IVASS
ISTITUTO PER LA VIGILANZA SULLE ASSICURAZIONI

Statistical Bulletin

Healthcare liability risks in Italy 2010-2019

Year VII – no. 11, October 2020

RESEARCH AND DATA MANAGEMENT DIRECTORATE – RESEARCH AND STATISTICS DIVISION

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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[1],
2. those that the public health facilities constitute through *self-retention of the risk*[2].

The insurance policies for healthcare liability risks are part of the broader general liability class of which they represented, in 2019, 13.1% of the total[3]. The data on this type of policies are acquired through an annual survey conducted by IVASS at the insurance undertakings, in the first months 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.

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 letters to the market published at the beginning of each year[4].

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 June 2020, covered in detail:

1) the premiums collected in 2019 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 2019,
4) the situation of the claims reported in the years from 2010 to 2019[5].

92 undertakings participated in the survey, of which only 37 have operated in the sector, collecting premiums in the course of 2019 (tab. 1).

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[1] All the policies sold contain the Claims made clause, which admits the compensation of only 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).
[2] 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.
[3] The percentage reaches 13.4% if we also consider policies for gross negligence taken out by healthcare personnel.
[4] For the survey conducted in 2020, see the letter to the market No. 0045614/20 of 11 February 2020.
[5] In a limited number of cases, the data on provisions or payments for claims and on premiums have been estimated. Data relating to premiums and risk units include some undertakings which have been excluded from the calculation of the other indicators since the data provided were incomplete. The data provided during the previous surveys can be reviewed by the undertakings in the following years, thus resulting in an update of the value of the indicators compared to the previous editions of the Bulletin.

Tab. 1 – Survey on healthcare liability (2019)
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
	54	27	38	10	92	25
Of which operating at:						
Public health care facilities		9		6		15
Private health care facilities		16		6		22
Healthcare professionals		26		8		34

(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)[6], 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

Since 1997, the Ministry of Health has made the budgets of public healthcare facilities available. When drafting this Bulletin, two items, available since 2012, relating to self-retention risk funds have been taken into consideration: 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[7].

Section 5 provides a comparison, for public structures, between healthcare liability risk managed through insurance and through self-retention. This comparison relates to 2018, the most recent available.

[6] The countries belonging to the EEA (European Economic Area) are the EU countries, Norway, Iceland and Liechtenstein.
[7] 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. THE MAIN RESULTS FOR 2019

- In 2019 premiums collected for healthcare liability risks amounted to 579 million euro, with a decrease compared to the previous year (–6.5%), due to the sharp decrease in the premiums (–14.7%) for the policies underwritten by public healthcare facilities. Premiums collected from private facilities and healthcare professionals have remained substantially unchanged.

- Over the decade 2010-2019, the number of insured public facilities more than halved (falling from 1,426 to 581).

- Half of the premiums were collected by undertakings with head office in a foreign State, particularly active in the underwriting of risks for public facilities, where Italian undertakings collect only 11.6% of premiums.

- Italian undertakings are more active in the coverage of private facilities and healthcare professionals: for these risk units they collect 72.6% and 76.8% of premiums respectively.

- Concentration in premium income in this sector remains high: the top 5 undertakings collect 92.4% of the premiums for public facilities. The level of concentration is lower for the risks underwritten by private facilities and healthcare professionals: here the top 5 undertakings collect respectively 81.2% and 61.2% of premiums.

- Over the five-year period 2014-2019 the concentration level for premium income has slightly decreased.

- The percentage of healthcare professionals who change companies from one year to another ranges from 5% to 7% in the four-year period 2016-2019. The mobility of the policyholders generally results in the reduction of the premium paid.

- The coverage for the risks of public and private facilities continues to record a permanent loss, for private facilities the loss is higher for the oldest generations of claims.

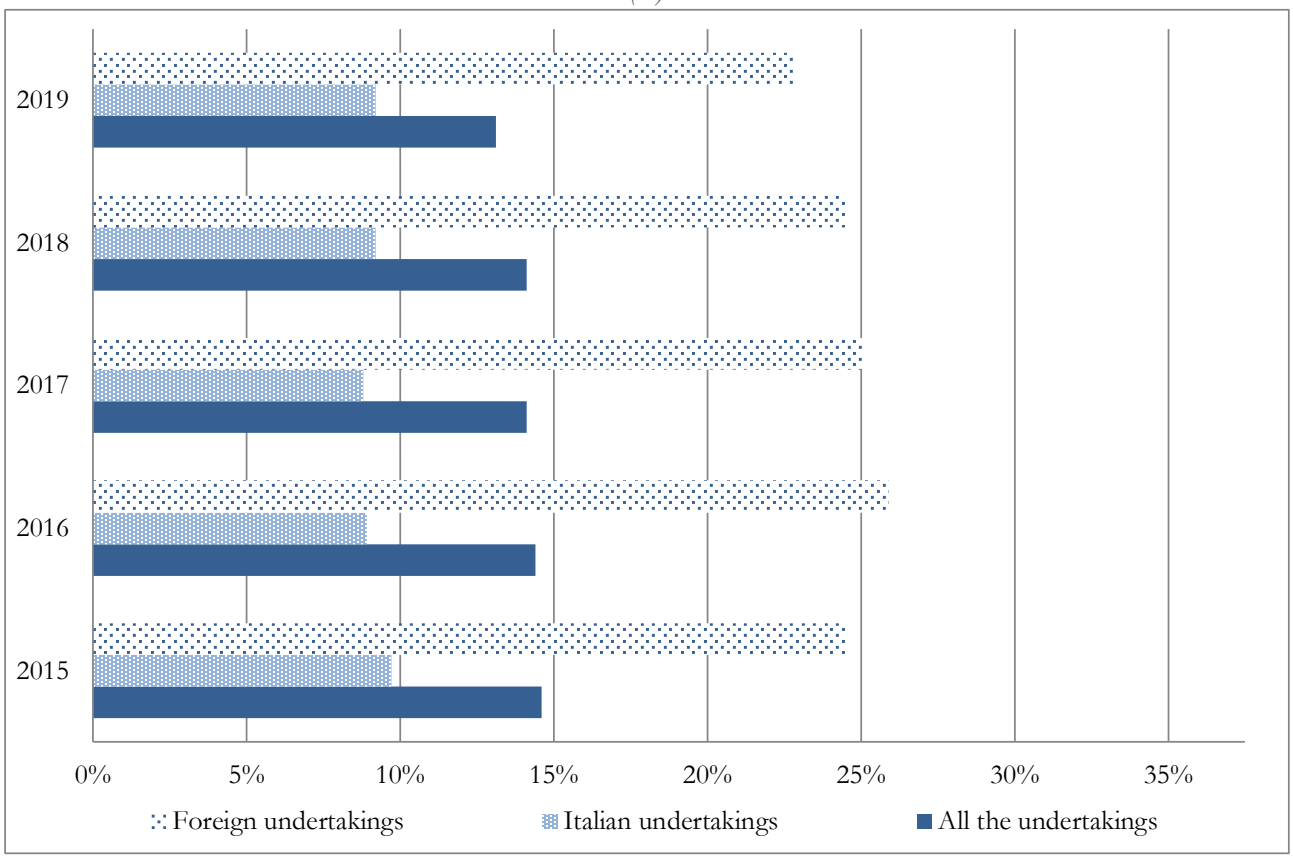
- Under the current regulations healthcare facilities can choose for the self-retention of the healthcare liability risk, as an alternative or additional solution to traditional insurance. For public facilities, this option has sharply increased in the medium-long term: in 2018 allocations to self-retention funds amounted to 187.9% of the value of the premiums for healthcare liability collected by undertakings in the same year (compared to 138.8% in 2014).

