# Italy

## Health system **summary** 2024

European Observatory on Health Systems and Policies
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**This Health System Summary is based on *Italy: Health System Review* (HiT) published in 2022 but is significantly updated, including data, policy developments and relevant reforms as highlighted by the Health Systems and Policies Monitor (HSPM) (www.hspm.org). For this edition of the Health System Summary, key data have been updated to those available in September 2024 unless otherwise stated. Health System Summaries use a concise format to communicate central features of country health systems and analyse available evidence on the organization, financing and delivery of health care. They also provide insights into key reforms and the varied challenges testing the performance of the health system.**

**Main sources**:

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# How is the health system organized?

The regions are responsible for health care organization and delivery in Italy's highly decentralized National Health Service

## Organization

The Italian National Health Service (*Servizio Sanitario Nazionale,* SSN) was founded in 1978 and provides universal coverage to all citizens and legal foreign residents. The national benefits package is established by the central government, which also oversees and allocates funding for regional health systems. The regions, through local health authorities, oversee financing, planning and provision of services at the local level. During the COVID-19 pandemic, the national government played a central role in directing the health system's response to the crisis through re-centralizing coordination and accelerating decision-making at the national level with flexible guidelines for the regions (see Box 1).

**Box 1** Capacity for policy development and implementation

The COVID-19 pandemic was instructive in highlighting the existing challenges for policy capacity within the health system. The crisis required a timely and massive response from the SSN and the adoption of extraordinary measures at national level to tackle health system overload and to slow down infection rates. A similar effort was required to define and implement the COVID-19 vaccination campaign, which took a few months before gaining full pace in 2021.

The National Recovery and Resilience Plan 2021–2026 allocated €15.6 billion for investments in policy capacity, in community care, telemedicine, health care innovation, research and digitalization (Ricciardi & Tarricone, 2021). Since the start of the plan's implementation in 2021, significant progress has been made, achieving over half of its targets (as of September 2024). Specifically, objectives related to the construction of Community Hospitals and seismic interventions were met, alongside other actions focusing on digitalization, continuity of care and specialized training in general medicine (Ministero della Salute, 2024).

## Planning

The key planning tools at the national level are the 3-year Health Plans and the Health Pacts between regions and the national government, as well as national programmes addressing particular health challenges. Planning is also shaped by guaranteeing delivery of the national benefits package through a monitoring system and budget allocations. The financing and distribution of funds among the Local Health Authorities (*Aziende sanitarie locali*), as well as the adaptation of national goals to local socio-epidemiological contexts, form the foundation of regional planning.

## Providers

GPs and paediatricians, who are independent contractors, act as gatekeepers to higher levels of care. The Local Health Authorities provide preventive medicine and public health services, primary care (including mental health, family medicine and community services) and secondary care. Hospital and specialist ambulatory services can be provided by the Local Health Authorities through directly

managed hospitals, semi-independent public hospitals (known as hospital trusts) or accredited private providers. National Institutes for Care and Scientific Research (*Istituti di Ricovero e Cura a Carattere Scientifico,* IRCCSs) are tertiary care and research centres. They can be public or private institutions and receive funding for research from the Ministry of Health. Dentists are almost all private providers or employees of private clinics providing dentistry services.

# How much is spent on health services?

**Health expenditure has slightly increased and remains below the EU average. Private health spending has grown over the past 10 years, largely through out-of-pocket payments**

## Funding mechanisms

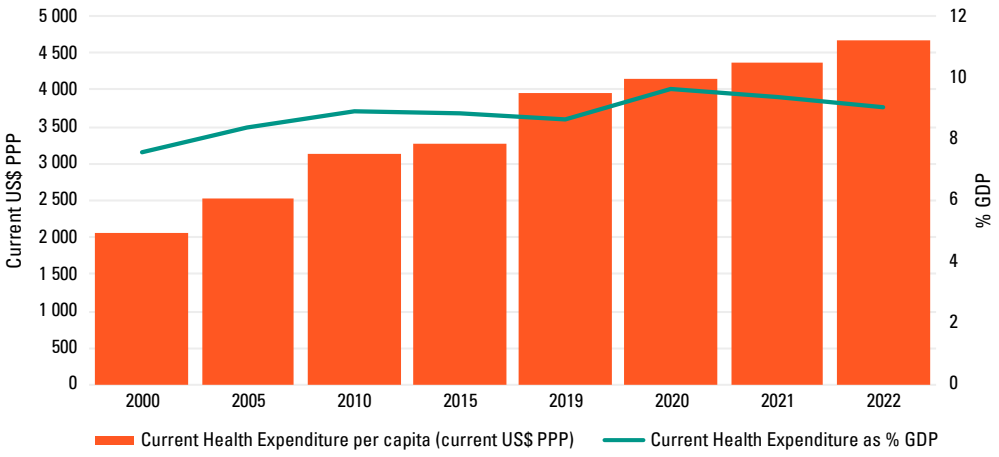
The main source of financing for the Italian SSN is a mix of taxes applied at both regional and national level, with pooling of funds managed at national level. Each region's share is calculated based on a capitation formula that considers the age structure of the population and other epidemiological indicators. The specific formula to be used is agreed annually between the national government and the regions at the State-Regions Conference, an intergovernmental forum for joint decision-making. For each region, the difference between their estimated financial need to deliver the benefits package to their populations and the revenues raised from their own sources determines the financial gap that ought to be covered by the national government. This gap is covered through an equalization fund which contains resources collected through the national value-added tax.

