GATEWAY TO GLOBAL AGING DATA

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# Gateway Policy Explorer: Retirement Series

# Italy

# Public Old-Age Health Insurance Plan Details

# 1992-2022

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## Preface

This document is intended for researchers who want to understand the evolution of policy or the policy in place at a particular point in time. This document is not intended for financial advice or to aid in decision-making. The authors have made significant effort to identify and collect historical information pertaining to these policies, to accurately represent these policies, and to communicate how policies may interact to determine legal requirements, eligibility for benefits, and/or benefits levels. The policies presented in this document focus on rules applicable to most individuals aged 50 and older from 1992. Many systems include special policies or alternative eligibility rules for specific groups. We encourage all users to complete their own review of literature in this area depending on the research questions they have in mind.

If you have feedback or questions or identify an error, please contact policy@g2aging.org.

## Background — *Gateway Policy Explorer: Retirement Series*

The *Gateway Policy Explorer* (http://g2aging.org/policy-explorer) is part of the Gateway to Global Aging Data (http://g2aging.org) project. The *Retirement Series* captures historical policy that affects the birth cohorts of respondents in the surveys covered by the Gateway. It was motivated by the rapid evolution of policies affecting older people across the world. As the Health and Retirement Study (HRS) began in 1992 and many of the international network of studies (HRS-INS) cover more than a decade, understanding the policies in place at the time of the survey has become more demanding for researchers.

*Why are we tracking past policy?* Individuals make choices based on current policies and the outcomes we see today may reflect responses to past policies. When interpreting the survey responses of individuals, an understanding of the policy environment under which those individuals operate is critical. The collection of contextual information in the *Gateway Policy Explorer* aims to support researchers who want to understand or use policy changes in their research and provide context for longitudinal or cross-country differences. Over the period 2023–2026 the *Gateway Policy Explorer* will be expanded to include information on retirement, long-term care, education, and other policies affecting the life cycle.

The key dimensions to the *Gateway Policy Explorer: Retirement Series* are country and time. We prioritize data collection for each country based on its first interview wave and are continuing to expand our data collection back in time to 1992, the earliest survey date in the HRS-INS.

A separate document, like this one, is developed for each country and each broad category of policies covered in the *Gateway Policy Explorer: Retirement Series*.

### Author and Contributor Disclaimers

† The opinions expressed here are those of authors and do not necessarily reflect the views of the OECD or of its member countries.

# Italy

Old-Age Health Insurance
Plan details 1992-2022 * †

In Italy, all residents are guaranteed health care by the National Health Service (Servizio Sanitario Nazionale - SSN). Health care services are provided by regional and local healthcare authorities (Azienda Sanitaria Locale - ASL) and SSN hospitals.

Long-term care services are funded and administered by municipalities, ASLs, nursing homes (residenze sanitarie assistenziali, RSAs) and the National Institute of Social Security (Istituto Nazionale Previdenza Sociale, INPS), although other institutions are involved.

The core functions of the SSN have not radically changed since 1992, but financial and operative responsibilities have shifted from the central government to ASLs.

**Key Dates**
First law: 1925
Major changes since 1992: 2001

## Contents



* If you have questions or suggestions, please contact policy@g2aging.org.

† Detailed information and definitions are provided in tables, formulas and a glossary at the end of this document. To facilitate switching back and forth, this document is designed with hyperlinks. Most PDF readers have shortcuts that permit a reader to return to the previous location after selecting a hyperlink. In Adobe Acrobat on a PC: "Alt" + "←"; In Adobe Acrobat on a MAC: "command" + "←"; In Preview on a MAC: "command" + "[".

# Chapter 1: Policy enacted 1992-2000

## Overview

In Italy, all residents are guaranteed health care by the National Health Service (Servizio Sanitario Nazionale - SSN). Residents must register with the SSN. Health care services are provided by regional and local healthcare authorities (Azienda Sanitaria Locale - ASL). SSN hospitals are part of ASLs. SSN services may also be provided by private healthcare bodies that have contracts with ASLs. The Ministry of Health is ultimately responsible for the administration of health services, but most operational responsibility is delegated to the ASLs. Each individual's general practitioner or urgent care doctor determines whether a patient requires healthcare services.

