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Table of Contents

1 Executive Summary

Following the major reforms adopted in 2009-2011, since 2012 only minor amendments have been introduced in the **pension sector**, but changes in pension parameters have resulted from the implementation of the latest 2010 and 2011 reforms (Sacconi and Fornero reforms). These aimed at reducing expenditure in the short-medium term by means of both measures directed to shorten previously introduced transition periods and quick implementation of much stricter eligibility conditions (section 2.1.3). Combined with the introduction of the NDC systems in 1995, most recent reforms have put the Italian pension system on a sound path with regard to financial sustainability. Actually, the fast implementation of tighter eligibility conditions jointly with the presence of three "automatic stabilizers" of pension expenditure are expected to cushion the impact of demographic transformation in the next decades. Consequently, Italy is one of the few countries in Europe where public pension expenditure is projected to decrease in 2010-2060 (section 2.2.2). The recent pension debate has thus mostly focused on the social sustainability of recent reforms (sections 2.2.2 and 2.3), the challenges implied by the latter (section 2.2.2), as well as the adequacy and the fairness of the pension system both in the short and the long run (sections 2.2.1 and 2.3).

Since the onset of the crisis the issue of the economic sustainability of the **health care system** has become central in Italy. Almost the whole debate about the NHS transformation has been monopolized by this issue. The necessity for cost-containment and the search for more efficiency does not come only from the need to improve the economic performance of the NHS, but also (and mainly) from the need to face the huge public debt. The reform targets in the most recent years have been mainly the following: increases in co-payments; more control on drugs and pharmaceutical expenditure; cuts in the expenditure for health care related goods and services; restructuring of the hospital care provision with the aim of reducing the number of hospital beds; a relatively strong freeze in terms of health care personnel salary increases and, also, in terms of new hiring. Cuts in health care public expenditure were clearly visible in 2009-2012: the annual growth rate of expenditure in public health care in real terms was on average -0.7% between 2009 and 2012. The financial sustainability of the NHS does not seem at risk from a strictly economic point of view, if expenditure remains under control as it has been in the last decade. However a series of problems might impoverish the quality and the performance of the system in the near future and some of them are already doing so. These problems are linked to: inequalities in the access, related to territorial as well as social class differences; long waiting lists and increasing co-payments; the aging of the workforce and the choices made in terms of its management (not particularly high salary levels, freezing of salaries, etc.). In terms of performance the Italian NHS has been able in the last decade to keep the pace of transformation in terms of performance as the other main Western European health care systems.

In comparison with major reforms introduced in the last two decades in many EU countries (for example: Germany, France, Spain, the Czech Republic, etc.), there have been no major policy changes in the Italian **Long Term Care** system. Overall the Italian LTC seems a system that so far has been able to invest a consistent amount of resources, at least in line with many other EU countries, but obtaining partially sub-optimal results. The strong role of uncontrolled cash allowances, the relative limited diffusion and coverage of professional (residential and home) services, the diffusion of migrant care work (often irregular), the absence of any selective universalism in order to partially restrict access to cash allowances to those in need both in terms of dependency but also economic resources, are elements that make the whole system not cost-effective, with limited quality and partially unfair.

2 Pensions

2.1 System description

2.1.1 Major reforms that shaped the current system

Italy is among the European countries which have proceeded the farthest in reforming old age protection arrangements in the last two decades. Firstly, the overall pension architecture was redesigned with the establishment of the regulatory framework for voluntary supplementary funded pensions in 1993; secondly, the earnings-related method was replaced by a NDC (Notional Defined Contribution) system in the public pillar (1995). Subsequently, after a number of smaller interventions (in 1997, 2000, 2004), in 2005 a "silent-consent" mechanism for enrolment in second pillar occupational schemes was introduced, with the aim to extend supplementary pension coverage.

Reforms adopted between 1992 and 2007 were not only important for the design of the new multipillar pension architecture, but also for the stepwise tightening of eligibility conditions for *old age* and especially *seniority pensions*[1]. Nevertheless, most measures were implemented gradually due to long phasing-in periods and exemptions from the new rules (cf. Ferrera and Jessoula 2007; Jessoula 2011). By contrast, recent reforms - adopted after the outbreak of the financial-economic shock in 2008-9 and the following sovereign debt crisis in 2010 – aimed at reducing expenditure in the short-medium term by means of both, measures directed to shorten previously introduced transition periods and quick implementation.
As illustrated below (section 2.1.3), since 2012 only minor amendments have been introduced, but changes in pension parameters (eligibility conditions/benefit formula) have resulted from the implementation of the latest 2010 and 2011 reforms (Sacconi and Fornero reforms).

2.1.2 System characteristics

The first public pillar is multi-tier. The bulk of the system is represented by second tier PAYGO schemes covering 100% of employed population (private and public employees, the self-employed and *parasubordinati*, i.e. "project workers"). Due to the long phasing-in period of the NDC system, until 2011 pensions were mostly calculated with the old earnings-related method; however, after the 2011 Fornero reform the NDC system is applied "*pro rata*" to all workers entered in the labour market before 1996 (full application already regarded those who entered the labour market after 1.1.1996). Contribution rates vary from 33% of gross earnings for private employees[2] to 20/21% for the self-employed and 27% for "project workers". As effect of the 2011 reform contribution rates for the self-employed will be gradually increased to 24% of declared income by 2018; also, the 2012 labour market reform (Law 92/2012) included the gradual increase of the contribution rate for project workers from 27% to 33% by 2018. According to the NDC logic, these variations will have a relevant impact on expected pension levels for the various professional categories in future decades.

Below contributory schemes, the "old age social allowance" (*assegno sociale*) constitutes the **first tier** of the public pillar. It is an income-tested programme, financed by general revenues, providing flat-rate and modest social assistance benefits to poor elderly over the age of 65

[1] Seniority pensions represented the main route to early retirement in Italy allowing workers to retire prior to reaching the pensionable age provided a pre-defined period of paid contributions.

[2] Contributions are not levied on earnings above EUR 99.034 gross.

years and 3 months. The yearly amount is EUR 5.749 in 2013, paid in 13 monthly instalments.

Eligibility conditions for both old age and early retirement pensions as well as the old age social allowance are linked and automatically adjusted to changes in life expectancy; also they are being rapidly tightened due to 2010 and 2011 reforms (see next section).

In addition to public pension provision, private sector employees and those hired in the public sector after 2001 are entitled to a severance-payment benefit (so called TFR) when they retire or change their employer[3]. In accordance with the 1993 regulatory framework, also proper supplementary funded pension schemes have been set up: i) "Closed" pension funds (CPFs) are typical occupational pensions for specific groups of employees set up by collective agreements (2nd pillar); ii) "Open" pension funds (OPFs) are hybrid institutions comprising both 2nd and 3rd pillar forms depending on affiliation modes (that is, individual *vs* collective) and, iii) Personal pension plans through life insurance contracts (PIPs) constitute the 3rd pillar (see more in section 2.2.3). Importantly, since 2007, a "silent-consent" mechanism for (quasi-automatic) transfer of TFR contributions to funded occupational pension schemes has been operating for private sector employees[4].

2.1.3. Details on recent reforms

After path breaking reforms in 1992-95 and subsequent adjustments in 2004-05, the third wave of reforms 2009-2012 has not implied a major transformation of the overall pension architecture; however rules concerning *eligibility conditions* and *benefit calculation* have been significantly modified. The main changes introduced by L. 102/09, Law 122/2010 and Law 214/11 regarded[5]:

i) the introduction of an *automatic link of eligibility conditions with demographic (i.e. life expectancy) trends*. The first *forfetaire* adjustment (3 months) has already been implemented in 2013, the following adjustments are scheduled in 2016, 2019 and every two years afterwards;

ii) the very rapid increase of the *pensionable age for female employees* in the *public sector* - from 60 to 65 between 2010 and 2012 – and for *female employees* in the *private sector* in order to equalize it with the age threshold for male employees: full equalization in 2018 at 66 and 7 months[6];

iii) the extension of the minimum contributory period to be entitled to old age pensions in the NDC system, from 5 to 20 years (5 years only in case of retirement at 70 years of age);

iv) the abolition of seniority pensions;

v) the introduction of the possibility of *late* retirement at 70 and *early* retirement at 63 years of age (the latter only for workers fully subject to the NDC system) in 2012, *de facto* re-introducing a flexible pensionable age in the bracket 63-70; the possibility to retire after 42

[3] Project workers and, obviously, the self-employed are not entitled to the TFR.
[4] See Jessoula (2011) for details.
[5] For full details about these reform, cf. ASISP Annual National Report – Italy 2011 and 2012.
[6] Indepenently from automatic adjustments, a "safeguard clause" set the standard pensionable age at 67 in 2021.

years and 5 months of paid contributions (for males, 41 years/5 months for women) in 2013 with penalisations when retiring before 62 years of age;

vi) the introduction of further conditions ("pension value thresholds") to be entitled to old age and early retirement pensions (cf. Jessoula and Pavolini 2012).

Finally, with regard to benefit calculation, the 2011 reform

vii) shortened the phasing-in of the NDC system: since January 2012 the latter is actually applied *pro-rata* (that is for working years after 2011) also to previously exempted workers (i.e older workers).

viii) the temporary freeze (2012 and 2013) of benefit indexation for pensions above €1400 gross/month.

The Bill for the 2014 Budget and Stability Law – proposed by the government in October 2013 - includes the temporary suspension of indexation *only* for pensions above €3000 gross/month. Interestingly, with regard to both adequacy and redistribution (cf. below section 2.2.1), the re-introduction of (at least partial) pension indexation for benefits between €1500 and €3000 gross/month could be financed by a solidarity contribution levied on pensions above €90.000 gross/year. However, the Budget and Stability Bill is still discussed in Parliament and measures are not fixed yet.

