IVASS
ISTITUTO PER LA VIGILANZA SULLE ASSICURAZIONI

Statistical Bulletin

Healthcare liability risks in Italy 2010-2018

Year VI - no. 12, October 2019

RESEARCH AND DATA MANAGEMENT DIRECTORATE − RESEARCH AND STATISTICS DIVISION

Text and database by Leandro D'Aurizio, in collaboration with Angela Lucia Dati and with Monica Angelini for the English version.

Editing: Caterina Visani.

Coordination: Lino Matarazzo.

(decree-law no. 95 of 6 July 2012, converted into law no. 135 of 7 August 2012)

Registration at the Court of Rome no. 56/2015 of 23 March 2015

Direction and Editing at the Istituto per la vigilanza sulle assicurazioni

Director in charge

Roberto NOVELLI

Address

via del Quirinale 21 – 00187 ROME

Telephone:

+39 06 42133.1

Fax

+39 06 42133.775

Website

http://www.ivass.it

ISSN 2421-3004 (online)

Contents

1. METHODOLOGICAL NOTE

Foreword

This bulletin includes the main quantitative evidence of the two forms of insurance providing cover for healthcare liability, as set forth by the law:

1. those acquired through *insurance policies* for healthcare risks, offered by insurance undertakings through payment of a premium,
2. those that the public health facilities constitute through *self-retention of the risk*[1].

The insurance policies for healthcare liability risks are part of the broader general liability class of which they represented, in 2018, 14% of the total.[2] The data on this type of policies are acquired through an annual survey conducted by IVASS on the insurance undertakings, at the beginning of each year. The data on the self-retention of the risk by public healthcare facilities are provided by the Ministry of Health, which has made available an information basis with the data of the budgets of these facilities.[3]

The insurance policies for healthcare liability risks

Statistical information is based on a survey conducted every year at the insurance undertakings since 2016, using specific communications to the insurance market published at the beginning of each year.

The scope of the survey

The survey is mandatory. All the undertakings authorised in Italy to pursue general liability insurance (including healthcare insurance) are required to respond, including those with the head office in a foreign State.

The last survey, conducted from March to April 2019, covered in detail:

1) the premiums collected in 2018 for risks situated in Italy relating to healthcare liability,
2) the prospects and obstacles in the sector from the point of view of the undertakings,
3) the main characteristics of the insurance covers placed in 2018,
4) the situation of the claims reported in the years from 2010 to 2018.[4]

91 undertakings participated in the survey, of which only 23 have claimed to operate in the sector, collecting premiums in the course of 2018 (tab. 1).

[1] The Law no. 24 of 8 March 2017 (Gelli law) envisages forms of self-retention of the risk also for private healthcare facilities, therefore complete statistical data are not available.
[2] The percentage reaches 14.7% if we also consider policies for gross negligence taken out by healthcare personnel.
[3] The communication to the insurance market announcing the survey conducted in 2019 is no. 0049691/19 of 11 February 2019.
[4] In a limited number of cases, the data on provisions or payments for claims and to premiums are estimated and the data provided during the previous surveys are reviewed by the undertakings in the following years. Data relating to premiums and risk units include some undertakings been excluded from the calculation of the other indicators since the data provided were incomplete.

Tab. 1 – Survey on healthcare liability (2018)
Undertakings surveyed and undertakings operating in the sector

	Italian undertakings[a]		Foreign undertakings[b]		Total	
	Surveyed	Operating in healthcare liability	Surveyed	Operating in healthcare liability	Surveyed	Operating in healthcare liability
	55	15	36	8	91	23
Of which operating at:						
Public health care facilities		5		4		9
Private health care facilities		9		4		13
Healthcare professionals		15		5		20

(a) Undertakings with head office in Italy subject to the prudential supervision of IVASS.
(b) Undertakings with head office in a foreign State, pursuing business in Italy through a permanent presence (by way of establishment) or directly from abroad (by way of freedom to provide services). Branches of foreign undertakings with head office in a country outside the European Economic Area (EEA)[5], subject to the prudential supervision of IVASS, are also covered by the survey.

The self-retention of the healthcare liability risk in public healthcare facilities

For the years 1997 to 2017, the Ministry of Health makes the budgets of public healthcare facilities available. Two items relating to self-retention risk funds are considered: one item in the profit and loss account containing the yearly resource allocation for these funds and another, taken from the balance sheet, with the amount of these funds at the end of the year. The chart of accounts provided by the Ministry respectively indicates the two items with the abbreviations BA2740 and PBA050.[6]

Section 5 provides a comparison, for public structures, between healthcare liability risk managed through insurance and through self-retention. This comparison is relative to 2017 data, the most recent available.

[5] The countries belonging to the EEA (European Economic Area) are the EU countries, Norway, Iceland and Liechtenstein.
[6] We thank the Ministry of Health for having made the most recent data available to IVASS, earlier than the official publication times. The complete data are available on the website of the Ministry of Health, at the address: http://www.salute.gov.it/portale/temi/p2_6.jsp?lingua=italiano&id=1314&area=programmazioneSanitariaLea&menu=dati.

2. ANNEXES “STATISTICAL TABLES”

The annex "statistical tables” (only in Excel format) contains the folder:

“RC_SANITARIA.XLSB”, showing the main results of the survey.

The amounts in the tables are expressed in euro.

3. SUMMARY

- Premiums collected for healthcare liability risks amounted to 612 million euro in 2018, on the increase when compared to 2017 (+3.7%); growth is driven by the increase in coverage of private facilities and healthcare professionals.

- For public healthcare facilities, the slight decline in premiums collected (265 million, –2.9% compared to 2017) is accompanied by the drop in the number of insured risk units (581 with respect to 751 of the previous year), in accordance with a multi-year trend.

- Premiums collected from public and private facilities by Italian undertakings, although much lower than those collected by foreign undertakings, have increased (103 million premiums, compared to 81 of the previous year).

- Italian undertakings collect 70% of the premiums for risks relating to healthcare professionals, a share that is slightly down when compared to 2017 (when it was 75.9%).

- Concentration in this sector remains high: the top 5 undertakings collect 93.5%, 82.1% and 64.7% of premiums respectively for public, private facilities and healthcare professionals.