## Health expenditure

Over the past two decades, per capita health spending in Italy has seen a modest nominal increase (that is, without adjusting for inflation) (Fig. 1). In 2022, health expenditure represented 9% of GDP, which equates to approximately US$ 4675 per capita (adjusted for differences in purchasing power), slightly below the average for EU/European Economic Area (EEA) countries and the United Kingdom (Fig. 2). Over the past decade, the share of private health spending has also increased, mostly driven by out-of-pocket (OOP) payments by households. In 2022, most of the health spending in Italy (74%) was financed through government or compulsory schemes. Private (voluntary) health insurance plays a minor role, accounting for only about 3% of total health expenditure.

Per capita public expenditure by the regional health care systems varies due to funding allocations (northern regions, with older populations, tend to receive more resources) and because some regions can deliver services beyond those covered by the national benefits package if they have sufficient resources available. Additionally, significant interregional mobility, with patients seeking care outside their region of residence, further contributes to regional disparities in per capita health spending.

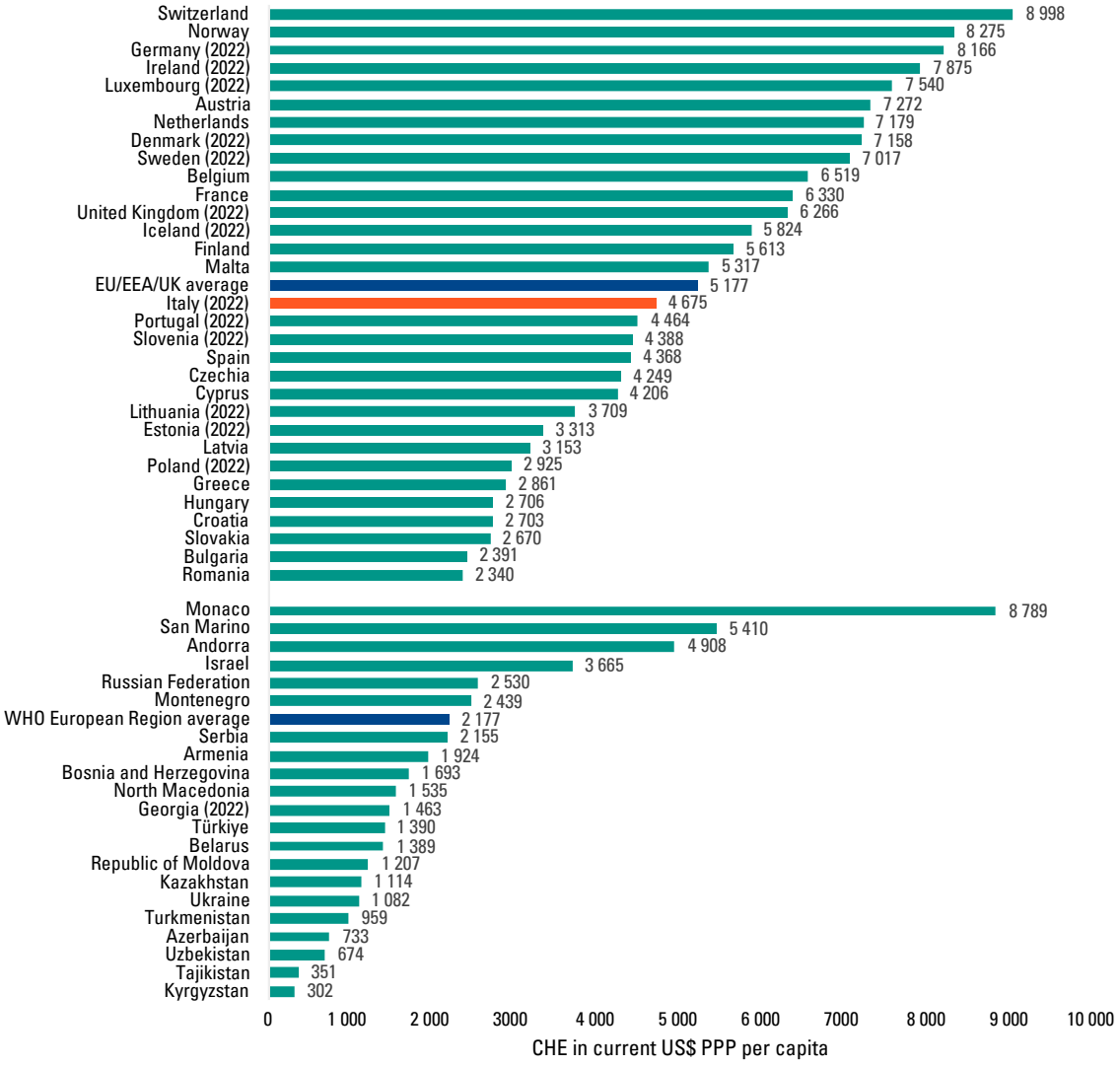
## Fig. 1 Trends in health expenditure, 2000–2022 (selected years)