Italy's long-term care (LTC) system is fragmented. Sources of funding, governance and management responsibilities differ by, and are spread over, local and regional authorities. The organizations most directly involved are municipalities, ASLs, skilled nursing facilities (SNF or residenze sanitarie assistenziali) and the National Institute of Social Security (Istituto Nazionale Previdenza Sociale, INPS). However, planning and funding LTC services often involve the central, regional and provincial governments.

**Key health care reforms**
Starting in 1992, the government approved a series of reforms to the SSN (Legislative Decree 502/1992 and Legislative Decree 517/1993). The initial reform delegated health care powers and managerial autonomy to ASLs, including responsibility for the containment of costs and for their own financial stability. This resulted in 21 regional health authorities and about 200 local authorities with organizational autonomy and independence. The delegation of healthcare management to ASLs was part of a broader reform of the healthcare system intended to introduce competition between private and public healthcare providers.

The 1993 reform changed payment for hospital care services from a fee-for-service system to a prospective payment systems (for both inpatient and outpatient procedures) based on Diagnosis-Related Groups (DRGs).

These reforms introduced essential care levels (Livelli Essenziali di Assistenza - LEA), divided in six different classes, in order to harmonize and ensure the provision of basic healthcare services between the different ASLs and regions. Although ASLs ensure the material provision of these services, regions may provide additional services and treatments for different conditions through their ASLs, and have different eligibility requirements for the same services and treatments.

In 1999, additional reforms were made to the prospective payment system and changed hospital funding such that annual financing is composed of two elements:

1. Payments for inpatient and outpatient care by the prospective payment system based on DRGs
2. Payments for other services based on the average production costs of specific service categories:
    - care for emergencies and accidents and, more generally, acute care activities
    - prevention schemes
    - social services
    - transplant activities
    - management of chronic illnesses

**Key LTC reforms**
In 1992, the Italian Parliament passed the Progetto Obiettivo Salute Anziano (POSA) Act, which was the first legislative effort aimed at providing LTC for elderly people needing it. POSA was not a law (although its text was included in Legislative Decree 502/1992), but an act written in the form of a series of recommendations to ASLs, which were responsible for implementing the recommendations. POSA recommended community-based Geriatric Evaluation Units (GEU) that integrated health and social services. GEUs are intended to be coordinated by a geriatrician and include registered nurses, social workers, physiotherapists, and patient's general practitioners. POSA focused on promoting home and community-based services (HCBS) and SNFs as a means of shifting the care burden from hospitals to the community. Initially, funding and guidance for the ASLs to support implementing POSA was limited.

## Eligibility

- **Qualifications**
  Healthcare and Health Services
  There are a few qualifications for healthcare services. Urgent or essential outpatient and hospital treatment, even if continuous for illness and accident, is granted to all individuals present in the country, regardless of residency or immigration status. All other levels of care are granted to all Italian citizens, EU citizens and non-EU citizens with a valid residence permit and who are signed up for the SSN.

Long-Term Care (LTC)

The public LTC system consists of two main components, although differences exist across Italy's 20 administrative regions:

- Cash benefits (Indennità di Accompagnamento) provided by INPS directly to disabled persons who meet one of the following conditions:
  - Inability to walk without the permanent assistance of a companion;
  - Inability to perform the Activities of Daily Living (ADLs) without continuous assistance.
- Continuing care services' eligibility and qualification depend on the individual ASLs and local municipality, depending on the services they provide.