- On average, a physician pays a premium of 1,000 euro, five and a half times the average premium paid by healthcare professionals other than physicians.

- In 2018 insurance undertakings received 17,262 claims, less than in 2017 (–9.7%) and in constant decline since 2012.

- More than half of the claims received before 2017 were closed without payments.

- Undertakings take a long time to pay claims: only 7.5% of those reported in 2018 have been settled, also as a result of the high number of litigations, which involves one claim out of four.

- In relation to the claims reported in 2010 against public facilities, undertakings paid, at the end of 2018, average compensations for 59,876 euro, while for those still outstanding at the end of the same year, provisions of 103,160 euro were set aside. This confirms the characteristic, common to all the liability covers, of long settlement processes, due not only to the complexity of the provision process for more serious claims, but also to lengthy litigations.

- The loss ratio for the policies covering healthcare facilities indicates a permanent loss.

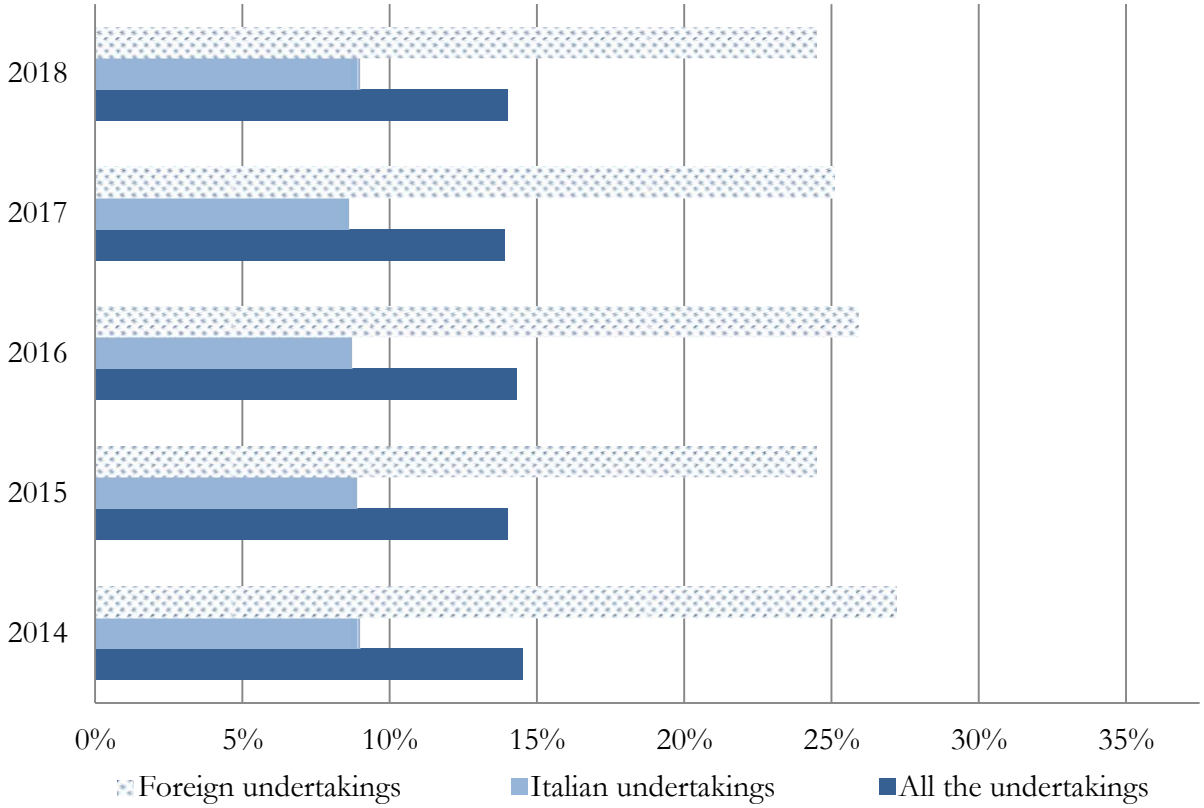
- The use of self-retention of the liability risk of public healthcare facilities keeps growing, the resources allocated for this purpose in 2017 were 592 million euro, more than twice the premiums paid for traditional insurance.

4. THE ACTIVITIES OF INSURANCE UNDERTAKINGS IN THE HEALTHCARE LIABILITY SECTOR IN ITALY

Healthcare liability in the context of the general liability - The healthcare liability risk is part of the general liability class and, in this context, the 612 million premiums collected in 2018 (Table A.1) represent 14% of the total direct premium income for this class in Italy (13.9% in 2017). This share increases to 24.5% for foreign undertakings (compared to 9% for Italian undertakings, fig. 1), witnessing a higher propensity by foreign undertakings to pursue business in this specific sector.

Fig. 1 – Share of healthcare liability premiums over premiums for general liability[a] (2014-2018)

(%)



(a) These shares are computed separately for the three groups of undertakings.