These measures should be effective in containing costs both in the short and the long run and will contribute to regulatory harmonization across generations, between genders and *among professional categories*. Also, the reforms have already implied a significant increase of the standard pensionable age, which is currently among the highest in the EU - 66 years and 3 months for male/female employees in the public sector as well as for males employed in the private sector.

Between mid-2012 and October 2013 some adjustments have been legislated in order to address what in the Italian jargon is known as the "*esodati*" problem. This concerns workers that had previously agreed with employers on a contracted exit pathway and, due to the new age and contribution requirements introduced by the 2011 reform, they actually run the risk of remaining with no job and no pension for relatively long periods. The problem emerged as a consequence of failed communication between the Ministry of Welfare and the National Social Insurance Institute about the extension of this group of workers and it was later addressed by the government by introducing derogation to ordinary rules. In the course of 2012, three legislative interventions have identified resources (roughly 9 billion euros) to allow concerned workers to retire: to date the problem has not been fully solved yet, but 130,000 individuals have been protected (65,000 by a government decree in June 2012, 55,000 by Law 135/2012 and 10,130 by Law 228/2012)[7].

[7] A fourth intervention is expected soon.

2.2 Assessment of strengths and weaknesses

2.2.1 Adequacy

Two dimensions are crucial to assess the adequacy of the Italian pension system: the temporal dimension (current situation *vs* medium/long run) and the distributional dimension (differences among the various categories).

As for the *current situation*, notwithstanding the (still) high public pension expenditure in Italy (cf. section 2.2.2), the level of average contributory pension is relatively low – € 881/month – with remarkable differences between old age benefits (€695/month on average), seniority pensions (avg. €1,527/month) and invalidity pensions (€606/month) (INPS 2012). Almost 50% of pensions (47.2%) are below €500/month, 28.7% are between 500 and 1.000 €/month, 24.1% are above 1.000 €/month[8]. By contrast, the public pension system also pays extremely generous pensions calculated with the old earnings-related formula: the top ten pensions paid by the National Social Insurance Institute (INPS) range from 41,700 €/month and 91,300 €/month[9]. Also, along the distributional dimension, it should be noted that women receive lower pension benefit than their male counterparts: the "typical" *old age* benefit for a female employee retiring in 2012 amounts (on average) to 710 €/month *vis a vis* 2.130 €/month for the "typical" seniority benefit a male employees (INPS 2012)[10].

In combination with the low amount of the means-tested social allowance (see section 2.1.2), these figures point at the limited vertical redistributive effectiveness of the public pension system in Italy.

Outcome indicators seem to confirm this consideration: using the Europe 2020 "At-risk-of poverty or social exclusion rate", Italian figures for elderly aged 65 and over are much higher (24.2%, and on the rise from 20.3% in 2010) than both in the EU-27 (20.5%) and the Euro-area (18.2%). Also when looking at the "At-risk-of-poverty rate" of older people (over 65 years of age, Eurostat), Italy fares worse (17%) than the EU-27 average (15.9%).

For the long-term, a contribution to benefit adequacy should come from the higher age requirements to be entitled to old age pensions. Actually, in a NDC system, the higher the pensionable age (and, consequently, the age of retirement) is the higher the pension benefit. In contrast with past debates about potentially inadequate old age protection in the new NDC system, a report by Patriarca (2011) for the National Social Insurance Office and the more recent calculations included in MEF (2013) actually showed that public pillar pensions are expected to remain at a high level in the next decades because of expected higher retirement ages. The net replacement rate for a worker retiring at *66 years+2 months in 2040*, after a full career of *38 years* as a dependent worker, is expected to be around *71%, or 62% gross* – around 80% net (70% gross) retiring at 69 years/2 months with 39 years/2 months of paid

[8] For a purposeful comparison, the average gross earnings in industry and service were € 28.230/year in 2010 (Eurostat).

[9] Figures reported by the Deputy Ministry of Labour and Social Policies during question time at the Chamber of Deputies (6 August 2013) based on data provided by INPS.

[10] The term "typical" points at the traditionally different exit routes from labour market for male/female employees in Italy: given their longer contributory periods, men usually retired before pensionable age when they became entitled to seniority benefits; by contrast women retired when reaching the (lower in the past) pensionable age. As a consequence, 76.8% of *seniority benefits* are paid to male retirees, 58.6% of *old age* benefits are paid to female pensioners (data INPS 2012).

contributions (MEF 2013). In case the same worker has subscribed a supplementary pension plan (occupational or individual), he might receive an additional 28% (net) replacement rate from the second/third pillar pension, thus totalling around 107% net replacement rate (Patriarca 2011). In spite of these high pension levels, the risk of inadequate old age protection in future decades persists for other categories of workers, particularly those with atypical/fragmented careers and the self-employed (Raitano 2007). This is mainly due to system design, based on the combination of NDC public pension combined with voluntary DC supplementary schemes (Jessoula 2012). On the one hand, NDC/DC systems directly transfer career fragmentation – and lower contribution rates as in the case of self employed - into lower pension levels, with the consequence of rapidly declining replacement rates in presence of shorter contribution periods: with *36 years of paid contribution* a dependent worker retiring at *66 years/2 months* would receive a (gross) pension around *58% of last wage* (i.e. a 2 year reduction of the contributory period implies a replacement rate decrease of 4 p.p.) with On the other hand, atypical - i.e. fixed term and temporary workers as well as project workers/false self-employed – are generally not covered by supplementary funded pensions schemes[11] and will likely rely on (much lower) public pension only. This is critical because workers with lower expected public pensions would benefit most from receiving additional pension income from supplementary schemes.

The distributional differences presented here with respect to the long term raise the issue of adequacy and social viability of the Italian pension system, which is based on a peculiar combination of NDC public pensions combined with voluntary DC supplementary pensions (cf. Jessoula 2012). In a nutshell, twenty years after the 1992-1995 reforms which launched the multipillar transformation of the pension architecture with the aim to provide future retirees with lower public pensions complemented with supplementary old age benefits from funded schemes, it can well be said the such a "grand plan" has failed. Not only supplementary pillar coverage is far from universal (see section 2.2.3), the same role of supplementary pillars is not entirely clear after the latest wave of reforms that has introduced much tighter eligibility conditions. For a share of the employed population – mostly workers on "standard" contracts with less fragmented careers in core economic sectors – public pension might be sufficient to enjoy adequate old age protection; however, these workers are also more likely to become members of supplementary pension funds, this leading to some sort of overprotection for this groups (replacement rates above 100%). On the other hand, workers with lower public pensions due to career fragmentation and job instability are also less likely to subscribe to supplementary schemes and they might well turn into poor pensioners in the next decade.

The design of the pension system, as well as its distributional profile, should possibly be (re-)assessed after subsequent reforms along the last two decades, also in light of enduring (and, possibly harsher) austerity and much increased labour market flexibility since the late-1990s.

2.2.2 Sustainability

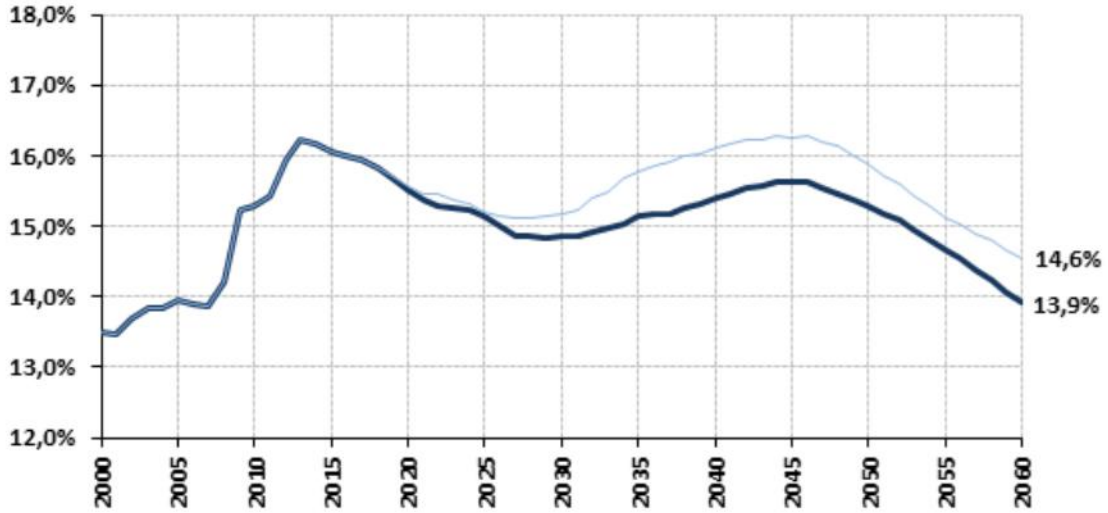
Despite faster population ageing than in most other European countries (see below), public pension expenditure trends appear under control in Italy both in the short term and the long run.

[11] Formally these workers might become members of supplementary pension schemes but lack of resources and employment instability usually prevent them from subscribe (cf. Jessoula 2012 for more details).

Figure 2.1 below (see also Annex) shows that, according to projections by the National General Accounting Office of the Ministry of Economy (MEF 2013), public pension expenditure is expected to decrease by slightly more than 1 percentage point after 2013, reaching 14.8% of GDP in 2029 - mostly due to the recently legislated changes in eligibility conditions and faster implementation of the NDC system (*pro rata*) since 2012 (cf. section 2.1.3 and Jessoula and Pavolini 2012). An increase up to 15.6% in 2045 is then expected because of the growing pensions/employed population ratio due to demographic transformation; a further decrease should follow afterwards (15.3% in 2050, 13.9% by 2060) due to the full implementation of the NDC system, the gradual disappearance of the "baby boomers" cohorts (born between the mid-1950s and the mid-1960s) as well as the automatic increase of eligibility conditions (MEF 2013).

