for nurses** and other staff)

«**Care devaluation**»

Covid-19 In Italy

- First European country to be significantly hit by Covid-19
- According to WHO (2024), **196,000 deaths** since the beginning of the pandemic (2nd in Europe, 8th in the world)
- 30 January 2020: 2 Chinese tourists infected in Rome
- First «Italian» cases: 20 February in Lombardy and then in Veneto
- National lockdown from 9 March 2020 to 3 May 2020
- **Unpreparedness** = absence of an updated pandemic plan and of clear indications by WHO and international institutions

Covid-19 In Italy

Four waves of infections (and responses)

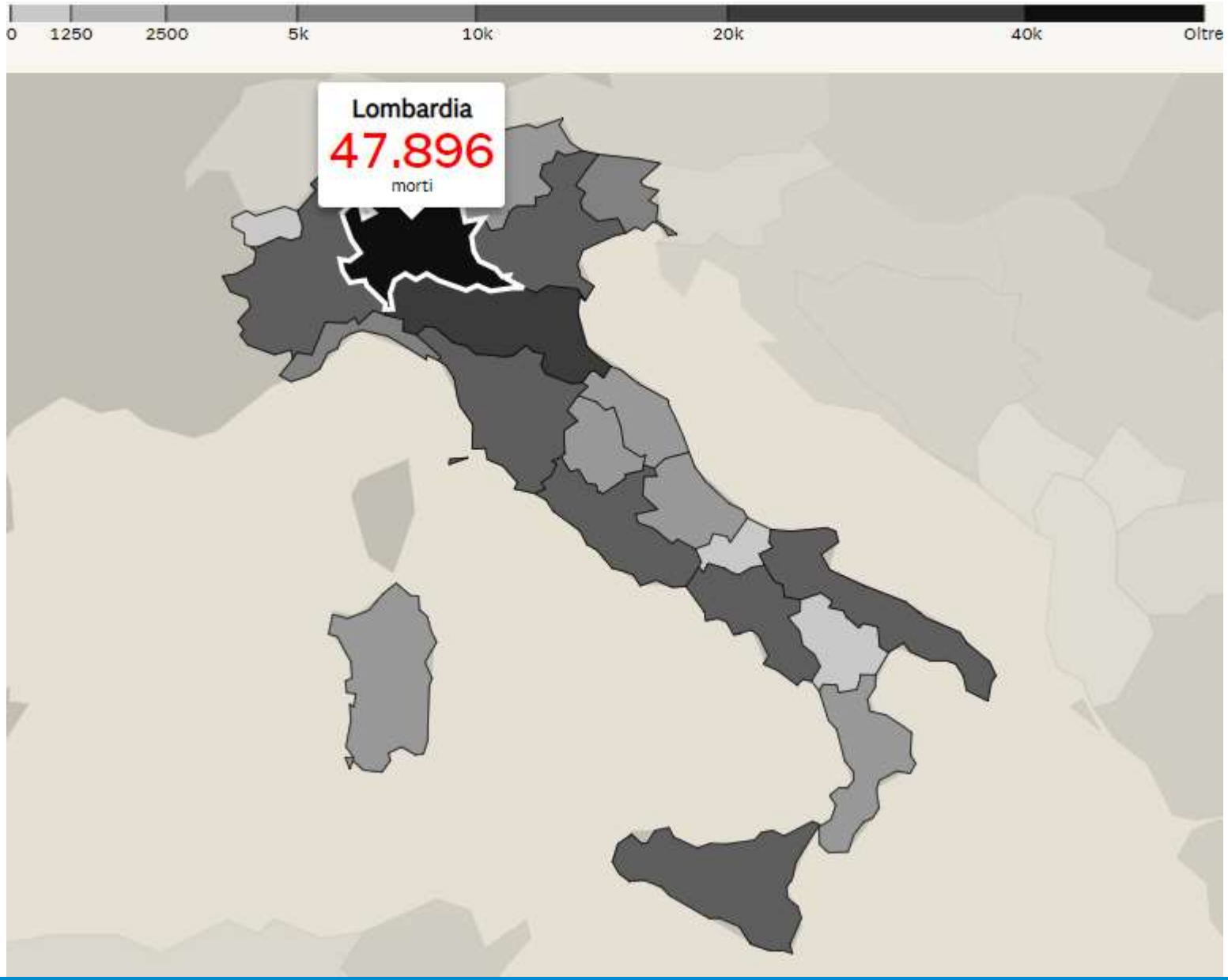
1) February-May 2020 (the «great lockdown»)