- **To receive health benefits, does an individual have to claim them?** Answer: Yes
- **To continue to receive health benefits, does an individual have to remain qualified?** Answer: No

## Coverage

Healthcare and Health Services

SSN provides healthcare or health services for essential care levels (Livelli Essenziali di Assistenza - LEA). Following the 1992 reform, a Presidential decree (Decreto del Presidente della Repubblica, December 24, 1992) established six LEAs:

1. Primary health care: Those services aimed at promoting health, through individual preventive medicine, diagnosis, treatment and primary rehabilitation and emergency intervention. This includes (among other services) medical visits, prescription drugs and referrals for specialist care.
2. Hospital care: Those services aimed at providing care for conditions that require emergency or urgent diagnostic or therapeutic interventions, particularly acute conditions that cannot be managed in an outpatient and/or home setting, as well as long-term conditions that require diagnostic or therapeutic treatment that cannot be provided outside hospital settings. Except in cases of emergency, individuals in need of hospital care must request it through their primary health care service provider (e.g., their general practitioner).
3. Semi-residential and territorial specialist assistance: Those services provided in an outpatient or territorial/semi-residential setting for diagnostic and treatment of morbid conditions and disabilities including specialized diagnostic, therapeutic and rehabilitative interventions such as mental health and addiction treatment services. Specialist assistance also includes some primary and/or urgent eye (i.e., optometry, ophthalmology) and dental care services.
4. Community public health care in living and working environments: Those services aimed at ensuring adequate level of public health regarding diseases, vaccination campaigns, environmental protection and others.
5. Care organization support activities: Those services aimed at planning and organizing healthcare services.
6. Residential health care for stabilized dependent and long-term care patients: Those continuing services provided to elderly and disabled persons, including outpatient, home-based, semi-residential and residential care services.

Although ASLs ensure the material provision of these services, regions may provide services and treatments for different conditions through their ASLs, and have different eligibility requirements for the same services and treatments.

Long-Term Care (LTC)

Coverage and benefits for the public LTC system depend on its two main components, although differences exist across Italy's 20 administrative regions:

- Cash benefits (Indennità di Accompagnamento)
  These benefits are provided to the disabled individual who meets the qualifications, independently of their age and financial situation. The monthly value of this kind of benefit can be found in Table 1.
- Continuing care services
  These services are provided at the local level by a number of local and national organizations. Through ASLs, SSN plans and manages health services provided in home and community-based settings as well as residential settings, such as SNFs. Additionally, personal care services are managed by the local municipality, such as domestic and personal care tasks provided at home (Servizi di Assistenza Domiciliare) or in other settings (e.g., at a SNF).
  *Note*: Health care services provided by the SSN are free of charge. Personal care services are typically means-tested and users can pay up to the full cost.

## Costs

Healthcare and Health Services

Healthcare and health services are typically provided with no charge or a small out-of-pocket payment (often called a *ticket*) and are funded by the general tax system. There are two main types of out-of-pocket payments.

1. Demand-side cost-sharing: a copayment for diagnostic procedures, pharmaceuticals and specialist visits.
2. Direct payment by users to purchase private health care services and over-the-counter (OTC) drugs.

Visits, procedures, medical devices and general care

Primary care and inpatient care are free at the point of use. Procedures and visits can be prescribed either by an individual's general practitioner or a specialist. Prior to 1993, all users paid a proportion (from 15% in 1982 to 50% in 1991) of the total cost of each outpatient specialist visit provided by the SSN, up to a maximum copayment fixed by law. Since 1993, users have paid for the total cost per prescription of procedures (each prescription may include up to eight procedures belonging to the same medical discipline), visits and/or drugs administered in hospital settings, but always up to a maximum amount determined by law. In 1993, the maximum was set at 36.15€, although individuals and families in disadvantaged economic conditions, younger than age 6 or at LEAst age 65 are exempt from the cost. The full cost for private visits and procedures are borne by the users. Patients with specific health conditions who need particular medical devices (such as absorbent products for urinary incontinence, stoma bags, prostheses, wheelchairs and catheters) can make a formal request to their ASL through their specialist. These devices are free of charge after a specialist's diagnosis; ASLs then grant authorization for delivery.

*Note*: All public healthcare services such as visits and procedures are capped at the maximum amount for each individual ticket (even if their price may differ by kind of service provided) established by law. The price of the ticket is often negligible and no outstanding debts affect recipients of public healthcare services.

