IVASS
ISTITUTO PER LA VIGILANZA SULLE ASSICURAZIONI

# Statistical Bulletin

## Healthcare liability risks in Italy 2010-2020

Year VIII - no. 11, October 2021

**RESEARCH AND DATA MANAGEMENT DIRECTORATE – RESEARCH AND STATISTICS DIVISION**

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## Contents

# 1. METHODOLOGICAL NOTE

## Foreword

Healthcare facilities may use either insurance or self-retention of the healthcare liability risk

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

The insurance policies for healthcare liability risks are part of the broader general liability class of which they represented, in 2020, 13.2% 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, even if not subject to the prudential supervision of IVASS. In order to assess the impact of the health emergency caused by COVID-19, specific additional information was acquired.

The last survey, conducted from March to June 2021, covered in detail:

1) the premiums collected in 2020 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 2020,

[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 14% if we also consider policies for gross negligence taken out by healthcare personnel.
[4] For the survey conducted in 2021, see the letter to the market No. 0035064/21 of 17 February 2021.

4) the situation of the claims reported in the years from 2010 to 2020[5],

5) the situation of the claims attributed to Covid-19,

6) the presence of exclusion clauses specifically referred to the pandemic risk,

7) the obstacles to the activities in this sector connected to the health emergency.

87 undertakings participated in the survey, of which only 32 have operated in the sector, collecting premiums in the course of 2020 (tab. 1).

**Table 1 – Survey on healthcare liability (2020)**
**Undertakings surveyed and undertakings operating in the sector**

| | Italian undertakings[(a)] | | | | Foreign undertakings[(b)] | | Total | |
|---|---|---|---|---|---|---|---|---|
| | Surveyed | Operating in healthcare liability | *of which:* | | Surveyed | Operating in healthcare liability | Surveyed | Operating in healthcare liability |
| | | | *Italian control* | *foreign entities* | | | | |
| | 53 | 25 | *12* | *13* | 34 | 7 | 87 | 32 |
| *Of which operating at:* | | | | | | | | |
| Public health care facilities | | 9 | *6* | *3* | | 2 | | 11 |
| Private health care facilities | | 16 | *9* | *7* | | 4 | | 20 |
| Healthcare professionals | | 24 | *12* | *12* | | 6 | | 30 |

(a) Undertakings with head office in Italy subject to the prudential supervision of IVASS, broken down by nationality of the parent company (Italian or foreign).
(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 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[7].

Section 6 provides a comparison, for public structures, between healthcare liability risk managed through insurance and through self-retention. **This comparison relates to 2019, the most recent available.**

[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 may have been 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.

[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 in euro.

## 3. THE MAIN RESULTS FOR 2020

- In 2020 premiums collected in healthcare liability amounted to 604 million euro (+4% compared to 2019). The growth mainly concerned the premiums for public and private healthcare facilities.

- The share of premiums collected by companies supervised by IVASS increases to 80% (from 50% in the previous year), due to acquisitions of Italian companies by foreign operators, followed by the transfer of the portfolio previously managed through branch offices established in Italy.

- The decrease in the number of insured public facilities continues (currently 535, down from 1,426 in 2010).

- Foreign-controlled undertakings, with head office in Italy or in other countries, collect 92% of the premiums for the coverage of public facilities, 34% for private facilities and 42% for healthcare personnel.

- Concentration in this sector remains high and shows no signs of declining, with the top 5 undertakings collecting 80% of premiums.

- Of the insured healthcare workforce, 4% switched companies during 2020, achieving premium reductions much more frequently than those who stayed with the same company.

- The impact of claims attributed to Covid-19 on compensations and reserves is very modest. However, future healthcare liability contracts may contain additional exclusion or aggravation clauses for pandemic risks.

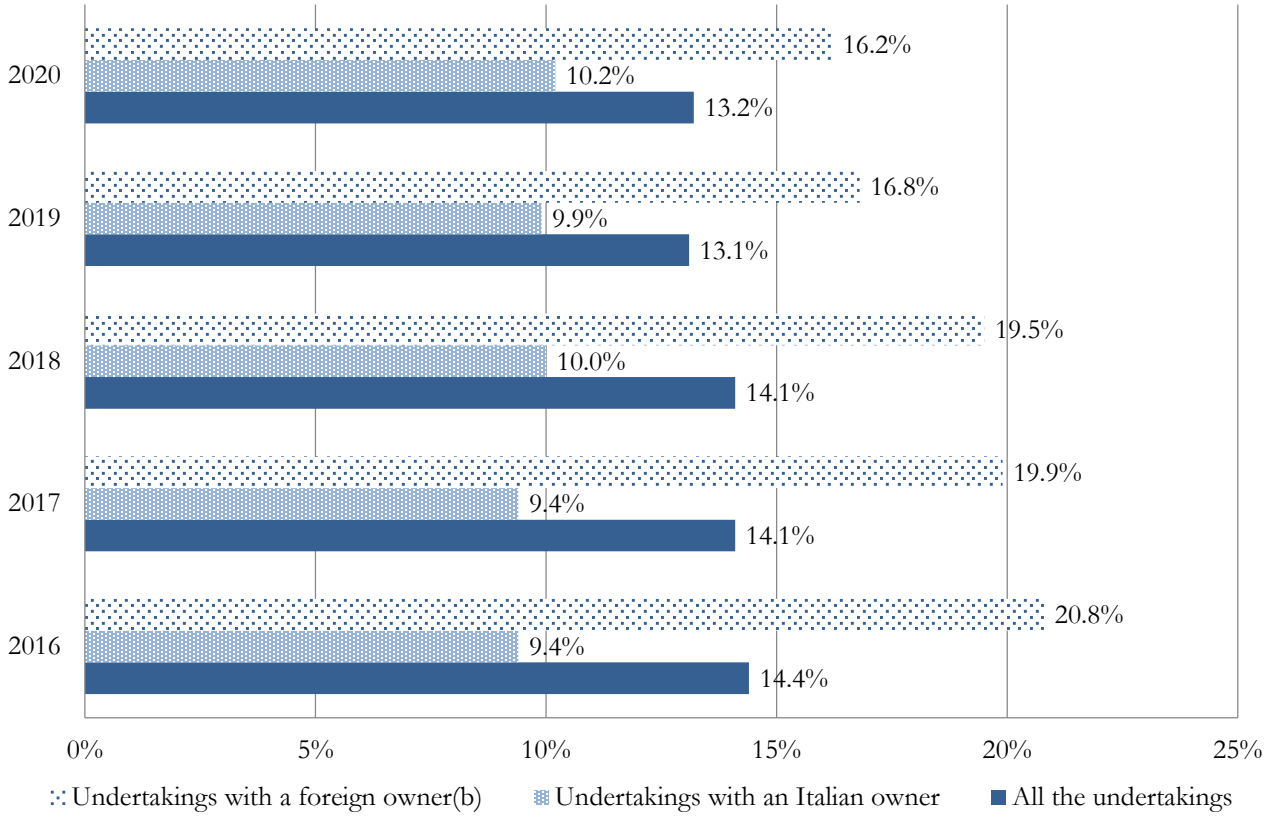
- Under the current regulations healthcare facilities can choose for the self-retention of the healthcare liability risk, as an alternative or additional solution to traditional insurance. The use of this option has sharply increased. In 2019, for public facilities allocations to self-retention funds amounted to 182% of the value of the premiums.