Also, figure 2.1 clearly shows that national and EU commission/Economic Policy Committee's[12] projections diverge only to a limited extent and onl for the period after 2030.

Figure 2.1 Projected public pension expenditure (% Gdp) 2000-60, National baseline scenario and EPC-WGA scenario



Blue line: National baseline scenario; Light blue line: EPC-WGA scenario

Source: Authors' elaboration from MEF (2013: 18)

As mentioned above, these results seems to be achievable despite the rapid process of demographic ageing in Italy due to both below EU average fertility rates and above average life expectancy levels (cf. EPC-EC 2012). The share of elderly population above 65 years of age as a percentage of total population is actually expected to grow from 20.3% in 2010 and 21.5% in 2015 to 23.7% in 2025, 28% in 2035 and 30.0% in 2040 – compared to EU-27 figures 17.4% in 2010, 18.9% in 2015, and 22.0%, 25.6%, 27% in 2025, 2035 and 2040 respectively (ECP 2012).

What is presented here testifies the strong impact of the series of reforms adopted since the early-1990s which allows the pension system to cushion the effects of the demographic transformation, at least to a great extent. This is mostly due two main factors: i) the tightening

[12] Economic Policy Committee - Working Group on Ageing (EPC-WGA). See EPC-EC (2012).

of eligibility conditions for old age pensions legislated in 2009-2011; ii) the introduction of automatic stabilizers. As for the latter, three crucial automatic adjustments mechanism are currently operating: a) the valorisation of paid contributions in the NDC system linked to average GDP growth (calculated annually on the last five years); b) the revision of coefficients (*coefficienti di trasformazione*) to transform total contribution amount into annuities at retirement in the NDC system. Recent reforms (2007 and 2010) have simplified the procedure to revise coefficients and they also made it a mere administrative task: coefficients will be revised every three years until 2021 and every two years afterwards; c) the link of eligibility conditions for old age pensions, early retirement pensions and the social allowance for poor elderly with changes in life expectancy.

As consequence, as reported in the EPC-EC Ageing Report (2012), Italy is one of the five countries where public pension expenditure is expected to diminish by 0.9 p.p. between 2010 and 2060 in contrast with an EU-27 average increase of 1.5 p.p.. Similarly, the maximum increase forcasted for Italy (+0.6 p.p. in 2040) will remains well below the EU-27 average (+1.2 p.p.).

In sum, as reported in the latest report by the National General Accounting Office (*Ragioneria Generale dello Stato*) figures show that demographic ageing should bring low risk for public finances and the financial sustainability of the pension system (MEF 2013).

This said, things are different when considering the economic sustainability of the public pension pillar and particularly its effect on labour costs. Contribution rates for dependent employees have been traditionally very high in Italy (33% of gross wage) – though they have not been increased since the 1995 reform – and the 2012 labour market reform has legislated the gradual harmonization of the contribution rate for project workers (*parasubordinati*) that is currently at 27%, but will reach 33% by 2018. In addition, employees (mostly in the private sector and in medium/large size firms) who are members of a supplementary ("private") pension funds pay additional contributions of around 9.3% of gross wage on average into DC pension schemes. Thus, for these workers (about 4 million, see section 2.2.3) the pension contribution rate totals ca. 42-43% of gross wage.

From a different perspective, as more extensively argued in the 2012 ASISP report (Jessoula and Pavolini 2012), recent reforms while improving financial sustainability also create challenges. The latter mostly concern labour market performance also in interaction with "active" social policies – i.e. active labour market policies, reconciliation measures, childcare services – which are notoriously underdeveloped in Italy. In brief, the quick implementation of much tighter eligibility conditions for retirement is expected to increase the effective average age of retirement[13] as well as older workers' labour market participation/employment rates. This puts pressure on the labour market, which is still in a critical conjuncture characterized by growing unemployment rates (12.2% in August 2013) – especially among the youngster (40.1% in the age bracket 15-24) – and declining employment rates (55.8%). Once again the open question is whether, and to what extent, labour demand will match the growing active population. The MEF (2013) report cited above forecasts an increase of total employment levels from 22,9 million to 24,3 million between 2010 and 2020 (+6.3%), resulting from the growth of both male and female employment: from 13.6 to 14.0 million the former, from 9.2 to 10.4 million the latter.

[13] According to forecast included in the Italian National Reform Program 2012, the actual average retirement age should rise from 60-61 2006-2010 to 64 in 2020 and 67 in 2040.

The actual contribution of the 2012 labour market reform to achieve this target still has to be assessed; nonetheless, in a country where the share of older workers participating in life-long learing programmes is negligible (cf. MEF 2012), it is plausible that measures aimed at improving placement services for a better matching between labour offer and demand, as well as at fostering labour offer by activating the inactive/unemployed and favouring work-life balance are needed in order to cope with major changes in pension rules. In a nutshell, pension retrenchment should be urgently accompanied by expansionary measures in underdeveloped social protection sectors.

2.2.3 Private pensions

All the considerations regarding supplementary funded schemes included in the 2012 Italian ANR for 2011 (cf. Jessoula and Pavolini 2012) are confirmed and might be replicated for the period May 2012-October 2013.

First, with respect to coverage, table 1 below clearly shows the "moderate growth" (Covip 2013a) of membership since December 2011 (+8.4% overall) as well as the still modest coverage – totalling slightly more than 6 million members out of 22.5 million employed by mid-2013. However, in light of the still critical economic and employment conjuncture in Italy (GDP growth – 2.4; total employment -1.2% in 2012), the modest increase should not be underestimated.

Second, total figures hide very different and divergent membership trends for the various types of supplementary pension schemes. Closed occupational funds (CPFs), which were thought to represent the main component of supplementary pillars, continued to loose members, passing from just above 2.0 million members in December 2010 to 1.99 million one year later and 1.95 million in June 2013 (nearly 2% decrease from December 2011 until June 2013). By contrast, individual third pillar pension plans, such as Open pension funds and especially PIPs, seem to be much more effective in attracting new members: +80,000 members for the former, + 500,000 for the latter (Dec.11/June13). For PIPs this means a +35% increase of membership in 1 ½ year only. Interestingly, both OPFs and PIPs' attraction capacity goes beyond the traditional constituency of self-employed workers: also dependent employees – in the past more inclined to become members of occupational CPFs – seem to have turned to individual pension plans, as testified by the impressive increase of membership in PIPs - +322,000 (+26,000 for OPFs) in contrast with -40,000 private employees in CPFs since December 2011.

With reference to the performance of the different supplementary pensions schemes, in 2012 all types of funds have recovered from the poor results of 2008 and 2011. Returns have oscillated between 8% and 9% with limited variance: +8.2% for occupational CPFs, 9.1% for OPFs, +8.9 for PIPs "unit linked".

Table 2.1 Membership of supplementary pension schemes in Italy, 2007-2013

		Members (x1000)					Variation (%)	
	Of which Private employees (June 2013)	June 2013	Dec. 2012	Dec. 2011	Dec. 2010	Dec. 2007	2011/13	2010/11
ClosedPF	1,800	1,959	1,969	1,994	2,010	1,989	-1.7	-0.8
Open PF	446	958	913	881	848	747	+8.7	+3.8
PIP *new*	1,216	1,959	1,777	1,451	1,160	445	+35.0	+25.1
PIP *old*	178	534	534	610	610	800 [a]	-	-
PEF	632	659	659	667[b]	667	649	-	-
Total	4,272	6,043	5,828	5,572[c]	5,271	4,635	+8.4	5.7

Note: a: Estimated data
b: Due to lack of data Covip assumes that membership has not changed from 2009
c: Total excludes double counting and includes members of the residual fund set up by Inps (ca. 40,000 members)
Source: Author's elaboration from Covip 2008, 2012, 2013b

In spite of similar returns, differences emerge when looking at the **costs** of the various forms of supplementary pension provision. Same as in 2011, the costs of occupational CPFs are invariably lower (0.2% on a 35 year contribution period) than costs of OPFs (1.1%) and PIPs (1.5%). *Ceteris paribus* over a 35 year period these differences may turn into lower benefits from OPFs (-17%) and PIPs (-23%) than from CPFs. The weak attraction capacity of second pillar CPFs illustrated above may thus be regarded as problematic for fund members in this respect.

Last but not least, coverage rates of supplementary pensions remain extremely variable according to a number of factors: they are higher in "core" economic sectors such as industry and manufacturing, characterized by high unionisation rates and medium-large size firms. This implies remarkable differences in both total contribution rates and expected pension levels between workers who are members of supplementary schemes and those who are not.

2.2.4 Summary

Most recent (both national and supranational) figures, show that fast population ageing should entail low risk for public finances and pension system financial sustainability in Italy. The series of major reforms adopted from the early-1990s until 2011 are expected to immunize the pension system from the impact of the demographic transformation in the next decades. This is especially due to the rapid implementation (by 2018) of tighter eligibility conditions as well as the presence of automatic expenditure stabilizers - regarding benefit calculation, the annual valorisation of paid contributions and the automatic link of eligibility conditions with demographic changes. Consequently, the projected increase of pension expenditure in Italy after 2030 is among the lowest in the EU and remains below 1 p.p.

However, while improving financial sustainability, recent reforms also create challenges mostly related to labour market performance in light of expected higher participation rates for older cohorts. In this perspective, a claim can be made that pension retrenchment should be urgently accompanied by expansionary measures aimed to strengthen "active" social policies: this is crucial for a better match of increased labour offer with labour demand.

Last but not least, the distributive impact of the Italian pension systems appears uneven both in the short and in the long run. This requires reconsider existing pension arrangements in order to reconcile adequacy and fairness in a condition of persistently scarce resources. Redistributive-solidarity mechanisms should possibly be reinforced and the role of supplementary funded pillars should be carefully assessed two decades after the launch of the (to date much uncompleted) multipillar transition.

