Health and the effect of universal health coverage in Italy

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As Italy celebrates the 40th anniversary of the establishment of its National Health Service, founded under the guiding principles of universality, equity, and solidarity, the very first national-level Global Burden of Disease (GBD) Study for the country by the GBD 2017 Italy Collaborators[1] was published in *The Lancet Public Health*. This Article is a timely contribution, shining a light on epidemiological trends in Italy over the past 27 years (1990–2017) in comparison with other European countries.

The availability and reporting of GBD figures for Italy is a valuable contribution towards public health research, practice, and policy, not only for the wealth of descriptive data, but also for the insight it offers to the analytical discussion on the impact of the national health system's performance on health and the drivers and health consequences of risk factors' distribution over time and across population strata. As is clearly underlined by the authors, in Italy in 2017, people lived longer, fewer died from specific diseases such as ischaemic heart disease and stroke (age-standardised years of life lost [YLLs] rate per 100 000 population decreased by 60·9% for ischaemic heart disease and by 64·1% for stroke between 1990 and 2017), fewer disability-adjusted life-years (DALYs) occurred due to road injuries (–59·3%), and most people exhibited healthier behaviours than in 1990. At the same time, this improvement in individual-level heath conditions combined with low fertility has contributed to steep population ageing and, in turn, an increase in the burden of ageing associated diseases. Indeed, while the YLLs component of DALYs has decreased by 20·1% between 1990 and 2017, the years lived with disability (YLDs) component increased by 17·6%. Overall, people in Italy are living longer but a higher proportion have chronic conditions. Several country-level health reports and statistics are available for Italy,[2,3] all consistently highlighting high life expectancy, population ageing, and mortality mainly driven by cardiovascular diseases and cancer in the population. Still, GBD data enriches the body of knowledge available on Italy's state of health by providing additional metrics, including YLLs, YLDs, DALYs, aggregated in different groups of causes and allowing global comparisons. However, when attempting to interpret the rich and neatly presented set of data provided by the GBD 2017 Italy Collaborators in the context of the evolution and performance of Italy's National Health Service, the multiple layers of complexity are notable. The determinants of the overall positive picture that emerges for Italy from the GBD data both over time and compared with other countries, is not easily attributable to a single phenomenon and cannot only be related to a well performing National Health Service. In fact, behavioural risk factors have a large effect on the burden of chronic conditions and although this Article reports encouraging results on decreasing trends in smoking and alcohol use, despite having a long-lasting tradition of the Mediterranean diet, Italy has the second highest rate of childhood obesity in Europe,[4] which will probably negatively affect their health in the future. For instance, the way that the recent financial crisis affected health was not only mediated by the cuts in health-care expenditure mentioned in the Article, but also by changing patterns in behavioural risk factors.[5] The 2015 mortality spike reported in the Article has been discussed in the literature and no clarity exists on whether in Italy, as well as in other European countries, this spike was driven by the financial recession.[6,7] With regards to health-care expenditure, despite a crisis-associated progressive decrease in public expenditure as a percentage of gross domestic product (from 7·0% in 2010 to 6·7% in 2015), the overall system showed a degree of resilience, as indicated by the health indicators reported in the GBD study. Private providers accredited by the Italian Ministry of Health also contribute to the health systems, accounting for nearly 30% of total hospital beds.[8] Additionally, an area worth exploring in future research is the regional and subnational distribution of health indicators. In the Italian National Health Service, single regions are responsible for health services' planning and delivery[9] and wide disparities in the performance exist between regional health services. These differences are reflected both in regional-level health indicators and in clinical outcomes. Life expectancy differences of over 4 years between different regions in Italy[2] and major health inequalities in access to care exist. As a result, people move across the country, mostly from southern to northern regions, to seek health care. For instance, the essential levels of care (*Livelli Essenziali di Assistenza*) intended to ensure universal health coverage provision

For more information from the **Italian National Agency for Regional Healthcare Services** see https://pne.agenas.it/main/doc/introduzione.pdf

For more on **essential levels of care** see http://www.salute.gov.it/portale/lea/menuContenutoLea.jsp?lingua=italiano&area=Lea&menu=monitoraggioLea

across the country are efficiently delivered in only 76% of Italian regions.

We see tremendous potential in building on this first analysis of GBD data to further explore patterns in health status and health determinants in Italy. Domestically, these data can be used both to retrospectively assess policy implementation via so-called natural experiment studies[10] and to prospectively inform selected health policies. Internationally, they provide unique ground for intercountry assessments that—to be informative—should always take into account setting-specific health systems' and services' features.

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