**Notes:** GDP: gross domestic product; PPP: purchasing power parity.

**Source:** WHO, 2024.

## Fig. 2 Current health expenditure (US$ PPP) per capita in WHO European Region countries, 2021 or latest available year



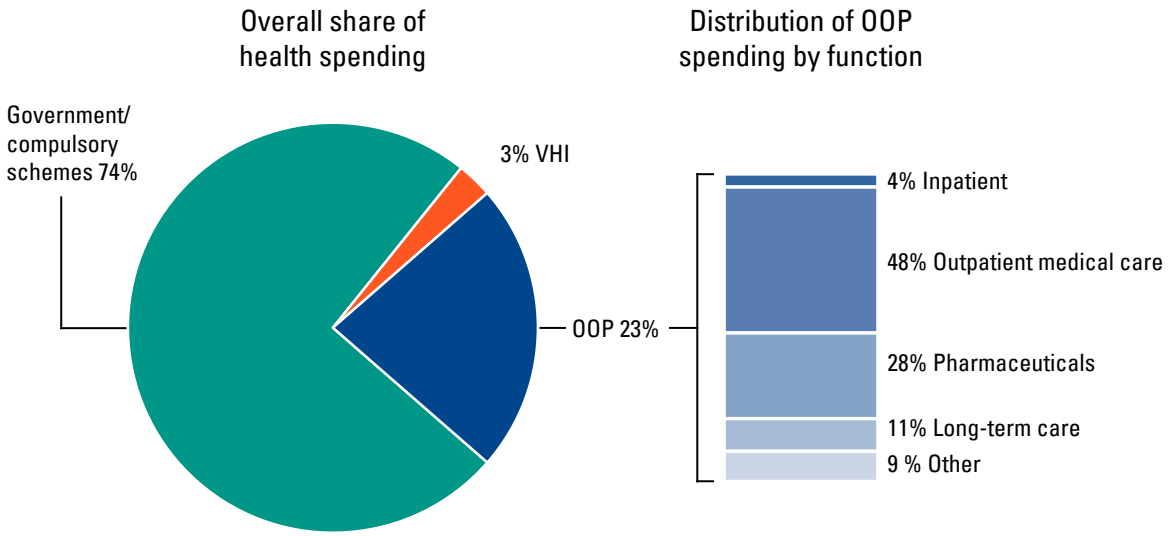

**Notes:** CHE: current health expenditure; EEA: European Economic Area; EU: European Union; PPP: purchasing power parity; UK: United Kingdom.

**Source:** WHO, 2024.

# Out-of-pocket payments

Household out-of-pocket (OOP) spending on health-care represented 23% of total health expenditure in both 2021 and 2022, which is higher than the EU average (15% in 2021). Within OOP spending, outpatient medical care and pharmaceuticals are the most substantial categories, together comprising over three quarters (76%) of all OOP expenditures (Fig. 3).

