



State of Health in the EU

Italy

Country Health Profile 2021

The Country Health Profile series

The State of Health in the EU's Country Health Profiles provide a concise and policy-relevant overview of health and health systems in the EU/European Economic Area. They emphasise the particular characteristics and challenges in each country against a backdrop of cross-country comparisons. The aim is to support policymakers and influencers with a means for mutual learning and voluntary exchange.

The profiles are the joint work of the OECD and the European Observatory on Health Systems and Policies, in cooperation with the European Commission. The team is grateful for the valuable comments and suggestions provided by the Health Systems and Policy Monitor network, the OECD Health Committee and the EU Expert Group on Health Systems Performance Assessment (HSPA).

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Data and information sources

The data and information in the Country Health Profiles are based mainly on national official statistics provided to Eurostat and the OECD, which were validated to ensure the highest standards of data comparability. The sources and methods underlying these data are available in the Eurostat database and the OECD health database. Some additional data also come from the Institute for Health Metrics and Evaluation (IHME), the European Centre for Disease Prevention and Control (ECDC), the Health Behaviour in School-Aged Children

(HBSC) surveys and the World Health Organization (WHO), as well as other national sources.

The calculated EU averages are weighted averages of the 27 Member States unless otherwise noted. These EU averages do not include Iceland and Norway.

This profile was completed in September 2021, based on data available at the end of August 2021.

Demographic and socioeconomic context in Italy, 2020

Demographic factors	Italy	EU
Population size (mid-year estimates)	59 641 488	447 319 916
Share of population over age 65 (%)	23.2	20.6
Fertility rate ¹ (2019)	1.3	1.5
Socioeconomic factors		
GDP per capita (EUR PPP ²)	28 002	29 801
Relative poverty rate ³ (% , 2019)	20.1	16.5
Unemployment rate (%)	9.2	7.1

1. Number of children born per woman aged 15–49. 2. Purchasing power parity (PPP) is defined as the rate of currency conversion that equalises the purchasing power of different currencies by eliminating the differences in price levels between countries. 3. Percentage of persons living with less than 60 % of median equivalised disposable income. Source: Eurostat database.

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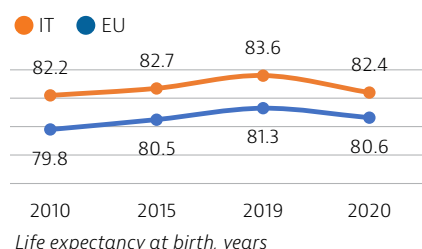
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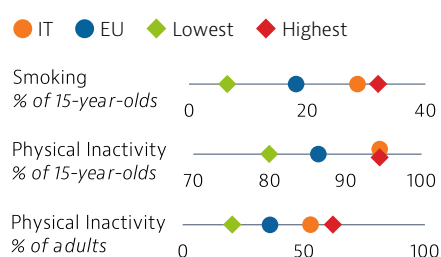
1 Highlights

Life expectancy in Italy is among the highest in Europe, but it fell at least temporarily in 2020 because of deaths due to COVID-19. While the Italian health system generally provides good access to high-quality care, the pandemic highlighted important structural weaknesses, including years of low investment in the health workforce and the health information infrastructure. The pandemic stimulated many innovative practices in Italy, such as the rollout of special units for continuity of care, which could be expanded to build a more resilient health care system.



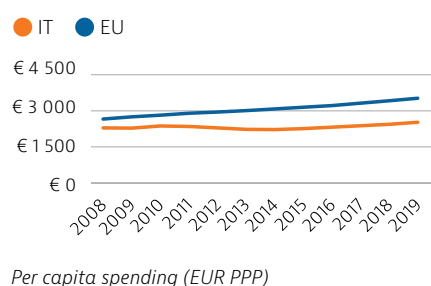
Health Status

Life expectancy in Italy in 2020 was almost two years higher than the EU average, but it fell by 1.2 years because of deaths due to COVID-19. Even before the pandemic, gains in life expectancy had slowed considerably since 2010 compared with previous decades, partly due to increased mortality rates from respiratory diseases among older people.



Risk factors

Risk factors for health are major drivers of mortality in Italy. While tobacco consumption has fallen among adults over the past decade, nearly 30 % of 15-year-olds reported that they had smoked in the past month in 2018. Physical inactivity among both adolescents and adults is also relatively high in Italy, contributing to overweight and obesity.

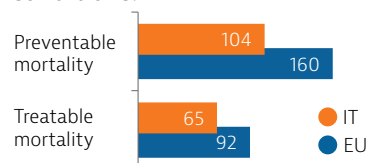


Health system

Spending on health in Italy grew slowly in the decade before the pandemic. In 2019, health expenditure was substantially lower than the EU average, both in per capita terms and as a share of GDP. About 74 % of health spending was publicly funded in 2019 – a lower share than the EU average of 80 %. In response to the COVID-19 pandemic, the Italian government allocated additional funding of EUR 3.7 billion in 2020 and EUR 1.7 billion in 2021 to the health system – an increase of 3.3 % and 1.7 % over the original funding plan.

Effectiveness

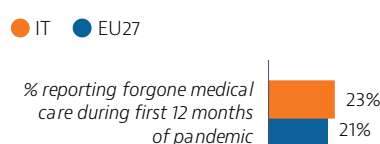
Mortality from preventable and treatable causes was lower in Italy than the EU average in 2018, indicating lower prevalence of many risk factors to health compared to the rest of the EU and a health care system that is generally effective in treating patients with life-threatening conditions.



Age-standardised mortality rate per 100 000 population, 2018

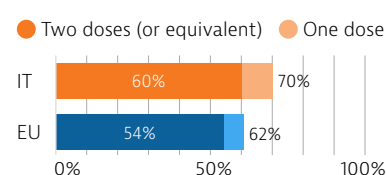
Accessibility

Although access to health care is generally good in Italy, the COVID-19 pandemic significantly hampered access to care: 23 % of the population reported some forgone care during the first 12 months of the pandemic – slightly more than the EU average of 21 %.



Resilience

Italy was among the EU countries hardest hit by COVID-19 in terms of death rates, particularly during the first wave. Like other EU countries, Italy accelerated its vaccination campaign in the first half of 2021 as the main way out of the pandemic, while continuing to implement other measures to protect its population and reduce pressure on its hospitals.



Share of total population vaccinated against COVID-19 up to the end of August 2021

2 Health in Italy

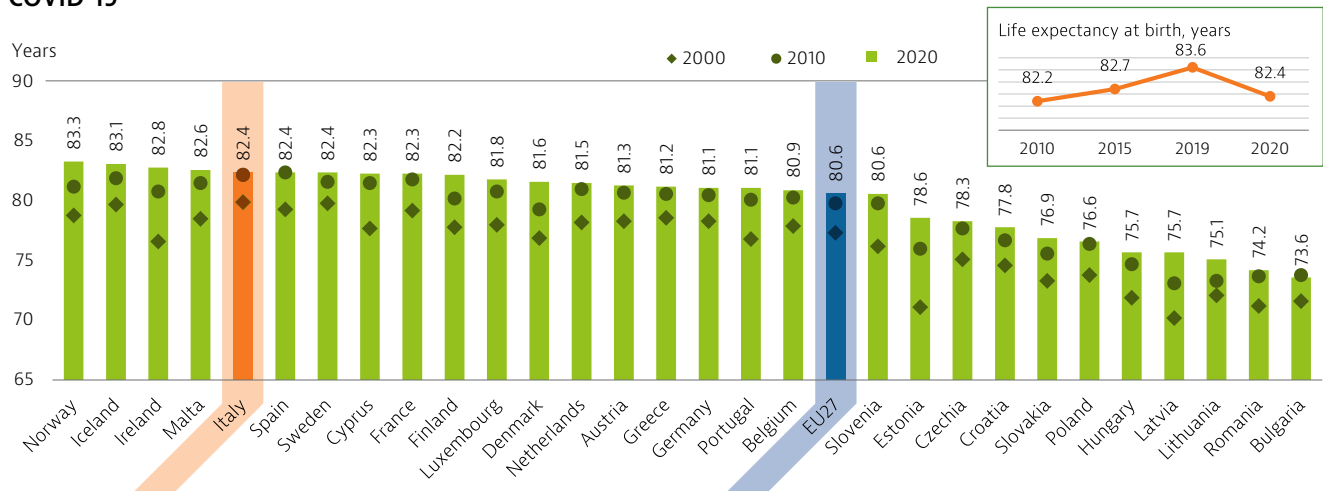
Life expectancy in Italy fell in 2020 due to COVID-19

Despite the sharp decline in life expectancy of more than one year caused by the COVID-19 pandemic, in 2020 people in Italy continued enjoying one of the highest life expectancies in the EU (Figure 1). Before the pandemic, gains in life expectancy had slowed considerably between 2010 and 2019, particularly among women (increasing by only about one year between 2010 and 2019 compared with about

two years in the previous decade) but also to a lesser extent among men. While the causes of this slowdown are not fully understood, it was in part related to an increase in mortality rates from some respiratory diseases among older people.

Preliminary estimates show a loss of 1.2 years in life expectancy between 2019 and 2020. This was higher in the north of Italy compared to the centre and the south and islands, as COVID-19 predominantly affected the northern part of the country.

Figure 1. Life expectancy in Italy was one of the highest in the EU in 2020, despite a sharp reduction due to COVID-19

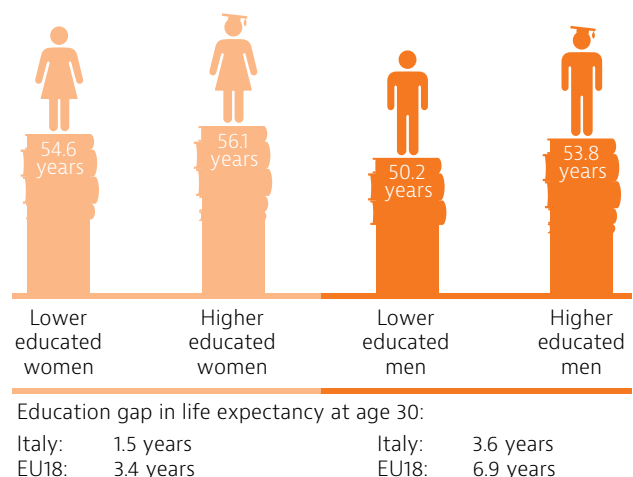


Note: The EU average is weighted. Data for Ireland refer to 2019.
Source: Eurostat Database.

Social inequalities in life expectancy are less pronounced than in other EU countries

Although less pronounced than in most other EU countries, inequalities in life expectancy by socioeconomic status are still significant in Italy. As shown in Figure 2, 30-year-old men with lower levels of education live on average 3.6 years less than those with the highest level. This longevity gap by education is smaller among women, at about 1.5 years. These gaps can be explained at least in part by differing levels of exposure to various risk factors and unhealthy lifestyles, including higher smoking rates and poorer nutritional habits among men and women with lower levels of education.

Figure 2. The education gap in life expectancy is 3.6 years for men and 1.5 years for women



Note: Data refer to life expectancy at age 30. High education is defined as people who have completed tertiary education (ISCED 5-8) whereas low education is defined as people who have not completed secondary education (ISCED 0-2).