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

**Healthcare liability in the context of the general liability** – Healthcare liability insurance is part of the general liability class and in 2020, with a premium income of 604 million, represented 13.2% of the total premium income (10.2% for Italian-controlled undertakings, 16.2% for foreign-controlled undertakings).

**Fig. 1 – Share of healthcare liability premiums over premiums for general liability by nationality of the parent company [a] (2016-2020)**

*(%)*




(a) These shares are computed separately for the three groups of undertakings. – (b) Undertakings with a foreign parent company include both foreign-controlled undertakings having their head office in Italy (supervised by IVASS) and those having their head office abroad pursuing business in Italy under the freedom of establishment or the freedom to provide services.

**Coverage of gross negligence** – The insurance covering gross negligence protects the healthcare personnel. 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 Law no. 24/2017, known as "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 Law no. 24/2017). 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 2020, the undertakings reported about 128,000 risk units and premiums amounting to 40 million for

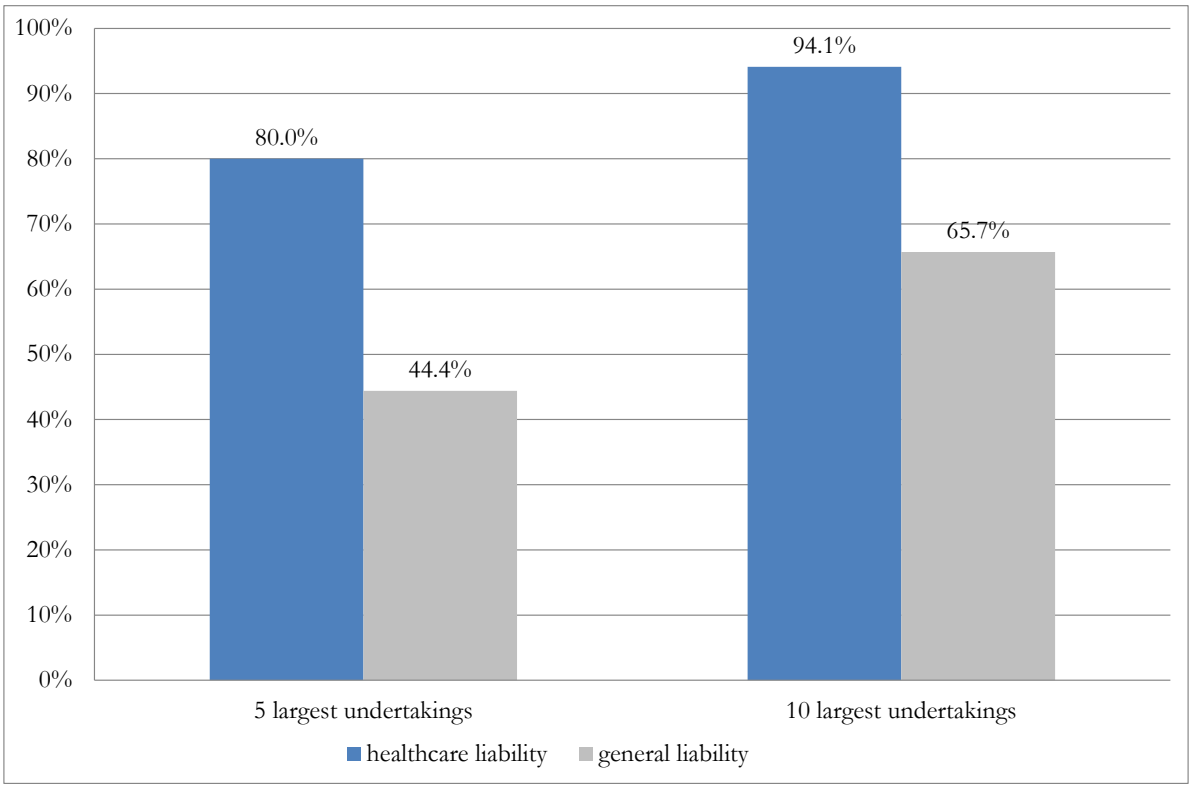
these coverages, showing a marked increase compared to the previous years.

The premium income for the healthcare liability sector is highly concentrated

**The characteristics of the undertakings providing healthcare liability** – The share collected by the first 10 undertakings on total premium income in this sector amounts to 94.1% (80% for the first 5 undertakings). The general liability class shows on the whole a lesser degree of concentration (the above two indicators amount to 65.7% and 44.4% respectively, fig. 2). Compared to 2019, concentration in healthcare liability is on the rise, in particular as regards the share of the premiums collected by the top 5 undertakings (which, in that year, reached 75.5%).