**Fig. 3** Composition of out-of-pocket payments, 2022




**Notes:** OOP: out-of-pocket; VHI: voluntary health insurance.
**Source:** OECD, 2024.

# Coverage

The SSN covers all citizens and ordinarily resident foreign nationals. Population coverage is automatic and universal. Undocumented migrants are entitled to access only urgent and essential services. The SSN guarantees the provision of health services included in the national benefits package (known as the *Livelli essenziali di assistenza,* LEA) across the entire country. Regions can choose to offer non-LEA services but must finance these themselves. Health care services provided within the SSN are identified by positive and negative lists. Dental care, specifically orthodontics and dental prostheses, is generally not covered and is paid for out of pocket or reimbursed through policies offered by private for-profit and not-for-profit insurance companies (Box 2).

**Box 2** What are the key gaps in coverage?

Two main coverage gaps within the Italian SSN include dental and mental health services. Dental care is provided only to certain segments of the population (e.g. children under 14 years) and excludes orthodontic prostheses. In addition, all psychotherapeutic services to patients whose conditions are not severe are generally unavailable, as are smoking cessation interventions. For several services explicitly covered by the SSN, access can be hampered by long waiting lists or lack of local availability in some rural and mountain areas. In fact, waiting lists vary a great deal across regions and even within regions. Co-payments for outpatient care are substantial (up to €36.15 per prescription, except for exempted categories).

Mental health conditions present a significant challenge for the SSN, with average onset generally falling between 15 and 35 years of age. Concerningly, this age range is getting younger, with a notable surge attributed to the impact of the COVID-19 pandemic. The provision of mental health services is included in the national benefits package (LEA) but services are unevenly distributed, with patchwork implementation across the Italian regions. Consequently, people are increasingly seeking assistance from the private sector due to the limited availability of these services and waiting times.

## Paying providers

There are three main types of payment methods which are often combined to fund SSN organizations and accredited providers (Fig. 4). Per capita funding is used for local health authorities, which, depending on regional policies, can be adjusted according to population age structure and other criteria, such as population density or altitude. A second type of payment method is volume-based. Different fee-for-service, diagnosis-related groups (DRGs) and day rates (for example for health services in nursing homes or rehabilitation units) are used to compensate providers. Finally, SSN organizations and, to a lesser extent, private-accredited providers, receive funds according to several specific budget lines. This funding type is generally used to compensate providers for specific activities that are not well captured by the fee-for-service and DRG mechanisms (such as ambulance services).

**Fig. 4** Provider payment mechanisms in Italy






| GPs | Specialists | Acute hospitals | Hospital outpatient services | Dentists | Pharmacies |
|---|---|---|---|---|---|
| Capitation + fee-for-service | Fee-for-service + budget line | [1]Case payment (DRG) + budget line | Fee-for-service + budget line | Fee-for-service | Margins proportional to the selling price |

[1] IRCC hospitals are paid per-diems and budget lines (for research).

**Note:** DRG: diagnosis-related group.

# What resources are available for the health system?

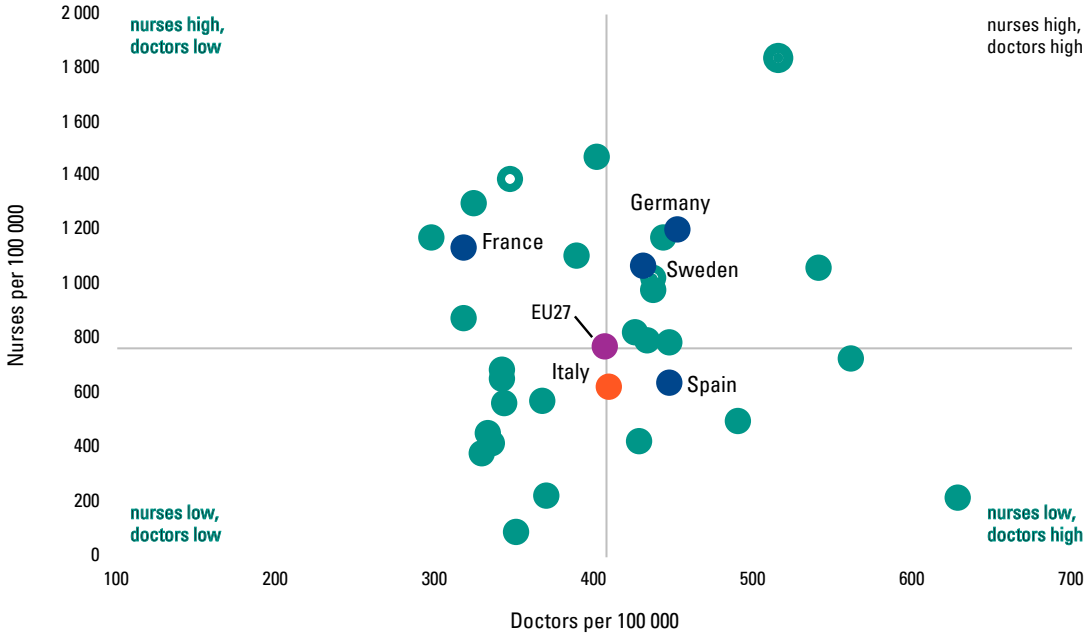
A shortage of physicians in some sectors is anticipated in the near future, in addition to the ongoing acute lack of nurses