2) October-November 2020 (partial closures of schools and economic activities)

3) January-March 2021 (partial closures of schools and economic activities)

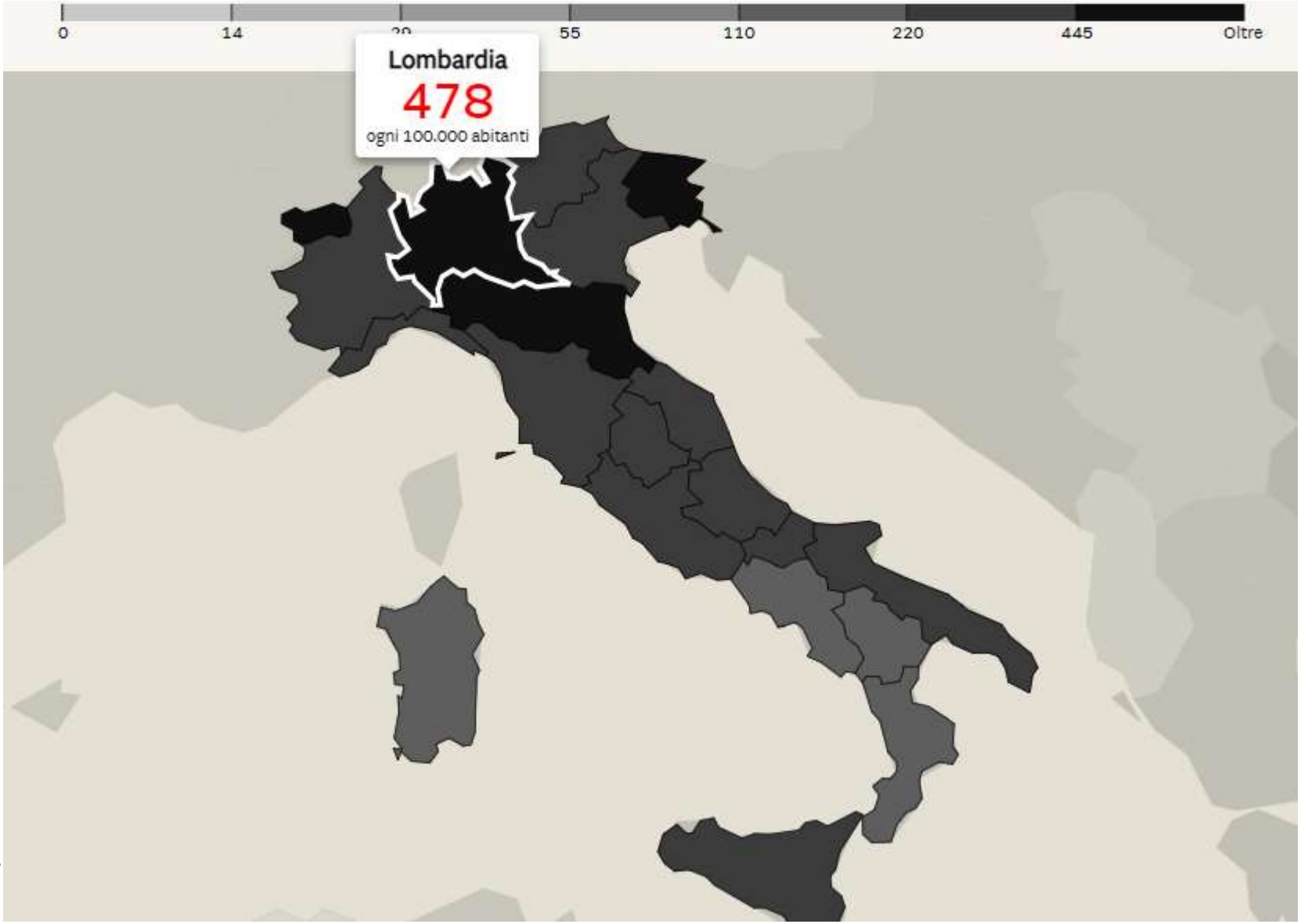
4) June-July 2021 (no closures)

Covid-19: number of deaths since 2020



Source: Lab 24

Covid-19: number of deaths per 100,000 inhabitants since 2020



Source: Lab 24

Annalisa Malara
“The young doctor who ignored
the rules to find Italy’s ‘Patient One’ “
(The Sunday Morning Herald)