**Fig. 2 – Share of the premiums collected by the major undertakings: comparison between healthcare liability and general liability (2020)**

*(%)*



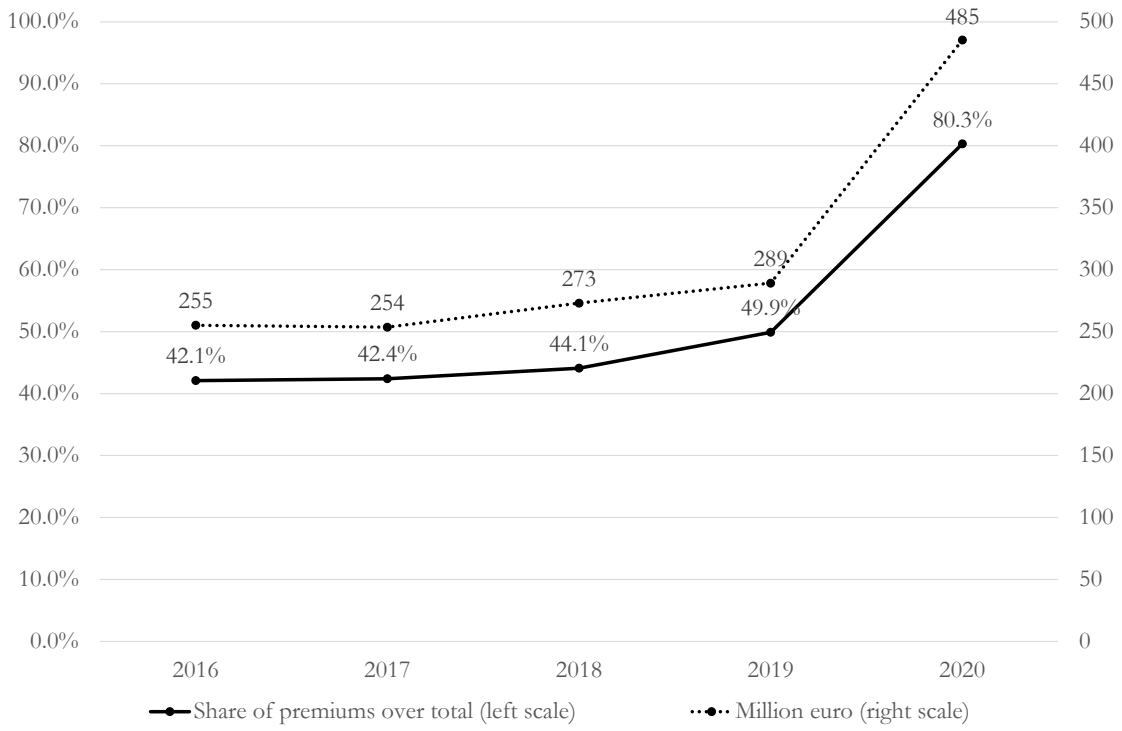

Different types of risk units correspond to different concentration values: as regards the share collected by the top 5 operators, the maximum (equal to 99.2%) is found for premium income from coverages for public facilities, which falls to 88.7% for private facilities and 71.7% for healthcare operators.

The acquisition of Italian companies by foreign operators, who have sold their portfolios, has increased the premium income of supervised companies.

Also as a result of Brexit, during 2020, foreign operators, previously operating in the sector on an establishment basis, accelerated the acquisition of Italian companies, to which they sold their portfolios. Of the premiums collected in the healthcare liability sector (figure 3), 485 million euro, representing 80.3% of the total, are attributable to insurance companies based in Italy and supervised by IVASS. In 2019, the two figures were 49.9% and 289 million euro, respectively.

**Fig. 3 – Premiums in healthcare liability written by companies supervised by IVASS (2016-2020)**

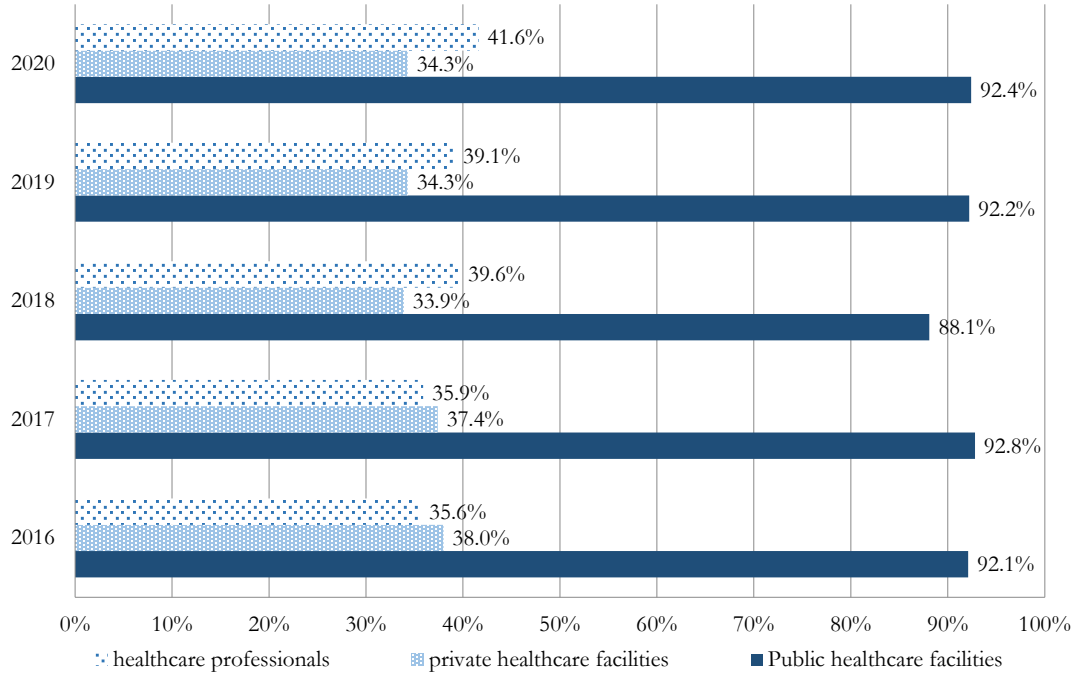
*(%, million euro)*




In 2020, foreign-controlled undertakings collected 92.4% of the premiums for the coverage of public facilities, 34.3% for private facilities and 41.6% for healthcare professionals (fig. 4).

**Fig. 4 – Share of premiums collected by undertakings with a foreign parent company[(a)] in healthcare liability (2016-2020)**

*(%)*




(a) Undertakings with a foreign parent company include both foreign-controlled undertakings having their head office in Italy (supervised by IVASS) and those having their head office abroad pursuing business in Italy under the freedom of establishment or the freedom to provide services.