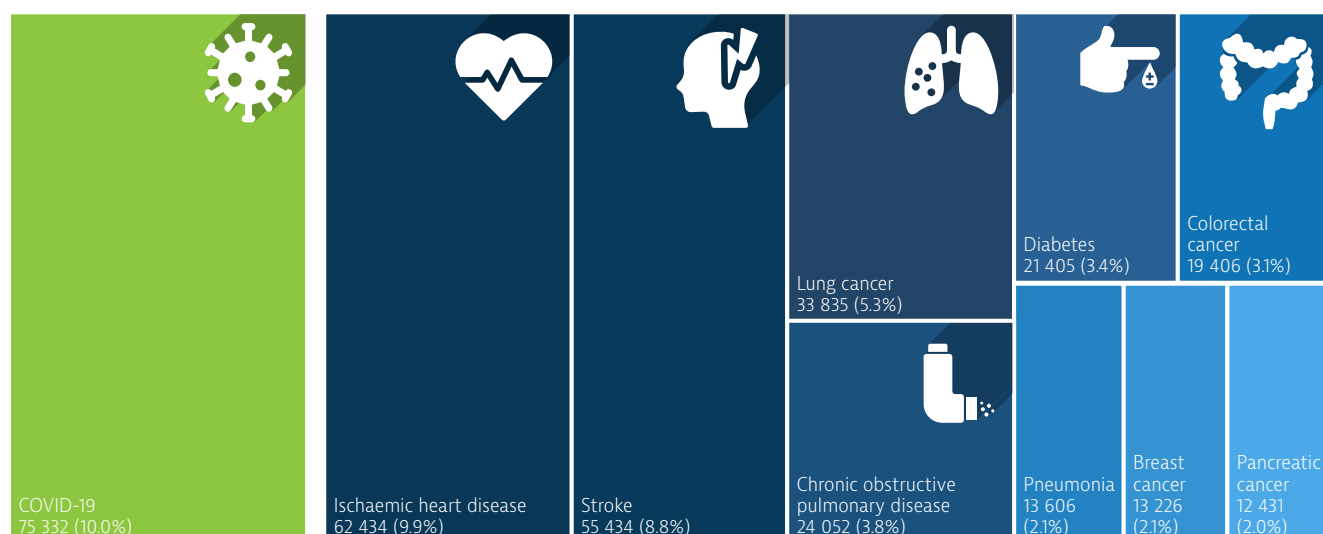
Source: Eurostat Database (data refer to 2017).

Geographical inequalities in life expectancy remain significant in Italy. In 2019, life expectancy for women born in the southern region of Campania was 2.7 years lower than that of women born in the northern autonomous province of Trento. Men born in Campania were expected to live 2.2 years less than men born in the central region of Umbria. The gap in geographical inequalities narrowed slightly between 2010 and 2019, and is expected to have narrowed even more in 2020 as the COVID-19 pandemic had a greater impact on the northern regions.

Circulatory diseases and cancer were the main causes of death in recent years, but COVID-19 accounted for many deaths in 2020

In 2018, circulatory diseases accounted for 35 % of all deaths in Italy, followed by cancer (27 %). Looking at more specific diseases, ischaemic heart disease (accounting for about 10 % of all deaths) and stroke (about 9 %) were the leading causes of mortality in 2018, followed by lung cancer, which remained the most frequent cause of death by cancer (Figure 3).

Figure 3. Ischaemic heart disease, stroke and lung cancer were the main causes of death, but COVID-19 accounted for a large number in 2020



Note: The number and share of COVID-19 deaths refer to 2020, while the number and share of other causes refer to 2018. The size of the COVID-19 box is proportional to the size of the other main causes of death in the previous year.

Sources: Eurostat (for causes of death in 2018); ECDC (for COVID-19 deaths in 2020, up to week 53).

In 2020, COVID-19 accounted for about 75 000 deaths in Italy (10 % of all deaths). Another 54 000 people died from COVID-19 in the first eight months of 2021. Most deaths were among older people: the average age of people who died from COVID-19 in 2020 was 81, and 86 % of deaths were among people aged 70 and over. While the mortality rate from COVID-19 in Italy was much higher than the EU average during the first wave in spring 2020, this gap narrowed, and many other EU countries had higher death rates in autumn 2020 and the first eight months of 2021. By the end of August 2021, the cumulative mortality rate from COVID-19 in Italy was about 35 % higher than the EU average.

The broader indicator of excess mortality suggests that the direct and indirect death toll related to COVID-19 might be substantially higher than official COVID-19 deaths in Italy, as in many other EU countries (Box 1).

Most Italians reported being in good health in 2019, but many have a chronic condition

In 2019, about three quarters (73 %) of Italian adults reported being in good health – a proportion slightly higher than the EU average (69 %). However, one in six Italian adults (16 %) reported having at least one chronic condition, according to EU-SILC, and this proportion increases with age (37 % of people aged 65 and over have one or more chronic conditions).

An emerging issue from the COVID-19 pandemic is the number of patients who experience persistent ill health for a long period after contracting the virus. “Long COVID” – characterised by symptoms including chest and muscle pain, fatigue, shortness of breath, anxiety and cognitive dysfunction – can impede a return to normal life, with potentially lasting health and economic repercussions. The percentage of people reporting persistent symptoms is particularly high among those who have been hospitalised for COVID-19.

Box 1. Italy's excess mortality in 2020 was substantially higher than officially registered COVID-19 deaths

As in many other countries, the actual number of deaths from COVID-19 in Italy is likely to be higher than the number of officially reported deaths because of limited testing and issues related to cause-of-death attribution. The number of COVID-19 deaths also does not take into account the possible increase in deaths from other causes that may have arisen during or after the pandemic – for example, reduced access to health services for non-COVID-19 patients or fewer people seeking treatment because of fear of contracting the virus (indirect deaths). The indicator of excess mortality (defined as deaths from all causes over and above what would have been normally expected based on the experience from the previous five years) can provide a broader measure of the direct and indirect deaths due to COVID-19.

At the peak of COVID-19 deaths during the first wave in March and April 2020 and again during the second wave in November 2020, excess mortality in Italy was substantially higher than the number of reported COVID-19 deaths. Overall, between early March and the end of December 2020, excess mortality (about 110 000 deaths) was about 45 % greater than reported COVID-19 deaths (about 75 000). The larger gap during the first wave can be explained by insufficient testing capabilities and by an overstretched national health system with limited capacity to code death certificates properly during that period. Without a positive test result, a large number of deaths were initially not attributed to COVID-19.

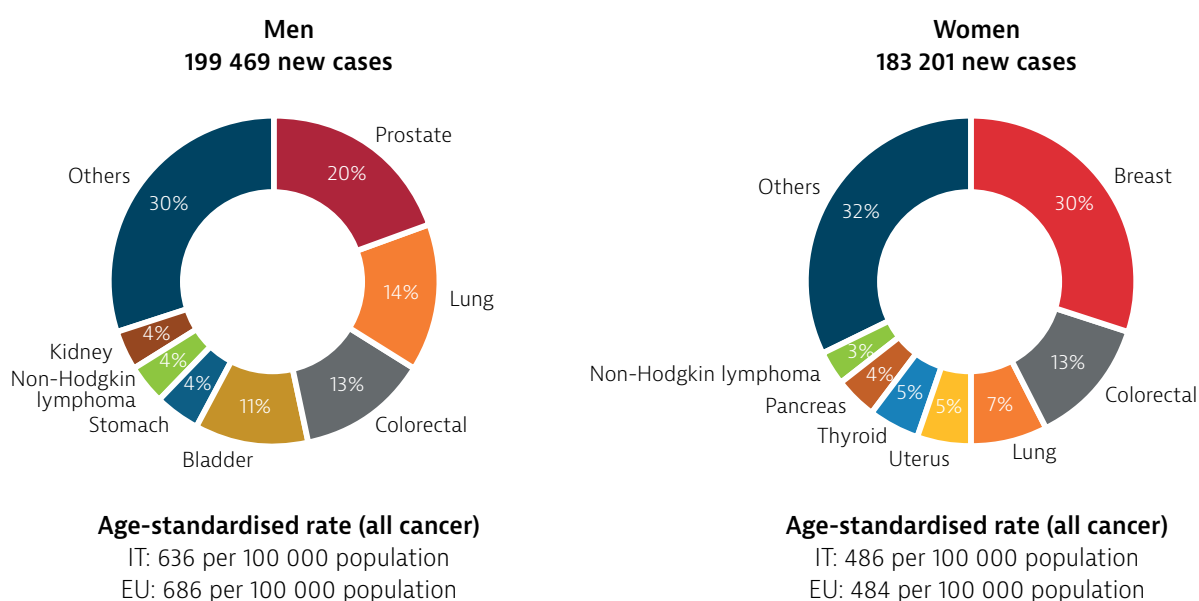
In the Gemelli University Hospital IRCCS in Rome, 87 % of patients previously hospitalised for COVID-19 reported the persistence of at least one symptom – particularly fatigue and breathing problems – in follow-up assessments taking place on average 60 days after the first COVID-19 symptom (Carfi et al., 2020).

The burden of cancer in Italy is close to the EU average

Over 180 000 people in Italy died from cancer in 2018, and according to estimates from the Joint Research

Centre based on incidence trends from previous years, over 380 000 new cases of cancer were expected in 2020. Cancer incidence rates were expected to be lower than the EU average for men and similar to the EU average for women. The main cancer sites among men are prostate (20 %), lung (14 %) and colorectal (13 %), while among women breast cancer is the leading cancer (30 %), followed by colorectal (13 %) and lung cancer (7 %) (Figure 4). Cancer prevention is one of the main priority areas of the five-year National Prevention Plan introduced in Italy in August 2020 (Ministry of Health, 2020).

Figure 4. More than 380 000 people in Italy were expected to be diagnosed with cancer in 2020



Note: Non-melanoma skin cancer is excluded; uterus cancer does not include cancer of the cervix.
Source: European Cancer Information System.

3 Risk factors

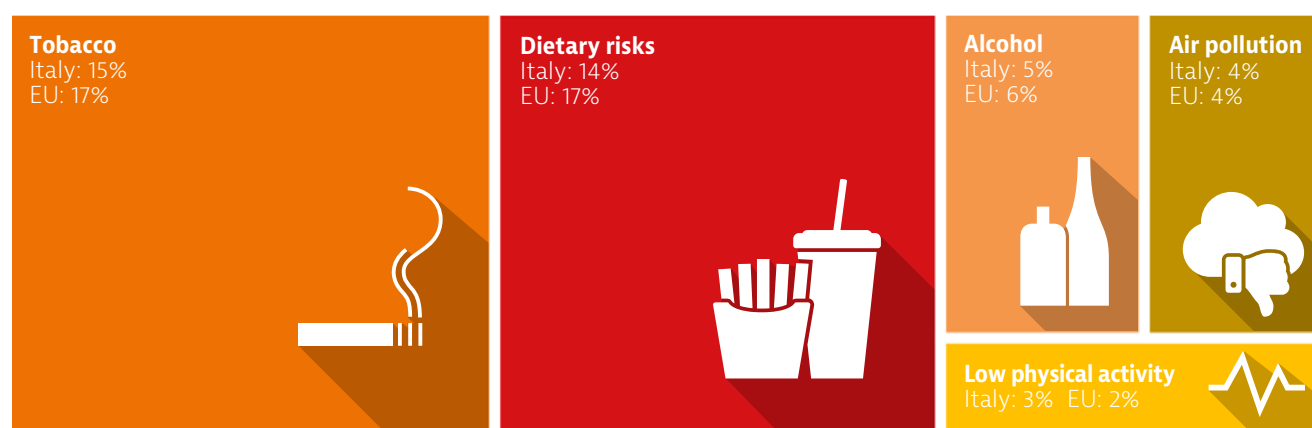
Behavioural and environmental risk factors are major drivers of mortality

Around one third of all deaths in Italy registered in 2019 can be attributed to behavioural risk factors, such as tobacco smoking, dietary risks, alcohol consumption and low physical activity. Environmental issues like air pollution also contribute to a sizeable number of deaths each year (Figure 5).

Some 15 % of all deaths in 2019 can be attributed to tobacco smoking (including direct and second-hand

smoking) – this share is lower than the EU average, but still amounts to 96 000 deaths. Dietary risks (including low fruit and vegetable intake, and high sugar and salt consumption) are estimated to account for about 14 % of all deaths (87 000 deaths). About 5 % of all deaths (30 000) can be attributed to alcohol consumption, while about 3 % (18 000) are related to low physical activity. Air pollution in the form of fine particulate matter (PM_{2.5}) and ozone exposure alone accounted for about 4 % of all deaths (28 000) in 2019, mainly from cardiovascular diseases, respiratory diseases and some forms of cancer.