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 2019, the 579 million premiums collected represented 13.1% of the total premium income. This percentage is much lower for Italian undertakings (9.2%, fig. 1) than for foreign undertakings (22.8%), although the latter too is on the decrease compared to the value for 2018 (24.5%).

Fig. 1 – Share of healthcare liability premiums over premiums for general liability[(a)] (2014-2019)

(%)



(a) These shares are calculated 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). Undertakings only report the single coverage and, in case of multiple coverage, the share of the premium relating to gross negligence, when it is possible to unbundle it.

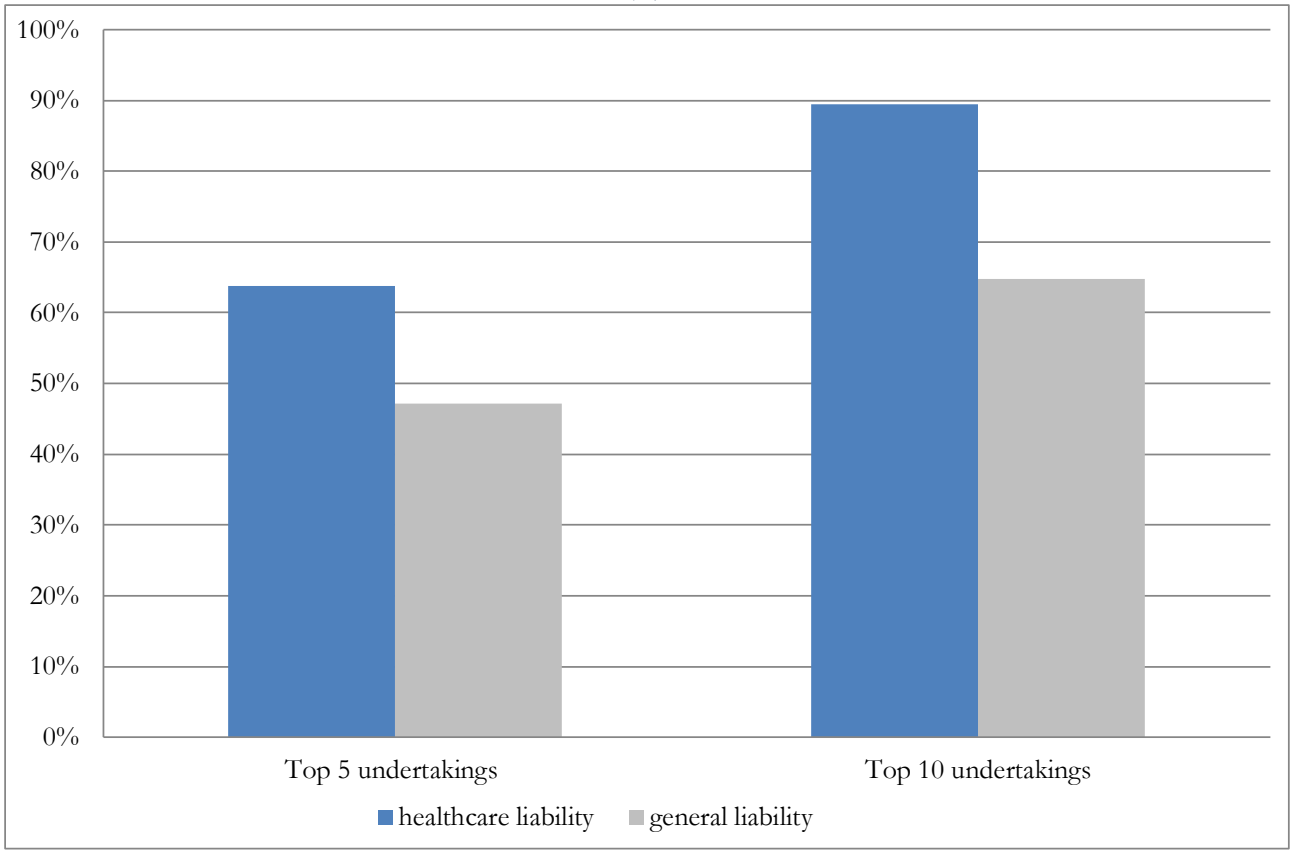
In 2019, the undertakings reported about 80,000 risk units and premiums amounting to 13 million for these coverages, showing an increase compared to 2018 and 2017.