Premium income increased (+4.4%) in the three healthcare liability sectors

**Premiums and insured units** – Premium income amounted to 604 million euro in 2020, up (+4.4%) compared to the previous year (Annex, Table 1). After 4 consecutive years of decline, premium income for public facilities has increased (+4.2%). The expansion of premiums for private facilities was greater (+10.4%) and has continued since 2016, while the increase in premium income for the risks of healthcare professionals was more modest (+1.5%).

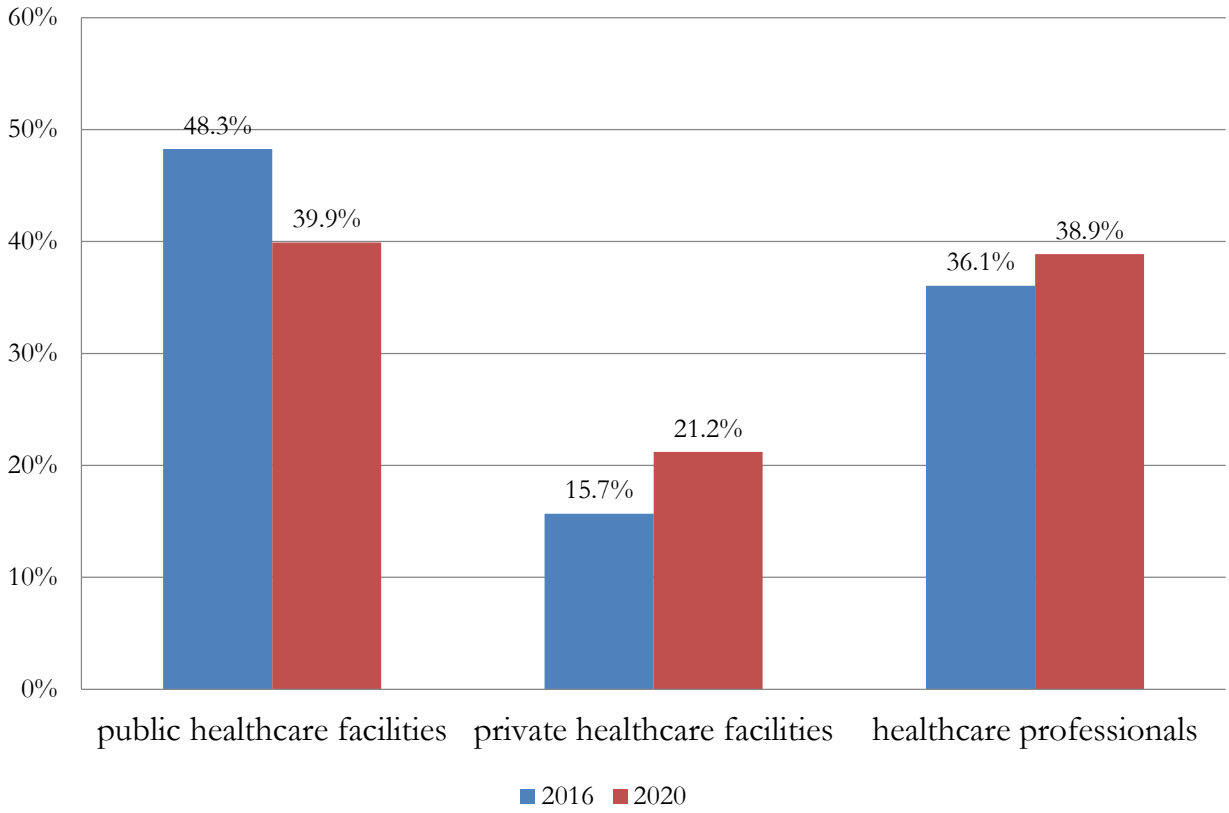
Premiums collected in 2020 for healthcare liability can be broken down as follows (fig. 5):

- 39.9% for public facilities,
- 21.2% for private facilities,
- the remaining 38.9% for the healthcare professionals' risks.

Over the five-year period 2016-2020, the share of premiums from public facilities fell by 8.4 percentage points, while the largest increase was recorded for premiums from private facilities (+5.5 percentage points). The growth in premiums for healthcare professionals was more moderate (+2.8 points).

**Fig. 5 – Breakdown of healthcare liability premiums according to sub-sectors, 2016 and 2020**

*(%)*




535 insured public facilities in 2020, compared to 1,426 in 2010

In 2020 the number of insured public facilities was 535 (–7.9% compared to 2019, –62.5% compared to 2010). The long-term trend of decreasing number of insured public facilities is contrasted by the growth of the number of private facilities, which is 7,995 (+18.3% compared to 2019, +45.2% on 2010), and of the number of healthcare professionals covered by insurance, which is about 327,000 (+5.7% compared to 2019, +89.8% on 2010).

For public facilities, the increase in premium income and the decrease in insured units resulted in a strong increase in the average premium (amounting to 450,905 euro) compared to 2019 (+13.2%), while that of private facilities (16,035 euro) decreased slightly (-6.7%).

In 2020 the average premium for healthcare personnel amounted to 719 euro (tab. 2), down by 30 euro compared to 2019 (–4.0%). Healthcare professionals other than physicians pay on average a premium equal to 22,8% of that of physicians. The median premium amounts to 385 euro. The high variability of premiums can also be explained by the different levels of risk exposure for the various medical specialities. Premiums paid by healthcare professionals in the South and Islands tend to be lower than those paid in other areas of the country. This gap could be observed also in the previous years[8].

**Table 2 – Average premium and median premium for healthcare liability of healthcare professionals (2020)**

*(euro)*

| Area of residence | Physicians | | Healthcare professionals other than physicians | | Total | |
|---|---|---|---|---|---|---|
| | average | median | average | median | average | median |
| North West | 1,005 | 528 | 225 | 72 | 761 | 405 |
| North East | 909 | 497 | 203 | 52 | 671 | 372 |
| Centre | 1,026 | 510 | 232 | 78 | 773 | 394 |
| South | 842 | 471 | 185 | 65 | 673 | 379 |
| Islands | 806 | 460 | 207 | 72 | 641 | 363 |
| Total | **939** | **497** | **215** | **69** | **719** | **385** |

The number of claims reported follows a downward trend.