Figure 5. Tobacco and dietary risks are major contributors to mortality in Italy



Note: The overall number of deaths related to these risk factors is lower than the sum of each one taken individually, because the same death can be attributed to more than one risk factor. Dietary risks include 14 components such as low fruit and vegetable intake, and high sugar-sweetened beverages consumption. Air pollution refers to exposure to PM_{2.5} and ozone.

Source: IHME (2020), Global Health Data Exchange (estimates refer to 2019).

Smoking remains an important public health issue

Although smoking among adults has decreased since 2000, in 2019 18 % of Italian adults still smoked regularly – a proportion slightly below the EU average (19.5 %). The smoking rate among adults in Italy remains much higher than in the best-performing countries such as Sweden and Norway, where 10 % or less of adults smoke every day. As in many other countries, there is a marked gender gap: 22 % of men were regular smokers in 2019, compared with 14 % of women.

During the COVID-19 pandemic, more than one million additional people smoked, which is equivalent to a rise of over two percentage points in the share of the Italian population smoking regularly. This increase was particularly strong among users of electronic cigarettes (National Institute of Health, 2021).

Smoking rates among teenagers in Italy also remain very high. In 2018, nearly 30 % of 15-year-olds reported having smoked in the past month, which is one of the highest rates in the EU. Smoking rates were greater among girls (33 %) than boys (24 %). Further, the use of e-cigarettes has become more popular, and 13 % of 15- and 16-year-olds reported smoking e-cigarettes in 2019 – a proportion close to the EU average (14 %), according to the ESPAD survey. The European Commission has set an ambitious goal of ensuring that less than 5 % of the population uses tobacco by 2040 under the Europe's Beating Cancer Plan (see Section 5.1).

Alcohol consumption is low among adults, but many adolescents report excessive alcohol intake

Alcohol consumption among adults in Italy is lower than in most EU countries, and was over 20 % lower than the EU average in 2019. The proportion of adults who report heavy alcohol consumption is also much lower than in nearly all other EU countries.

However, about one in five (19 %) 15-year-olds reported having been drunk at least twice in their life in 2018 – a proportion close to the EU average (22 %).

Overweight and obesity rates are high among children and adolescents

Nearly one in five 15-year-olds in Italy (19 %) was overweight or obese in 2018, according to the Europe-wide HBSC survey, which is a proportion similar to the EU average. A national survey, focusing on primary school children, reports even higher rates: 30 % of children aged 8-9 were either overweight or obese in 2019, although this rate was down slightly from 31 % in 2016 (Ministry of Health et al., 2019).

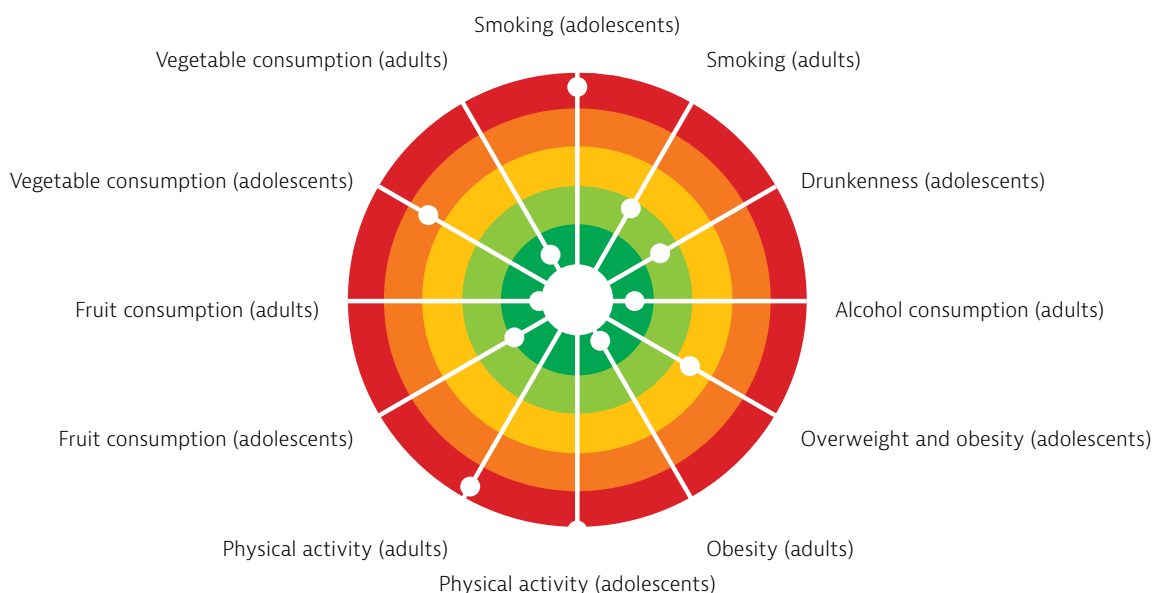
Overweight and obesity are more prevalent in the south of the country, among households with poor socioeconomic conditions and children who were breastfed for less than one month.

Obesity rates among adults have increased slightly over the past 15 years, up from 9 % in 2003 to 11 % in 2019, but remain lower than in most other EU countries.

Poor nutrition is the main factor contributing to overweight and obesity. In 2019, nearly 40 % of Italian adults reported not eating vegetables every day, and 30 % reported not regularly eating fruit – although these proportions are lower than in most EU countries. Daily fruit consumption among 15-year-olds is also slightly more common in Italy than in most EU countries. However, over 70 % of 15-year-olds do not eat vegetables every day – a share higher than in most EU countries.

Low physical activity also contributes to overweight and obesity. Only 4 % of 15-year-old girls and 7 % of 15-year-old boys reported doing at least moderate physical exercise each day in 2018; these are the lowest rates across EU countries (Figure 6). Similarly, the level of physical activity among Italian adults is among the lowest in the EU.

Figure 6. Adolescent smoking and obesity, as well as low physical activity are important public health issues



Note: The closer the dot is to the centre, the better the country performs compared to other EU countries. No country is in the white "target area" as there is room for progress in all countries in all areas.

Sources: OECD calculations based on HBSC survey 2017-18 for adolescents indicators; OECD Health Statistics, EHIS 2014 and 2019 for adults indicators.

4 The health system

The regions are responsible for organising and delivering health care

Italy's National Health Service (NHS) is decentralised and regionally based. The central government channels general tax revenues for publicly financed health care, defines the benefits package and exercises

overall stewardship. Each region is responsible for organisation and delivery of health services through local health units and via public and accredited private hospitals. This model was maintained during the COVID-19 pandemic, but leadership and administrative authority for the national response to the crisis were partly centralised (Box 2).

Box 2. Governance arrangements for Italy's COVID-19 response were coordinated at the national level

Italy's emergency response to the COVID-19 pandemic was led by the Prime Minister's Office, supported by the national Department of Civil Protection and the "Extraordinary Commissioner" appointed in March 2020 to coordinate measures to combat the pandemic. Binding decisions were issued via Prime Ministerial decrees, although these increasingly reflected consultation and mediation with regional leaders, particularly with regard to imposing lockdowns and other restrictions under the state of emergency activated in March 2020. A Scientific and Technical Committee was established in February 2020 to provide technical support and scientific evidence for the central government's decision-making on preventive and protective measures. The National Health Institute

Source: COVID-19 Health System Response Monitor.

was also instrumental in coordinating the national disease surveillance system and using the network of reference laboratories to gather and analyse key data daily.

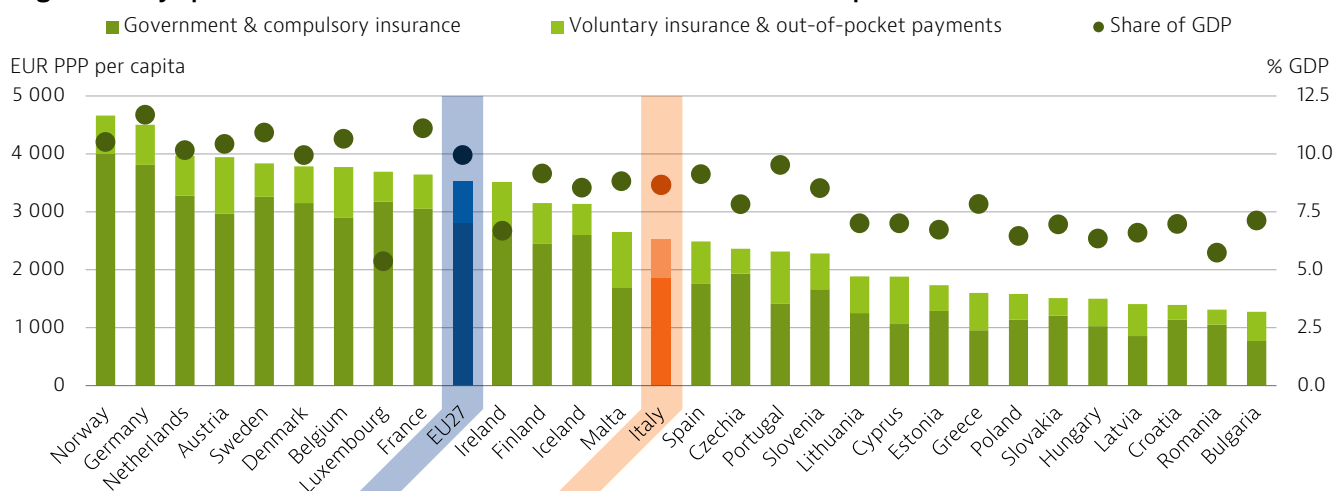
The national Ministry of Health was the main authority for the health system response, coordinating with regional ministries. The regions set up crisis management units with regional health authorities, directors of local health units and the prefectures as representatives of the central state. In the early response, the government also activated the Department of Civil Protection to support regions in the procurement of pharmaceuticals, medical devices, human resources and infrastructure.

Health spending grew slowly before the pandemic

In 2019, Italy spent 8.7 % of GDP on health care, compared to the EU average of 9.9 %. In the same year, per capita spending reached EUR 2 525 (adjusted for differences in purchasing power), which is over 25 % below the EU average (EUR 3 523) (Figure 7). Historically, health expenditure in Italy has always been lower than the EU average, but slow increases

have occurred over the last five years, mainly driven by a growth in private spending. Public spending as a proportion of total health expenditure was 74 % in 2019 – lower than the EU average of 80 %. Most of the remaining expenses came from direct out-of-pocket (OOP) payments by households (23 %), as voluntary health insurance (VHI) only plays a minor role (covering only 3 % of the total). The COVID-19 emergency prompted additional funding injections in 2020 to support the health sector (Box 3).

Figure 7. Italy spends less on health care than most other western European countries



Note: The EU average is weighted. Source: OECD Health Statistics 2021 (data refer to 2019, except for Malta 2018).

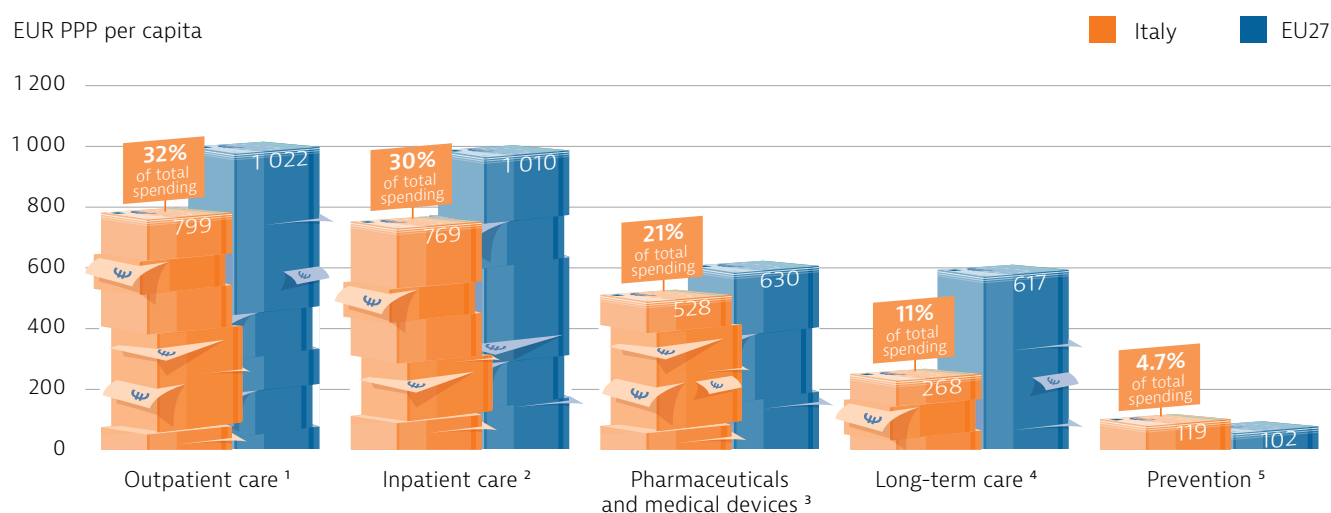
Box 3. Extra funding was secured for Italy's health system response to COVID-19

In 2020, the national government approved a EUR 7.5 billion funding injection for the NHS and the Department of Civil Protection to support ongoing pandemic response measures such as hiring new health workers and paying overtime, boosting the National Emergency Fund, increasing the number of intensive care unit beds, subsidising companies that produce surgical masks and related products, and allocating resources for prevention and sanitation in schools and public infrastructure (see Section 5.3).