## Health professionals

In 2021, the density of physicians in Italy was just above the EU average (410 practising doctors per 100 000 population compared with 407) but the number of doctors practising in public hospitals and within primary care is declining. Currently, around 26% of doctors in Italy are generalists. Italy is facing a significant wave of doctors retiring over the next decade, with an estimated 109 000 physicians expected to leave the workforce. However, between 2018 and 2027, approximately 141 000 spots have been allocated for medicine and surgery degree programmes (Quotidiano Sanità, 2024). While this growth in the number of doctors may seem beneficial, it may also lead to a potential oversupply of doctors, with uneven distribution and a mismatch between types of specialization and needs.

The number of nurses per 100 000 population in Italy is considerably lower than the EU average (621 compared with 770 in 2021) (Fig. 5). In addition to shortages, there are also regional imbalances in the numbers of health care workers across the country. One of the issues behind the shortage of health care professionals is the rigid turnover schemes that have historically been in place as cost-saving measures, especially in SSN facilities, which do not allow new hiring. To address these issues, the central government has increased the number of specialist training contracts and available positions for medical students. Moreover, a portion of the healthcare budget for the years 2024–2026 is earmarked for the renewal of staff contracts and for compensating doctors and healthcare workers involved in efforts to reduce waiting times.

**Fig. 5** Practising nurses and physicians per 100 000 population, 2021 or latest available year



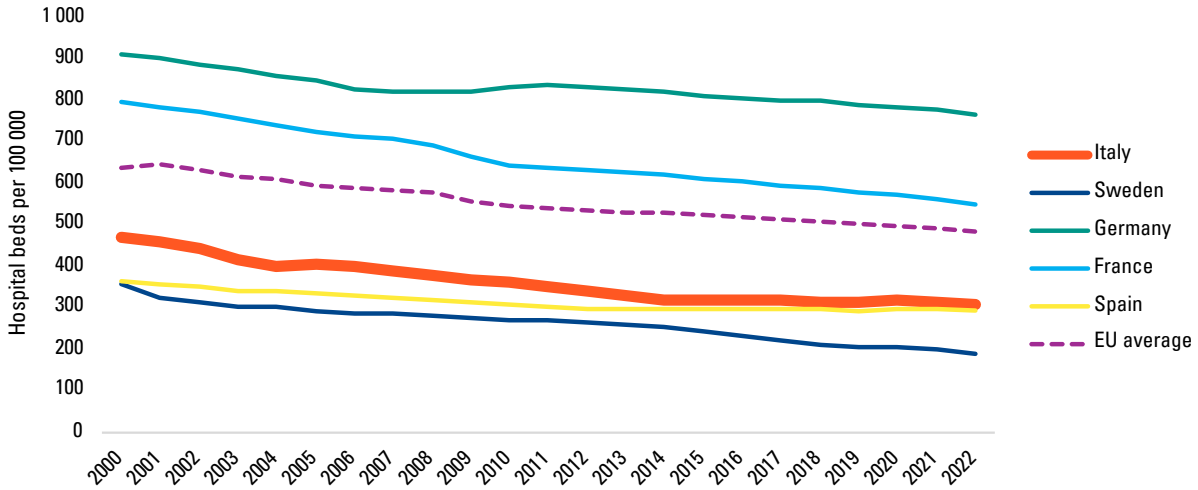

**Note:** Nurse numbers are for practicing nurses (with EU recognized qualification).
**Source:** Eurostat, 2024.

# Health infrastructure

In 2022, Italy's health care infrastructure comprised 996 hospitals, 9085 outpatient centres, 1185 rehabilitation facilities, 8045 residential facilities and 3126 semi-residential establishments. Hospitals and outpatient care facilities are mostly public (51.3% and 86.2%, respectively) whereas establishments that provide residential, semi-residential and rehabilitation assistance are mostly private for-profit and not-for-profit accredited organizations (Ministero della Salute, 2024).