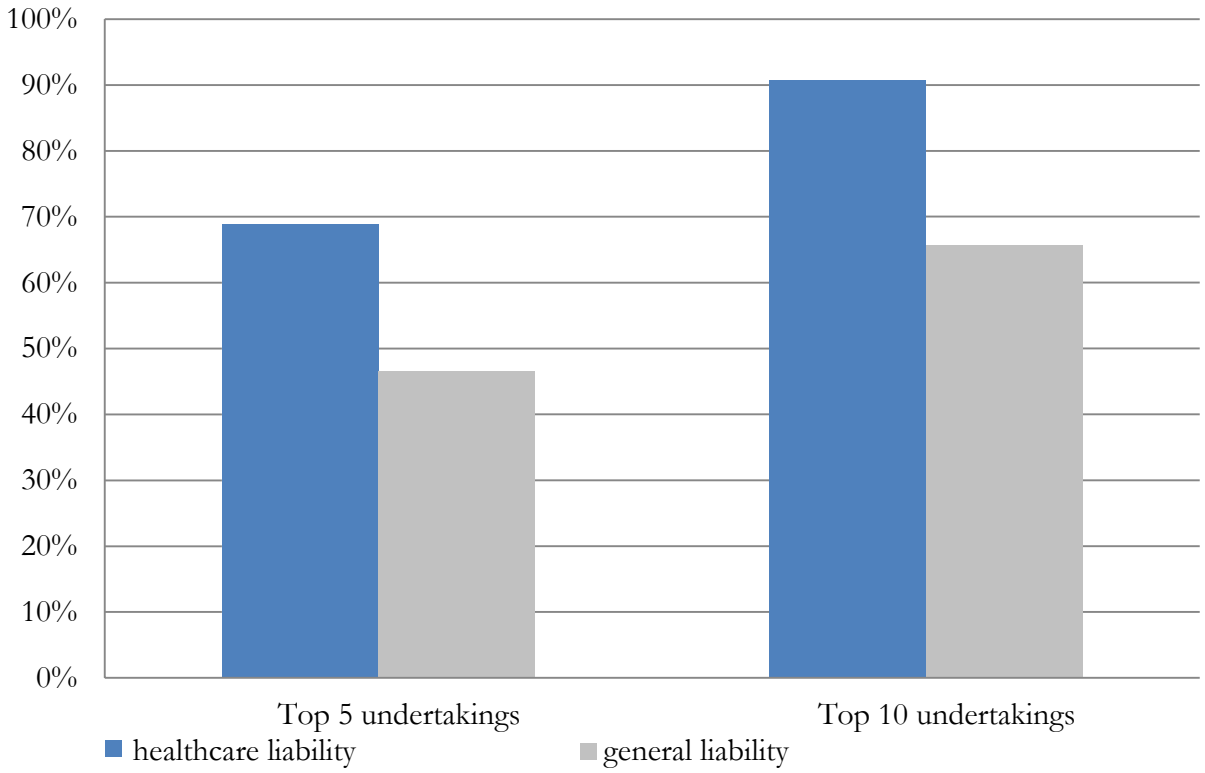
Coverage of gross negligence – The insurance covering gross negligence protects the healthcare professional. It is an ancillary guarantee in healthcare liability that can be taken out together with the latter or as a stand-alone guarantee. The healthcare professionals working in any capacity in a public or private healthcare facility are required to protect themselves (article 10, paragraph 3 of the Gelli law) with a policy covering wilful misconduct or gross negligence. This policy guarantees against any legal action initiated against them by the facility itself or by the insurance undertaking covering the facility (article 9, paragraph 1 and article 1, paragraph 3 of the Gelli law). In 2018, the undertakings reported about 56,000 coverages of this type, for a total premium amount of 31 million euro (risk units and premiums collected have slightly increased with respect to 2017).

The characteristics of the undertakings providing healthcare liability – In 2018 the first 5 undertakings collected 68.8% of the premiums, this share rises to 90.7% for the first 10 undertakings (fig. 2). The degree of concentration is higher than that of the general liability class, where the first 5 undertakings collect 46.6% of the premiums (65.7% for the first 10 undertakings). The concentration

has slightly declined for the contracts entered into by public healthcare facilities (93.5% of the related premiums are collected by only 5 undertakings, compared to 94.2% in the previous year) and for contracts of healthcare professionals (64.7%, down from 65.6%). On the contrary, the share of premiums of private healthcare facilities collected by the top 5 operators has slightly increased (82.1%, compared to 81.0% in 2017).

Fig. 2 – Share of the premiums collected by the major undertakings: comparison between healthcare liability and general liability (2018)

(%)

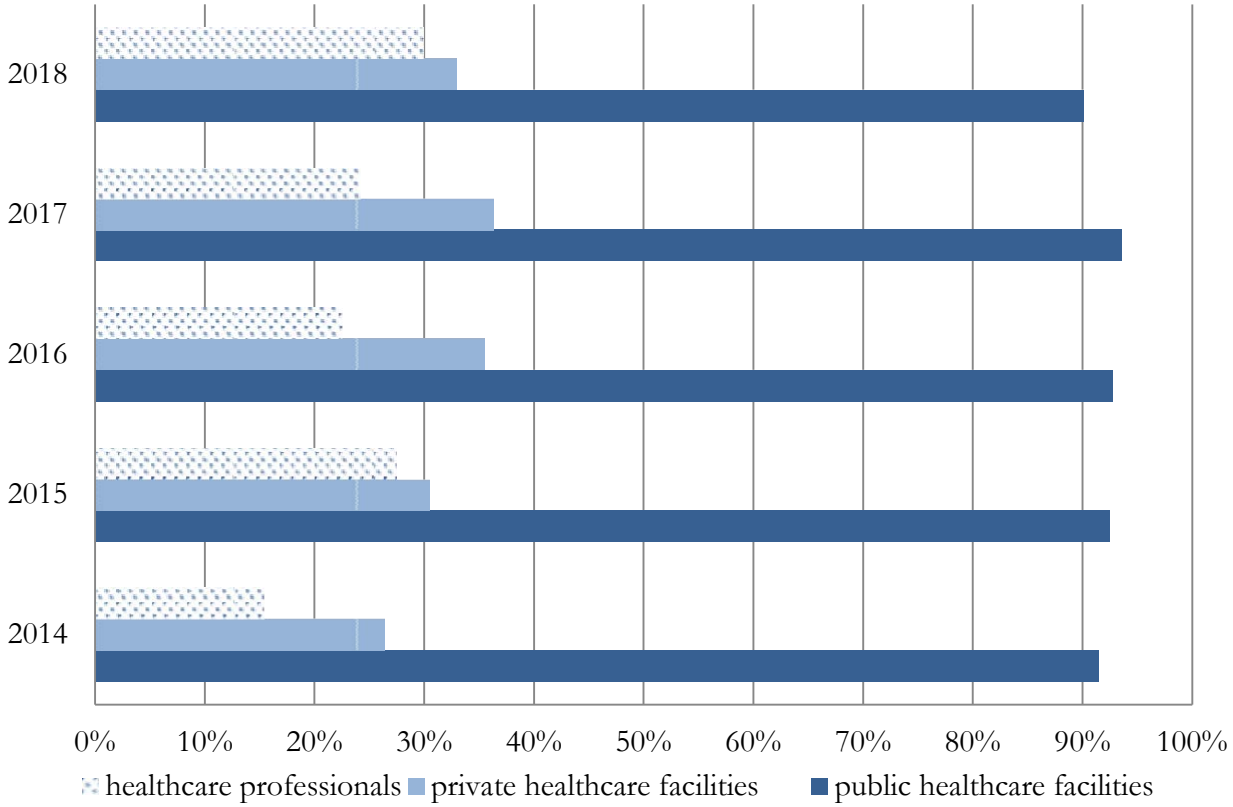


The role played by foreign undertakings in this sector remains significant (fig. 3), in 2018 they collected 90.1% of the premiums for public healthcare facilities, 32.9% of the premiums for private facilities and 29.8% of premiums for the coverage of healthcare professionals.