Spending on outpatient care has overtaken expenditure on hospital care

Outpatient care was the largest category of health spending in Italy in 2019, accounting for one third of current health expenditure – slightly higher than spending on inpatient services (Figure 8). On a per capita basis, Italy spent one fifth less than the EU averages on both outpatient and inpatient care. Pharmaceuticals and medical devices accounted for one fifth of health expenditure in 2019. Long-term care, which is increasingly important due to Italy's rapidly ageing population, accounted for a limited share of spending (11 %), and is substantially lower than the EU average in per capita terms. On the other hand, spending on prevention was higher than the EU average both as a share of health spending (4.7 % compared with 2.9 %) and in per capita terms.

Figure 8. Spending across most health services, except prevention, is lower in Italy than in the EU



Note: The costs of health system administration are not included. 1. Includes home care and ancillary services (e.g. patient transportation); 2. Includes curative-rehabilitative care in hospital and other settings; 3. Includes only the outpatient market; 4. Includes only the health component. 5. Includes only spending for organised prevention programmes. The EU average is weighted.
Sources: OECD Health Statistics 2021, Eurostat Database (data refer to 2019).

Italy has relatively few hospital beds but a long average length of stay

Prior to the pandemic, the number of hospital beds per 1 000 population had remained stable at 3.2 in Italy between 2014 and 2019, which is considerably below the EU average of 5.3. There are large regional differences: southern regions generally have lower capacity, at 2.4 beds per 1 000 population in 2019, compared to 3.4 beds per 1 000 population in the northern part of Italy. The stable number of hospitals has been accompanied by a sharp reduction in hospital discharges. In 2019, the hospital discharge rate in Italy was the third lowest in the EU after the Netherlands and Portugal. The discharge rate decreased by 18 % between 2010 and 2019.

On the other hand, the average length of stay has increased slightly since 2010, while it has decreased in most EU countries: in 2019 the average length of stay in hospital in Italy was 8.0 days – higher than the EU average (7.4 days). The slight increase in Italy may be due to a substitution of low-intensity inpatient care with ambulatory care and home care. Therefore, the remaining inpatient cases are more complex and have longer stays on average.

During the first wave of the COVID-19 pandemic in 2020, Italy's hospitals were quickly overwhelmed, with drastic shortages of acute care and intensive care unit (ICU) beds, especially in some of the northern regions at the epicentre of the outbreak (see Section 5.3).

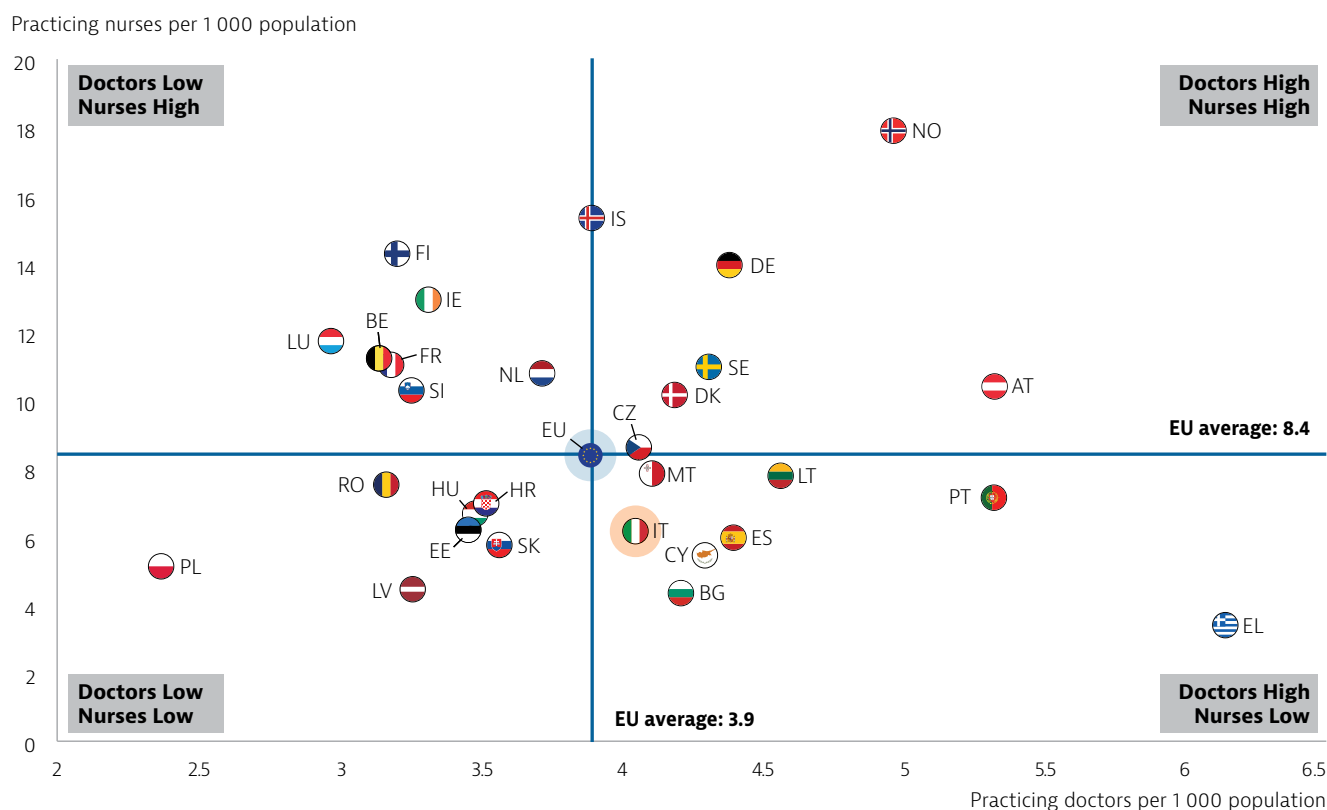
Falling numbers of nursing graduates are keeping nurse numbers low

The total number of doctors in Italy is slightly higher than the EU average, at 4.1 compared to 3.9 per 1 000 population in 2019. However, the number of doctors working in public hospitals and general practitioners (GPs) is declining. As the average age of Italian doctors has increased, a significant shortage is projected in the years to come – especially in some specialties and

general practice – if the current criteria for accessing specialty training remain unchanged.

Italy employs fewer nurses than nearly all western European countries, and the number (6.2 per 1 000 population) is 25 % lower than the EU average (Figure 9). As the number of nursing graduates has declined since 2014, nurse shortages are likely to exacerbate in the future.

Figure 9. Italy has a relatively high number of doctors but far fewer nurses



Note: The EU average is unweighted. In Portugal and Greece, data refer to all doctors licensed to practise, resulting in a large overestimation of the number of practising doctors (e.g. of around 30 % in Portugal). In Greece, the number of nurses is underestimated as it only includes those working in hospitals. Source: Eurostat Database (data refer to 2019 or the nearest year).

5 Performance of the health system

5.1 Effectiveness

Before the pandemic, Italy had low rates of preventable and treatable causes of mortality

Italy had the lowest preventable mortality rate in the EU in 2018 (Figure 10). As for all other countries, this rate will increase when data for this indicator become available for 2020 and 2021 because of the COVID-19 pandemic. The low rate in 2018 reflected low mortality rates from ischaemic heart disease, lung cancer, accidental deaths, suicide and alcohol-related

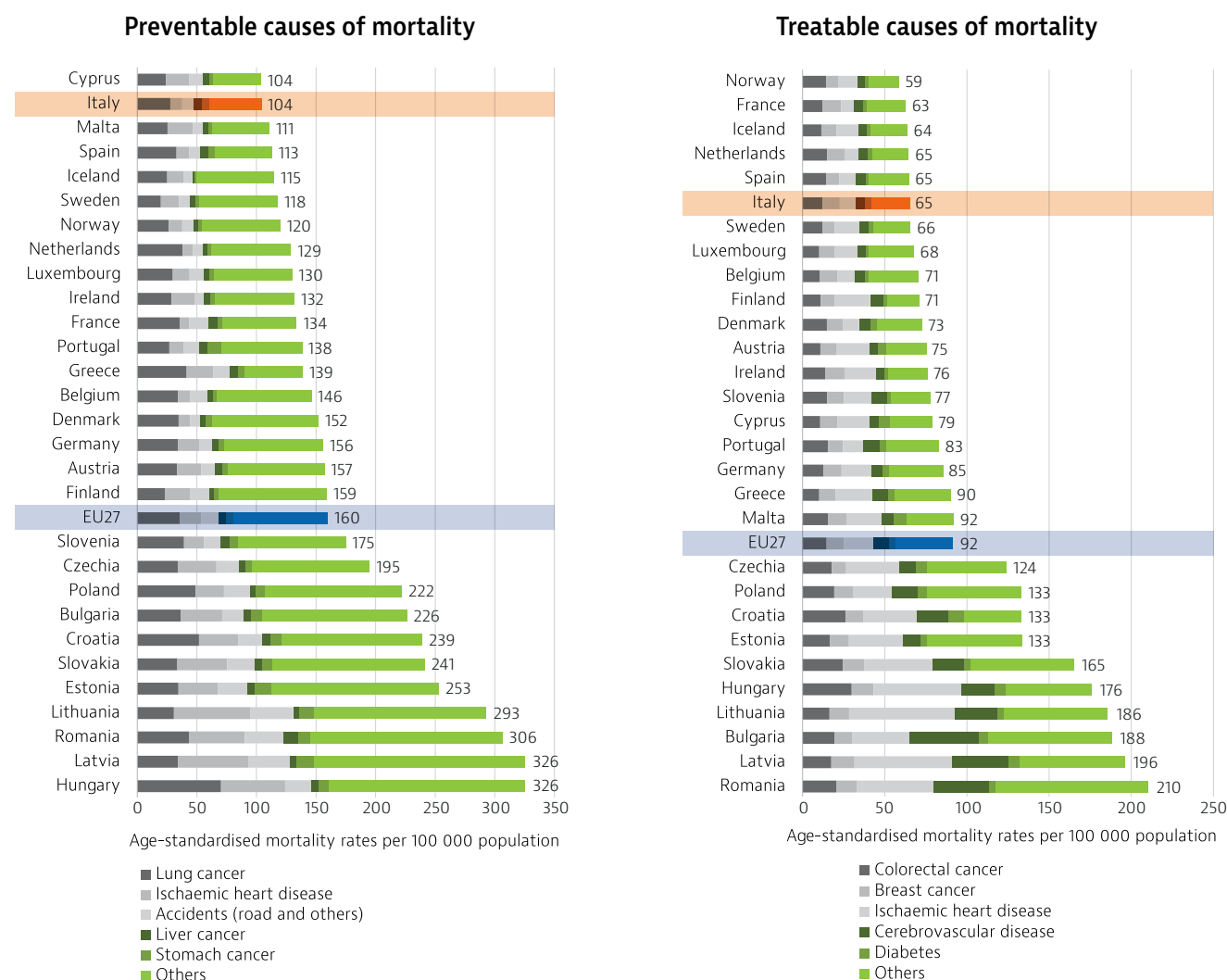
diseases, which were all well below the EU averages because of lower prevalence of risk factors and lower incidence of these health issues. Examples of active prevention policies, coordinated by the National Centre for Disease Prevention and Control in the context of the Gaining Health Programme, include schools with active health promotion programmes/activities and increasing food literacy among citizens.