Overall, the number of hospital beds in Italy has decreased over the past two decades, falling from 470 per 100 000 population in 2000 to 309 in 2022, in line with trends in many other EU countries (Fig. 6). Of these, the number of acute care beds has been falling and stood at 257 acute beds per 100 000 population in 2022. There are significant differences in bed numbers across regions. Since 2015, the national government has encouraged regions to rationalize and decrease the number of hospital facilities, and to increase outpatient facilities. The number of magnetic resonance imaging (MRI) units and computerized tomography (CT) scanners units has increased over the past decade, and Italy ranks among the countries with the highest number of units per capita in the EU (Fig. 7).

**Fig. 6** Hospital beds per 100 000 population in Italy and selected countries, 2000–2022




**Source:** Eurostat, 2024.

**Fig. 7** Magnetic resonance imaging (MRI) and computed tomography (CT) scanners in Italy per 100 000 population, 2022

| | MRI scanners per 100 000 population | CT scanners per 100 000 population |
|---|---|---|
| Italy | 3.3 | 4.0 |
| Lowest and highest in EU (range) | 0.56 (Hungary) – 3.73 (Greece) | 1.07 (Hungary)–4.88 (Greece) |

**Source:** Eurostat, 2024.

## Distribution of health resources

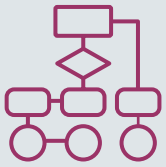
Substantial heterogeneity persists among regions in terms of the availability of health professionals. At the regional level, the northern and central regions of Liguria, Emilia-Romagna, Tuscany, Umbria, Lazio and Abruzzo have above-national averages for both doctors and nurses. Furthermore, the islands of Sicily and Sardinia have a higher-than-average rate only for doctors.

The number of doctors varies from 3.4 doctors per 1000 inhabitants in the autonomous province of Trento[1] to 5.0 in the region of Lazio. In terms of GPs, the northern part of the country is the most disadvantaged geographical area, with 0.60 GPs per 1000 inhabitants in 2022, compared to 0.64 in central and 0.72 in southern regions. For nurses and midwives, higher rates are recorded mostly in northern and central regions, with numbers ranging from 5.9 nurses and midwives per 1000 inhabitants in Calabria to 8.8 in Molise.

Such differences are not as critical for physicians as they are for nurses: Italy is experiencing an acute shortage of nurses. The causes are most likely related to declining investment in health personnel, which has been decreasing since 2010, alongside a reduction in the overall number of health workers, including physicians and nurses, and a deterioration of working conditions, particularly in regions under recovery plans.

There are also large regional differences in the capacity of health care infrastructure. For example, the supply of hospital beds is highest in the north-east of the country, with 10 beds per 1000 residents, while in the south it is just over 3 beds per 1000 residents and covers only 11 % of the total number of beds. Hospital planning has detailed specifications on the number of beds, minimum volumes of care and hospital networks, as well as on human resources and technological standards. Since 2015, hospitals have been arranged in hub and spoke networks, where 43 hubs (hospitals with over 802 beds and large catchment areas) provide the full assortment of services, with part of their patient inflow deriving from 112 spokes (hospitals with 382 to 802 beds), which are secondary settings with fewer specialties. Both hub and spoke hospitals are distributed across the country, with the majority located in northern Italy.

# How are health services delivered?



Although primary care is well established, it is under-resourced, while hospital care has been reorganised, including efforts to promote the integration of care

## Public health

Public health in Italy is well established as part of SSN activities. The Ministry of Health is the main institution responsible for public health at the national level. It undertakes a stewardship role and sets the general policies targeting health improvement and prevention. Public health policies are implemented by the regions through their departments of health and local health authorities, the remits of which include protection of the population's health, health promotion, preventing diseases and/or disability and improving quality of life. Activities include interventions in the fields of prevention of communicable diseases, occupational health, cancer screening and tobacco control (see also Box 7).

1 Italy has 20 regions, one of which (Trentino-Alto-Adige/Südtirol) is made up of two autonomous provinces: Trento and Bolzano.

## Primary and ambulatory care

Primary care is provided by GPs for adults and by paediatricians, generally for children under 6 years of age. Patients are entitled to choose GPs and paediatricians from among the physicians operating in the patient's municipality (covered by the local health authority). Primary care is generally well developed, though under-resourced, and in recent years has experienced a reorganization. It aims to strengthen the role of GPs and paediatricians (who act as gatekeepers to specialist care), promote the integration of care between GPs and other professionals through advanced information technology, and foster the involvement of primary care in preventive activities, including personalizing health interventions based on patients' risk profiles and being more proactive with healthy individuals. Despite this progress, most GPs still work in solo practices (Box 3).