The characteristics of the undertakings providing healthcare liability – The share of premiums on total income collected by the first 10 undertakings in this sector amounts to 89.4% (63.8% for the first 5

undertakings). The general liability class shows on the whole a lesser degree of concentration (the above two indicators for the first 5 and 10 undertakings amount to 64.8% and 47.2% respectively, fig. 2).

Fig. 2 – Share of the premiums collected by the major undertakings: comparison between healthcare liability and general liability (2019)

(%)



The situation is extremely diverse by type of risk unit: we observe the highest concentration for public healthcare facilities, with 92.4% of the premiums collected by the top 5 undertakings. This share falls to 81.1% and 63.2% for private facilities and healthcare professionals.

The high concentration in the insurance supply for healthcare liability is however on the decrease over the five-year period 2014-2019 (fig. 3).

The role played by foreign undertakings in this sector continues to be significant (fig. 4), in 2019 they collected 88.4% of the premiums for public facilities, 27.4% of the premiums for private facilities and 23.2% of premiums for the coverage of healthcare professionals.

Premiums collected from public facilities by Italian undertakings remain low, down in 2018 in absolute terms (from 32.6 to 26.9 million). The slight fall in the share of foreign undertakings is explained by the decline in total premiums collected in this sub-sector.

The minimal increase in premiums covering risks of private healthcare facilities is almost entirely attributable to Italian undertakings, which collected premiums for 84 million euro (versus 76 million in 2018).

Italian undertakings recorded a rise in premiums for the coverage of healthcare professionals (178 million, compared to 164 of the previous year), with a growth in their share (76.8%, compared to 70.3% in 2018).

Fig. 3 – Trend in the share of premiums collected by the top 5 undertakings in healthcare liability (2014 and 2019)

(%)

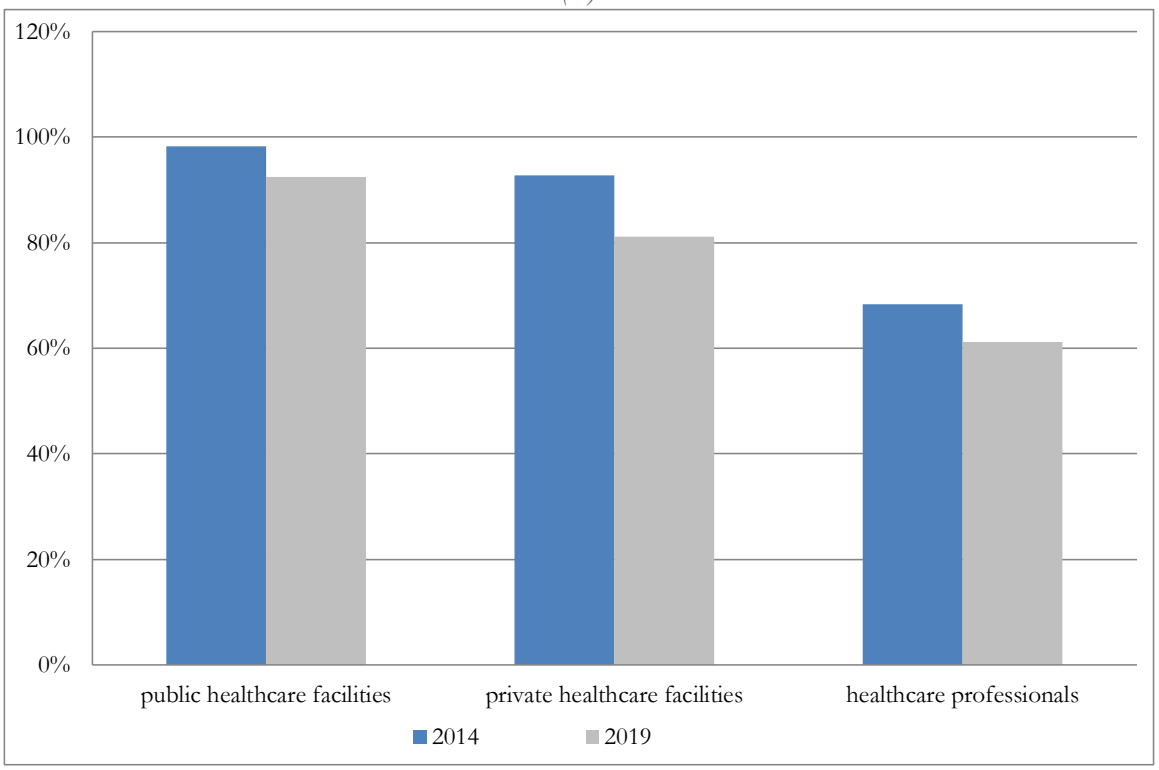
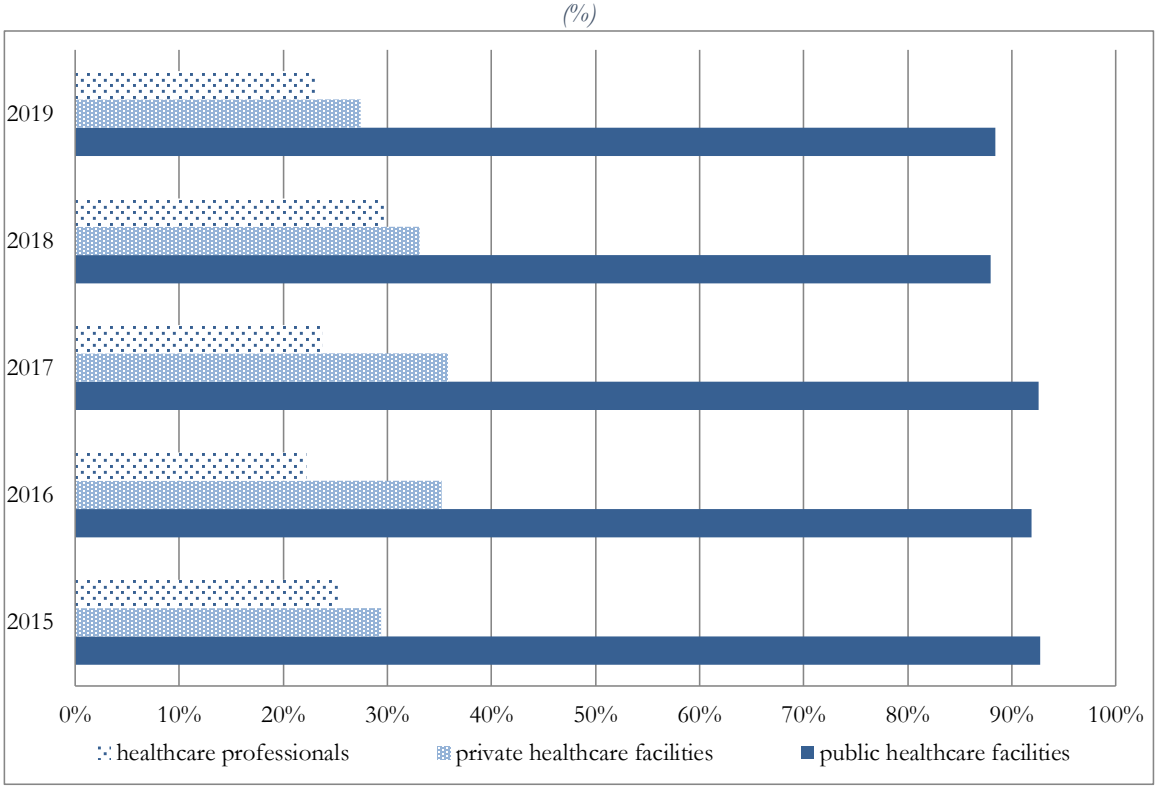