The number of deaths deemed potentially avoidable through health care interventions was also one of the lowest in the EU in 2018 (Figure 10), indicating that the Italian health system is generally effective in treating patients with life-threatening conditions.

This positive result is related to relatively low mortality rates from ischaemic heart disease, stroke and colorectal cancer.

Preventable and treatable causes of mortality decreased more rapidly in Italy between 2011 and 2018 than in the EU as a whole.

Figure 10. Italy had among the lowest rates of preventable and treatable mortality in the EU in 2018



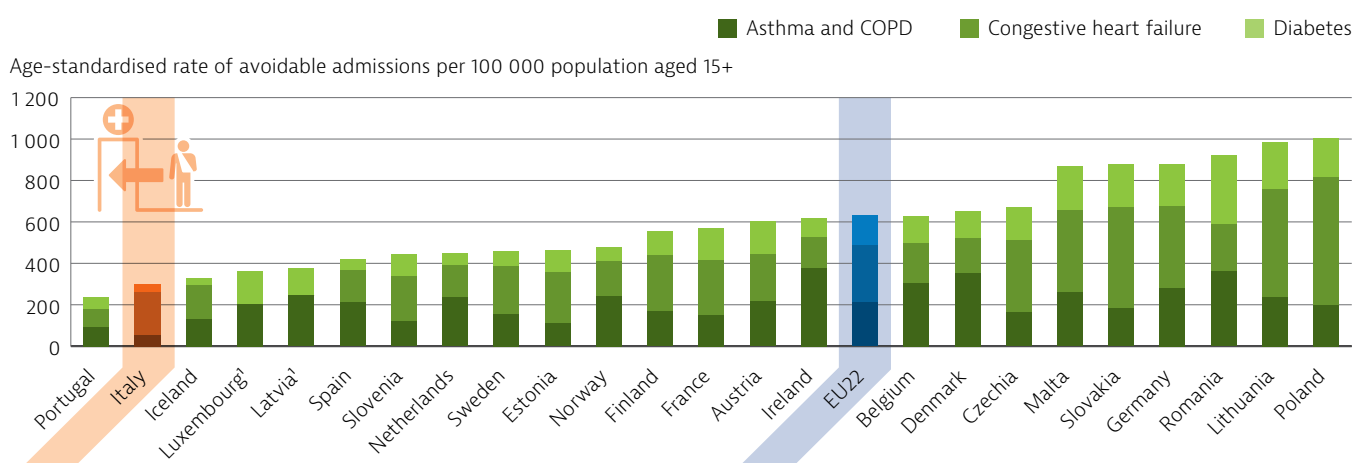
Note: Preventable mortality is defined as death that can be mainly avoided through public health and primary prevention interventions. Treatable mortality is defined as death that can be mainly avoided through health care interventions, including screening and treatment. Half of all deaths for some diseases (e.g. ischaemic heart disease and cerebrovascular disease) are attributed to preventable mortality; the other half are attributed to treatable causes. Both indicators refer to premature mortality (under age 75). The data are based on the revised OECD/Eurostat lists.

Source: Eurostat Database (data refer to 2018, except for France 2016).

Effective primary care helps to keep people out of hospital

Hospital admission rates for chronic diseases such as asthma, chronic obstructive pulmonary disease (COPD) and diabetes in Italy are among the lowest in the EU (Figure 11). This reflects a fairly effective primary care system, where GPs act as gatekeepers and – in some regions – multidisciplinary teams provide acute and chronic care, as well as preventive services for the whole population.

Performance indicators reported by the National Healthcare Outcomes Programme show important regional differences in the rate of hospitalisations for COPD, which may reflect a lower threshold for admission in several southern regions compared to the northern part of Italy (Agenas & Ministry of Health, 2020).

Figure 11. Avoidable hospital admissions for chronic conditions are well below the EU average

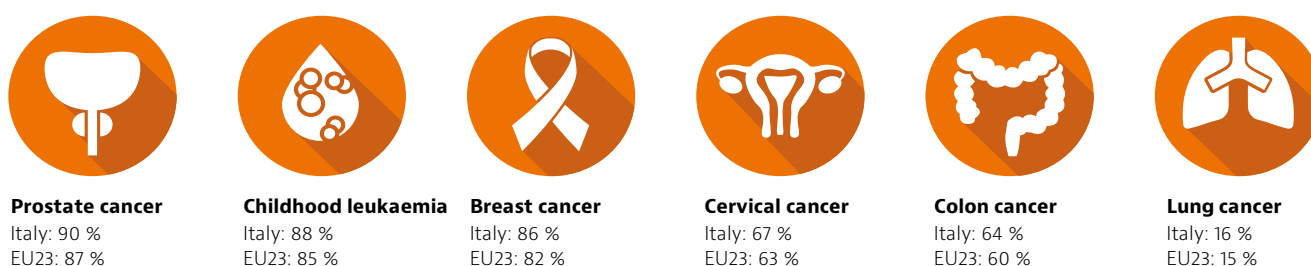
Note: 1. Data for congestive heart failure are not available in Latvia and Luxembourg.

Source: OECD Health Statistics 2021 (data refer to 2019 or nearest year).

Cancer survival rates are above the EU averages, despite limited coverage of screening programmes

In spite of limited take-up of cancer screening programmes, five-year survival rates following diagnosis for common cancers (prostate, breast, cervical and colon cancer) and childhood leukaemia

are higher in Italy than the EU average (Figure 12). This strong performance suggests that the Italian health care system is by and large able to provide effective and timely treatment for patients with these common cancers. On the other hand, survival rates for people with lung cancer remain relatively low in Italy, as in other EU countries.

Figure 12. Italy fares well compared with other EU countries for five-year cancer survival rates

Note: Data refer to people diagnosed between 2010 and 2014. Childhood leukaemia refers to acute lymphoblastic cancer.

Source: CONCORD Programme, London School of Hygiene and Tropical Medicine.

Several national screening plans have been put in place over the last decade to promote screening for common types of cancer such as breast, cervical and colorectal cancer. Although these programmes are offered free of charge to their target populations, coverage remains limited. Only 61 % of women in the target age group of 50-69 had been screened for breast cancer over the past two years in 2019. This is slightly higher than the EU average of 59 %, but much lower than in leading countries in northern Europe (Sweden, Finland and Denmark), where breast cancer screening rates exceed 80 %.

Improving equity of access and quality of cancer screening programmes are among the main objectives of the National Prevention Plan 2020-25, which was

endorsed in August 2020 (Ministry of Health, 2020). In particular, this plan recommends transition to a human papillomavirus DNA test for primary cervical cancer screening, and implementation of genetic counselling and testing programmes for breast cancer risk. Before the adoption of this new plan, in April 2019 the government had already approved new guidelines for governance of the regional oncology networks, aimed at regulating hospital acute and post-acute care for cancer patients. These strategies are consistent with the recent Europe's Beating Cancer Plan, which is structured around four key action areas of prevention, early detection, diagnosis and treatment, and quality of life improvement for cancer patients (European Commission, 2021a).

COVID-19 had a dampening effect on the uptake of cancer screening programmes

The pandemic resulted in a large drop in cancer screening rates in 2020 compared to 2019. Screening rates fell by 38 % for breast cancer, 43 % for cervical cancer and 46 % for colorectal cancer (National Screening Observatory, 2021). This corresponds to 2.5 million fewer screening appointments for these three types of cancer. These drops were much higher in some regions in the north (Liguria and Lombardy) and the south (Campania). It is estimated that it will take at least the equivalent of four months of standard capacity to eliminate the backlog for each type of screening. Delays in screening will result in later diagnosis and treatment, with possible impact on survival.

5.2 Accessibility

Unmet needs for medical care are close to the EU average

Prior to the COVID-19 pandemic, only 1.8 % of the Italian population reported unmet needs for medical care in 2019, mostly for financial reasons. This was close to the EU average of 1.7 %, according to EU-SILA. As in many other countries, the proportion of unmet medical care needs was much greater among people in the lowest income quintile (3.5 %) than among those in the highest (0.5 %).

There are sizeable disparities in access to care across regions, with citizens from poorer regions in the south more than twice as likely to report unmet medical care needs than those living in wealthier regions in the north, due to financial reasons, waiting times or travel distances.

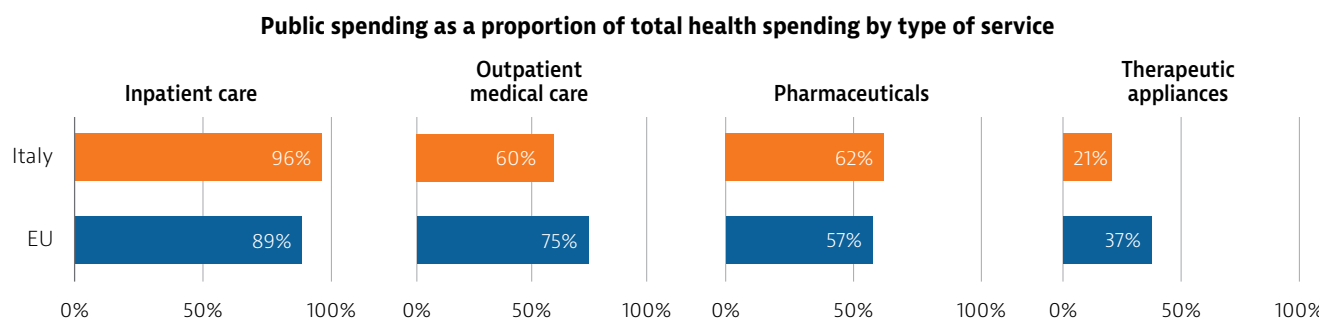
The COVID-19 crisis and lockdown measures limited access to health services in 2020. A survey carried out in February/March 2021 found that 23 % of the population reported having forgone a needed medical examination or treatment during the first 12 months of the pandemic. This was slightly higher than the EU average of 21 % (Eurofound, 2021).¹

Regions can enlarge the benefits package if they have sufficient resources

As noted in Section 4, the NHS covers all citizens and legal foreign residents. Coverage is automatic and universal, and care is generally free for hospital and medical services. Irregular migrants are entitled to access urgent and essential services. The basic benefits package covers a wide range of services, and must be guaranteed uniformly across the country. A compliance monitoring system is organised at the national level to identify regions that do not guarantee the basic package to their populations (Ministry of Health, 2021). Regions can also choose to offer services beyond the benefits package list, but must finance these with funds collected from regional taxes.

Compared to the EU average, the share of public financing for health services in Italy is higher for inpatient care and pharmaceuticals, but lower for therapeutic appliances such as glasses and hearing aids (Figure 13). Due to constraints in data reporting, spending on dental care from public sources is included under outpatient medical care in Italy.

Figure 13. The public share of financing for pharmaceuticals in Italy is higher than the EU average



Note: Outpatient medical services mainly refer to services provided by generalists and specialists in the outpatient sector. Pharmaceuticals include prescribed and over-the-counter medicines as well as medical non-durables. Therapeutic appliances refer to vision products, hearing aids, wheelchairs and other medical devices. n.a. = not available.

Source: OECD Health Statistics 2021 (data refer to 2019).

1. The data from the Eurofound survey are not comparable to those from the EU-SILC survey because of differences in methodologies.