Premiums collected from public facilities by Italian undertakings remain low, although up compared to 2017 (from 17.6 to 26.3 million), even though there was a slight fall in premiums collected by foreign undertakings. The growth in premiums covering risks of private healthcare facilities is almost entirely attributable to Italian undertakings, which collected premiums for 77 million euro (versus 64 million in 2017). Foreign undertakings saw a rise only in premiums for the coverage of healthcare professionals (69 million, compared to 53 of the previous year), with a drop in the share of premiums collected by Italian undertakings (70.2%, compared to 75.9% in 2017).

Fig. 3 – Share of premiums collected by foreign undertakings in healthcare liability (2014-2018)

(%)



Premiums and insured units – For healthcare liability 612 million premiums were collected in 2018 (+3.7% compared to 2017), which can be broken down as follows:

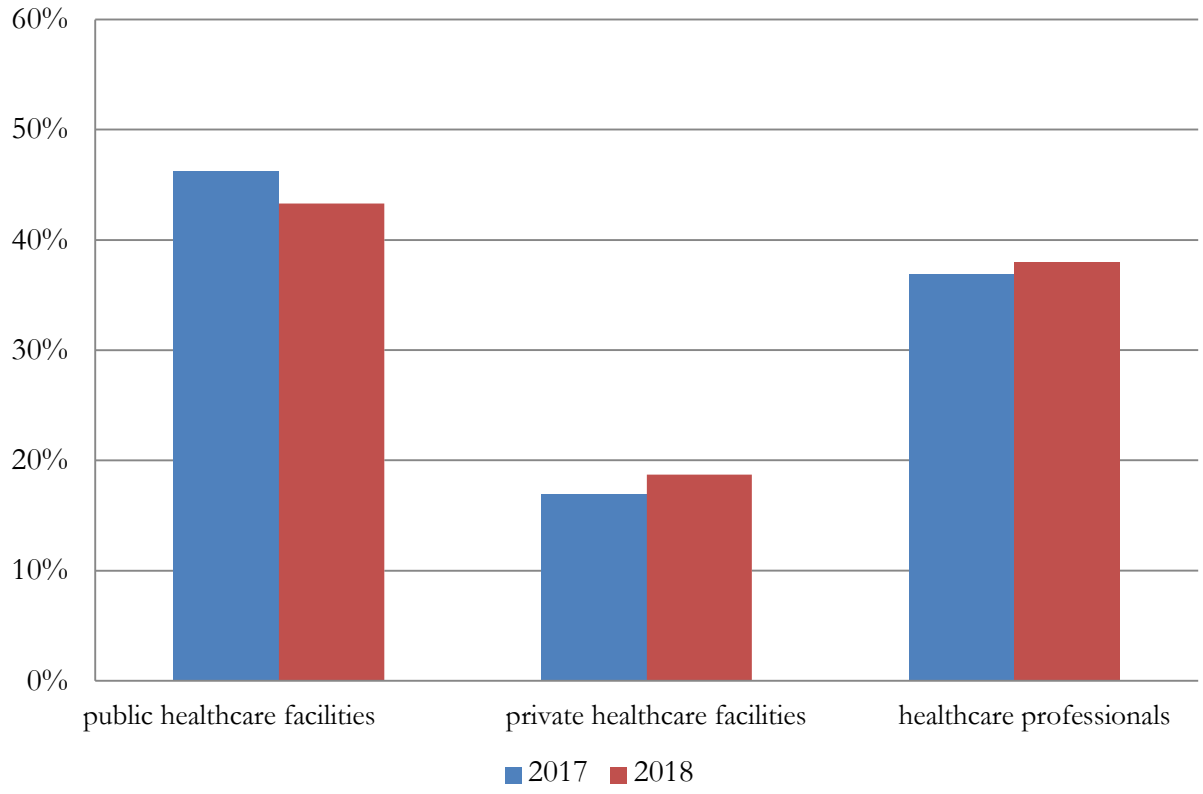
- 43,3% for the coverage of public facilities (46.2% in 2017),
- 18.7% for private facilities (16.9% in 2017),
- the remaining 38.0% for the risks of healthcare professionals (36.9% in 2017).

Compared to the previous year, the share of premiums for public facilities has declined (fig. 4).

Since 2010 premiums covering risks of public healthcare facilities have fallen (–49.0%), while those collected from private facilities and healthcare professionals have increased (respectively +44.2% and +65.2%).

Fig. 4 – Breakdown of healthcare liability premiums according to sub-sectors, 2017 and 2018

(%)



In 2018, 581 public facilities, 6,156 private facilities and around 286,000 healthcare professionals were insured (Annex, Table 1). The number of insured public facilities has declined compared to 2017, in line with a long-term trend which has more than halved their number compared to 2010 (1,426)

The average premium paid for the coverage of a public facility was 456,000 euro (+25.5% compared to that of 2017). This value is more than 24 times greater than that paid by a private facility (equal to 19,000 euro), also due to the greater complexity of the public facilities.[7]

The average premium for covering the healthcare liability of healthcare personnel (tab. 2) amounted to 813 euro (+1.2% compared with 2017), whereas the premium covering gross negligence was 543 euro.

[7] This is the largest gap recorded since 2011, which could also result from the propensity of bigger public facilities to continue to use insurance without completely replacing it with systems for the self-retention of risks.