2.3 Reform debates

Against the background provided in the previous sections, since the adoption of latest reform in 2011 the pension debate has focused on two main issues: i) the conditions for retirement, ii) distributional aspects with particular reference to high variation in pension levels.

First, as a reaction against both non-involvement in the policymaking process on the 2011 pension reforms and the very rapid implementation of adopted measures[14], trade unions complained that fiscal consolidation packages including the (much) stricter eligibility conditions for retirement and the temporary freeze of pension indexation (for pensions above € 1400 gross/month) disproportionately affect workers close to retirement and pensioners – that are unions' main constituencies[15]. Following trade unions initial complains a two-pronged debate on eligibility conditions debate has emerged since early 2012.

On the one hand, trade unions - backed by leftist parties such as "Left, Ecology and Freedom" (SEL, *Sinistra, Ecologia e Libertà*) - put pressure on the two subsequent governments (led by Monti and Letta) in order to solve the **"***esodati*" problem (cf. section 2.1.3): this regards those workers who had agreed with employers on a contracted exit pathway and, in light the fast implementation of tighter eligibility conditions and the elimination of seniority pensions, run the risk of remaining with no job and no pension for relatively long periods. As illustrated above (section 2.1.3), this question started to be addressed by the government in 2012 but to date it has not been fully solved. On 24 September 2013, following a declaration by the current Ministry of Welfare Giovannini, the president of the Labour Commission of the Chamber of Deputies, Cesare Damiano (*Democratic Party*) revived the issue by claiming a further intervention aimed to protect 20-30 thousand people with a cost around 1.4 billion euros.

[14] Both in 2010 and 2011, due to powerful international/supranational pressures, the decisional process was very fast and social partners were not even consulted though they voiced (especially the unions) to protest against reform plans proposed by the government.

[15] In particular, the major trade union CGIL mostly complained about the abolition of seniority pensions and the sharp increase of the pensionable age for female employees in the private sector, CISL attacked on the faster implementation of the NDC system while UGL protested against the temporary suspension of indexation. Opposition in parliament also came from the Northern League party and partly from IDV party (*Italia dei Valori*).

On the other hand, a broader discussion on the (social) sustainability of much tighter eligibility conditions for retirement aroused involving worker organisations but also partisan and politico-institutional actors. Trade unions, though appreciating the re-introduction of the flexible pensionable age (63-70), actually believe that penalization when retiring before 62 years of age[16] is not fair. In April 2013, the president of the Labour Commission of the Chamber of Deputies has put forward a proposal aimed at introducing more flexibility in retirement conditions for older workers in the short term. Jointly with roughly 60 MPs from the Democratic Party, Damiano presented a reform bill by which i) retirement would be allowed in the age bracket 62-70 years (also for workers subject to the NDC system pro rata), provided a contributory period of 35 years, with penalisations in case of retirement before 66 years and bonuses for late retirement; ii) early retirement would be possible after 41 years of paid contributions regardless of age[17]. Reactions to the proposal have varied among the different parties and single MPs, the President of the Council Letta and the Ministry of Welfare are, at least in principle, favourable to increase flexibility in eligibility conditions[18]: nevertheless, fiscal rigour is a major constraint in this respect[19] and the bill is still discussed in parliamentary commissions.

As for the second front concerning distributive aspects, a debate has emerged around so called "golden" (and "silver") pensions" - i.e. those very high old age benefits calculated with the past earnings-related method - and more generally the high variation of current and (estimated) future pension levels. For the short term, the debate was also prompted by a recent ruling of the Italian Constitutional Court (ruling n. 116, 5 June 2013) which has declared illegitimate the "solidarity contribution" levied on pensions above € 90,000 gross/year introduced by Law decree 98/2011. With the aim to increase the redistributive profile of the pension system, in a phase characterized by limited resource availability and the adoption of severe austerity measures, the sanctioned legislation levied 5% of the pension amount between 90,000 and 150,000 euros per years, 10% above 150,000 euros and 15% over 200,000 euros.

As mentioned, the ruling has contributed to an on-going debate[20] on the intra- and intergenerational fairness of the public pension system. Already prior to the 2013 general elections the main unions CGIL, CISL and UIL signed a joint letter to party candidates by which they asked to take actions aimed at: i) maintaining the purchasing power of pensions; ii) revising the tax system in order to make it more elderly-friendly; iii) to adopt a national law to protect dependent people[21]. Just before the ruling of the Constitutional Court, Boeri and Nannicini (2013) assessed the potential of levying additional contributions on pensions above a pre-defined threshold and especially in cases where the implicit rate of return on paid contributions is very high. As explained by the two economists, these interventions would not entail substantial savings, yet they might be important in signalling the need to increase the intra- and intergenerational fairness of the system. In the same vein the Ministry of Labour

[16] This is possible when retiring via "early pensions" provided a contributory period of 42 years and 5 months (males) or 41 years and 5 months (females).
[17] Chamber of Deputies, bill n. 857.
[18] The President of the Council also mentioned this issue in his investiture programmatic discourse at the Chamber of Deputies on 29 April 2013.
[19] This point has also been made explicitly by the Ministry of Labour Giovannini in early October 2013 during discussions on the 2014 budget law.
[20] Cf. for example Salerno (2013) and Galasso (2013).
[21] See www.pensionati.cisl.it/documenti/news/1758_allegato1.pdf.

Giovannini suggested the possibility to reduce higher pensions in order to pursue "social justice"[22].

Interestingly, the Ministry has also more recently raised the issue of pension adequacy with regard to future decades. Pointing at the interplay of pension rules and labour market performance[23] - with particular reference to increased flexibility, delayed entrance and fragmented careers in the Italian the labour market – the Ministry acknowledged that, under these conditions, the current NDC system has limits and it may well fall short of providing adequate old age protection to a relatively large share of current workers[24]. Though the Ministry has not proposed specific measures to address the problem, his statements have the merit to re-introduce in the Italian pension debate the issue of the long-term adequacy of the Italian pension system. This is important in light of what was presented above regarding the failure of the "grand plan" launched in the early-1990s, according to which in future decades (all) workers would receive a pension income composed of (lower) public pensions and supplementary old age benefits provided by funded schemes.

A final note concerns the impact of the EU on Italian pension debate and reforms. As it is well known, the supranational institutions have traditionally influenced domestic developments by means of "direct", but "soft", processes of policy coordination (the OMC, Europe 2020) as well as "indirect", but hard, fiscal constraints. After the sovereign debt crisis and the launch of Europe 2020, the European influence is ambivalent. Soft coordination processes has favoured cognitive convergence and the adoption of common indicators. As reported in the National General Accounting Office report (MEF 2013), for instance, a broad consensus has been reached at the European level on the need to introduce automatic stabilizers of pension expenditure – e.g. with regard to benefit calculation and automatic adjustment of eligibility conditions to demographic trends – in order to improve financial sustainability. Also, with regard to adequacy, an agreement on the importance to consider different career profiles has been reached and related indicators have been effectively developed and adopted. Nevertheless, turning to EU's impact on actual policy choices, it is unquestionable that the ability of supranational bodies to influence domestic political decisions in order to promote adequacy has significantly diminished while pressures for the implementation of cost containment measures have significantly increased. This is due to a number of interacting factors. On the one hand, the social dimension of Europe has been heavily constrained by the launch of the Europe 2020 strategy and the weakening of the "Social OMC" governance architecture[25]: especially in the field of pensions (and health-care) recommendations included in the three Annual Growth Surveys issued so far have dealt with economic and financial sustainability, disregarding the second and the third objective of the OMC pension, that is adequacy and modernization. On the other hand - although Italy has not received Country Specific Recommendations on pensions since the launch of Europe 2020 - not only indirect/hard constraints have grown stronger in more recent years, they have also coupled with unprecedented "hard and direct" pressures in the form of "soft conditionality" mechanisms, such as in the case of the ECB/Bank of Italy letter to the Italian government in summer 2012 (cf. Jessoula and Pavolini 2012). As a consequence, in recent times

[22] Interview reported on "Corriere della Sera", 25.5.2013.

[23] Cf. Hinrichs and Jessoula (2012) on this issue.

[24] These considerations were expressed by the Ministry in two subsequent interventions at the Commission of labour and social protection of the Chamber of Deputies (October 8th, 2013) and at a Conference organised by the Italian newspaper "Il Sole 24 Ore" (October 18th, 2013). See also Jessoula (2012) on this point.

[25] Cf. Copeland and Daly (2012); Agostini, Sabato and Jessoula (2013).

recommendations included in supranational processes of soft coordination actually influence the policy choices of Italian policymakers only when they are backed by indirect/direct but hard measures, as occurred with the introduction of the automatic link of eligibility conditions with demographic trends.

3 Health care

3.1 System description

3.1.1 Major reforms that shaped the current system

Since the turn of the century no major reforms have affected the Italian NHS (Pavolini and Vicarelli, 2013). In comparison with the 1990s (see section 3.1.2), the 2000s were more a time of implementation of reforms introduced in the previous decade (decentralization, managerialization and partial privatization of provision), than substantial innovation.

However this picture has started to change in more recent years and the ongoing changes might strongly affect the functioning of the Italian NHS in the near future. Until 2008 no relevant changes (meaning also cuts) were noticed, even if Italy maintained a relatively lower level of public expenditure (see section 3.1.2). Since the onset of the crisis the issue of the economic sustainability of the NHS has become even more central in Italy. Almost the whole debate about the NHS transformation has been monopolized by this issue. The necessity for cost-containment and the search for more efficiency does not come only from the need to improve the economic performance of the NHS, but also (and mainly) from the need to face a huge public debt. The reform targets in the most recent years have been mainly the following:

- increases in co-payments;

- more control on drugs and pharmaceutical expenditure, thanks to a set of measures aimed at, on one side, to increase competition in the drugs and pharmaceutical distribution market, on the other, to reduce the costs for the NHS through a series of mechanisms (automatic pay-backs systems, expenditure caps, etc.);

- cuts in the expenditure for health care related goods and services, also including private contracted-out ambulatory and diagnostic services;

- restructuring of the hospital care provision with the aim of reducing the number of hospital beds;

- a relatively strong freeze in terms of health care personnel salary increases and, also, in terms of new hiring.