Fig. 4 – Share of premiums collected by foreign undertakings in healthcare liability (2015-2019)

(%)



Premiums and insured units – The 579 million premiums collected in 2019 for healthcare liability (-

6.4% compared to 2018) can be broken down as follows (fig. 5):

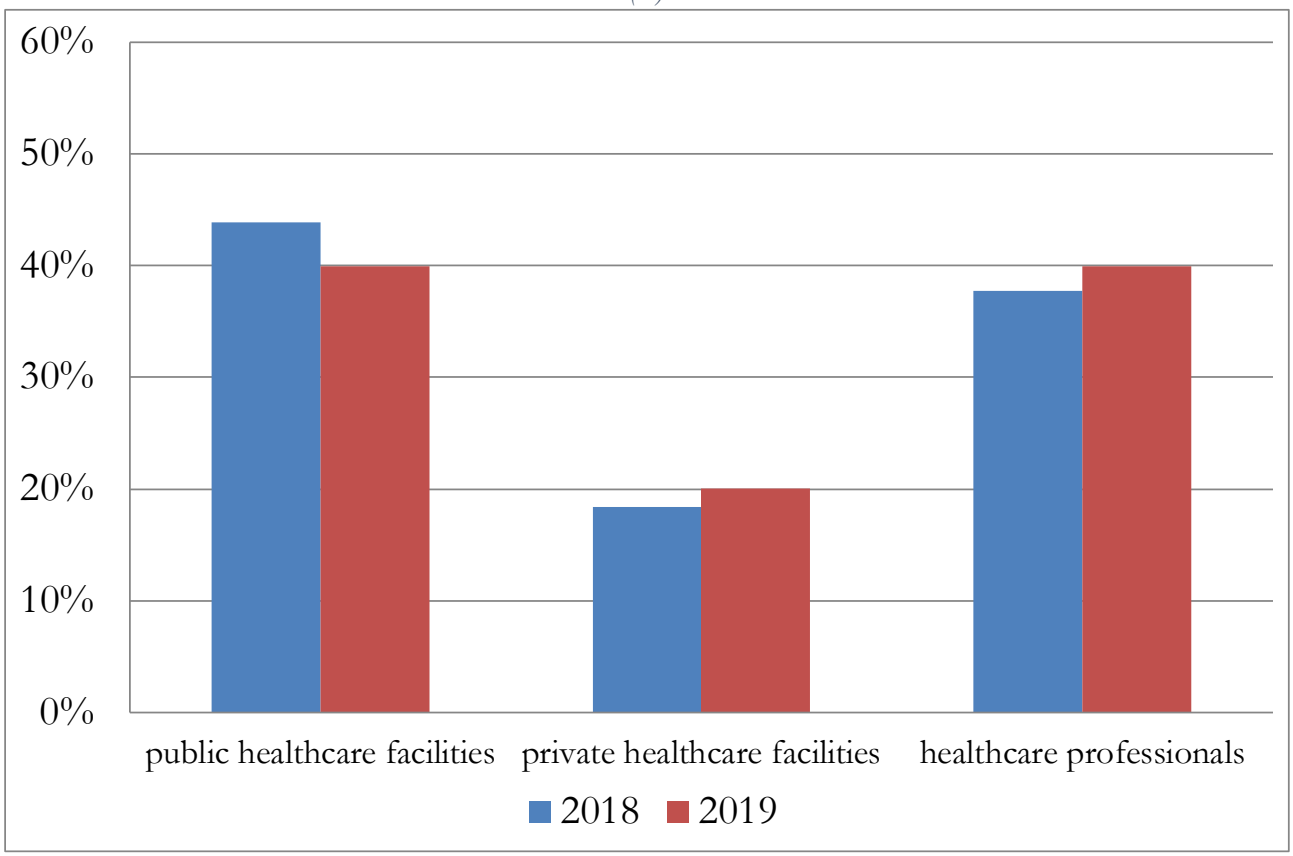
- 40.0% for the coverage of public facilities (43.9% in 2018),
- 20.0% for private facilities (18.4% in 2018),
- the remaining 40.0% for the risks of healthcare professionals (37.7% in 2018).