Tab. 2 – Average premiums for healthcare liability of healthcare professionals (2018)

Geographic area of residence	Physicians	Healthcare professionals other than physicians	Total
North West	1,028	195	838
North East	962	182	754
Centre	1,080	187	851
South	954	168	816
Islands	884	144	741
Total	**1,001**	**183**	**813**

Physicians pay on average a premium of 1,001 euro, compared to 183 euro paid on average by healthcare professionals who are not physicians.

The evolution of claims and compensation – In 2018 the undertakings received 17,262 claims (Annex, Tab. 4) down (–9.7%) compared to those received in 2017. The decrease recorded for the sixth consecutive year concerned mainly public and private facilities.

Among of the claims received in 2018, 21.4% were closed without payment, slightly down compared to 2017 (22.7%).[8] The sector is characterised by the high number of claims closed without payment, higher than that for MTPL.[9] The number of claims closed without payment increases for the less recent claims (more than half of the claims received before 2017 were closed without payment), due to the long time necessary to correctly classify a claim in this sector.

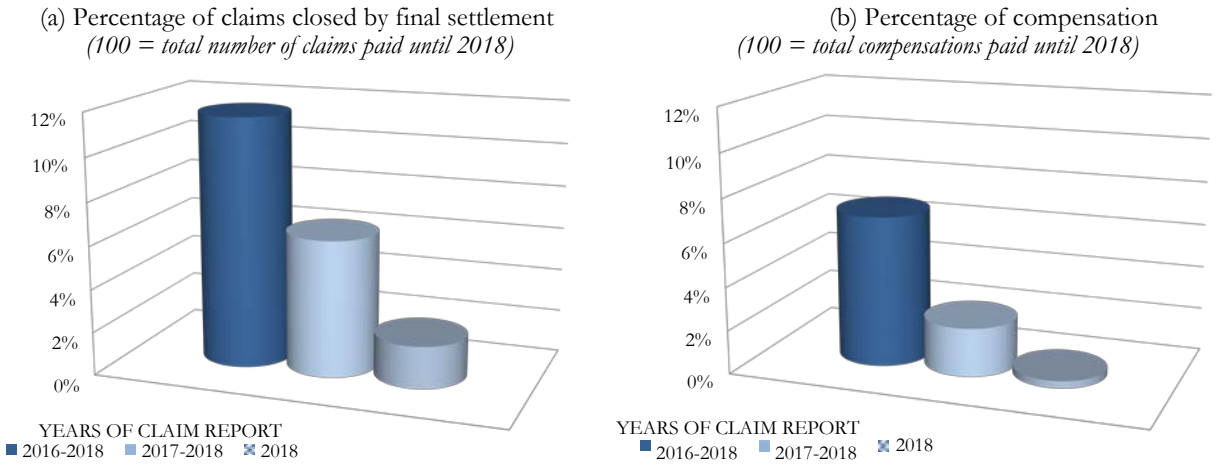
The ratio between claims received and risk units covered in the same year provides an average number of claims by insured unit (these are all *claims made* policies[10]). For the more recent 2018 period (Annex, Table 4.1), a public healthcare facility received on average 8 claims, of which just under 6 either closed with a payment or classified as outstanding. For the private facilities, the two indicators are respectively 0.52 and 0.42, while for healthcare professionals they are much lower (both around 3%).

Insurance undertakings paid final settlement for 52,329 claims reported between 2010 and 2018 (Annex, Table 6) by the end of 2018. Of these, only 11.6% refer to claims received in the previous 36 months, between 2016 and 2018, down to 6.3% for claims received in the previous 24 months, fig. 5.a).

In the same period, the compensations paid (including final and partial payments) amounted to 2,308 million euro, of which 6.9% for claims received between 2016 and 2018 and 2.2% for claims received between 2017 and 2018 (fig. 5.b). The emerging trend is that the insurance sector tends to pay compensations first for less complex claims, characterized by lower amounts.

[8] See Statistical Bulletin on healthcare liability risks in Italy 2010-2017, November 2018, no. 14.
[9] In the motor liability sector, the percentage of claims closed without payment compared with all claims reported for the year 2017, is 10.6% (Statistical Bulletin on insurance activities in the motor insurance sector 2012-2017, October 2018, no. 13).
[10] Clause which admits the compensation only of the claims reported during the period of validity of the policy with reference to claims which occurred within the same period, even if the event that caused the claim occurred previously, up to a maximum of 10 years before the start of the validity of the cover (period of retroactivity).

Fig. 5 – Compensation paid up between 2010 and 2018 by recent years of claims



Claims settlement time – As regards public healthcare facilities (Annex, Table 7), 3.9% of claims with indemnification reported in 2018 were settled and paid in the same year (in 2017 they were 4.6%). For private healthcare facilities, the two percentages were 16.5% for 2018 and 16.1% for 2017, while they amount respectively to 6.0% and 5.0% for the healthcare personnel.

In terms of amounts, only 0.7% of all compensations expected for claims received in 2018 from public facilities were paid in the same year (Annex, Table 8). This percentage goes up to 2.5% for the private facilities and 2.9% for the healthcare personnel. As regards the claims reported in 2017, the three percentages were respectively 1.0%, 2.3% and 2.8%.

These figures relate to the settlement of claims reported in the same year and once again they show the great length of settlement procedures. This fact is confirmed by the observation of the generations of claims reported in 2010 and 2011 (the oldest ones available), for which respectively 25.0% and 34.9% of the amounts were still to be settled at the end of 2018.

The percentage of claims settled within three years shows little signs of improvement compared to 2017, as this percentage goes up from 46.2% to 47.3%.

The average cost of claims – In 2018 the average compensations for the claims reported in the same year was 12,678 euro for public healthcare facilities (Annex, Table 9), while these values are lower for private facilities (5,101 euro) and healthcare professionals (8,072 euro). The three indicators show a decline compared those for the generations of claims reported in 2017.

The above-mentioned trend of undertakings to settle larger claims later is one of the reasons determining higher average compensations for older claims[11]. For the public healthcare facilities, the average compensation of claims reported in 2010 was 59,876 euro, equal to 4.7 times the amount of claims reported in 2018.