Co-payments are applied across several categories of care, but COVID-19 services are free of charge

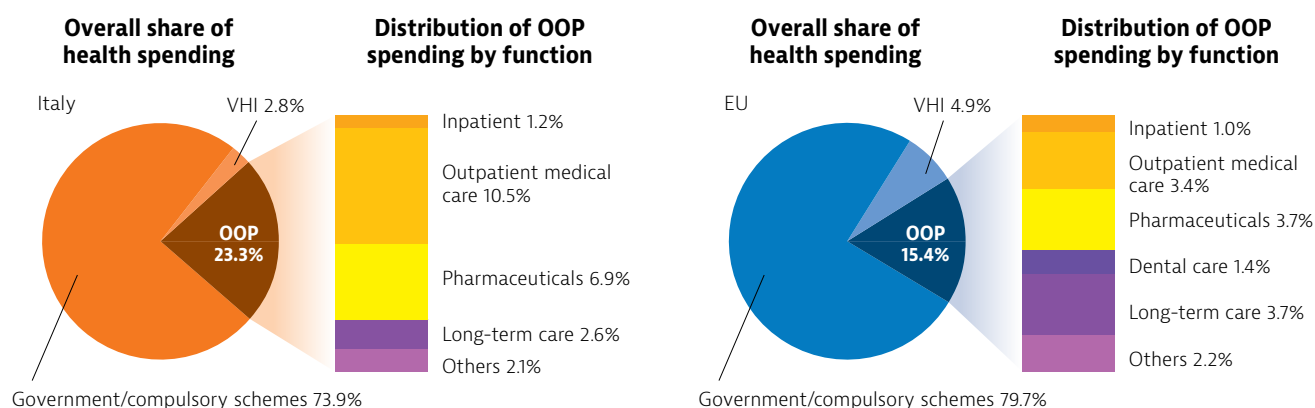
Out-of-pocket (OOP) expenditure as a share of health spending in Italy increased from 20.5 % in 2010 to 23.2 % in 2019. This is well above the EU average of 15.4 % (Figure 14). Voluntary health insurance plays a minor role in Italy, representing just 2.8 % of total health spending.

A large proportion of OOP payments in Italy are spent on outpatient medical care, making up 45 % of the total, and on outpatient pharmaceuticals, which constitute 30 % of total OOP spending. While GP consultations are free, co-payments are levied

on specialist visits with a GP referral (without a referral, the full cost is paid by patients) and diagnostic procedures. For pharmaceuticals, there may be regional co-payments and direct OOP costs resulting from the difference between the price of the purchased product and that of a cheaper alternative. Catastrophic household expenditure due to OOP spending is relatively high in Italy (8 % of households in 2016), and is mostly concentrated in the lowest income quintile (OECD/EU, 2020).²

All COVID-19-related treatment, testing prescribed by a doctor if the individual was in direct contact with another individual who tested positive for COVID-19 and vaccinations are available to all residents free of charge.

Figure 14. Out-of-pocket payments are high, driven by outpatient specialist care and pharmaceuticals



Note: The EU average is weighted. VHI also includes other voluntary prepayment schemes. Outpatient medical care includes dental care in Italy. Sources: OECD Health Statistics 2021; Eurostat Database (data refer to 2019).

Uptake of generics is constrained by a pharmacy remuneration system linked to the drug sale price

Italy has implemented a series of measures to promote greater use of generics to improve affordability and value for money in pharmaceutical spending. Unless a reason is provided by the doctor to preclude substitution, the pharmacist must let customers know if a cheaper equivalent product exists. If the doctor indicates that the medicine is not substitutable, or if the customer insists on purchasing the brand name, the customer must pay the difference between the price of the dispensed medicine and the cheapest alternative.

Between 2005 and 2019, the generics market share in Italy increased from 7 % to 28 % in volume. Nevertheless, this remains 20 percentage points below the EU average – a gap similar to that reported in 2005.

Between 2015 and 2019, customer spending to cover the difference between the price of the dispensed medicine and the cheapest alternative continued to increase by 3 % annually (Italian Medicines Agency, 2020). This increase may in part be explained by the fact that pharmacies are remunerated according to a fixed percentage of the consumer price of each product, which creates a disincentive for them to dispense (cheaper) generic medicines.

Further measures to improve access to medicines would be consistent with the EU's pharmaceutical strategy for Europe (European Commission, 2020), which was adopted in November 2020 to ensure that patients have access to innovative and affordable medicines. The strategy is also expected to allow Europe to cover its pharmaceutical needs, including in times of crisis, through robust supply chains.

² Catastrophic expenditure is defined as household OOP spending exceeding 40 % of total household spending net of subsistence needs (i.e. food, housing and utilities).

5.3 Resilience

This section on resilience focuses mainly on the impacts of and responses to the COVID-19 pandemic.³ As noted in Section 2, the COVID-19 pandemic had a major impact on population health and mortality in Italy in 2020 and 2021. Italy had registered about 129 000 deaths from COVID-19 as of the end of August 2021, with most concentrated among older people. Measures taken to contain the pandemic also had a huge impact on the economy. GDP decreased by 8.9 % in 2020 – more than the EU average of 6.2 % – and is not projected to return to 2019 levels before 2022. The unemployment rate increased, particularly among young people, rising from 28 % in March 2020 to 33 % in March 2021 among people aged 15-24.

Italy was the first EU country affected by the pandemic and among the hardest hit during the first wave

Italy was the first European country affected by the pandemic: the first cases of COVID-19 were identified in early February 2020. The spread accelerated at an exponential rate; the threshold of 1 000 cases was crossed on 29 February, and on 10 March more than 10 000 people were infected by the virus. The spread of the virus across the Italian territory was uneven. The north of the country – Lombardy in particular, and to a lesser degree the Veneto, Emilia-Romagna and Piedmont regions – saw the largest concentration of

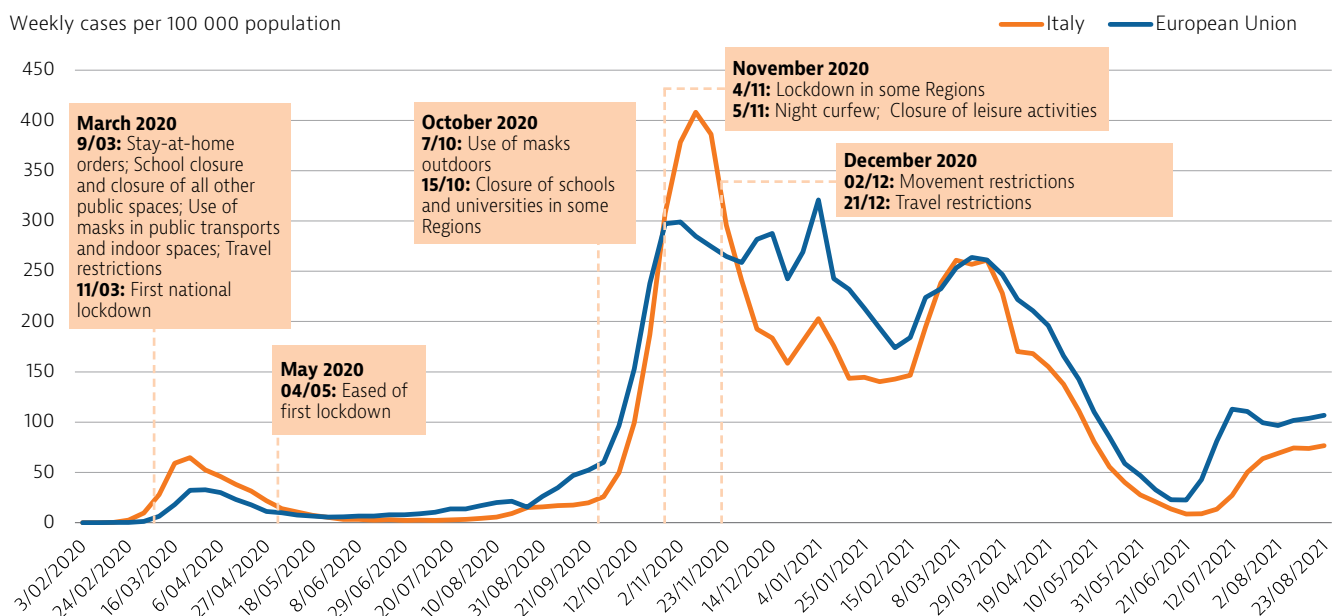
cases, while southern regions were relatively spared, in particular during the first wave of the pandemic.

During the first wave, the decision to shift COVID-19 non-acute patients from hospitals to care homes to free up hospital capacity and the reluctance to impose “red zones” to avoid hindering local economic activity caused a dramatic rise in cases and deaths in Lombardy. At the same time, regions such as Veneto did their best to keep people out of hospitals by bolstering primary and home-based care and increasing their testing, tracking and tracing capacity.

Despite a well-developed health care system in the regions most affected by the pandemic, Italy was unable to flatten the curve of infections early enough (Figure 15). This led to rapid saturation of hospital capacity and a dramatic acceleration in deaths, which reached a peak of 800 per day at the end of March 2020. During the first wave from early March to the end of May 2020, Italy recorded more than 34 000 deaths, which was one of the highest death rates in Europe at that time (Figure 16).

The number of COVID-19 deaths during the second wave – which started at the end of September 2020 – exceeded those in the first wave, with nearly 40 000 deaths registered between October and December 2020 (ISTAT & National Health Institute, 2021). An additional 54 000 people died from COVID-19 between January and August 2021.

Figure 15. Italy implemented two national or regional lockdowns in 2020 to contain transmission

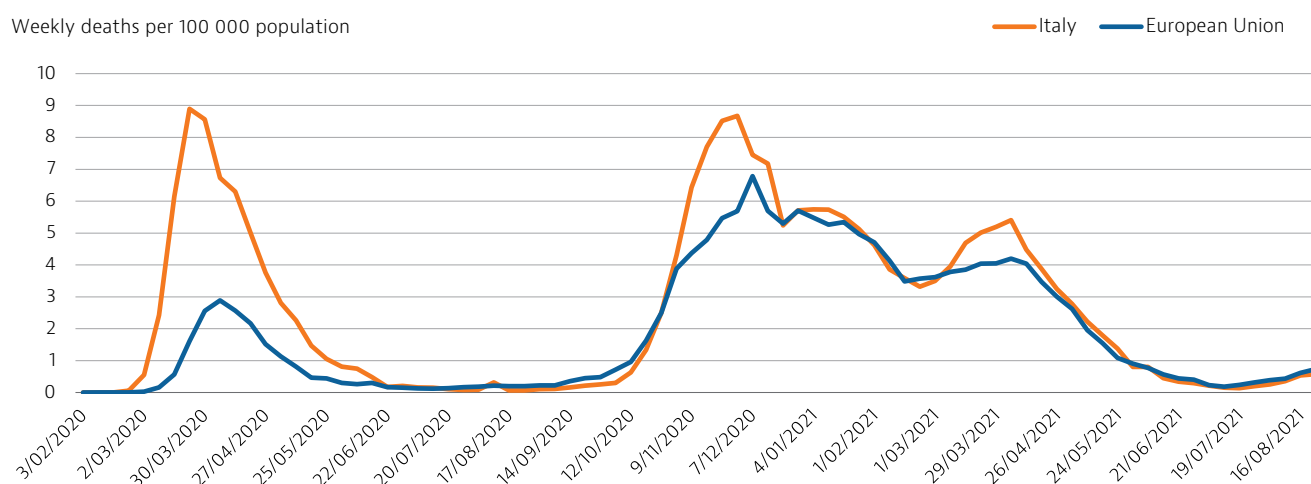


Note: The EU average is unweighted (the number of countries used for the average varies depending on the week).
Source: ECDC for COVID-19 data and authors for containment measures.

3. In this context, health system resilience has been defined as the ability to prepare for, manage (absorb, adapt and transform) and learn from shocks (EU Expert Group on Health Systems Performance Assessments, 2020).