The 2011 “Finance Law” (now called “Financial Stability Law”), the main national legislation regulating the amount of resources that are given yearly to the public sector, represented a potential important turning point for the Italian NHS: for the years 2013-2014, it introduced an amount of expenditure cuts equal to around 8 billion Euros (the overall NHS financing from the State in 2012 was around 106 billion Euros). Among the measures that the Law introduced there were: the substantial hiring freeze of new health care workers in the NHS; a new “nationally-set” co-payments system on pharmaceutical goods and health care services from 2014, for an amount equal to 2 billion Euros.

Cuts in health care public expenditure were clearly visible in the period of 2009-2012: the annual growth rate of expenditure in public health care in real terms was on average -0.7% between 2009 and 2012 (OECD, 2013).

3.1.2 System characteristics

Italy has a National Health Care System (NHS) which was introduced in 1978, substituting a previous Social Health Care Insurance model. Since the 1990s important transformations took place: NHS reforms had to follow a difficult path between cost containment given the huge public debt of the Italian State and innovation, which though often costly, was required by an increasingly demanding and aging population.

In order to solve the dilemma of containing costs and trying to keep pace with social demand, the institutional changes in the NHS reform took different directions, three of which are of particular interest: rescaling, privatisation and managerialization.

As in many other European countries, rescaling largely meant a shift of power and responsibilities from the national level to sub-national (regional) governments (decentralization). Following the regionalisation reforms of the 1990s a good part of the regulatory public power in health care has been shifted from the national State to Regions: the former essentially maintained two tasks (a substantial part of financing and setting "homogeneous standards of health provision" for the country), the latter received all other tasks (from planning to managing health care provision).

A strong attempt has been made to modernise the NHS administration following for the most part, a New Public Management approach: the local health care authorities created by the 1978 reform were transformed into health care agencies and Hospital Trusts. Politicians appointed by local governments were substituted by managers (called "General Directors") heading these agencies and trusts.

In connection with managerialization, there has been the introduction of competition and a broader use of private providers within the NHS. This has paved the way for using "quasi-markets" and increasingly replacing public provision with provision contracted-out to the private sector: between 1990 and 2010 the percentage of beds in privately owned (contracted-out) hospitals of the overall number of hospital beds increased from 23.5% to 31.6%; among European NHS, Italy is together with Spain one of the countries with the highest incidence of private contracted-out provision (Pavolini and Guillén, 2013).

In the case of Italy it is also difficult to detect a progressive privatization of expenditure, at least until 2011. Italy has followed a bell curve in private out-of-pocket (OOP) expenditure: there was a strong increase in the 1990s (in 1990 the incidence of OOP on the overall health care expenditure was equal to 17.1%, whereas in 2000 was equal to 24.5%) and then a decrease in more recent years (it was in 2011 equal to 18.3%) (OECD, 2013).

Looking at the amount of resources devoted to the health care system, Italy spends less than EU-average, especially in relation to the "old" EU-15. Total per capita expenditure on health (at purchasing power parity) was in 2011 equal to 2,964 dollars. The public one was equal to 2,359 dollars. Health care expenditure, considering both the public and the private one, was in 2011 23.9% lower compared than EU-15 average (-22.2% and -29.4% respectively in relation to public and private expenditure) (CEIS, 2013). At the beginning of the 2000s the distance in terms of Italian per capita expenditure with Western Europe was quite more limited (around -10%). The increasing difference between the level of expenditure in Italy and

Western Europe is the result of expenditure annual growth rates that have been considerably lower than in the EU-15 average since the beginning of the 2000s (OECD, 2013).

3.1.3 Details on recent reforms

The last two years have witnessed important changes, especially the ones adopted in October 2013 with the last "Finance Law" (now called "Financial Stability Law"). Before discussing the contents of the most recent Financial Stability Law, it is important to focus on two previous relevant policy decisions: the 2012 "Balduzzi Reform" and the "Integrative Note on the Document of Economic and Financial Planning" (DEF) for 2013.

In 2012 the former Monti government introduced a health care reform, called the "Balduzzi Reform" (named after the Minister of Health Care) (Legislative Decree n° 158/2012). The reform focused on different issues, the most prominent ones were the re-organization of primary care and the redefinition of the "guaranteed levels of health care assistance" (LEAs). The reform intended to offer a 24 hours – 7 days a week coverage in primary care with General Practitioners (GPs), through a system of "health homes" (Case della salute), where GPs could and should work jointly[26]. In relation to the guaranteed levels of health care coverage, the reform recognised new LEAs, which meant a new public coverage for emerging new pathologies. The problem with the Balduzzi reform has not been the contents, but the absence of specific financial resources to implement it: especially in relation to the transformation of the organization of primary care, no relevant changes have taken place since its introduction, given that the creation of "health homes" would have required investments that neither the Legislative Decree nor other legislative norms have provided.

The other main Act is the September 2013 "Integrative Note on the Document of Economic and Financial Planning" (DEF). The DEF is one of the main planning tools in relation to public finances: it is divided in three parts and the third one contains the National Reform Programme (NRP). The "integrative note" stated that relevant changes will be needed in the Italian NHS in order to keep it sustainable. In particular the NHS must become more "selective" (meaning a – probably stricter - review of the types of health needs included and financed among the LEAs) and provision will be offered only to those who are "really in need" (the quotes are from the document). The DEF also sets public health care expenditure for 2014 at 7.1% of the GDP and 6.7% in 2017. The DEF fosters also a reorganization of hospital and out-patient care (meaning a reduction of hospital beds, especially in acute care and more provision in LTC and chronic care coverage), more prevention (with a new "National Plan for Prevention") and a stricter drugs expenditure regulation.

The last main change is the most recent one and it is probably the most relevant one. The Financial Stability Law, just produced by the National Government in mid-October 2013, has made quite important decisions in relation to the functioning of the NHS:

1. it has decided not to introduce the 2 billion co-payments that the Financial Law of 2011 (see section 3.1.1) had reckoned on for 2014; therefore one of the main worries for the social sustainability of the NHS seems to have been removed;
2. moreover no direct financial cuts in NHS are introduced, as it happened in the previous years; this aspect, together with the previous one, is quite relevant, because it is the first time after the onset of the austerity plans that public health care expenditure should not decrease from one year to another;

[26] The previous system was based on a GPs coverage, offered usually individually by this type of doctors during the working week and from 8 am to 8 pm, whereas nights and weekends were covered by specific doctors ("guardie mediche").

3. however indirect cuts have been maintained mainly in relation to NHS workforce expenditure; the Law prescribes that also for 2014 the "freeze" on salary increases in the whole public sector will be maintained (including the NHS), as well as for 2014 the total stop to any possibility to apply what it is called "turn-over" (the possibility for public administrations to hire new workers when older ones retire); the total stop for "turn-over" will be lowered in 2015 (a 40% turn-over will be allowed) but only in 2018 the ban will be totally abandoned;
4. moreover the Law prescribes that cuts will not be introduced as long as in the coming months the Central Government and the Regions (running the NHS) will sign a new "Health Pact" where major revisions will have to be introduced in terms of hospital care organization (starting with beds reduction in acute care), types of LEAs accepted in the NHS, and similar standard costs all over the country for the provision of LEAs.

3.2 Assessment of strengths and weaknesses

3.2.1 Coverage and access to services

Formally the Italian NHS offers a universal coverage. However a series of indicators shows that there are problems in providing effectively such a coverage. The problems are not connected to formal rights. Apart from dental care, which is mostly covered by the private market, the main health problems are treated by the NHS. The problems rise from three different sources:

a. Waiting lists in the access to health care provision;
b. Level of co-payments;
c. Social and territorial differences in the access to health care.

A recent document from the Ministry of Health (2013a) offers an updated view on waiting lists in Italy. The three most important results from the study are: for many types of provision (in diagnostic, acute care, etc.) the waiting times are relatively long; moreover between 2010 and 2012 these waiting times increased; there are quite strong territorial differences in waiting lists for similar needs (for example the waiting time for a coronography in Campania is 101 days, whereas it is just 5 days in Tuscany). An OECD publication (Siciliani et al., 2012), comparing waiting times and policies to reduce them in a series of countries, underlines that Italy has the double problem of relatively long waiting lists, as many other NHS, and of having so far adopted less effective policies to reduce them.

Apart from waiting lists, Italy has increasingly used co-payments in recent years. The result is that, as shown by an AGENAS study (the National Agency for Regional health care provision), co-payments for specialists visits, drugs and emergency rooms amounted in 2009 to 2,7 billion Euros and they had reached in 2011 around 4 billion (around 3.5% of the overall public health care expenditure) (Giuliani and Cislaghi, 2012).

The problems of long waiting lists and increasing co-payments can help to explain the following figures. In 2011 7.2% of Italians reported unmet needs for medical examination in the EU-SILC survey (table 3.1): this percentage was at only around 4% in the UK and Denmark, and 5.5% in Spain and France. Only Germany showed a situation relatively similar to the Italian one (6.5%). Moreover this percentage reaches 9% among the elderly (65 and over), whereas in the other countries, that have been just quoted, it is around 2-4% (figures not reported in the table).