**The evolution of claims and compensation** – In 2020 the undertakings received 15,926 claims (Annex, Table 4), down compared to those received in 2019 (–16.2%) and following a medium-long term downward trend (–29.1% compared to 2016, –51.8% compared to 2011). The decrease compared to the previous year is due to both the decrease in claims regarding public facilities (-23.8%), partly attributable to the decrease in the number of insured units, and the decrease in claims regarding healthcare professionals (-18.8%).

Of the claims reported during 2020, 19.6% were found to be closed without payment at the end of the year (a share up one percentage point on 2019[9] and higher than the corresponding share for motor liability[10]). The share of claims closed without payment increases significantly for older years (accounting for more than half of all claims reported prior to 2018). This effect is due to the complexity of the sector, which makes it necessary to take a long time to correctly classify claims as closed without payment.

Healthcare claims are settled very slowly

At the end of 2020, 68,514 claims, reported between 2010 and 2020, were closed with final payment by undertakings (Annex, Table 6). A measure of the slowness of compensations is the breakdown by year of report of claims closed by final settlement: claims reported after 2017 are only 10.3% of the total (the share drops to 5.3% for claims

[8] See previous Statistical Bulletin on healthcare liability risks in Italy, available on IVASS' website.

[9] See Statistical Bulletin on healthcare liability risks in Italy 2010-2019, October 2020, no. 11.

[10] In the motor liability sector, the percentage of claims closed without payment compared with all claims reported for the year 2019, is 11.3% (Annex A, tab. 11, to Statistical Bulletin on insurance activities in the motor insurance sector 2014-2019, December 2020, No.15).

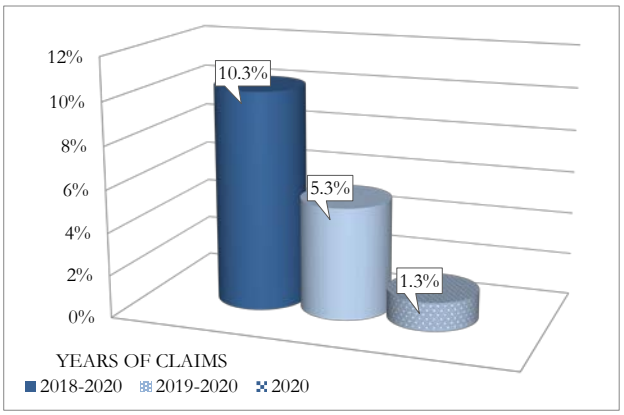
reported after 2018, figure 6.a).

The trend is to settle smaller claims first

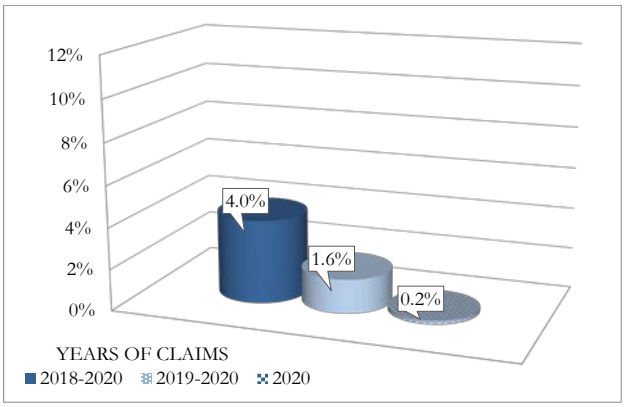
In the same period of time, the compensations paid (including final and partial payments) amounted to 3,266 million euro (Annex, Table 5), of which only 4% concern claims received after 2017 (1.6% for claims reported after 2018, fig. 6.b). The differences in the percentages in the two graphs 6.a and 6.b give a measure of how the insurance sector tends to pay compensations first for less complex claims, characterized by relatively low amounts.

**Fig. 6 – Final compensation paid up by 2020 for the recent years of claims 2018-2020**

(a) Percentage of claims closed by final settlement
*(100 = total number of claims paid until 2020)*




(b) Percentage of compensation
*(100 = total compensations paid until 2020)*




**Claims settlement time** – As regards public healthcare facilities, 8.2% of claims with indemnification reported in 2020 were settled and paid in the same year (Annex, Table 7), a percentage that is slightly higher compared to 6.7% of the previous year. The two percentages were 9% and 5.8% respectively for private healthcare facilities and for the healthcare personnel.

The settlement time by amount has much lower values (Annex, Table 8): 0.4% for public facilities, 1.3% for private facilities, 2.9% for healthcare personnel.

The slowness of claims management procedures results in a substantial outstanding balance even for the oldest generations of claims[11]. For example, for the 2010 generation, 11.9% of claims and 18% of amounts remained outstanding at the end of 2020.

**The average cost of claims** – The year 2020, characterized by the pandemic emergency, stands out for a strong decline in the average value of compensations of public and private facilities (Annex, Table 9), amounting respectively to 3,915 (–43.6% compared to 2019) and 6,245 euro (–40.7%). By contrast, the average value of compensations for healthcare personnel, equal to 10,833 euro, increased (+19.7%).

The delays in the settlement of more serious claims also explains the growth in average compensations as claims become older[12]. For example, with regard to the claims reported in 2010 relating to public facilities, the average compensation until end 2020 was 61,132 euro, equal to three and a half time the

[11] The term "anti-duration" indicates the number of years that have elapsed since the contract was entered into.

[12] 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.

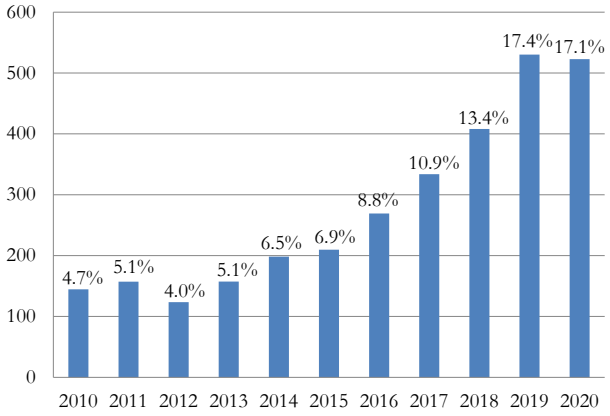
average compensation in 2010.