Primary care played a key role in the pandemic response through the establishment of special continuity-of-care units, created to assist COVID-19 patients in home isolation. These units provided telephone and video consultations, and home visits to patients who did not require hospitalization or who had recently been discharged from hospital.

**Box 3** What are the key strengths and weaknesses of primary care?

Strengths: GPs and family paediatricians are the backbone of primary care: 74% of Italians attend their clinics at least once a year, and these are an easy-to-contact entry point to the SSN. Organizationally, there is a progressive, although uneven, switch from the traditional single practice model to group practice. There has also been some progress towards achieving greater horizontal and vertical integration of care involving other health care professionals, which is expected to improve accessibility and patient satisfaction and lower admissions to emergency care.

Weaknesses: Progress towards integrated models of care is still slow and heterogeneous. Resistance to change is common and often justified on the basis of reduced proximity for patients. Most GPs still work in solo practices with limited opportunities to share knowledge with other colleagues and no access to diagnostic technologies. Attempts to incentivize different forms of group practice have only taken hold in a handful of regions. Moreover, because of retirements and limited new hiring, the number of GPs has declined over time and a major shortage is expected in the years to come. Furthermore, GPs' workloads are growing due to population ageing, increased prevalence of chronic conditions and consequent burdens on caregivers, who increasingly seek assistance from GPs for psychological conditions.

## Hospital care

Hospital and outpatient specialist care is provided by SSN organizations (independent hospitals or local health authorities) and private-accredited providers which are mainly for-profit organizations. Patients are free to choose providers and there is a high level of cross-regional mobility, mainly from patients residing in southern regions seeking care in central and northern regions. Legislation in 2015 set out new standards to reorganize hospital care as well as to promote greater integration and continuity of care (Box 4). The reorganization of acute care hospital networks into the hub and spoke model means that the most expensive technologies and most complex care services are centralized into second-level hospitals while the less complex technologies and interventions are reallocated to the hospitals classified as basic-level hospitals. Implementation is not yet homogenous across the country.

**Box 4** Are efforts to improve integration of care working?

Ministerial Decree 70/2015 proposed a reorganization of the acute hospital model, aiming for hospital services to work in synergy with primary care, community medicine and social service. The decree made direct reference to the need to ensure the provision of care that is appropriate, effective, efficient, good quality and safe, while acknowledging that resources may be limited.

Under this new model, hospital activities should focus on conditions with acute onset and/or significant functional impairment, or elective services that are more technologically and organizationally complex. In turn, the hospital network has been integrated with local outpatient facilities following guidelines for the integrated management of clinical or critical pathways and supported patient discharge protocols. Organizational guidelines and recommendations have been defined for oncological care, other time-dependent conditions and integrated inpatient acute and outpatient post-acute care.

More recently, Decree 77/2022 introduced new models and standards to enhance primary care, in line with the objectives of the National Recovery and Resilience Plan (NRRP), aimed at restructuring care beyond hospital settings. Specifically, it establishes organizational models, standards, and key initiatives focusing on community proximity networks, structures, and telemedicine for primary healthcare. The overarching goal is to mitigate territorial fragmentation by integrating telemedicine services.

## Pharmaceutical care

Pharmaceutical services are mainly provided through local pharmacies. A considerable share of medicines (mainly those used in hospitals or prescribed to patients admitted to hospital for day surgery) is also distributed through hospital pharmacies and/or the pharmaceutical service of local health authorities. Since 2010 pharmacies have been authorized to provide additional services, including tests (such as blood glucose, cholesterol and triglycerides tests) and services (such as non-invasive measurement of blood pressure and testing lung capacity). Nurses and physiotherapists can also provide some regulated services in pharmacies, such as nurses administering intramuscular injection cycles. In reality, the implementation of these extra activities is still sporadic, due to the reluctance of other health care professionals and facilities to delegate part of their activities to pharmacies and to the limited regional resources available to remunerate pharmacies. In 2021 pharmacies were allowed to vaccinate individuals against COVID-19 and receive extra remuneration for distribution of medicines on behalf of the SSN.

## Mental health care

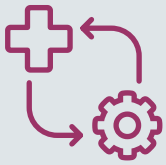
In 1978, Italy was the first country in Europe to close the approximately 100 mental hospitals that were active at that time and abolish compulsory treatments on psychiatric patients. Italy's hospitalization rate for psychiatric conditions decreased steadily from 2001 to 2018, in line with the trend for all hospitalizations, with the objective of shifting the management of mental health conditions mostly to community care. In 2020, mental health services in hospitals experienced a significant decline, with admissions dropping by about 20.8% compared to 2019. However, this decrease does not reflect a reduction in cases needing treatment but rather stems from a shift in resources towards managing the COVID-19 pandemic, impacting other health services, including mental health (ONSRI, 2022).