The problem of access is not widespread in a similar manner among different social groups. A first line of distinction comes through social classes. The percentage of individuals with unmet medical needs belonging to the lowest income quintile in 2011 in Italy was equal to around 13%: practically no other Western European country had such a high level. Also middle classes are affected by access problems: around 9% of individuals in the second quintile reported unmet needs for medical examination (again a figure not found in any other Western European country). The problem is not only the relatively high percentage of individuals in the lower quintiles with access problems, but it is also the gap with those in the higher ones: only around 3% of individuals in the fifth quintile reported in 2011 in Italy unmet needs. The distance between the first and the fifth quintile was equal to 10.4% (last column on the right of the table). Again such a wide gap cannot be found in any other Western European country (see table 3.1).

Table 3.1 Self-reported unmet needs for medical examination by income quintile (%)

	First quintile	Second quintile	Third quintile	Fourth quintile	Fifth quintile	Total	Difference I and V quintile
Denmark	94.4	97.0	94.8	96.5	97.9	96.1	3.5
Germany	88.2	92.6	94.6	95.6	96.3	93.5	8.1
Spain	93.4	95.7	94.2	94.5	95.2	94.6	1.8
France	90.3	93.7	95.6	96.3	96.5	94.5	6.2
United Kingdom	95.0	96.4	95.9	96.4	97.3	96.2	2.3
Italy	**86.8**	**91.2**	**93.5**	**95.4**	**97.2**	**92.8**	10.4

Source: Eurostat online database

The problem of access by different social groups is not only related to social class differences but also to territorial differences. There is a relatively vast scientific literature that clearly shows how Southern Italians have a worse public health care system than Center-Northern Italians (see, for example Pavolini, 2011; Pavolini and Vicarelli, 2013). A recent publication from the Italian Health Ministry confirms this view: the "Health Care Outputs and Outcomes Programme" ("Programma Nazionale Esiti") clearly shows that the performance of the hospitals of the Centre-Northern Regions is by far better than the one of Southern Regions for practically all the 47 indicators used (from infraction and stroke mortality after 30 days of hospital care to cesarean sections, to prevention, etc.) (Health Care Ministry, 2013b).

3.2.2 Quality and performance indicators

In the last years Italy has been developing a system to monitor in depth its public health care system. The "Health Care Outputs and Outcomes Programme", quoted in the previous section is a good example of this attempt. The results are published in a transparent way on the web in order to allow patients, professionals and policy makers to have a clearer view of their local health care system[27]. Even if the Ministry denies that this "Programme" offers a clear ranking

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

of hospital facilities, the opportunity is high to use the information to provide orientation for patients[28] and potentially policy makers.

In an international comparative perspective the Italian health care system performs relatively well. Table 3.2 confronts the Italian case with the other biggest (in terms of population) four health care systems in Western Europe (Spain, France, UK and Germany), hereby defined as EU-4. The Italian NHS is in line with the other Western European healthcare systems for many indicators. Italy shows good performance rates in terms of prevention, bed occupancy, relatively low level of child mortality and relatively high survival rates after serious cardio-circulatory diseases.

These favorable results were obtained using fewer resources (measured by the lower share of healthcare public expenditure of GDP) compared to the other countries and without significant differences in terms of private expenditure. However, there are also other indicators that highlight lower performance in the Italian NHS. Health and social care integration is more limited, especially in the care of the elderly (see section 4). There are important differences in access to services based on income (and social class) and territorial residence, as shown in the previous section. There are also huge differences in terms of user satisfaction (approximately a 15 per cent gap): these differences are also related to problems of long waiting lists that were not sufficiently dealt with by policies during the last two decades, as already underlined in the previous section.

Problems are arising also in terms of how the NHS workforce is changing and has been managed in recent years. Italy has one of the most aging health care workforces in Western Europe: for example physicians aged 55 years old or more in 2010-2011 represented 43.2% of the overall physicians (this figure was equal to 12.9% for the UK, 23.2% for Spain, 33.3% for Sweden, 40.4% for Germany and 42.0% for France) (OECD, 2013). The choices made in recent years, on one side, to stop substantially the possibility to hire new doctors and health care personnel, on the other to freeze salaries increases, make the situation even more complicated (see section 3.1). These choices have been made inside a system that tended to remunerate its professions with lower salaries and contracts than in many other EU-15 countries (Pavolini and Oesterle, 2013). Negative spill-over on professionals' motivations and satisfaction and from there to quality of provision might be possible.

[28] In the Italian NHS patients have a relatively high degree of freedom to choose the hospital facility they prefer for elective surgeries or diagnostic treatments.

Table 3.2 The performance of the Italian NHS in a comparative perspective (2009-11)

Dimensions	Indicators	Italy	EU-4
Human, financial and technological resources	No. magnetic resonance units for each 1 million inhabitants	23.7	9.5
	Public health care expenditure as a percentage of GDP	7.2	8.0
	Private health care expenditure as percentage of total health care exp.	22.2	22.7
Prevention	Percentage of women undergoing mammography, age 50-69 years	70.1	73.2
	Peruses vaccination, children	96.2	96.3
Hospital Efficiency	Average length of stay: days	7.6	7.7
	Acute care occupancy rate (percentage of available beds)	79.9	79.3
Integrated social care and health care	No. of residential facilities beds for frail elderly per 1,000 elderly	17.9	32.4
Citizens satisfaction	Percentage of people unsatisfied with their health care systems	46.0	30.6
Results	Infant mortality rates	3.4	3.7
	Mortality rate for heart attack after 30 days of hospitalization	4.0	6.2

Source: Author' elaboration from OECD (2013) and Eurobarometer (2010)

3.2.3 Sustainability

Dr. F. Massicci, Chief Inspector of the General Inspectorate of the Ministry of Finance, stated in a recent audit at the Chamber of Deputies in the Italian Parliament (October 2nd 2013) that public health care expenditure is becoming increasingly under control and its growth rate has strongly decreased in recent years thanks to the governance tools adopted. Moreover the Chief Inspector argued that this low pace of growth is expected also for the coming years thanks to the cost-containment measures introduced in these last years. In general, even if the political debate is partially heading to another direction (see section 3.3), the data seems to show that public health care expenditure is under control and it is lower than the Western European average both in terms of incidence on the GDP as well as (and even more) on a per capita PPP level.

3.2.4 Summary

The Italian NHS has been able in the last decade to keep the pace of transformation in terms of performance as the other main Western European health care systems. It has also been able to do so absorbing less financial resources (in terms of GDP and per capita expenditure) than many other systems. The financial sustainability of the NHS does not seem at risk from a strictly economic point of view, if expenditure remains under control as it has been in the last decade.However there is a series of problems that might impoverish the quality and the performance of the system in the near future and some of them are already doing so.Inequalities in the access, related to territorial as well as social class differences, are quite

visible.Long waiting lists and increasing co-payments help to explain why Italians are much more unsatisfied with their health care system than other Western Europeans.Moreover the aging of the workforce and the choices made in terms of its management (not particularly high salary levels, freezing of salaries, low "turn-over" rates, etc.) risk to create a very serious problem in the medium term.

3.3 Reform debates

In the last two years the main debate in relation to the Italian NHS has been around its economic sustainability in the long run, possible alternative ways to finance it and the impact on the principle of universalism of access. The debate grew stronger already during the Monti Government in 2012. In November 2012 the former Prime Minister argued that "we cannot take for granted in the future the NHS if we do not find new sources for financing it… We should think about the opportunity to integrate the resources coming from taxes with a second integrative source of financing"[29]. The idea Monti had was to strengthen the second pillar in Italian health care system.

"Integrative Health Care Funds" were introduced at the end of the 1990s in the Italian legislation (Legislative Decree n° 229/1999) in order to strengthen the Italian health care system, acting as the "second pillar". In the 1999 Legislative Decree the word "integrative" had a dual (and ambiguous) meaning: a guarantee of coverage of benefits not offered by the NHS, in some way in addition to State provision; a coverage of costs borne by patients within the NHS (such as co-payments, etc.). A good part of funds has been created thanks to sector-level collective bargaining agreements between trade unions and employers representatives. In recent years the funds are booming. If the estimates for the end of the 1990s indicated the presence of 657 thousand subscribers and 1,4 million participants (this last category includes, in addition to members, also relatives), more recent figures state much higher estimations: about 6,4 million members and over 11 million participants, more than one sixth of the total number of Italians and about 30% of employees. Moreover, in 2011 health care funds managed assets for around 4 billion Euros (equal to 3% of total expenditure of the NHS) (Pavolini et al. 2013).

The comments from Monti opened up a debate that still continues. Recently the current Minister of Health has stated: "we need to strengthen integrative health care funds" (September 2013). This statement was given during the debate that followed the "Integrative Note on the Document of Economic and Financial Planning" (DEF) of 2013 where, as stated in section 3.1, the idea that the NHS must be in the future more "selective" and health care provision will be given to those "really in need" was introduced.

Clearly after these new statements the debate has heated again given the fact that some commentators, from politics and the health professional world, fear that "strengthening" integrative health care funds is part of a broader strategy to reduce the level of universalism in the Italian health care system and will smoothly dismantle the NHS.

The debate and the decisions taken at the Italian level are increasingly influenced by EU institutions. The EU institutions have two types of instruments potentially affecting national social policies, among which health care (De La Porte and Heins, 2013): instruments aimed at the sustainability of public finances (e.g. the Six Pack and the FC), but which put indirect pressure on welfare state policies; and instruments that aim at re-calibrating social and labour market policy (Europe 2020). In the case of Italy it is not through the latter (EU social policies) that this process is taking place, but the former: the instruments aimed at the

[29] Speach given by Former Prime Minister Mario Monti on the occasion at the Ri.Med. Foundation.

sustainability of public finances. All the EU impact comes mainly from the more general Italian public financial sustainability problem and how this issue has to be dealt with in the EU framework. The recent and increasing worries around the risk of an "Excessive Deficit Procedure" for Italy have meant that health care, given the level of expenditure of the NHS, is in recent years (at least since the onset of austerity) in the front line whenever cuts in the public budget have to be made (see section 3.1). Therefore in the last years Italian public health care has been characterised so far, on one side, by no explicit and relevant reform, on the other, by severe financial cuts, which could jeopardize in the medium term the meaning of universalism. Most of these cuts are strongly related to tighter pressures from the EU institutions through instruments aimed at the sustainability of public finances.