**The provisions for claims outstanding** –The provisions set aside at the end of 2020 for claims reported between 2010 and 2020 amounted to 3,055 million[13] (Annex, Table 2) for 49,473 claims (Annex, Table 3).

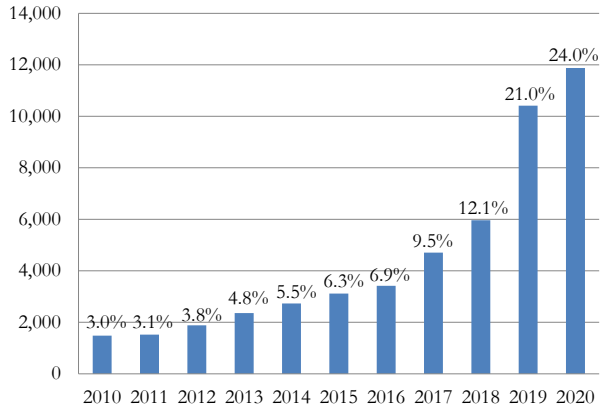
82.9% of the value of the provisions relate to claims reported before 2020 (fig. 7.a), which account for 76% of claims outstanding (fig. 7.b).

**Fig. 7 – Breakdown of provisions at end 2020 for claims reported in the years 2010-2020**

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




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




At the end of 2020, the average provision for claims reported in the same year amounted to 86,239 euro for public facilities, 47,921 for private facilities and to 19,811 euro for healthcare professionals (Annex, Table 10). The year, which is quite special due to the health emergency, records a strong increase in the indicator compared to 2019 for private facilities (+29.4%) and healthcare professionals (+24.8%), compared to a slight decrease for public facilities (-6.8%).

The provisions for claims outstanding in this sector show a very slow downward trend (run off) for older generations and a tendency to hold the most expensive claims in the provision for a long time. Consequently, the ratio between the average value of the provision at the maximum available anti-duration and that at zero anti-duration is very high: for the generation of claims reported in 2010 relating to public facilities, this ratio is 3.1.

**Total average cost of claims** – The total average cost of claims with indemnification reported in 2020 amounts to 79,519 euro for public facilities (Annex, Table 11), 44,186 for private facilities and 18,491 for healthcare personnel[14].

**Claims frequency and pure premium** – The claims frequency for public healthcare facilities was 648% in 2020 (Annex, Table 4.1), which means about 6.5 annual claims per insured unit. The high value of the indicator (up by +8% compared to 2019) stems mainly from the size and complexity of the public facilities insured.

[13] The provisions are broken down between public facilities (59.7%), private facilities (17.2%) and healthcare personnel (23.1%).

[14] Obtained from the averages of compensations and provisions, weighted respectively with the number of claims closed by final settlement and those outstanding.

For private facilities, the frequency amounts to 37.1% and to 1.9% for healthcare professionals, both of which are down (by -16.6% and -24%, respectively) from 2019.

For public facilities, the pure premium[15] in 2020 amounts to 515,315 euro, +14.3% higher than the average premium, indicating a prospective technical loss in the sector, which is less pronounced than in 2019 (when the pure premium was +29.7% higher than the average premium).

The pure premium of private facilities for 2020 reaches 16,403 euro, slightly higher (+2.3%) than the average premium, evidence of a more moderate prospective technical loss with respect to public facilities.

In the case of healthcare professionals, the pure premium, amounting to 374 euro, is much lower (–48%) than the average premium. The size of the gap makes a positive technical result likely, which cannot be quantified due to the lack of data on operating costs.

**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.

Structural technical loss for healthcare facility coverage.

Better profitability for healthcare professional coverage

The data updated at end 2020 confirm a systematic technical loss in the coverage of the risks of public healthcare facilities (Annex, Table 12). For private facilities, the indicator takes on a value of less than 100 for 5 generations of claims between 2014 and 2018, an indication of a better profitability situation than for public facilities, with the exception of the least recent generations 2010-2012, characterised by a very high claims-to-premium ratio.

Profitability is higher for healthcare professional coverage, for which the loss-ratio is always less than 100 for generations of claims reported since 2015.

One out of 4 claims involves a litigation

**Litigation in the healthcare liability sector** – A high number of civil litigations is found in this sector, which in Italy has always been characterised by proceedings much more lengthy than in other European countries. This factor explains, at least in part, the high level of provisions and the slowness of the settlement procedures followed by undertakings[16].

On the whole, 26.4% of the claims managed between 2010 and 2020 involved a litigation (Annex, Table 4.2), namely 23.9% of claims paid and 29.8% of claims outstanding[17]. Litigation for private healthcare facilities, accounting for 14.5% of claims managed, is below average.

[15] The pure premium is 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.

[16] One of the objectives of Law no. 24/2017, which reformed the rules on the safety of healthcare treatments, was precisely to discourage the use of civil justice, encouraging alternative forms of dispute resolution.

[17] In the motor liability sector, which is also characterised by strong litigation, at the end of 2019 the percentage of claims in litigation was 3.3% of paid claims and 21.1% of reserved claims (Statistical Bulletin on Insurance Activity in the Motor Insurance Sector 2013-2019, December 2020, no. 15).

When considering litigation relating only to managed claims reported in the year, this is 3.6% of claims reported in 2020, down from the corresponding figures for 2019 (5.1%) and 2018 (14.4%)[18].

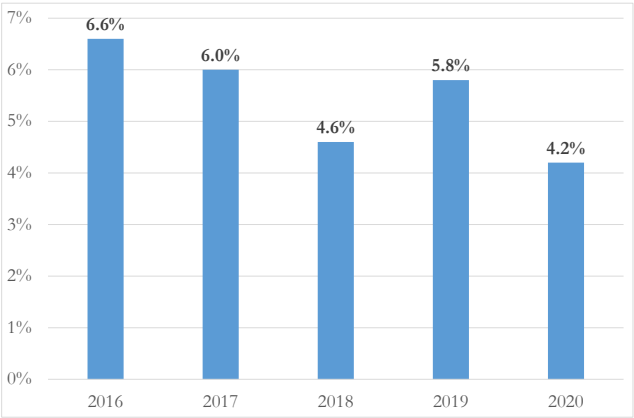
**Distribution channels for healthcare liability contracts** – Brokers mediate contracts covering risks of public healthcare facilities accounting for 55.2% of premiums for 2020 (Annex, Table 13), compared to 52.8% of 2019[19]. The rest of the contracts for these structures are managed almost entirely by the General Directions of companies.