The provisions for claims outstanding – At the end of 2018 insurance undertakings set aside provisions for claims outstanding amounting to 2,914 million for the future compensation of claims (Annex, Table 2)[12][12], of which only 15.1% regards more recent claims reported in 2018 (fig. 6a). 59.7%

[11] Other explaining factors are the complexity of the assessment of the physical impairment, which leads to underestimating the extent of the damage in the initial phase, as well as to the frequent lack of information available immediately after the occurrence of the claim, as well as the uncertainty caused by the developments in the case law concerning compensation.

[12] The correct claim provisioning is of paramount importance in healthcare liability, with its long claims settlement times and its strong presence of foreign insurance undertakings not subject to the prudential supervision of IVASS (see EIOPA 2018-2019 Supervisory Convergence Plan).

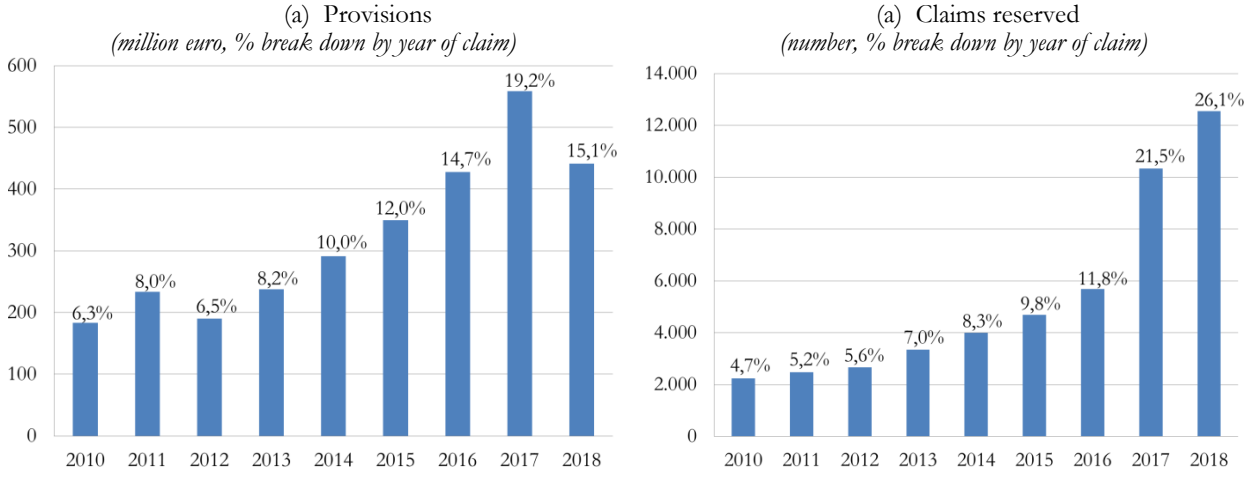
of these provisions are allocated to public facilities.

Claims outstanding at the end of 2018 relating to claims with indemnification received since 2010 (Annex, Table 3) were 47,999 (32.0% relating to public facilities) and only 26.1% resulted from claims reported in 2018 (fig. 6b).

At the end of 2018 the average provision for claims reported in the same year amounted respectively to 76,634 euro for public facilities, 38,262 for private facilities and to 17,582 euro for healthcare professionals (Annex, Table 10), showing a decline compared to the amounts for claims with indemnification reported in 2017. The decrease concerned all the three sub-sectors (–8.6% for public facilities, –20.0% for private facilities and –4.2% for healthcare professionals respectively).

Similar to the average cost, also the average provision increases as claims become older. For example, for the generation of claims reported in 2010 relating to public facilities, the end-of-2018 average provision amounts to 103,160 euro, representing 264% of the end-of-2010 average provision.

Fig. 6 – Provisions at end 2018 for claims reported in the years 2010-2018



The comparison between final payments and provisions for claims outstanding for the same generation provides further evidence that the less costly the claims, the quicker the compensations, while more complex claims, generally less numerous, require high average values of the provisions over time. For example, with regard to public facilities, 6,846 claims reported in 2010 were closed with final payment by the end of 2018 (for an average amount of 59,876 euro), versus 1,153 claims of the same generation still outstanding at the end of the same year (for an average amount of 103,160 euro).

Total average cost of claims – The total average cost of claims with indemnification reported in 2018, obtained from the weighted average of the average value of compensations and provisions, amounts to 74,139 euro for public facilities (Annex, Table 11), 32,806 for private facilities and 17,009 for healthcare personnel.

Litigation in the healthcare liability sector – A high number of civil litigations is found in this sector, with extremely lengthy proceedings explaining, at least in part, why the undertakings tend to maintain high provisions and to delay compensations. One quarter of the overall claims managed reported between 2010 and 2018 involved a litigation (Annex, Table 4.2)[13]. The recourse to the courts mainly concerns the settlement of the claims involving public healthcare facilities (representing 30.1%

[13] In the motor liability sector, characterised by high levels of litigation, the percentage of claims under litigation versus the claims classified as outstanding at the end of 2017 is 21.7% (Statistical Bulletin on insurance activities in the motor liability sector 2012-2017, October 2017, no. 12).

of claims in litigation).

Litigations were on the rise between 2017 and 2018, as they regarded 14.4% of the claims managed reported in 2018, compared to only 6.3% of the claims reported in the previous year[14].

Claims/premiums ratio – The profitability index used is the usual claims/premiums ratio (loss-ratio). Even taking into account the singularities of the healthcare liability risk, it is a homogeneous indicator for evaluating the technical results of the risk and indicates a technical loss for the insurance undertakings whenever its value exceeds 100.

The data updated to 2018 shows a systematic technical loss for the risks of public healthcare facilities (Annex, Table 12). Private facilities record positive results for the more recent generations 2015-2018, but show losses exceeding those recorded by public facilities for the less recent generations 2010-2012.

The profitability of insurance covering healthcare personnel is generally positive and the loss ratio calculated for the claims reported in 2018 has improved compared to the corresponding value for the previous year (57.6% versus 66.6% in 2017).