4 Long-term care

4.1 System description

4.1.1 Major reforms that shaped the current system

In order to understand the Italian LTC system, it should be kept in mind that, in comparison with major reforms introduced in the last two decades in many EU countries (for example: Germany, France, Spain, the Czech Republic, etc.), there have been no major policy changes in Italy (Ranci and Pavolini, 2012).

It is only since the beginning of the new millennium that LTC has entered at least the public reform agenda, when several national reform proposals were put forward, but so far with limited success (Costa, 2012). The only public action specifically directed to address care needs over the last ten years was the creation of a very modest and temporary "National Fund for Dependency" in 2007. Two other measures have also indirectly offered some assistance to those with caring needs: the establishment of a national contract for homecare workers (including personal assistants) and the "regularization" (i.e. legalization) of migrants who wished to work as personal care assistants in 2009.

4.1.2 System characteristics

The Italian LTC public system is based around two institutional pillars.

The main one is the "Companion Allowance" (CA), a cash allowance programme for individuals with severe disability. The *National Institute of Social Security – INPS* runs it and it is financed through general taxation. Italy spends the equivalent of 0.86% of its GDP in cash benefits: this expenditure is mainly related to the CA. This amount of resources is provided directly to households without any request of accountability to beneficiaries: frail elderly people can use the around 500 Euros per month they receive without the need to explain or justify to public authorities how they have spent these resources. Until October 2013 the admission to the CA was only based on dependency needs.

The second pillar are home and residential care services, provided by Municipalities (for the social care part) and Regions (more for the health care – nursing related part). The admission is based on needs but also on income levels: co-payments play a relevant role and together with often long waiting lists tend to shape who the users of these services are.

To this general picture we have to add two other relevant aspects of information. Neither the access nor the amount of social transfers related to the main cash benefits programme (the "Companion Allowance" - CA) are means-tested. The CA is provided only on the base of needs. The criteria of access to residential and home care are quite differentiated in the country as well as the criteria of co-payment. Practically in the whole country means-testing is applied to define the amount of economic resources households have to provide in order to receive the service.

4.1.3 Details on recent reforms in the past 2-3 years

As stated in section 4.1.1, no relevant reforms have been taken place in the past few years.

4.2 Assessment of strengths and weaknesses

4.2.1 Coverage and access to services

When compared to the EU situation, especially the one in most of the Western European countries, the main features of the Italian LTC public system are:

- the overall public expenditure, measured in terms of incidence on the GDP, is similar to the average one in the EU-27 (1,9% vs. 1,8%);
- a very strong prevalence of cash benefits programmes over services;
- a relatively weak investment in residential care;
- a medium investment in home care, although this type of service is fundamentally and informally supported by migrant care workers (working and being paid directly by families).

The main cash programme, the CA, covers around 10% of frail elderly individuals. The share of this type of programme on the overall LTC expenditure is around 45%. A first shortcoming of this programme is the absence of any accountability requirements for beneficiaries. Another shortcoming of the functioning of the "Companion Allowance" is the fact that benefits are provided on the base of a flat rate: there is no differentiation on the base of how severe the disability is (as it happens instead in most other EU countries: for example, Germany – which has a three-level system -, France, England, Spain, etc.).

The second specificity of the Italian system is the fact that any serious "aging in place" strategy needs anyway a strong residential care pillar. LTC beds in hospitals per 100 000 inhabitants are just 17,1, whereas in the EU on average they are 26,5. However, given the type of care needed, the LTC hospital beds density cannot be considered the best indicator in order to evaluate how relevant is residential care for the frail elderly (quite often LTC residential facilities are outside hospitals or even outside the strict health care field and in the social care one). The "Multilinks database on Intergenerational Policy Indicators", created by the WZB in Berlin by Saraceno et al. provides useful information in relation to residential elderly care coverage[30]. Italy presented a 2% coverage rate, which was quite lower than the one registered in most other Central-Northern European countries: for instance Germany 3.8%, Denmark 4.7%, Sweden 5.9%, and France 6.4%. One limit of the Multilinks database for Italy is that the data refer to 2004, whereas for the other countries the statistics refer to

[30] For a general introduction: http://multilinks-project.eu/uploads/papers/0000/0016/technical-report-version-1-2.pdf, and for accessing the database directly: http://multilinks-database.wzb.eu/info/project-info.

2009. However the most recent available data from Italian national sources confirm substantially the information provided: Istat (2013a) published a report on "Residential Care Facilities" (year 2010). The residential care recipients aged 65 or more were around 295,000. If we include all the elderly, the coverage rate is 2.4%. If instead, we calculate the coverage rate only in relation to the number of non-independent elderly, the figure drops to 1.8%. However, no matter how the calculation is done, the coverage rate remains quite lower than the one registered in many other Western European countries by Multilinks. Not only there is a lower diffusion of residential care, but there is also a problem of the characteristics of this type of supply: for example there is a very limited diffusion in Italy of housing facilities thought for elderly still able to partially manage themselves (e.g. flats with home automation) and not needing yet neither residential homes nor nursing homes.

Istat provides yearly data on the number of recipients of social home care (Istat, 2013b): in 2010 175,929 elderly individuals received social home care (equal to 1.4% of the 65+) with a expenditure per capita around 2,000 Euros. In relation to 2010 Istat provides also information on the number of recipients who receive both social home care and nursing home care: 86,381 elderly beneficiaries (coverage rate 0.7%). The Ministry of Health provides yearly information on home care recipients of nursing services: the number of elderly beneficiaries was equal to 501,607 (coverage rate 4.1%) in 2010 (Ministry of Health, 2013c). If we estimate the overall home care recipients as social home care beneficiaries + home care recipients for nursing services – beneficiaries of both services, there should be almost 600,000 elderly beneficiaries receiving either / or one of the two types of home care, equal to around 4,8% of the overall 65+ population.

However the relevance of this relatively medium coverage level, if compared to other EU countries, should not be overestimated: the number of hours of home care for nursing services, which is the most widespread service, per capita per year is equal to 20. Therefore if we analyse not simply the coverage level but the (hourly) intensity of public home care, the help provided is quite scarce and limited over time.

Overall, given:

- the limited coverage provided through residential care,

- the presence of a home care system with a medium level of coverage, but with a low intensity of care provided,

- the relatively vast access to a cash benefit (the CA), which covers more than 10% of the 65+, and it is not neither means-tested nor requiring accountability on how it is spent, explains why Italy present one of the highest diffusion (if not the highest) of migrant care workers, often with irregular contracts.

4.2.2 Quality and performance indicators

The fact that residential care coverage is relatively low creates more tensions on public home care provision (Ranci and Pavolini, 2012): it means that in Italy many (severe) cases, that elsewhere would/could be treated through different forms of residential care (last stages of Alzheimer or other forms of dementia, etc.), are left at home (also respite care is not spread in the country). This means that a good part of the elderly in need of care at home has a quite complex health status.

At the same time it is difficult to discuss of performance and quality in a system that is mainly based on informal care by relatives and provided by migrant care workers, which do not have often regular contracts and an adequate training for the care functions they have to perform.

4.2.3 Sustainability

It is complicated to verify if sustainability is at stake in the Italian LTC system. The amount of resources devoted to LTC is similar to the EU-average (see section 4.2.1). Given its aging population (after Germany, Italy has the highest incidence of elderly population – 20.2% - in the EU; moreover, considering only the very elderly population aged 80 years old and more, Italy reaches the first place – 5.8%, 4.6% in the EU), the necessity for resources will increase in the future.

However the current problem seems more related to how the resources are spent (cash programmes without any accountability on how the transfers are used, instead of residential and home services) and to whom they are given (that is why the issue of "selective universalism" discussed in sections 4.1.3 and 4.3 becomes fundamental): what could be criticised is that the actual system (before October 2013) has institutional facets that might hinder cost-effectiveness, maintaining equal the amount of resources provided by the State.

4.2.4 Summary

Overall the Italian LTC seems a system that so far has been able to invest a consistent amount of resources, at least in line with many other EU countries, but obtains partially sub-optimal results. The strong role of uncontrolled cash allowances, the relative limited diffusion and coverage of professional (residential and home) services, the diffusion of migrant care work (often irregular), the absence of any selective universalism in order to partially restrict access cash allowances to those in need both in terms of dependency but also economic resources, are elements that make the whole system not cost-effective, with limited quality and partially unfair.

4.3 Reform debates

The main debated around LTC in the last year and half has concentrated around the possible introduction of an income criteria (means-testing) in relation to the access to the main cash allowance programme, the CA.

Many organizations representing people with disabilities have been substantially contrary to the introduction of a cap, whereas other policy actors (for example part of the trade union world and some members of the last governments and parliamentary majorities) have been more favourable in relation to discuss and introduce a more articulated system of access to LTC (cash) provisions.

The 2013 Stability Law was supposed to go exactly into the direction of introducing selective universalism and some sort of relatively light means-testing (the income cap would have been relative high given the Italian income distribution). As a matter of facts, in a first version of this Stability Law (mid-October 2013) a quite relevant innovation was introduced: for the first time since the programme was established in the 1980s, the Stability Law established a form of means-testing. The idea behind this type of means-testing was "selective universalism": the first draft of "Financial Stability Law" prescribed that all those potential beneficiaries with a yearly income above 60,000 Euros, if living alone, or 80,000 Euros, for those living in a couple and considering the whole couple income, will be excluded from the CA. Also for those below this threshold some changes should have taken place: the sum of personal/couple income and the amount of resources provided through the CA should be lower than 60,000-

80,000 Euros. Otherwise the CA generosity should be reduced proportionally. However, given the fact that the Financial Stability Law is going through Parliamentary vote, the debate around the introduction of selective universalism has been so heated that the Government has decided to withdraw from the Law any reference to CA, leaving the system as it was (totally universalistic) (mid-November 2013).