The share of premiums mediated by brokers leapt to 69.8% for private facilities, from 25% in 2019, while agencies manage almost all the coverage of healthcare personnel.

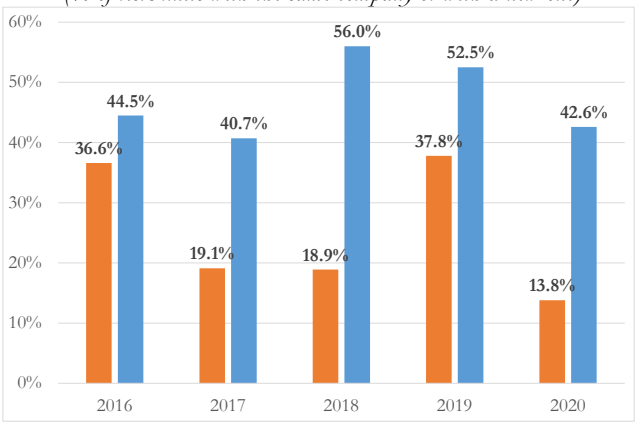
**The insurance mobility of healthcare personnel** – The frequency of change of insurance company by healthcare personnel amounted to 4.2% in 2020 (fig. 8.a), down by 1.6 percentage points compared to 2019 and close to the level observed in 2018.

**Fig. 8 – Change of company and reduction in the premium paid by healthcare personnel, 2016-2020**

(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)*




Reductions in the premium paid are much more common for healthcare professionals who change companies.

The reduction in the premium paid is seemingly one of the reasons for moving to another company: the percentage of policyholders who benefited from a reduction in the premium paid compared to the previous year is in fact higher for those who have taken out a contract with a new company. In 2020, premium rebates concerned 42.6% of the contracts taken out with a new company (compared to 13.8% of the contracts renewed with the same company of the previous year, fig. 8.b).

[18] About this matter, see Statistical Bulletin on healthcare liability risks in Italy 2010-2020, October 2020, no. 11.

[19] See Statistical Bulletin on healthcare liability risks in Italy 2010-2019, October 2020, no. 11, for the 2019 figures reported in this paragraph.

## 5. THE IMPACT OF COVID-19 ON HEALTHCARE LIABILITY

In the survey conducted in 2021, specific additional information was requested from insurance companies operating in the healthcare liability sector[20], with the aim of quantifying the overall impact of claims directly attributable to Covid-19 and assessing the possible effects of the pandemic on the contractual characteristics of insurance coverage.

Claims attributable to Covid-19 accounted for 2.5% of the claims reported in the year

In 2020, 404 claims were reported in relation to Covid-19, accounting for 2.5% of total claims reported for the year[21]: insurance companies made provisions for 346 claims; the other 58 were closed without payment (Annex, Table 14).

Compensation paid for claims caused by Covid-19 is a small proportion of the total

The impact of Covid-19 on the payments made by companies for claims reported in 2020 turned out to be rather small (Annex, Table 15): compensation for claims caused by Covid-19 amounted to approximately 190 thousand euro and referred exclusively to claims paid partially. This amount is equal to 6% of the total partial payments and 3% of the total (partial or final) payments for claims incurred in 2020, respectively[22].

Reserved amounts represent 6.4% of the total

Provisions for claims reported, related to Covid-19, set aside in anticipation of future compensations, amount to 33.7 million euro and represent 6.4% of the total amount reserved for 2020 claims generation. Of the amounts set aside, 65% refer to private healthcare facilities, a sector that may have been affected by the outbreaks of contagion recorded in Assisted Living Facilities.

The impact of Covid-19 was found to be moderate…

… however, the effects could be broader and could include contractual clauses

Although the impact observed up to this point is rather limited, it is important to remember that the management of claims in the healthcare liability framework tends to be protracted over time and wider effects of the pandemic on the claims rate in the sector could be seen in subsequent years.

In the context of the health emergency, companies have been called upon to assess risks even more carefully. In relation to the contractual clauses applied, 14 companies, out of a total of 28 with at least one active coverage between 2020 and 2021, state that they have introduced or intend to introduce risk exclusion or limitation clauses or tariff escalation clauses to cover pandemic risks (Annex, Table 16).

[20] For further details on the type of additional information required, please refer to the Methodological note.

[21] A total of 15,926 claims were reported in 2020 (see Annex, Tab. 4).

[22] Partial or final payments for claims reported and incurred in 2020 amounted to 6.3 million euro (see Annex, Tab. 5).

## 6. 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[23]. If they choose this option, they allocate specific funds to compensate victims of medical malpractice, financed by yearly specific allocations[24]. The Ministry of Health makes available the data on yearly resource allocations and funds of public healthcare facilities (Table 3).

**Table 3 - The self-retention of the healthcare liability risk in public healthcare facilities**
**Yearly resource allocation to funds (2012-2019)**