Drugs and medications

The Italian Pharmaceutical Agency (Agenzia Italiana del Farmaco - AIFA) publishes an annual list of pharmaceuticals and drugs divided into three classes that determined the user's out-of-pocket cost:

- Class A: Essential drugs and medications for chronic diseases.
- Class H: Drugs and medications that can only be dispensed in hospital and/or healthcare settings.
- Class C: All drugs not included in the previous two classes, including all the over-the-counter drugs and medications.

The cost of the first two drug classes (Class A and Class H) are covered by SSN; however, a copayment is required up to the maximum ticket amount unless the user is exempt due to a disadvantaged economic condition. The third drug class (Class C) is not covered by SSN and users must pay the full cost.

Long-Term Care (LTC)

These services are means-tested and the users can pay up to the full cost. Means-test conditions and relative out-of-pocket costs depend on the financial situation of the users. These policies are set by region, ASLs and local municipalities depending on the service provided.

# Chapter 2: Policy enacted 2001-2022

**Policy change in 2001**

Constitutional Law 3/2001 (Gazzetta Ufficiale, 2001a) - enacted on October 18, 2001, and effective from January 1, 2002 - introduced the following substantial reforms to the healthcare system:

- Increased the role and responsibility of the regional authorities in providing basic healthcare services.
- Through a subsequent Prime-Minister Decree implementing this legislation (Decree of the Prime Minister no. 448 of November 29, 2001 - Gazzetta Ufficiale, 2001b) incorporated essential care levels in the Italian Constitution. The effect of this was to establish the right to receive some essential healthcare services at a constitutional level, which is less subject to political changes and reforms over time, and to provide a detailed list of the services provided for free, under a payment of a ticket, by the SSN. The definition of these care levels differed slightly from the essential care levels defined in 1992. The complete list included more than 35,000 services, which were increased to 57,000 in 2008.

Other reforms during this period include:

- Budget Law 2002 (Gazzetta Ufficiale, 2001c) abolished copayments at the national level for those pharmaceutical drugs and medications that are considered essential, those for treating chronic diseases, and those that are only dispensed in a hospital and/or healthcare setting. At the same time, this law allowed each of Italy's 20 administrative regions to introduce separate copayments on drugs, with the purpose of containing each region's rising pharmaceutical expenditures and to promote the financial viability of the region's healthcare system. In 11 of the 20 regions, copayments were introduced at a flat rate or a percentage of the price.
- Budget Law 2007 (Gazzetta Ufficiale, 2006) introduced, in an attempt to reduce non-urgent visits to hospital emergency departments, a copayment on these types of visits. Children under 14 are exempt.
- In 2011, the Ministry of Health issued a strategic plan for rehabilitation (called "Piano di Indirizzo per la Riabilitazione"), in which rehabilitation is seen as a component of prevention and therapy within an effective integrated patient pathway. The plan proposed the establishment of rehabilitation departments within ASLs to coordinate the provision of care across providers. Implementation varied by region and ASL.

## Overview

In Italy, all residents are guaranteed health care by the National Health Service (Servizio Sanitario Nazionale - SSN). Residents must register with the SSN. Health care services are provided by regional and local healthcare authorities (Azienda Sanitaria Locale - ASL). SSN hospitals are part of ASLs. SSN services may also be provided by private healthcare bodies that have contracts with ASLs. The Ministry of Health is ultimately responsible for the administration of health services, but most operational responsibility is delegated to the ASLs.

Essential care levels (Livelli Essenziali di Assistenza - LEA, divided in three different classes, harmonize and ensure the provision of basic healthcare services between the different ASLs and regions. Although ASLs ensure the material provision of these services, regions may provide additional services and treatments for different conditions through their ASLs, and have different eligibility requirements for the same services and treatments.

Italy's long-term care (LTC) system is fragmented. Sources of funding, governance and management responsibilities differ by, and are spread over, local and regional authorities. The organizations most directly involved are municipalities, ASLs, skilled nursing facilities (SNF or residenze sanitarie assistenziali) and the National Institute of Social Security (Istituto Nazionale Previdenza Sociale, INPS). However, planning and funding LTC services often involve the central, regional and provincial governments.