Distribution channels for healthcare liability contracts – Contracts covering risks of public healthcare facilities are usually mediated by brokers, which collect 69.7% of premiums (Annex, Table 13). Compared to 2016 there has been an increased role for the general directions of undertakings[15], which directly collect about one quarter of the premiums. With regard to private facilities, brokers mediate one third of the premiums relating to the coverage of their risks, while agencies manage the remaining share (with a few exceptions, the only channel for the coverage of healthcare personnel).

[14] On this matter, see Statistical Bulletin on healthcare liability risks in Italy 2010-2017, October 2018, no. 14.
[15] On this matter, see Statistical Bulletin on healthcare liability risks in Italy 2010-2016, December 2017, no. 14.

5. SELF-RETENTION OF THE RISK FOR HEALTHCARE LIABILITY IN PUBLIC HEALTHCARE FACILITIES

Resource allocation and funds covering the self-retention of risk in public healthcare facilities

The healthcare facilities may internally manage, in whole or in part, the healthcare liability risk[16]. If they choose this option, they allocate specific funds to compensate the victims of medical malpractice. These funds are regularly financed by specific allocations[17].

The Ministry of Health makes available the data on yearly resource allocations and funds of public healthcare facilities (tab. 3).

The resources allocated in 2017 totalled 592.4 million (+16% with respect to 2016), while the funds for self-retention at end 2017 amounted to 1,952.3 million (up by 25.2% compared with the previous year). Regional administrations set aside 15.3% of the total yearly resource allocation and 18.1% of the funds.

While the growth in yearly resources allocated between 2013 and 2016 was attributable to the contemporary rise in the number of facilities allocating them and in the value of the average provision, their more recent increase between 2016 and 2017 was almost entirely due to this latter factor. The average yearly resource allocation in 2017 was in fact 4.1 million euro, up from 3.3 million in 2016, while the percentage of facilities that allocated resources in 2017 reached 69.8% (just above 68.4% in 2016, fig. 7).

62.6% of funds for 2017 is attributable to the top five regions (Lombardia, Lazio, Veneto, Sicilia, Emilia-Romagna, fig. 8), 79.0% to the major seven regions (adding Campania and Piemonte to the previous ones).

[16] Article 27, paragraph 1 bis of the Decree-law no. 90 of 24 June 2014, converted with amendments into Law no. 114 of 11 August 2014, introduced the obligation for the public or private healthcare facilities to "take out an insurance cover or have other similar measures in place for third parties liability". Law no. 24 of 8 March 2017 reiterates a similar obligation (art. 10, paragraph 1) and confirms the possibility to use measures alternative to traditional insurance.

[17] The system for managing the healthcare liability of public healthcare facilities is very heterogeneous. In many Italian regions, forms of risk self-retention and insurance coverages acquired from insurance undertakings co-exist in the same facility. A typical mixed form uses self-retention for claims below a given threshold, with an insurance-type compensation activated for higher claims. About this matter, see the report from Agenzia Nazionale per i Servizi Sanitari Regionali [National Agency for Regional Healthcare Services] (AGENAS) "Monitoraggio delle denunce di sinistri 2015 – Rapporto Annuale – Novembre 2016" (2015 Monitoring of claims – Annual Report – November 2016).

Tab. 3 – Self-retention of the healthcare liability risk in the public healthcare facilities Yearly resource allocation to funds (2012-2017)

(million euro)

	2012	2013	2014	2015	2016	2017
			Yearly resource allocation			
Geographical area						
North	53.9	143.2	196.6	199.0	249.8	293.0
Centre	63.5	55.0	81.5	111.4	97.6	126.5
South -Islands	52.8	58.9	133.7	157.2	163.1	172.9
Type of facility						
Healthcare facility	144.6	225.2	380.0	410.6	443.9	501.9
Regional administration	25.6	32.0	31.9	57.0	66.6	90.5
Total for Italy	**170.2**	**257.1**	**411.8**	**467.6**	**510.5**	**592.4**
			Funds			
Geographical area						
North	200.8	324.3	490.4	540.2	725.2	931.7
Centre	59.5	148.4	202.4	227.8	331.9	417.1
South -Islands	58.5	265.0	240.1	362.5	502.1	603.5
Type of facility						
Healthcare facility	247.8	608.2	758.2	936.7	1,311.0	1,598.4
Regional administration	71.0	129.6	174.7	193.8	248.2	353.9
Total for Italy	**318.8**	**737.8**	**932.8**	**1,130.5**	**1,559.2**	**1,952.3**

Fig. 7 – National health care facilities financing funds for healthcare liability risk self-retention (2012-2107)

(% over total facilities)