Dr. Andrea Crisanti: the doctor who suggested to test also non-symptomatic patients in Veneto, unlike international recommendations

State-Regions relationships during the pandemic

Three phases

1) March-May 2020: prominence of the **central government** during the lockdown

But: **different regional responses** (Lombardy vs. Veneto)

2) June 2020-February 2021: regional resurgence; alternation of conflicts and cooperation, with an increasing trend to «**Regional autarky**»

3) February 2021-2022: searching for **stable cooperation**

Anti-pandemic measures for the NHS

A huge number of measurements were taken in 2020-2021, to deal with the emergency, aimed at:

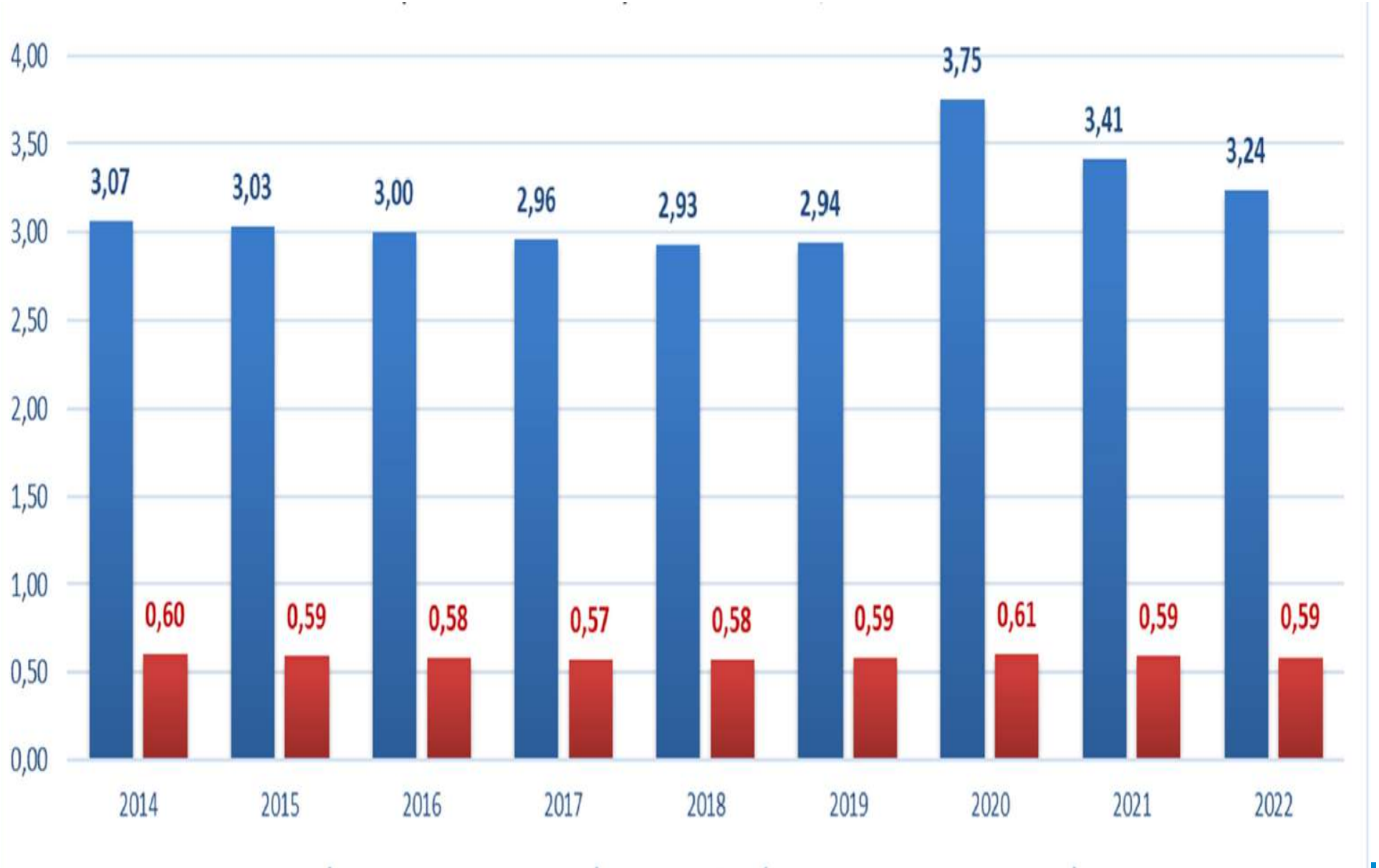
1) increasing the number of beds and intensive care units within hospitals