## Eligibility

- **Qualifications**

  Healthcare and Health Services

  There are a few qualifications for healthcare services. Urgent or essential outpatient and hospital treatment, even if continuous for illness and accident, is granted to all individuals present in the country, regardless of residency or immigration status. All other levels of care are granted to all Italian citizens, EU citizens and non-EU citizens with a valid residence permit and who are signed up for the SSN.

Long-Term Care (LTC)

The public LTC system consists of two main components, although differences exist across Italy's 20 administrative regions:

- Cash benefits (Indennità di Accompagnamento) provided by INPS directly to disabled persons who meet one of the following conditions:
  - Inability to walk without the permanent assistance of a companion;
  - Inability to perform the Activities of Daily Living (ADLs) without continuous assistance.
- Continuing care services' eligibility and qualification depend on the individual ASLs and local municipality, depending on the services they provide.

- **To receive health benefits, does an individual have to claim them?** Answer: Yes
- **To continue to receive health benefits, does an individual have to remain qualified?** Answer: No

## Coverage

Healthcare and Health Services

SSN provides health care or health services for essential care levels (Livelli Essenziali di Assistenza - LEA). The 2001 Prime Minister Decree (Gazzetta Ufficiale della Repubblica, 2001) defined three different classes of LEAs:

1. District-based assistance
   This class includes all those healthcare and personal care services that are spread over the local territory of a user's residence and that can, in turn, be divided into further sub-classes:
   - Primary health care: Those services aimed at promoting health, through individual preventive medicine, diagnosis, treatment and primary rehabilitation and emergency intervention. This includes (among other services) medical visits, prescription drugs and referrals for specialist care.
   - Semi-residential and territorial specialist assistance: Those services provided in an outpatient or territorial/semi-residential setting for diagnostic and treatment of morbid conditions and disabilities including specialized diagnostic, therapeutic and rehabilitative interventions such as mental health and addiction treatment services. Specialist assistance also includes some primary and/or urgent eye (i.e., optometry, ophthalmology) and dental care services.
   - Residential health care for stabilized dependent and long-term care patients: Those continuing services provided to elderly and disabled persons, including outpatient, home-based, semi-residential and residential care services.

   Residents may be guaranteed additional services by individual regions.

2. Hospital care
   Those services aimed at providing care for conditions that require emergency or urgent diagnostic or therapeutic interventions, particularly acute conditions that cannot be managed in an outpatient and/or home setting, as well as long-term conditions that require diagnostic or therapeutic treatment that cannot be provided outside hospital settings. Except in cases of emergency, individuals in need of hospital care must request it through their primary health care service provider (e.g., their general practitioner).

3. Community public health care in living and working environments
   Those services aimed at ensuring adequate level of public health regarding diseases, vaccination campaigns, environmental protection and others.

Although ASLs ensure the material provision of these services, regions may provide additional services and treatments for different conditions through their ASLs, and have different eligibility requirements for the same services and treatments.

Long-Term Care (LTC)

Coverage and benefits for the public LTC system depend on its two main components, although differences exist across Italy's 20 administrative regions:

- Cash benefits (Indennità di Accompagnamento)
  These benefits are provided to the disabled individual who meets the qualifications, independently of their age and financial situation. The monthly value of this kind of benefit can be found in Table 1
- Continuing care services
  These services are provided at the local level by a number of local and national organizations. Through ASLs, SSN plans and manages health services provided in home and community-based settings as well as residential settings, such as SNFs. Additionally personal care services are managed by the local municipality, such as domestic and personal care tasks provided at home (Servizi di Assistenza Domiciliare) or in other settings (e.g., at a SNF).

*Note*: Health care services provided by the SSN are free of charge. Personal care services are typically means-tested and users can pay up to the full cost.

## Costs

Healthcare and Health Services

Healthcare and health services are typically provided with no charge or a small out-of-pocket payment (often called a *ticket*) and are funded by the general tax system. There are two main types of out-of-pocket payments.

1. Demand-side cost-sharing: a copayment for diagnostic procedures, pharmaceuticals and specialist visits.
2. Direct payment by users to purchase private health care services and over-the-counter (OTC) drugs.