Compared to the previous year the shares of premiums covering private facilities and healthcare professionals have increased, with a corresponding fall in the share for public healthcare facilities.

Over the decade 2010-2019, premiums covering risks of public healthcare facilities have fallen (–55.5%, Annex, Table 1), while those collected from private facilities and healthcare professionals have increased (respectively +46.0% and +64.8%).

Fig. 5 – Breakdown of healthcare liability premiums according to sub-sectors, 2018 and 2019

(%)



In 2019, 581 public facilities, 6,757 private facilities and 309,116 healthcare professionals were insured. The number of insured public facilities declined compared to 2018 (–5.1%), in line with long-term trend which has more than halved their number compared to 1,426 units in 2010.

The average premium paid for the coverage of a public facility was 398,497 euro (-10.2% compared to that of 2018). This value is more than 23 times greater than that paid by a private facility (equal to 17,179 euro), due to the larger size and greater complexity of the public facilities.

In 2019 healthcare professionals paid on average a premium of 749 euro (Table 2), down compared to 2018 (–8.3%). The ratio between the average premium paid by physicians and that paid by healthcare professionals who are not physicians is 3.5 to 1 (946 euro against 271).

Tab. 2 – Average premium and median premium for healthcare liability of healthcare professionals (2019)

(euro)

Area of residence	Physicians		Healthcare professionals other than physicians		Total	
	average	median	average	median	average	median
North West	1,103	458	328	102	866	379
North East	943	444	210	54	713	342
Centre	975	446	254	109	758	358
South	796	418	280	109	667	340
Islands	727	399	254	79	598	318
Total	**946**	**431**	**271**	**82**	**749**	**352**

The median premium amounts to 352 euro. The major difference between average and median is due to the high variability of premiums, which can be explained by the different levels of risk exposure for the various medical specialities.

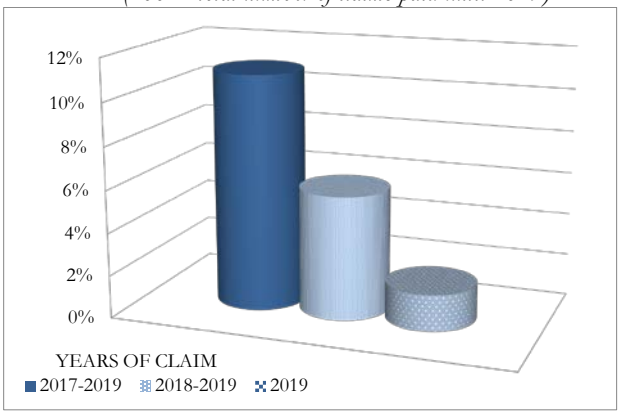
The evolution of claims and compensation – In 2019 the undertakings received 17,904 claims (Annex, Table 4), down (–6.7%) compared to those received in 2018 and with a dramatic fall (–42.9%) compared to the claims reported in 2010. The driver of this trend is the fall in claims relating to contracts covering public facilities (–16.0% compared to the previous year and –67.7% compared to 2010).

At the end of 2019, of all the claims received in 2019, 18.6% were closed without payment, a figure slightly down on that of 2018 (21.4%)[8]. The sector is characterised by a number of claims closed without payment higher than that for MTPL[9]. The long time necessary to correctly classify a claim explains why the number of claims closed without payment increases for the less recent claim: more than half of the claims received before 2017 were in fact closed without payment.

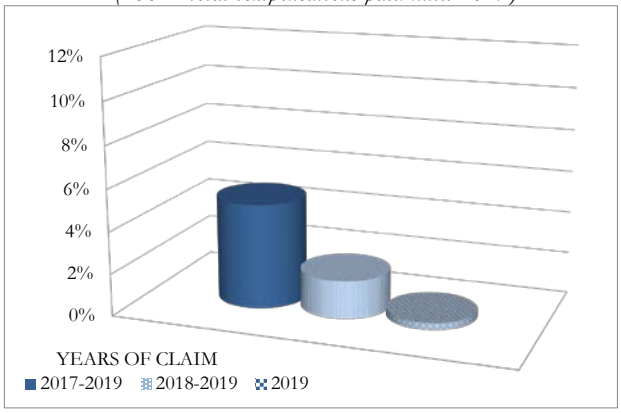
At the end of 2019, 60,518 claims reported between 2010 and 2019 were closed with final payment by undertakings (Annex, Table 6). Of these, only 11.0% concern claims received since 2017; this percentage falls to 5.8% for claims received in 2018-2019 (fig. 6.a).

Fig. 6 – Final compensation paid up by 2019 for the recent years of claims 2017-2019

(a) Percentage of claims closed by final settlement
(100 = total number of claims paid until 2019)



(b) Percentage of compensation
(100 = total compensations paid until 2019)



In the same period, the compensations paid (including final or partial payments) amounted to 2,822

[8] See Statistical Bulletin on healthcare liability risks in Italy 2010-2018, October 2019, no. 12.
[9] In the motor liability sector, the percentage of claims closed without payment compared with all claims reported for the year 2018, is 11.28% (Annex A to Statistical Bulletin on insurance activities in the motor insurance sector 2013-2018, November 2019, Table 11).

million euro (Annex, Table 5). Of these, 4.9% relate to claims received between 2017 and 2019 (1.8% for claims received between 2018 and 2019, fig. 6.b). The differences in the percentages in the two graphs 6.a and 6.b give a measure of how the insurance sector tends to pay compensations first for less complex claims, characterized by lower amounts.

Claims settlement time – As regards public healthcare facilities, 6.7% of claims with indemnification reported in 2019 were settled and paid in the same year (in 2018 they were 6.1%, Annex, Table 7). The two percentages were 10.1% and 16.9% respectively for private healthcare facilities, (while they amounted to 6.2% and 6.9% for the healthcare personnel).