At the same time the Ministry of Welfare has been chairing for months "tables of discussion" with social partners, experts and associations in order to frame in the most effective way a reform in the criteria of access to the CA. All this work had not come yet to a conclusion, but it could very soon, finally introducing selective universalism.

In relation to LTC the Italian debate has not at all been influenced by the EU institutions level.

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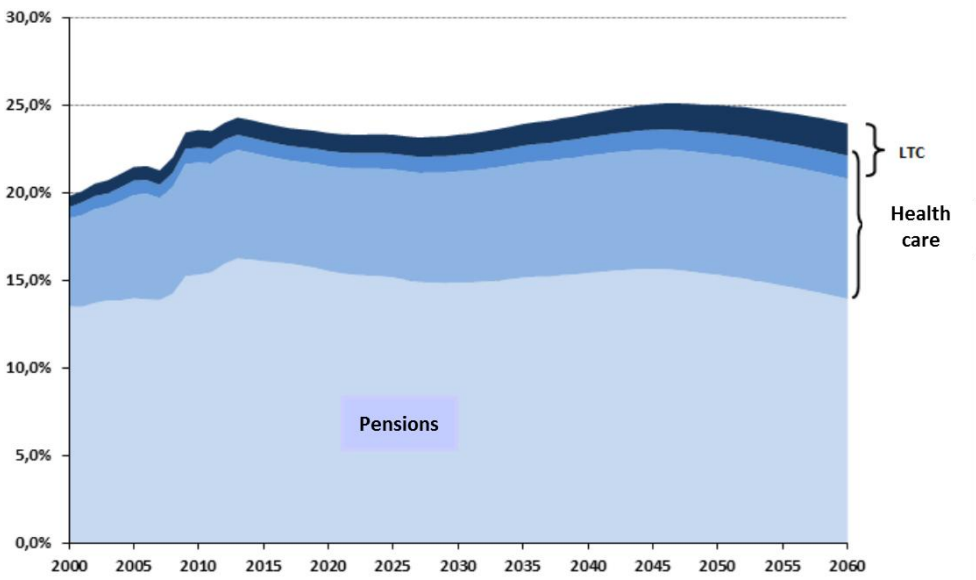
Annexes

Figure A. Public expenditure for pensions, health care and long term care (% Gdp), 2000-60, national baseline scenario



Source: MEF (2013: 21)

Table A. Public expenditure for pensions, health care and long term care (% Gdp), 2000-60, national baseline scenario.

	2010	**2015**	**2020**	**2025**	**2030**	**2035**	**2040**	**2045**	**2050**
Pensions	15.3	16.1	15.6	15.2	15.2	15.8	16.1	16.3	15.9
Health care	7.3	6.9	6.8	7.0	7.2	7.4	7.6	7.8	7.9
- of which LTC	*0.9*	*0.9*	*0.8*	*0.8*	*0.9*	*0.9*	*1.0*	*1.1*	*1.2*
LTC	1.0	1.0	1.0	1.0	1.1	1.2	1.2	1.3	1.4

Source: Authors' elaboration on MEF (2013: 17)

Annex – Key publications

[Pensions]

COVIP (2013a), Relazione per l'anno 2012,Official Report, retrieved on 10.9.2013 at www.covip.it

Annual Report 2012

The annual report by the Supervisory Body for Supplementary Pensions includes very detailed information and data about development of funded pillars. It analyses the various forms of supplementary pension provision by focusing on coverage, performance and returns, costs and other relevant indicators.

INPS (2012), Rapporto Annuale 2012, Official Report, retrieved 23.11.2012 at http://www.inps.it

Annual Report 2012

The Annual report by the National Social Insurance Insitute contains detailed data and information regarding recent reforms and legislative changes, expenditure trends, number of paid social protection benefits, benefit amount, beneficiaries, related to the activity of INPS. The report is updated until mid-2012.

MINISTERO DELL'ECONOMIA E DELLE FINANZE (2013), Le tendenze di medio-lungo periodo del sistema pensionistico e socio-sanitario, Rome, Official government report, retrieved on 5.10.2013 at http://www.rgs.mef.gov.it/VERSIONE-I/Attivit--i/Spesa-soci/Attivit--d/2013/index.html

Medium-lomg term trend of the Italian pension and healh care systems

This is the most updated official report on the Italian public pension and health care systems. It includes projections on both expenditure trends and the evolution of pension replacement rates in the next few decades. Published in 2013, it includes the effects of the latest reform adopted in December 2011.

PATRIARCA, STEFANO (2011), L'adeguatezza del sistema pensionistico contributivo, Roma, INPS, article.

The report, commisioned by the National Social Security Institute (INPS), presents updated estimates of gross/net replacement rates for public pension for the next decades. Interestingly, replacement rates are calculated taking into account the (already legislated) increases of the age of retirement in 2012-2050

[Health care]

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"*IX Healthcare Report*"

The Healthcare Report is, together with the OASI – Cergas and Osservasalute, the most comprehensive annual publication on healthcare transformation in Italy. The 2013 edition, apart from a series of chapters on different aspects of healthcare (domiciliary care, hospital care, etc.) focuses on the issue of healthcare performance measurement.

CERGAS, Rapporto OASI 2012, Milano, Università Bocconi Editore (Egea), 2013.

"2012 OASI Report on the Italian NHS"

The OASI Report is, together with the Osservasalute Report and CEIS, the most comprehensive annual publication on health care transformation in Italy. The 2012 Report provides a comprehensive overview of the structure and operational arrangements of the Italian NHS. It also provides detailed statistical information on the financial management of individual regional systems, and sheds light on the criteria which are used to set the tariffs for the various medical services.

OSSERVATORIO SULLA SALUTE NELLE REGIONI ITALIANE, Rapporto Osservasalute 2012, 2013, Rome/retrieved from: http://www.osservasalute.it/

"2012 Report on health in the Italian Regions"

The Report "Osservasalute" is, together with the OASI – Cergas publication, the most comprehensive annual publication on health care transformation in Italy. Single chapters are dedicated to health care needs and the main caracteristics of the Italian NHS answer to these needs.

PAVOLINI, Emmanuele and GUILLEN, Ana Marta (eds.) (2013), Health Care Systems in Europe under Austerity. Institutional Reforms and Performance, book, Palgrave.

The book analysis the changes in some of main EU health care systems (Sweden, England, France, Germany, Spain, Italy and Poland), offering an interpretation on what, how and why health care systems have changed in the last 15 years and comparing their performance.

PAVOLINI, Emmanuele, NERI, Stefano, CECCONI, Stefano e FIORETTI, Ilaria (2013), Verso un sistema multipilastro in sanità? Luci ed ombre nell'esperienza dei fondi sanitari, in PAVOLINI, EMMANUELE, ASCOLI, UGO and MIRABILE, MARIALUISA (EDS.), Tempi moderni. Il welfare nelle aziende in Italia, book, Il Mulino, Bologna.

"Toward a multi pillar system in the Italian NHS?"

This book chapter probably represents the most updated analysis on Integrative health care funds in Italy, with an empirical analysis on how these funds work and what type of coverage they offert.

Apart from the titles above, there is a series of Italian websites which regularly publish articles on pensions, health care and LTC:

- La Voce (www.lavoce.info)
- Nel Merito (www.nelmerito.com)

Both these On Line Websites have been created by a mix of social scientists and they host an updated and good quality debate also on Welfare State and Social Policies issues.

More specifically on health care and LTC, there are other four websites:

- Monitor (www.agenas.it/archivio_monitor.html): it is the official online journal of the National Agency for Regional Health Care Services;

- Il Sole 24ore sanità (www.sanita.ilsole24ore.com): it is the website of the main economic magazine specialized on health and health care (and LTC) issues;

- Panorama Sanità (http://www.panoramasanita.it/ita/news.asp): it is an online magazine discussing up to date information on health care and LTC;

- QS Quotidiano sanità (http://www.quotidianosanita.it): it is an online magazine discussing up to date information on health care and LTC.

[Long-term care]

MINISTERO DEL LAVORO E DELLE POLITICHE SOCIALI, Secondo rapporto sulla non autosufficienza in Italia, 2011, Roma.

"Second National Report on LTC. Year 2011"

The Report is the relatively most updated government document on LTC. The first part of the report deals with the transformation of needs (ageing, etc.). The second part focuses on dependency and the third one on LTC public provision. The last part of the document analyses more in depth the main issue concerning LTC: home care, funding, residential care, dementia, etc.

NETWORK NON AUTOSUFFICIENZA (eds.) (2011), L'assistenza agli anziani non autosufficienti in Italia. Terzo Rapporto, book, Maggioli Editore, Bologna.

"Long-term care assistance to the elderly in Italy. Third Report"

The book is a collection of interesting essays on different aspects and issues related to LTC in Italy, mainly focusing in this third report on residential care.

RANCI, Costanz and PAVOLINI, Emmanuele (eds.) (2012), Reform in Long-term Care Policies in European Countries, book, Springer, New York.

The book offers a comparative analysis on different European countries LTC programs (Denmark, Sweden, England, the Netherlands, France, Germany, Spain, Italy and the Czech Republic), how and why they have changed over time and what are their main caracteristics nowadays.

This publication is commissioned by the European Union Programme for Employment and Social Solidarity – PROGRESS (2007-2013)

This programme is implemented by the European Commission. It was established to financially support the implementation of the objectives of the European Union in the employment, social affairs and equal opportunities area, and thereby contribute to the achievement of the Europe2020 Strategy goals in these fields.

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