Visits, procedures, medical devices and general care

Primary care and inpatient care are free at the point of use. Procedures and visits can be prescribed either by an individual's general practitioner or a specialist. Users pay for the total cost per prescription of procedures (each prescription may include up to eight procedures belonging to the same medical discipline), visits and/or drugs administered in hospital settings, but always up to a maximum amount determined by law. In 2001, the maximum was set at 36.15€, although individuals and families in disadvantaged economic conditions, younger than age 6 or at LEAst age 65 are exempt from the cost. The full cost for private visits and procedures are borne by the users. Patients with specific health conditions who need particular medical devices (such as absorbent products for urinary incontinence, stoma bags, prostheses, wheelchairs and catheters) can make a formal request to their ASL through their specialist. These devices are free of charge after a specialist's diagnosis; ASLs then grant authorization for delivery.

See Table 2 for national rates of typical user copayments and annual maximum out-of-pocket costs. Regions can set their own appointment or procedure rates up to a maximum out-of-pocket cost determined by law, which is currently 36.15€.

*Note*: All public healthcare services such as visits and procedures are capped at the maximum amount for each individual ticket (even if their price may differ by kind of service provided) established by law. The price of the ticket is often negligible and no outstanding debts affect recipients of public healthcare services.

Drugs and medications

The Italian Pharmaceutical Agency (Agenzia Italiana del Farmaco - AIFA) publishes an annual list of pharmaceuticals and drugs divided into three classes that determined the user's out-of-pocket cost:

- Class A: Essential drugs and medications for chronic diseases.
- Class H: Drugs and medications that can only be dispensed in hospital and/or healthcare settings.
- Class C: All drugs not included in the previous two classes, including all the over-the-counter drugs and medications.

The cost of the first two drug classes (Class A and Class H) are covered by SSN. However, users in regions that maintained copayment requirements after the Budget Law for 2001 are required to pay for the cost of these drug up to a maximum copayment amount between 1€ and 3€ per box, which specific amount is established by individual regions. Copayment exceptions exist for users in a disadvantaged economic condition. The third drug class (Class C) is not covered by SSN and users must pay the full cost. See Table 2 for detailed drug copayments.

Long-Term Care (LTC)

These services are means-tested and the users can pay up to the full cost. Means-test conditions and relative out-of-pocket costs depend on the financial situation of the users. These policies are set by region, ASLs and local municipalities depending on the service provided.

## Tables and Formulas

**Table 1: Cash Benefits for Long-Term Disability (Indennita di Accompagnamento)**

| Year | Monthly Values |
|---|---|
| 1992 | 347.64 € |
| 1993 | 367.19 |
| 1994 | 375.02 |
| 1995 | 382.86 |
| 1996 | 388.57 |
| 1997 | 396.63 |
| 1998 | 404.48 |
| 1999 | 411.08 |
| 2000 | 417.36 |
| 2001 | 422.11 |
| 2002 | 426.09 |
| 2003 | 431.19 |
| 2004 | 436.77 |
| 2005 | 443.83 |
| 2006 | 450.78 |
| 2007 | 457.66 |
| 2008 | 465.09 |
| 2009 | 472.04 |
| 2010 | 480.47 |
| 2011 | 487.39 |
| 2012 | 492.97 |
| 2013 | 499.27 |
| 2014 | 504.07 |
| 2015 | 508.55 |
| 2016 | 512.34 |
| 2017 | 515.43 |
| 2018 | 517.84 |
| 2019 | 520.29 |
| 2020 | 520.29 |
| 2021 | 522.10 |
| 2022 | 525.17[1] |

**Note:**

[1] Provisional values

- Cash benefits for long-term disability take the form of 12 monthly payments in a year

**Sources:** Authors' collection of data deriving from publications of Circulars on Renewal of Equalization Tables, published yearly by INPS [Istituto Nazionale della Previdenza Sociale - National Institute of Social Security], 1992-2022. Values until 2001 have been converted from Italian Liras (ITL) into Euros (EUR) following the conversion rate: 1 EUR = 1,936.27 ITL.