In terms of amounts, only 0.6% of all compensations expected for claims received in 2019 from public facilities were paid by the end of the same year (Annex, Table 8). This percentage goes up to 3.2% for the private facilities and 3.6% for the healthcare personnel.

The above figures, related to the settlement of claims reported in the same year, are evidence of the slowness of the settlement procedures, confirmed by the observation of the oldest generations of claims available: for example, as regards the generations of 2010 and 2011, respectively 20,9% and 28.1% of the amounts were still to be settled at the end of 2019.

The average cost of claims – In 2019 the average compensation for the claims reported in the same year was 6,946 euro for public healthcare facilities (Annex, Table 9). These values are higher for private facilities and healthcare professionals (11,321 and 9,105 euro respectively). For private facilities and healthcare professionals, these values increased compared to those for the generation of claims reported in 2018, versus a decline in public facilities.

The above-mentioned trend of undertakings to settle larger claims later results in higher average compensations for older claims[10]. For the public healthcare facilities, the average compensation of claims reported in 2010 was 60,407 euro after 9 years (end 2019), equal to approximately 350% of the value for claims of the year 0 (end 2010).

The provisions for claims outstanding – At the end of 2019 insurance undertakings set aside provisions for claims outstanding amounting to 2,998 million for the future compensation of claims with indemnification reported between 2010 and 2019 (Annex, Table 2)[11]. Only 18.0% of the provisions regarded more recent claims reported in 2019 (fig. 7a).

The provisions are broken down between public facilities (60.2%), private facilities (16.9%) and healthcare personnel (22.9%).

Claims outstanding at the end of 2019 were 48,019 (Annex, Table 3), and only 28.3% resulted from claims reported in 2019 (fig. 7b). One third of the claims outstanding relates to contracts taken out by public facilities.

At the end of 2019 the average provision for claims reported in the same year amounted respectively to 88,700 euro for public facilities, 38,039 for private facilities and to 15,908 euro for healthcare professionals (Annex, Table 10). Compared to the previous year, the indicator has increased considerably

[10] Other determining factors are the complexity of the assessment of the physical impairment, which leads to underestimating the extent of the damage in the initial phase, 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.

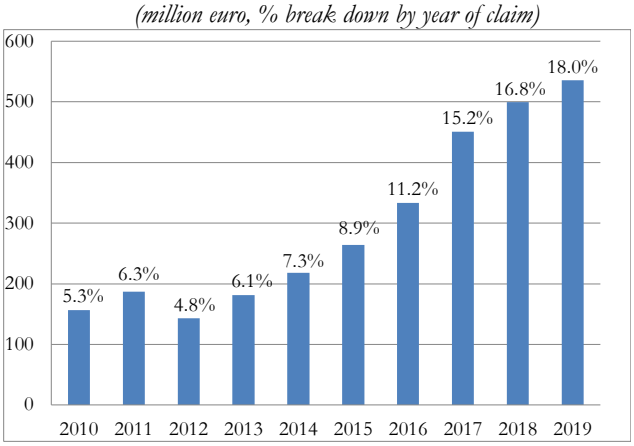
[11] The correct calculation of the provisions is of paramount importance in healthcare liability, which is characterized by long claims settlement times and by the marked presence of foreign insurance undertakings not subject to the prudential supervision of IVASS.

for public facilities (+16.0%), while it showed a decline for private facilities and healthcare professionals (with a decrease of –0.7% and –9.7% respectively).

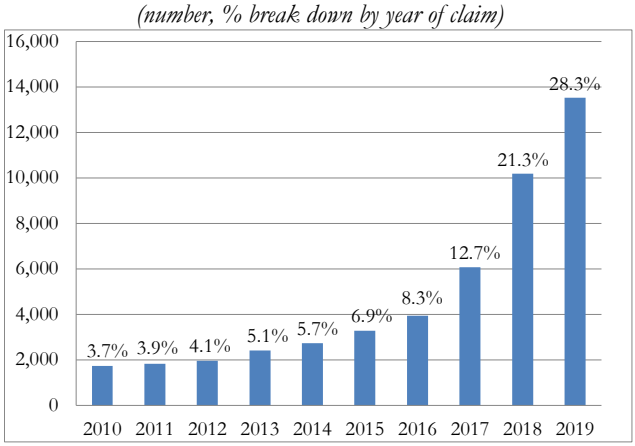
Similarly to the average cost, also the average provision increases as claims become older. For example, for the generation of claims reported in 2010 relating to public facilities, the average provision for claims dating back to 9 years (end 2019) amounts to 107,415 euro, equal to 275% of provision for claims of the year 0 (end 2010).

Fig. 7 – Provisions at end 2019 for claims reported in the years 2010-2019

(a) Provisions
(million euro, % break down by year of claim)



(b) Claims reserved
(number, % break down by year of claim)



With regard to public facilities, 7,611 claims reported in 2010 were closed with final payment by the end of 2019 (for an average amount of 60,407 euro), versus 1,041 claims of the same generation still outstanding at the end of the same year (for an average amount of 107,415 euro). This large gap in a given year between average provisions and average cost until that year for claims for the same generation shows how 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.

Total average cost of claims – The total average cost of claims with indemnification reported in 2019 amounts to 83,201 euro for public facilities (Annex, Table 11), 35,332 for private facilities and 15,483 for healthcare personnel[12].

Claims frequency and pure premium – In 2019 the frequency of the claims reported in the same year (compared to the number of risk units) was 662.8% for public healthcare facilities (Annex, Table 4.1), while these values are lower for private healthcare facility (43.8%) and healthcare personnel (2.5%). These values increased compared to those for the generation of claims reported in 2018 both for public (+5.0%) and private facilities (+7.1%), while they were down for healthcare professionals (–10.7%). Compared to 2010, the first year of observation, the claims frequency over a decade has significantly decreased (–35.5% for public facilities).