Figure 16. COVID-19 deaths in Italy exceeded the EU average, particularly during the first wave in 2020

Weekly deaths per 100 000 population

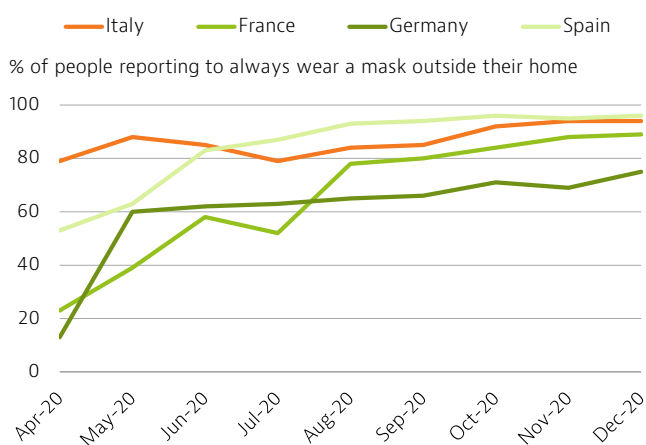


Note: The EU average is unweighted (the number of countries used for the average varies depending on the week).

Source: ECDC.

As the spread of COVID-19 cases started to increase rapidly during the first wave, the government declared a state of emergency in February 2020. Radical measures were taken to combat the pandemic, including decisions to quarantine the main outbreak spots by establishing widespread lockdowns throughout the peninsula (on 9 March 2020) and suspending all activities not essential to the life of the country (on 11 March 2020). The containment measures also included wearing a mask inside all public spaces, social distancing, a national curfew and stay-at-home requirements for people with a fever.

As the second wave of the pandemic began, the government extended the obligation to wear masks outdoors throughout the country on 7 October 2020. Even before this, at least four out of five Italians reported that they always wore a mask outside their home (Figure 17).

Figure 17. Four out of five Italians reported always wearing a mask outdoors throughout the pandemic

Source: YouGov data (<http://www.coviddatashub.com/>).

A broad strategy was developed to mobilise additional laboratory capacity for COVID-19 testing

Notwithstanding regional differences, a broad testing strategy developed at the beginning of the pandemic enabled Italy to estimate more accurately the spread of the virus. While the high test positivity rates in the first weeks of the pandemic indicate that testing was probably limited to certain groups of population – mainly hospitalised patients or people with serious symptoms – the steady increase in the volume of tests from mid-March to the end of April 2020 allowed an expansion of the testing strategy. This resulted in the detection of more positive cases but with lower levels of test positivity rates (Figure 18). By mid-April 2020, 50 000 tests were performed each day, compared with 19 000 tests per day in mid-March. By the end of August 2020, this number reached 90 000 tests per day.

The rapid expansion of laboratory capacity over the course of the pandemic was mainly the result of conversion to COVID-19 testing of diagnostic laboratories previously focused on performing other types of tests, an increase in the availability of reagents and the additional offer of testing at home and at drive-through facilities.

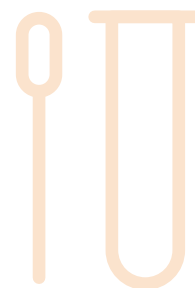
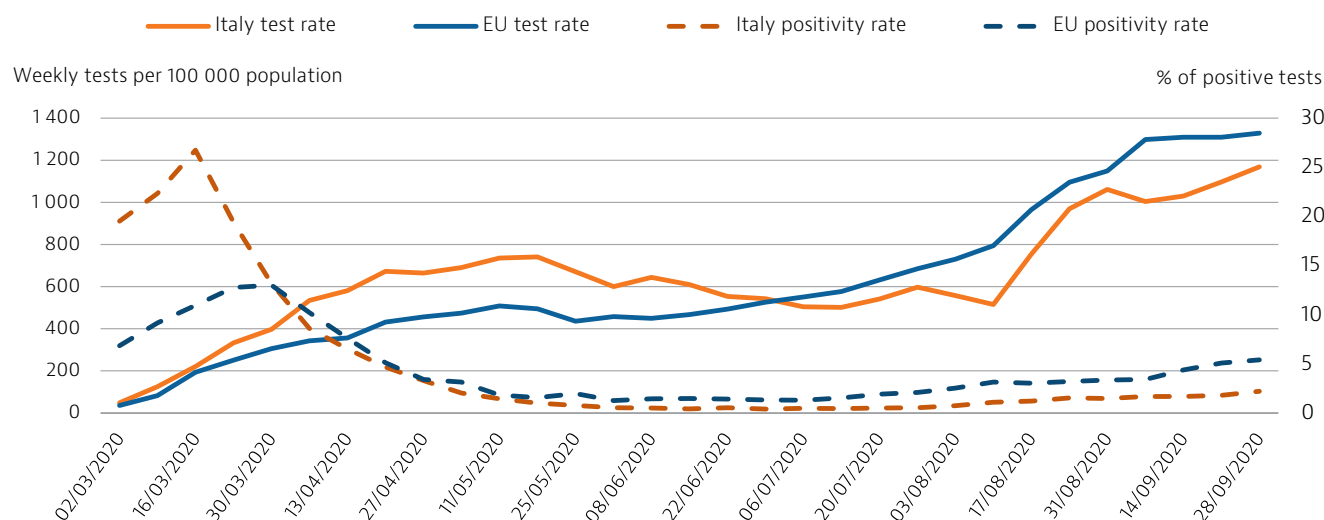


Figure 18. Italy rapidly increased its testing capacity at the beginning of the pandemic

Note: The EU average is weighted (the number of countries included in the average varies depending on the week).
Source: ECDC.

In November 2020, the National Health Institute released a set of guidelines for testing, recognising the strategic role of antigenic rapid tests for close contacts of a confirmed case even for people without symptoms, for people displaying milder symptoms, for people arriving from countries at risk, for community screening and for those voluntarily taking the test for personal reasons, travel or work needs.

Use of the national COVID-19 contact tracing app was low

The COVID-19 contact tracing application “Immuni” was launched on 1 June 2020. As of February 2021, fewer than one in five Italians had downloaded the app. The number of users who uploaded their data when they had tested positive for COVID-19 and the number of notifications sent was quite low. A call centre to help with the data upload when someone had tested positive was activated at the beginning of 2021.



Intensive care unit capacity was boosted during the COVID-19 crisis

Before the COVID-19 crisis, the number of ICU beds in Italy stood at 8.6 per 100 000 population, which was 50 % below the level of most other EU countries for which data are available. In April 2020, the Ministry of Health set a safety target of 14 ICU beds per 100 000 population. However, by mid-October 2020 – just before the start of the second wave – only four of the 20 regions had managed to increase their ICU capacity to comply with this level. On average, 11.8 ICU beds per 100 000 population were available on that date.

During the second wave, several regions reported ICU bed occupancy rates by COVID-19 patients higher than the alert threshold of 30 % set by the Ministry of Health. In the second half of November 2020, around two thirds of the available ICU beds in the Lombardy region were occupied by COVID-19 patients (Figure 19). At the opposite end of the range, Sicily never reported an occupancy rate above the alert threshold during the second wave.

Thereafter, the situation improved significantly, and by March 2021 only four regions had not reached the set target of 14 ICU beds per 100 000 population.

Figure 19. Intensive care unit bed occupancy rates exceeded the alert threshold for the most part in the north and centre of Italy during the second wave in late 2020

North	4-Nov	11-Nov	17-Nov	24-Nov	1-Dec	8-Dec	15-Dec	22-Dec	29-Dec	4-Jan
Bolzano	26	54	57	52	44	39	31	29	26	32
Emilia Romagna	20	34	35	34	33	31	28	27	29	31
Friuli Venezia Giulia	19	26	25	31	35	37	32	32	32	36
Liguria	25	47	53	53	47	41	33	32	28	35
Lombardy	32	58	64	64	61	56	51	44	41	39
Piedmont	25	59	61	64	60	53	42	37	33	29
Trento	15	47	39	47	49	53	59	54	50	48
Valle d'Aosta	29	57	46	38	39	27	18	12	12	5
Veneto	12	21	27	30	30	32	35	34	36	37
Centre										
Lazio	20	26	32	37	37	36	34	33	33	34
Marche	23	45	45	46	44	45	40	33	28	30
Tuscany	29	48	47	48	44	42	37	32	29	25
Umbria	40	58	55	55	49	44	35	32	26	34
South and Islands										
Abruzzo	18	29	37	39	40	37	31	23	20	21
Basilicata	12	n.a.	33	21	23	17	12	9	7	5
Calabria	6	13	34	28	26	16	14	14	9	12
Campania	23	31	34	34	29	23	20	19	16	15
Molise	15	24	26	29	38	24	24	26	24	29
Puglia	20	33	41	45	48	43	41	36	30	30
Sardegna	22	31	37	40	38	34	32	27	24	24
Sicily	19	28	30	29	27	25	23	23	22	23

Note: Cells highlighted in orange indicate a value higher than the alert threshold of 30 % set by the Ministry of Health. n.a.: not available.

Sources: Ministry of Health (Monitoraggio COVID-19 Fase 2, Report settimanale, various editions).

New initiatives boosted the emergency health workforce, particularly in primary care

To boost the supply of emergency health workers during the first wave of COVID-19, in March 2020 the Italian government allowed the NHS temporarily to hire retired doctors, nurses and final-year medical students for a period of six months. Furthermore, to alleviate pressure on both GP offices and hospital emergency departments, the government began rolling out new special units for continuity of care – Unità Speciali di Continuità Assistenziale (USCAs). These special units were set up to undertake proactive management of suspected COVID-19 cases with home health advice and diagnostic tests, follow-up at home of less severe COVID-19 cases and supervision of COVID-19 cases in long-term care residential facilities. Staffed by volunteer medical doctors, specialists, nurses and administrative staff paid on an hourly basis, they were active 12 hours a day, seven days a week. To strengthen and broaden their effectiveness in managing COVID-19 cases, the government subsequently permitted USCAs to be staffed also by psychologists and social care assistants.

In May 2020, Italy introduced the profile of the “family and community nurse”, a new type of advanced practice nurse designed to strengthen home-based care and support the activity of the USCAs. The government allocated EUR 480 million to hire an estimated 9 600 of these nurses over the course of 2021.

Health information systems were strengthened to improve communication and assist policy-making

In Italy, the main sources of information about the COVID-19 pandemic are the Civil Protection Organisation and the National Health Institute. The Civil Protection Organisation collects aggregate information on the total number of positive tests, deaths, hospitalisations and intensive care admissions in all Italian provinces on a daily basis. It created and manages a publicly accessible database containing data about COVID-19. The data are collected daily by the regional institutions, which send them – through the Ministry of Health – to the Civil Protection Organisation, which analyses them and updates the database.

By contrast, the National Health Institute requests that regions provide individual-level data on all laboratory-confirmed COVID-19 infections, including demographic data, clinical conditions and comorbidities. The Department of Infectious Diseases of the National Health Institute processes and analyses the data on the platform and makes the information available to ensure monitoring of the pandemic across the country.

A parallel surveillance system of the bed occupancy rate of ICUs by COVID-19 patients was promptly activated by the Ministry of Health in February 2020. Data are collected daily by regions and sent to the Ministry of Health. A data portal containing this information has also been implemented by the National Agency for Regional Healthcare Services (Agenas, 2021).

The COVID-19 integrated surveillance system proved to be a necessary and useful tool to inform the general population about the impact and evolution of the pandemic and to help authorities make public health decisions.