**Table 2: Typical Patient Copayments and Annual Maximum Out-of-Pocket Costs**

| Service | Fees per service | Maximum out-of-pocket costs per year |
|---|---|---|
| Primary care visit | None | Not applicable |
| Specialist consultation | First appointment: 20.66€<br>Follow-up appointment: 12.91€ | No maximum per-year caps but individuals with out-of-pocket payments over 129€ in a given year are eligible for a tax credit equal to roughly one-fifth of their spending |
| Hospitalization (per day or visit) including pharmaceuticals | Public hospitals: None<br>Private hospitals: Mostly free; fees vary for patients paying out of pocket. | Not applicable |
| Non-urgent and non-necessary emergency hospital visit | 25.00€ (introduced in 2007) | No maximum |
| Outpatient care | 10 | No maximum |
| Prescription drugs (outpatient) | Tier 1 (Class A) drugs prescribed by a physician: None for generic drugs. The cost for brand-name drugs is the difference between the reference price for the generic drug and the market price for the brand-name one.<br><br>Tier 2 (Class H) drugs administered in a hospital setting: Free in public hospitals; mostly free in private hospitals, unless fees and/or copayments apply<br><br>Tier 3 (Class C) drugs: Patients pay full price<br><br>Some regions have introduced additional copayments for Tier 1 drugs, ranging from 1€ to 3€ per box | No maximum per-year caps but individuals with out-of-pocket payments over 129€ per year are eligible for a tax credit equal to roughly one-fifth of their spending |

**Note**: Values stated in Budget Law of 2001 - active for the 2022 fiscal year - which have not substantially changed at a governmental level during the whole policy period considered. However, the actual values set by regional authorities have indeed changed depending on the region considered.
**Source**: Law no. 448 of December 28, 2001 - Budget Law 2002 (Gazzetta Ufficiale, 2002

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## Glossary of terms

This section summarizes key definitions from the main text. To facilitate switching back and forth, this document is designed with hyperlinks. Most PDF readers have shortcuts that permit a reader to return to the previous location after selecting a hyperlink. In Adobe Acrobat on a PC: "Alt" + "←"; In Adobe Acrobat on a MAC: "command" + "←"; In Preview on a MAC: "command" + "[".

**ASL**: Public institutions of the Italian public administration, responsible for the provision of health services in a given territory, usually provincial.

**Claimable Benefit**: A pension where the beneficiary must actively file a claim for benefits with the government's pension authority.

**Imposta sul Reddito delle Persone Fisiche - IRPEF**: Personal income tax in Italy

**LEA**: Essential Care Levels (Livelli Essenziali di Assistenza) are groups of health services published by the Italian government, with the aim of ensuring and harmonizing essential health services across the whole country.

**National Social Security Institute (Istituto Nazionale della Previdenza Sociale - INPS)**: The administering agency of Italy's social insurance and assistance benefits.

**Qualified Benefit**: A benefit is qualified if an individual must continue to meet certain standards, such as a means test, to continue receipt of benefits.

**SNF**: Skilled nursing facility.

**SSN**: Italian National Health Service (Servizio Sanitario Nazionale), which is represented by the array of healthcare functions, activities and services managed and provided by the Italian Regions.

## Version information

*Current Version: 2.0 (August 2023)*

**Version History**

- 1.0 (May 2022): First version
- 2.0 (August 2023): Extended policy period from 2019 to 2022, and updated formatting

## Additional resources

The following resources provide additional details for the interested reader:

*Gazzetta Ufficiale della Repubblica Italiana*. https://www.gazzettaufficiale.it/
Features: Official database for the Italian legislation, laws and acts over the years

*INPS Acts and Documentation's database*. https://www.inps.it/inps-comunica/atti
Features: Official database of acts, internal communications and official documents from the Italian institute of social security (INPS – Istituto Nazionale della Previdenza Sociale) over the years. It contains useful documents and data on all aspects of the Italian pension system.

*Ministero della Salute (Ministry of Health)*. https://www.salute.gov.it/
Official website for the Italian Ministry of Health, which provides information and resources regarding the healthcare system