The pure premium is obtained as the product of the claim frequency and the average cost of claims. A negative difference between the average premium and the pure premium is evidence of a prospective technical loss, since the premiums collected are unable to cover the costs for compensation evaluated at the end of each year of report. For public facilities the indicator is 551,477 euro (+19.9% compared to that for 2018). This value is more than 35 times greater than that paid by a private facility (equal to 15,483

[12] It is obtained from the average of the average value of compensations and provisions, weighted respectively with the number of claims closed by final settlement and those outstanding.

euro). By contrast, the pure premium for healthcare personnel is much lower, totalling 388 euro (–18.3% compared to 2018). Compared to 2010, the pure premium has increased sharply for public facilities (+45.6%), because the increase in the average cost (+125.9%) has more than offset the reduction in the claims frequency, while it decreased for private facilities (29.7%) and for healthcare personnel (–46.3%). For public facilities, the average premium is lower than the pure premium for all the years considered, while for private facilities it is higher than the pure premium for three recent generations of claims (2016, 2018 and 2019). By contrast, the premium for healthcare personnel is always sufficient to cover compensations to injured parties.

Litigation in the healthcare liability sector – A high number of civil litigations is found in this sector, which in Italy is characterised by extremely lengthy proceedings. This factor explains, at least in part, the high level of provisions and the slowness of the settlement procedures followed by insurance undertakings.

On the whole, almost one quarter of the claims managed reported between 2010 and 2019 involved a litigation (Annex, Table 4.2)[13]. The recourse to the civil courts mainly concerns the settlement of the claims involving public healthcare facilities and healthcare personnel (having a percentage of claims in litigation respectively of 27.5% and 26.1%), while for private facilities this percentage amounts to 14.7%.

Litigations reported a decline between 2018 and 2019, as they regarded only 5.1% of the claims managed reported in 2019, compared to 14.4% of the claims reported in the previous year[14].

Claims/premiums ratio – The profitability index used is the usual claims/premiums ratio (loss-ratio). Though taking account of the particularities 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 2019 confirm a systematic technical loss for the risks of public healthcare facilities (Annex, Table 12). Private facilities record positive results for the more recent generations 2014-2019, but show losses exceeding those recorded by public facilities for the previous generations 2010-2013.

The profitability of insurance covering healthcare personnel is generally positive and the loss ratio calculated for the claims reported in 2019 (51.9%) has improved compared to the corresponding value for the previous year, referring to claims of the year 0 (58.1%).

Distribution channels for healthcare liability contracts – Contracts covering risks of public healthcare facilities mediated by brokers account for 52.8% of premiums for 2019 (Annex, Table 13). This percentage shows a decline compared to 2018 (when it was 69.7%). At the same time there has been an increased role for the general directions of undertakings, which directly manage contracts amounting to 44.0% of premiums (compared to 26.0% in 2018)[15].

With regard to private facilities, brokers mediate contracts accounting for one quarter of the premiums (in 2018 it was one third), while agencies manage almost all the remaining share. The latter channel is the most important for the coverage of healthcare personnel.

The insurance mobility of healthcare personnel – The frequency of change of insurance company by

[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 2018 is 21.7% (Statistical Bulletin on insurance activities in the motor liability sector 2012-2018, November 2019, no. 14).

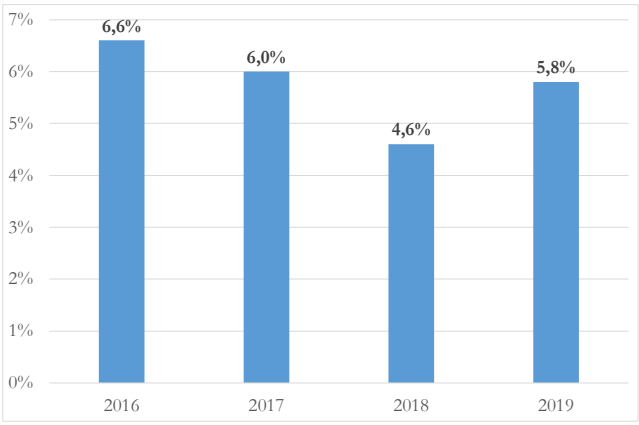
[14] About this matter, see Statistical Bulletin on healthcare liability risks in Italy 2010-2018, October 2019, no. 12.

[15] About this matter, see Statistical Bulletin on healthcare liability risks in Italy 2010-2018, October 2019, no. 12.

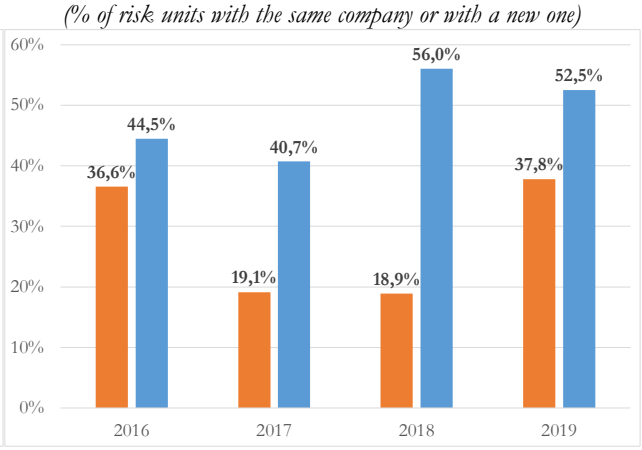
healthcare personnel amounted to 5.8% in 2019 (fig. 8.a).

Fig. 8 – Change of company and reduction in the premium paid by healthcare personnel, 2016-2019

(a) Change of company compared to the previous year
(% of risk units)



(b) Reductions in the premium compared to the previous year
(% of risk units with the same company or with a new one)



This means that during the year a healthcare professional out of 17 has taken out an insurance policy for healthcare liability with a company other than that used the year before. The frequency is similar for the three previous years 2016-2018.