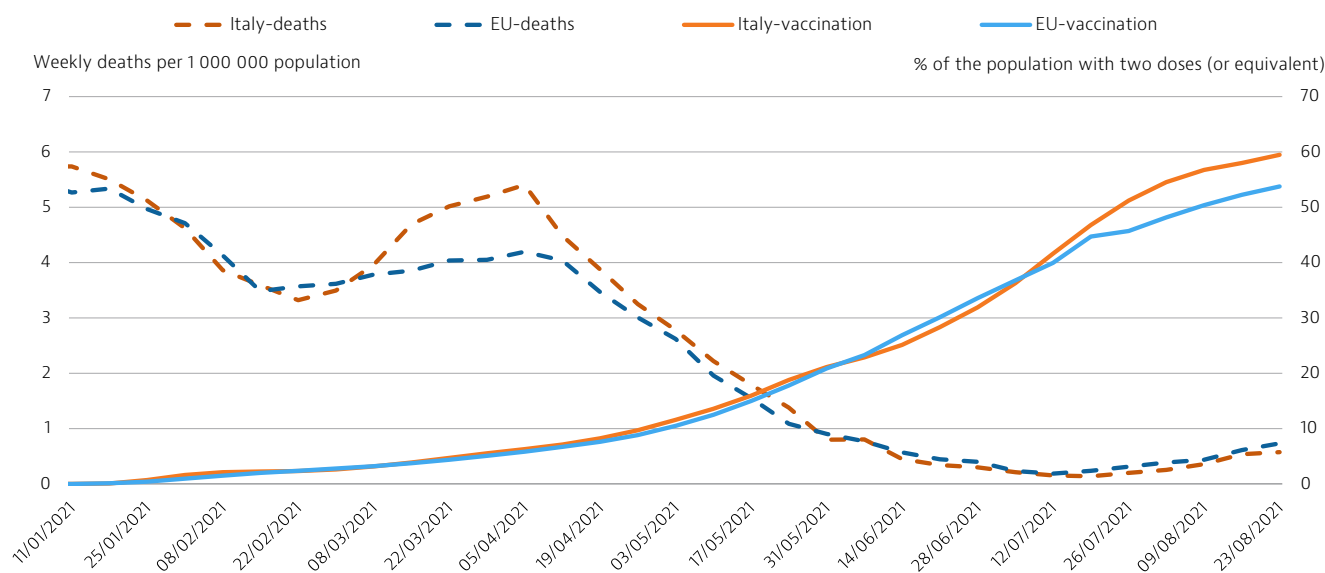
The COVID-19 vaccination plan was rolled out via ad-hoc hubs, general practitioners, nurses and other specialists

As part of the EU's coordinated COVID-19 vaccine procurement programme, Italy started administering the first vaccines at the end of December 2020. A budget of EUR 2.8 billion was earmarked for purchasing COVID-19 vaccines and for the supply of medicines used in the treatment of COVID-19 patients.

To expedite the rollout of the vaccination plan, the NHS and private accredited organisations arranged vaccination centres under the coordination and supervision of regional authorities and the Extraordinary Commissioner. To expand the vaccination campaign further, regions could engage with GPs, nurses, dentists, paediatricians and other specialists. A fund of EUR 345 million was approved to cover the additional cost of administering vaccinations administered through these providers. The government also authorised pharmacists who complete two online training courses to administer COVID-19 vaccines in their pharmacies.

By the end of August 2021, 70 % of the population had received at least one dose and 60 % were considered to be fully vaccinated with two doses or the equivalent – a rate higher than the EU average (Figure 20).

Figure 20. The share of the population vaccinated against COVID-19 was higher than the EU average at the end of August 2021



Note: The EU average is unweighted (the number of countries used for the average varies depending on the week).
Sources: ECDC for COVID-19 cases and Our World in Data for vaccination rates.

Massive investment in health systems was approved in response to the pandemic

To tackle the COVID-19 pandemic, the Italian government allocated an additional EUR 3.7 billion in 2020 and EUR 1.7 billion in 2021 to the health system – increases of 3.3 % and 1.7 % over the original funding plan (Court of Audit, 2020).

In May 2020, the Ministry of Health allocated additional funding to regions to take into account additional hospital costs related to the care of COVID-19 patients. This included funding to cover additional spending on four main items:

- additional ICU beds (computed based on the target of 14 beds per 100 000 population, equivalent to 3 500 additional beds);
- additional high-care beds (a total of 4 225);
- additional emergency room activity;
- financial incentives for personnel and new hires.

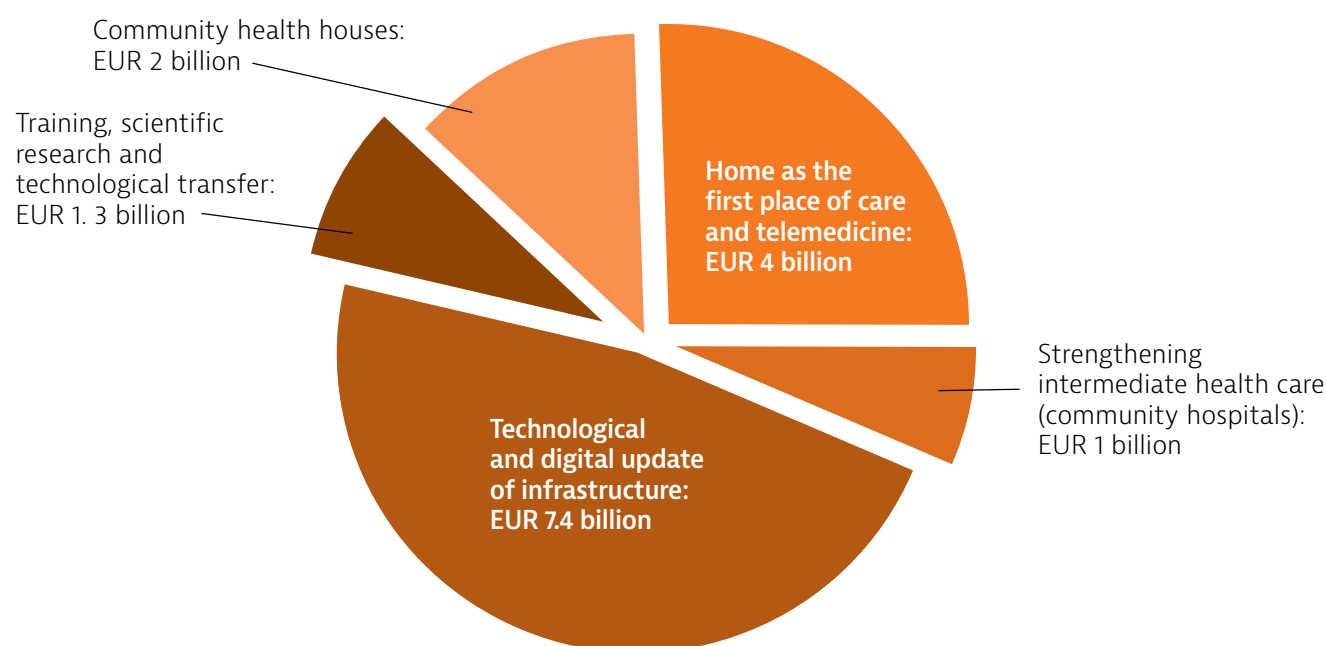
The total amount of additional funding was EUR 1.83 billion, of which EUR 1.4 billion was allocated for capital expenditure on ICU and high-care beds and EUR 431 million for personnel (including EUR 190 million for financial incentives and EUR 241 million for new hiring).

The Ministry of Health also allocated an additional EUR 1.2 billion to strengthen primary care in 2020. Funds were mainly allocated to improve tracing and monitoring of COVID-19 cases, to increase home-based services and to introduce the new professional role of family and community nurses.

Italy's EU-funded Recovery and Resilience Plan was adopted in June 2021. The funding for the health components of the Plan, which total EUR 15.6 billion over five years, is designed to invest in using new technologies to improve hospitals and home health care, including through enhancing the use of telemedicine while reducing territorial fragmentation. A significant share of the funding is also planned for strengthening human resources for health (Figure 21).



Figure 21. The Recovery and Resilience Plan is designed to strengthen the resilience and capacity of the Italian health system



Source: Government of Italy (2021)

6 Key findings

- Italy had one of the highest levels of life expectancy in the EU in 2020, despite the sharp reduction of more than one year due to the COVID-19 pandemic. Geographical inequalities in life expectancy are significant: the gap between those living in southern and northern regions reached almost three years in favour of the latter before the pandemic. This geographical gap is expected to narrow at least temporarily in 2020, as the COVID-19 pandemic had a greater impact on the northern regions.
- The burden of cancer is considerable in Italy: over 180 000 people died of cancer in 2018, which is more than twice the registered number of COVID-19 deaths in 2020 (slightly more than 75 000). Screening rates for breast, cervical and colorectal cancer dropped by approximately 40 % to 45 % in 2020 due to disruptions of services or people being afraid of catching the virus. Delays in screening can be expected to result in later diagnosis and treatment.
- Risk factors for health – notably smoking, poor nutrition, physical inactivity and obesity – are major drivers of ill health and mortality in Italy. Smoking rates among teenagers remain very high. In 2018, nearly 30 % of 15-year-olds reported that they had smoked in the past month, which is one of the highest rates in the EU. The proportion of children and adolescents who are either overweight or obese is also greater than the EU average. Three in ten children aged 8-9 were either overweight or obese in 2019. Higher rates of overweight and obesity were reported in the south of the country and in households with poor socioeconomic conditions.
- Health spending per capita in Italy was EUR 2 525 in 2019, representing 8.7 % of GDP, which is below the EU average of 9.9 %. A growing share of health spending has been paid out of pocket by households in recent years. However, public spending on health increased sharply in 2020 in response to the COVID-19 pandemic.
- Italy was the first European country affected by the COVID-19 pandemic. Despite a well-developed health care system in the most affected regions, it was unable to flatten the curve of infections early enough, leading to saturation of hospitals and a dramatic acceleration in deaths. Italy had one of the highest death rates from COVID-19 during the first wave of the pandemic from March to May 2020. Many other EU countries had a higher death rates during the second wave in the autumn 2020; nevertheless, the number of deaths in Italy from October to December 2020 was greater than during the first wave. The death toll continued to increase from January to April 2021, before stabilising in summer 2021. By the end of August 2021, the cumulative mortality rate from COVID-19 in Italy was about 35 % higher than the EU average.
- A broad set of measures – including establishing widespread lockdowns, strengthening laboratory capacity and establishing a COVID-19 integrated surveillance system – was implemented to try to reduce the virus transmission from the beginning of the outbreak. However, the restriction measures were not sufficient to prevent a second wave of the pandemic in autumn 2020, which lasted until summer 2021. Increases in the initially low intensive care bed capacity and mobilisation of additional health workers helped to respond to pressures during the peaks of the pandemic.
- The vaccination campaign against COVID-19 started at the end of December 2020. By the end of August 2021, 60 % of the total population were considered to be fully vaccinated through two doses or the equivalent – a proportion higher than the EU average.

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Country abbreviations

Austria	AT	Denmark	DK	Hungary	HU	Luxembourg	LU	Romania	RO
Belgium	BE	Estonia	EE	Iceland	IS	Malta	MT	Slovakia	SK
Bulgaria	BG	Finland	FI	Ireland	IE	Netherlands	NL	Slovenia	SI
Croatia	HR	France	FR	Italy	IT	Norway	NO	Spain	ES
Cyprus	CY	Germany	DE	Latvia	LV	Poland	PL	Sweden	SE
Czechia	CZ	Greece	EL	Lithuania	LT	Portugal	PT		

State of Health in the EU

Country Health Profile 2021

The Country Health Profiles are an important step in the European Commission's ongoing *State of Health in the EU* cycle of knowledge brokering, produced with the financial assistance of the European Union. The profiles are the result of joint work between the Organisation for Economic Co-operation and Development (OECD) and the European Observatory on Health Systems and Policies, in cooperation with the European Commission.

The concise, policy-relevant profiles are based on a transparent, consistent methodology, using both quantitative and qualitative data, yet flexibly adapted to the context of each EU/EEA country. The aim is to create a means for mutual learning and voluntary exchange that can be used by policymakers and policy influencers alike.

Each country profile provides a short synthesis of:

- health status in the country
- the determinants of health, focussing on behavioural risk factors
- the organisation of the health system
- the effectiveness, accessibility and resilience of the health system

The Commission is complementing the key findings of these country profiles with a Companion Report.

For more information see: ec.europa.eu/health/state

Please cite this publication as: OECD/European Observatory on Health Systems and Policies (2021), *Italy: Country Health Profile 2021, State of Health in the EU*, OECD Publishing, Paris/European Observatory on Health Systems and Policies, Brussels.

ISBN 9789264448117 (PDF)
Series: State of Health in the EU
SSN 25227041 (online)