*(million euro)*

| | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 |
|---|---|---|---|---|---|---|---|---|
| **Yearly resource allocation** | | | | | | | | |
| **Geographical area** | | | | | | | | |
| North | 53.9 | 143.2 | 196.6 | 199.0 | 249.8 | 293.0 | 274.3 | 250.0 |
| Centre | 63.5 | 55.0 | 81.5 | 111.4 | 97.6 | 126.5 | 81.9 | 42.1 |
| South -Islands | 52.8 | 58.9 | 133.7 | 157.2 | 163.1 | 172.9 | 154.0 | 128.9 |
| **Type of facility** | | | | | | | | |
| Healthcare facility | 144.6 | 225.2 | 380.0 | 410.6 | 443.9 | 501.9 | 451.6 | 380.0 |
| Regional administration | 25.6 | 32.0 | 31.9 | 57.0 | 66.6 | 90.5 | 58.5 | 41.1 |
| **Total for Italy** | **170.2** | **257.1** | **411.8** | **467.6** | **510.5** | **592.4** | **510.1** | **421.1** |
| **Funds** | | | | | | | | |
| **Geographical area** | | | | | | | | |
| North | 200.8 | 324.3 | 490.4 | 540.2 | 725.2 | 931.7 | 1,087.2 | 1,140.3 |
| Centre | 59.5 | 148.4 | 202.4 | 227.8 | 331.9 | 417.1 | 412.8 | 342.3 |
| South -Islands | 58.5 | 265.0 | 240.1 | 362.5 | 502.1 | 603.5 | 704.1 | 665.4 |
| **Type of facility** | | | | | | | | |
| Healthcare facility | 247.8 | 608.2 | 758.2 | 936.7 | 1,311.0 | 1,598.4 | 1,844.3 | 1,780.9 |
| Regional administration | 71.0 | 129.6 | 174.7 | 193.8 | 248.2 | 353.9 | 359.8 | 367.0 |
| **Total for Italy** | **318.8** | **737.8** | **932.8** | **1,130.5** | **1,559.2** | **1,952.3** | **2,204.1** | **2,147.9** |

In 2019 public healthcare facilities allocated resources amounting to 421.1 million euro, down compared with 2018 (–17.5%): therefore, the reduction observed since 2018, which followed the significant growth recorded in 2013-2017, continued. The decline concerned the facilities of all the areas of the country, including those which directly provide healthcare services (–15.9%) as well as regional administrations (-

[23] 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.

[24] The system for managing the healthcare liability of public healthcare facilities is heterogeneous. In many Italian regions, forms of risk self-retention and insurance coverages acquired from insurance undertakings coexist in the same facility. A quite common mixed form uses self-retention for claims below a given value threshold and the intervention of an insurance-based compensation for claims above this level. 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).

29.9%).

In 2019, fund allocation decreased for the first time in 6 years

The amount of the total resources allocated in 2019 was 2,147.9 million euro, slightly down compared to 2018 (–2.6%), after 6 consecutive years of growth. The decrease recorded reflects the reduction in the funds set aside by healthcare facilities (-3.4%), not offset by the slight increase observed for regional administrations (+2.0%), whose relative incidence on the total coverage funds goes from 16.3% to 17.1%.

There are differences in the accumulation of funds between individual geographic areas: the North continues to record a growth (+4.9%) in coverage funds (albeit at a slower rate than in previous years), bucking the trend of the decline in other areas of the country.

If we consider the breakdown on a territorial basis, in 2019 the region that allocated the largest amount of resources was again Veneto (22.2% of the total, for an amount of 93.5 million, Table 4), followed by Lombardy (72.2 million) and Campania (61.8 million). The resources allocated in Latium decreased significantly (22.6 million, against 60.8 million in 2018)[25].

**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 (2019)**
*(thousands of euro, amounts per inhabitant in euro)*

| Regions and autonomous provinces | Yearly resource allocation | | | Funds | | |
|---|---|---|---|---|---|---|
| | Total | % | Per inhabitant | Total | % | Per inhabitant |
| Piedmont | 91 | 0.0% | 0.0 | 127,411 | 5.9% | 29.6 |
| Valle d'Aosta | 0 | 0.0% | 0.0 | 0 | 0.0% | 0.0 |
| Lombardy | 72,156 | 17.1% | 7.2 | 329,329 | 15.3% | 32.8 |
| Autonomous Province of Bolzano | 0 | 0.0% | 0.0 | 34 | 0.0% | 0.1 |
| Autonomous Province of Trento | 7,833 | 1.9% | 14.4 | 31,281 | 1.5% | 57.4 |
| Veneto | 93,477 | 22.2% | 19.2 | 351,212 | 16.4% | 72.0 |
| Friuli V.G. | 0 | 0.0% | 0.0 | 1,362 | 0.1% | 1.1 |
| Liguria | 23,867 | 5.7% | 15.7 | 67,939 | 3.2% | 44.6 |
| Emilia Romagna | 52,621 | 12.5% | 11.8 | 231,689 | 10.8% | 51.9 |
| Tuscany | 2,559 | 0.6% | 0.7 | 19,135 | 0.9% | 5.2 |
| Umbria | 15,951 | 3.8% | 18.3 | 66,240 | 3.1% | 76.1 |
| Marche | 1,000 | 0.2% | 0.7 | 33,127 | 1.5% | 21.9 |
| Latium | 22,566 | 5.4% | 3.9 | 223,755 | 10.4% | 38.9 |
| Abruzzo | 0 | 0.0% | 0.0 | 12,323 | 0.6% | 9.5 |
| Molise | 0 | 0.0% | 0.0 | 0 | 0.0% | 0.0 |
| Campania | 61,845 | 14.7% | 10.8 | 219,897 | 10.2% | 38.5 |
| Puglia | 19,731 | 4.7% | 5.0 | 64,633 | 3.0% | 16.3 |
| Basilicata | 1,944 | 0.5% | 3.5 | 18,248 | 0.8% | 33.0 |
| Calabria | 5,488 | 1.3% | 2.9 | 4,533 | 0.2% | 2.4 |
| Sicily | 34,716 | 8.2% | 7.1 | 295,655 | 13.8% | 60.6 |
| Sardinia | 5,207 | 1.2% | 3.2 | 50,089 | 2.3% | 31.1 |
| **Total for Italy** | **421,050** | **100.0%** | **7.1** | **2,147,891** | **100.0%** | **36.0** |

Compared to the number of inhabitants, the largest amount of allocated funds is observed in Umbria

[25] See Statistical Bulletin on healthcare liability risks in Italy 2010-2020, October 2020, no. 11 for these issues.

(76.1 euro per inhabitant), followed by Veneto (72 euro per inhabitant), Sicily (60.6 euro) and by the autonomous province of Trento (57.4 euro).

Since 2014, the resources allocated for risk self-retention of public facilities have exceeded the premiums

**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).

Looking only at public facilities, between 2014 and 2019 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 181.9% in the period 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 (2012-2019)**

*(million euro)*