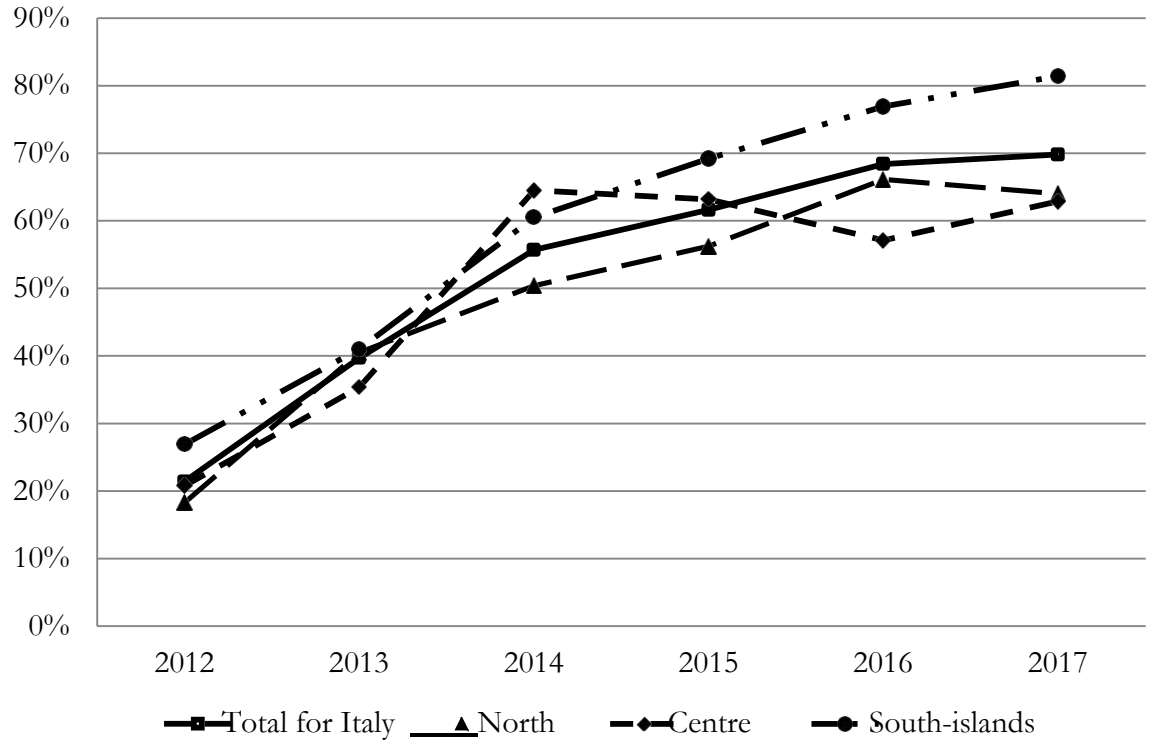
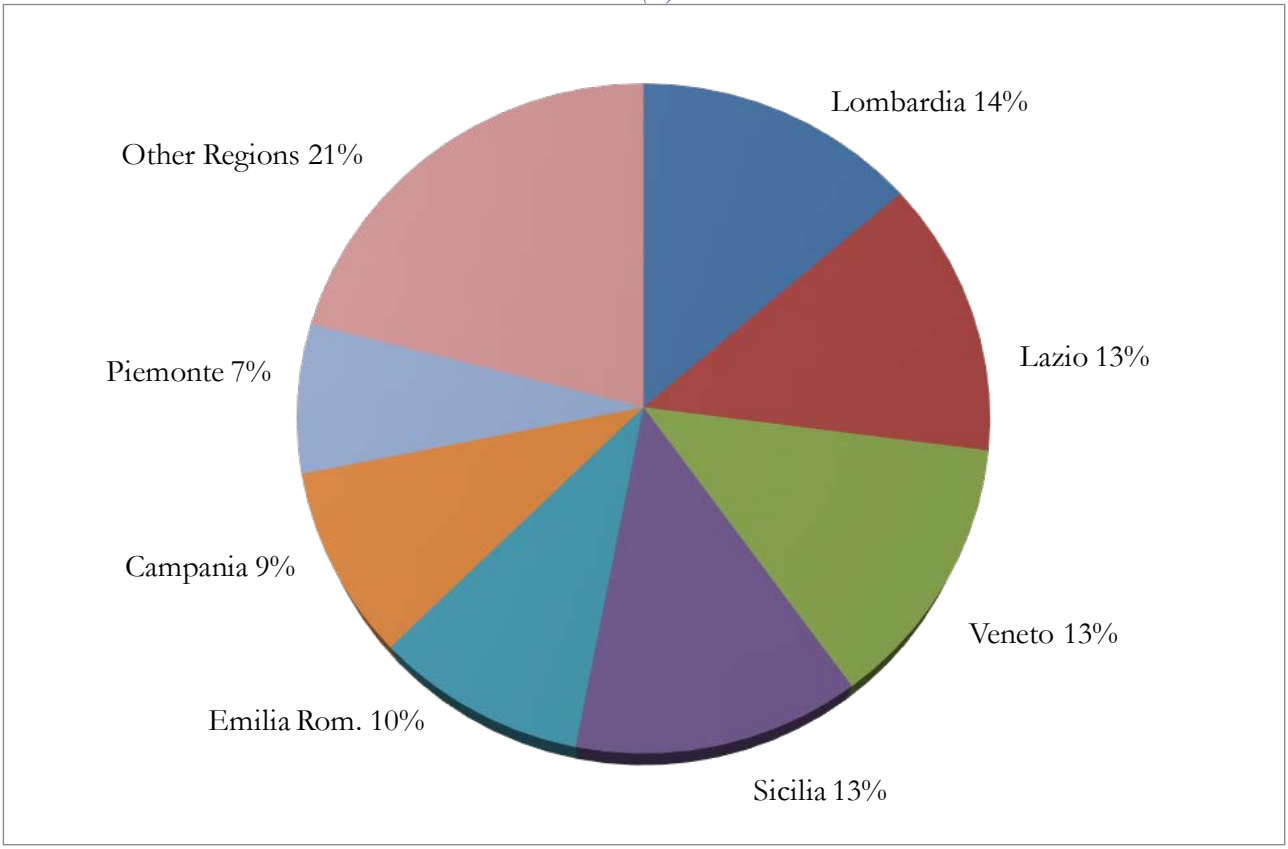


Fig. 8 – Healthcare liability risk in the public healthcare facilities
Regional breakdown of the funds for self-insurance retention (2017)

(%)



Comparison of the resource allocation for self-retention of risk and premiums for healthcare liability of public facilities – Yearly resource allocation for self-insurance and premiums paid to the insurance undertakings for healthcare liability risks of public facilities are financial flows to some extent comparable. They are in fact resources allocated against the same risk, managed either internally (with resource allocations) or through recourse to the market (with the premiums). Between 2012 and 2017 premiums have diminished (–35.6%), while yearly resource allocations have increased (+248.0%, fig. 9). As a result, since 2014 the value of premiums has been lower than the amount of resources allocated every year. In 2017 the ratio of these two values was 0.46 (versus 0.57 in 2016).

In per capita terms (by using the resident population), in 2017 the public health system spent 4.5 euro per capita in insurance premiums for healthcare liability risks, while it allocated resources amounting to 9.8 euro per capita. The two regions with the per-inhabitant highest premiums are Molise (14.6 euro) and Abruzzo (12.1 euro), those with the highest resource allocation are the autonomous province of Trento (35.6 euro) and Veneto (22.4 euro).

Fig. 9 – Healthcare liability risk in the public healthcare facilities
Comparison of the resource allocation for self-retention of risk and insurance premiums (2012-2017)

(million euro)