The reduction in the premium paid is seemingly one of the reasons for moving to another company, given that a premium reduction between 2018 and 2019 can be observed in 52.5% of the contracts taken out with a new company (compared to 37.8% of the contracts renewed with the same company, fig. 8.b).

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 victims of medical malpractice, fed yearly by specific allocations[17]. The Ministry of Health makes available the data on yearly resource allocations and funds of public healthcare facilities (Table 3).

In 2018 public healthcare facilities allocated resources amounting to 510.1 million euro, down compared with 2017 (–13.9%). The decline concerned the facilities of all the areas of the country, including those which directly provide healthcare services as well as regional administrations.

Table 3 – The self-retention of the healthcare liability risk in public healthcare facilities
Yearly resource allocation to funds (2012-2018)

(million euro)

	2012	2013	2014	2015	2016	2017	2018
				Yearly resource allocation			
Geographical area							
North	53.9	143.2	196.6	199.0	249.8	293.0	274.3
Centre	63.5	55.0	81.5	111.4	97.6	126.5	81.9
South -Islands	52.8	58.9	133.7	157.2	163.1	172.9	154.0
Type of facility							
Healthcare facility	144.6	225.2	380.0	410.6	443.9	501.9	451.6
Regional administration	25.6	32.0	31.9	57.0	66.6	90.5	58.5
Total for Italy	**170.2**	**257.1**	**411.8**	**467.6**	**510.5**	**592.4**	**510.1**
				Funds			
Geographical area							
North	200.8	324.3	490.4	540.2	725.2	931.7	1,087.2
Centre	59.5	148.4	202.4	227.8	331.9	417.1	412.8
South -Islands	58.5	265.0	240.1	362.5	502.1	603.5	704.1
Type of facility							
Healthcare facility	247.8	608.2	758.2	936.7	1,311.0	1,598.4	1,844.3
Regional administration	71.0	129.6	174.7	193.8	248.2	353.9	359.8
Total for Italy	**318.8**	**737.8**	**932.8**	**1,130.5**	**1,559.2**	**1,952.3**	**2,204.1**

The amount of the total resources allocated, equal to 2,204.1 million, is on the rise (+12.9%). The accumulation of funds by the regional administrations was more moderate (+1.7%) and the percentage of funds that could be allocated to them has decreased with respect to 2017 (equal to 16.3%, compared

[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 and in many Italian regions, a coexistence, also in the same facility, is noted as regards forms of risk self-retention and insurance coverages acquired from insurance undertakings. A typically adopted mixed form provides for the use of self-retention for claims below a given value threshold, with the intervention of an insurance-type compensation for claims of a greater value. 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).

to the previous 18.1%).

If we consider the breakdown on a territorial basis, the region that in 2018 allocated the largest amount of resources is Veneto (14.4% of the total, for an amount of 110.7 million, Table 4), followed by Lombardy (74.1 million), Latium (60.8 million) and Campania (59.2 million). Compared to the number of inhabitants, the largest amount of allocated funds is observed in Veneto (66.5 euro per inhabitant), followed by Sicily (60.8 euro), Umbria (58.3 euro) and Latium (50.9 euro).

Table 4 - The self-retention of the healthcare liability risk in public healthcare facilities
Yearly resource allocation to funds broken down by regions and autonomous provinces
(in thousands euro, amounts per inhabitant in euro)

Regions and autonomous provinces	Yearly resource allocation			Funds		
	Total	%	Per inhabitant	Total	%	Per inhabitant
Piedmont	197	0.0%	0.0	145,610	6.6%	33.4
Valle d'Aosta	0	0.0%	0.0	0	0.0%	0.0
Lombardy	74,052	14.5%	7.4	302,813	13.7%	30.1
Autonomous Province of Bolzano	0	0.0%	0.0	34	0.0%	0.1
Autonomous Province of Trento	9,249	1.8%	17.1	27,341	1.2%	50.5
Veneto	110,691	21.7%	22.6	326,148	14.8%	66.5
Friuli V.G.	0	0.0%	0.0	337	0.0%	0.3
Liguria	23,816	4.7%	15.4	68,255	3.1%	44.0
Emilia Romagna	56,285	11.0%	12.6	216,649	9.8%	48.6
Tuscany	5,041	1.0%	1.4	16,576	0.8%	4.4
Umbria	16,072	3.2%	18.2	51,391	2.3%	58.3
Marche	0	0.0%	0.0	45,698	2.1%	30.0
Latium	60,759	11.9%	10.3	299,116	13.6%	50.9
Abruzzo	5,942	1.2%	4.5	35,212	1.6%	26.8
Molise	0	0.0%	0.0	0	0.0%	0.0
Campania	59,230	11.6%	10.2	201,796	9.2%	34.8
Puglia	20,905	4.1%	5.2	78,861	3.6%	19.6
Basilicata	8,923	1.7%	15.9	20,801	0.9%	37.0
Calabria	5,964	1.2%	3.1	14,127	0.6%	7.3
Sicily	44,331	8.7%	8.9	303,850	13.8%	60.8
Sardinia	8,665	1.7%	5.3	49,496	2.2%	30.2
Total for Italy	**510,122**	**100.0%**	**8.5**	**2,204,111**	**100.0%**	**36.5**

Comparison of the resource allocation for self-retention of risk and premiums for healthcare liability of public facilities – The yearly resource allocation and the premiums paid to the insurance undertakings for healthcare liability risks of public and private facilities are financial indicators that are to some extent comparable. They are in fact resources allocated annually against the same risk, managed either internally (with the yearly resource allocations) or through recourse to the market (with the premiums).

If we consider public facilities alone, between 2014 and 2018 the amount of resources allocated was always higher than the value of premiums (fig. 9) and the ratio between the two indicators went from 138.8% to 187.9% in the five years considered, although it did not follow a steady trend of growth.

Fig. 9 – Healthcare liability risks in the public healthcare facilities
Comparison of the resource allocation for self-retention of risk and insurance premiums (2012-2018)

(million euro)