2) increasing the number of hospital staff

3) (later) creating primary care Covid units to treat patients at home

4) increasing the testing capacity

Acute (in blue) and non-acute (in red) hospital beds in the NHS (2014-2022)



Main staff measures

1) Urgent and massive callings of **public competitions to recruit** doctors, nurses and other health staff (with temporary jobs)

2) State examination (after graduation and specialisation) **no longer necessary** to be registered as doctors

- Abolition of a significant entry barrier

3) Incentives to **postpone retirements** from below 67 years old (70 years old in 2023, with debate about extending to 72)

4) Incentives to recall retired doctors to work

Main staff measures

4) Extended use of **specialising doctors**

5) Temporary measures to **increase work flexibility** within hospitals in

- the division of labour
- the use of doctors, nurses and health staff among wards
- task shifting

6) Temporary **greater flexibility in employment regulation** by hospitals and local health authoristies, with the possibility to:

- extend working time and working hours
- suspend and postpone holidays, leaves and permissions

Impact of staff measures

1) **Huge increase in the no. of NHS staff**: NHS employees were about 675,000 in 2021 (the same level as 2012)

   (2018 = 693,000)

2) But: most new hirings are **temporary**

Permanent staff: 625,000 in 2022 (more than 2020, but not so much)

However: planned progressive stabilisation

3) Significant **weakening of hierarchies** within workplaces and increasing task shifting

But: these changes seems to have been only **temporary**

Doctor and nurse dissatisfaction

1) **Increasing (and massive) workload**, not only during the emergency but **also now**

- staff mobilised to deal with the postponed procedures
- staff shortage

2) **Decrease in public health expenditure** planned in the next years, with a lack of investment in the NHS staff

3) **«from heroes to neglected»**

- claims nearly ignored by the political system
- increase in disputes and agrressive behaviour against staff

Public health expenditure on GDP before and after the pandemic (%)

2019	2020	2021	2022	2023 (provisional)	2024 (forecast)	2025 (forecast)
6.4%	7.4%	7.2%	7.0%	6.4%	6.3%	6.3%

Source: Ministry of Economy and Finance (2024)

«Escape from the NHS» and its consequences

Loss of attractiveness by medical and healthcare professions

- Low salaries in the NHS
- Worsening in working conditions

So:

1) Increasing move to the **private sector**

2) Young doctors and nurses increasingly going **abroad**

3) Increasing number of doctors working **«on call»**

4) Increasing recourse to **cooperatives and private agencies** to provide NHS staff

5) Official (regional and national) plans to **recruit nurses abroad**

Mobilising public opinion

1) **General dissatisfaction** with the NHS by the public

- waiting times
- increasing recourse to private practices
- lack of GPs

2) **Doctors and health staff try to mobilise public opinion to «safe the NHS»**

- Main doctors'unions in favour of the NHS
- Common strikes in March 2024
- Public statement by a group of famous doctors

3) But: **loss of influence as interest group?**

The National Recovery and Resilience Plan (2021)

- Italy as **one of the NRRP main recipients**

191 billion € (126 in loans and 65 in subsidies)

- Plan articulated in 6 missions, covering a very large range of issues, to be completed by **2026**

- NRRP as a **great gamble** on country's modernisation and its capacity to implement the plan

NRPP in health

1) Huge investment in ICTs, both in hospitals and home care

2) creation of multiprofessional primary care health centres («Community Homes») by 2026 and strengthening of home care assistance

Primary care reform launched in 2021-22

- In the Community Homes, along with GPs and specialists, the «family and community nurse» is created, aimed at following groups of patients for prevention and health promotion

The primary care reform

However, so far:

- **strong differences among Regions** in implementation (increasing inequalities)
- **a few GPs within the primary care centres**
- **financial problems**: cuts in the number of new centres (from about 650 to about 400)
- priority given to hospital and specialty care (waiting lists)

The primary care reform

Main critical factors

A) **lack of administrative capacity** by many Regions

B) **GP strong opposition**

C) lack of available healthcare staff (nurses)

D) partial loss of interest by current central government