Tackling the crisis of the Italian National Health Fund

The planned National Health Fund (NHF) in Italy for 2024–25 is estimated to be less than 6·5% of gross domestic product (GDP).[1] This value is substantially lower than the percentage of GDP invested in most health systems in Europe that are founded on the principles of universality, solidarity, and distributive justice.[1] Italy has the highest prevalence of older people in Europe—24% of the population is older than 65 years.[2] There is a gap between available resources and actual needs. The ageing population is projected to increase health-care demand that is not covered by the Italian NHF. Private expenditure in Italy is €41 billion per year for health care and €25 billion per year for the long-term care of older people. Therefore, total household spending in Italy is €66 billion per year, compared with the €130 billion Italian NHF budget. This ratio might be a serious threat to the principle of universalism that is the basis of the Italian NHF because private health spending is structurally uneven across Italian regions (ie, €800 per person in northern regions such as Lombardy and Emilia-Romagna *vs* €300 per person in southern regions such as Calabria) and shows social clustering, and as there is a historical gap in some regions in the achievement of targets for health-care performance in terms of volume, quality of services, and outcomes—despite resources per inhabitant being similar.

To mitigate these problems, more than 7% of GPD should be dedicated to the public health expenditure, although this would be still far from the standards of other countries, to avoid serious difficulties and an increase in social inequalities. The current apportionment of resources should be strengthened by increasing, for example, the weight attributed to social deprivation. Incremental funding (eg, at least €3 billion per year) should be allocated to a special fund for regions that are below the performance standards, but exclusively on the basis of innovative policies that should be monitored. These innovative policies would aim to reorganise the geography and quality of services and the mix of available skills to reduce differences in performance. As the development of institutional and administrative capacity is a complex challenge, especially in regions of Italy with lower income and more organisational problems in delivering health services, an experimental approach should be promoted throughout the NHF.

Another important aspect is the health-care workforce; staff shortages are one of the greatest threats to health-system resilience.[3] Despite the widespread feeling in Italy that the NHF is understaffed,[4] Italy's medical density (ie, 4 doctors per 1000 population) is higher than that of the UK (ie, 3 doctors per 1000 population) or France (ie, 3·3 doctors per 1000 population).[5] However, Italy is still far behind other countries in terms of number of nurses per each doctor. The serious problems are not due to a generic understaffing, but to the lack of nurses and specific specialists, particularly if we consider future projections.[6–8]

In Italy, the number of medical graduates relative to the population (ie, 18·7 per 100 000 inhabitants) is already one of the highest in Europe, compared with France (ie, 9·9 per 100 000 inhabitants) and Germany (12 per 100 000 inhabitants). Even the increase in medical graduates recorded in Italy in the past 4 years is unmatched by trends in other European countries.[8] However, there are wide gaps in specialty training, particularly in disciplines such as microbiology and virology, radiotherapy, clinical biochemistry, community and primary care medicine, pathology, palliative care, thoracic surgery, and general and vascular surgery. The problem, therefore, is not the shortage of doctors in general, but the shortage of specialists in some disciplines that can be attributed to poor attractiveness for these specialities, such as community and primary care medicine. By contrast, disciplines that offer opportunities in the private sector, such as dermatology, ophthalmology, and cardiology, show no signs of crisis. There is a clear correlation between the underfinancing of the Italian NHF and increasing professional geography distortions as a result of private health market incentives.[7]

We are concerned by the serious underfunding of the NHF, which increases the share of private spending and strengthens the private sector. A reduced NHF implies giving up on one of its founding principles, universalism, and might lead to even more severe health inequalities in Italy.

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*Francesco Longo, Franco Locatelli, Mario Del Vecchio, Paola Di Giulio, Silvia Giordano, Anna Odone, Vito Marco Ranieri, Paolo Vineis
francesco.longo@unibocconi.it

Centre for Research on Health and Social Care Management–Scuola di Direzione Aziendale, Department of Social and Political Sciences, Bocconi University, Milan 20136, Italy (FLon); Department of Pediatric Hematology and Oncology and Department of Cell and Gene Therapy, Istituto Di Ricovero e Cura a Carattere Scientifico Ospedale Pediatrico Bambino Gesù, Catholic University of the Sacred Heart, Rome, Italy (FLoc); Department of Experimental and Clinical Medicine, University of Firenze, Florence, Italy (MDV); Department of Public Health and Pediatric Sciences (PDG) and Department of Oncology (SG), University of Turin, Turin, Italy; Candiolo Institute, Fondazione del Piemonte per l'Oncologia, Istituto di Ricovero e Cura a Carattere Scientifico, Turin, Italy (SG); Department of Public Health, University of Pavia, Pavia, Italy (AO); Department of Medical and Surgical Sciences, Alma Mater Studiorum, University of Bologna, Bologna, Italy (VMR); School of Public Health, Imperial College London, London, UK (PV)

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