Services for individuals with addiction (*Servizi per Dipendenze*, SERD, and Servizi per le Tossicodipendenze, SERT) are multidisciplinary outpatient services dedicated to the treatment, prevention and rehabilitation of people abusing narcotic substances (drugs or alcohol) or affected by other types of addictions (such as gambling, compulsive shopping, social media or food). SERT and SERD are multi-professional organizational units within local health authorities led by a clinician, often a psychiatrist.

## Dental care

Dental care is almost exclusively provided by private clinics, with most dental treatments purchased privately, either out of pocket or through private insurance. The SSN only covers costs for children aged 0–14 years, and clinically or socially vulnerable people. The services in the national benefits package include the treatment of caries and monitoring of malocclusions as well as treatment of severe orthodontic pathologies. Although citizens are eligible for urgent interventions (for example, for acute pain), use of SSN dental services by the population is limited due to a mix of factors, including poor reputation, lack of supply, long waiting times and consolidated use of private services (Ministero della Salute, 2017).

# What reforms are being pursued?



Recent health reforms have focused on prevention, hospital care and redefining the national benefits package, while major investments are planned to strengthen the resilience of the Italian SSN after COVID-19

Over the past 15 years, although the SSN's essential structure has not undergone significant changes (Box 5), most regional health systems have consolidated their governance, planning and delivery systems. At national level, a new preventive services plan has expanded vaccination coverage and target populations, increased the number of vaccines offered within the benefits package and established an online vaccination registry. Patient safety measures have also been enhanced. For hospital care, the Ministry of Health has set specific standards for both SSN facilities and private accredited hospitals and their activities, and introduced hospital networks. However, the degree of implementation varies among regions. In terms of redefining the benefits package, a thorough revision and update were actioned in 2017, with some new services and health devices added.

Special attention has also been given to financial probity, with the introduction of recovery plans for regions that exceed their health budget and/or do not deliver the guaranteed core services of the national benefits package. Regions undergoing financial recovery plans fall into a region-specific cost-reduction regime, which applies to all SSN organizations and private accredited providers. In 2024, seven regions (Abruzzo, Calabria, Campania, Lazio, Molise, Puglia and Sicily) were running under such recovery plans, and two of them (Calabria and Molise) were also in receivership and run by a nationally appointed health commissioner, a measure implemented when a region consistently fails in both economic–financial terms and in the provision of essential services.

The COVID-19 pandemic exposed several issues requiring attention, such as the need for further investment in the digitalization of the SSN, as well as addressing sustainability and health system resilience. Italy's EU-funded National Recovery and Resilience Plan provides €15.6 billion for the health component over the period 2021–2026, and aims at strengthening primary and community care by investing in infrastructure facilities, improving SSN digital infrastructure, as well as upgrading medical equipment and investing in training. Moreover, in December 2021, the government introduced the so-called psychologist bonus, a contribution aimed at supporting individuals dealing with anxiety, stress, depression and psychological fragility due to the COVID-19 pandemic and socio-economic crisis. The 2023 Budget Law made it a permanent part of the benefits package, with

allocations of €5 million for 2023 and €8 million from 2024 onwards to sustain support for psychotherapy sessions.

In terms of governance developments, in June 2024, the Italian Parliament passed the differentiated autonomy law for regions, to effectively implement and broaden the autonomy of the regions. This extension covers various policy domains, including those areas that significantly influence the delivery of healthcare throughout the country.

**Box 5** Key health system reforms over the past 20 years

- **Financial recovery plans for underperforming regional health systems (2005)**: addresses overspending and guaranteeing the national benefits package.
- **Ministerial decree 70/2015 (2015)**: sets standards for planning of hospital care and setting up hospital networks.
- **Law 24/2017 Gelli Law (2017)**: sets out patient safety measures.
- **National Vaccination Plan (2017–2019)**: expands vaccination coverage.
- **Ministerial decree 77/2022 (2022)**: strengthens primary and community care services, intermediate care, digitalization, research and innovation.
- **Psychological bonus (2023)**: entrenches financial support for psychological sessions for eligible individuals suffering from mental health issues associated with the COVID-19 pandemic and socio-economic crisis.
- **Differentiated autonomy law (2024)**: broadens the autonomy of regions in several policy domains, including in the delivery of healthcare.

# How is the health system performing?

Italy's health system provides high-quality care at a relatively low cost, although sizeable disparities exist in access to care across regions

## Health system performance monitoring and information systems

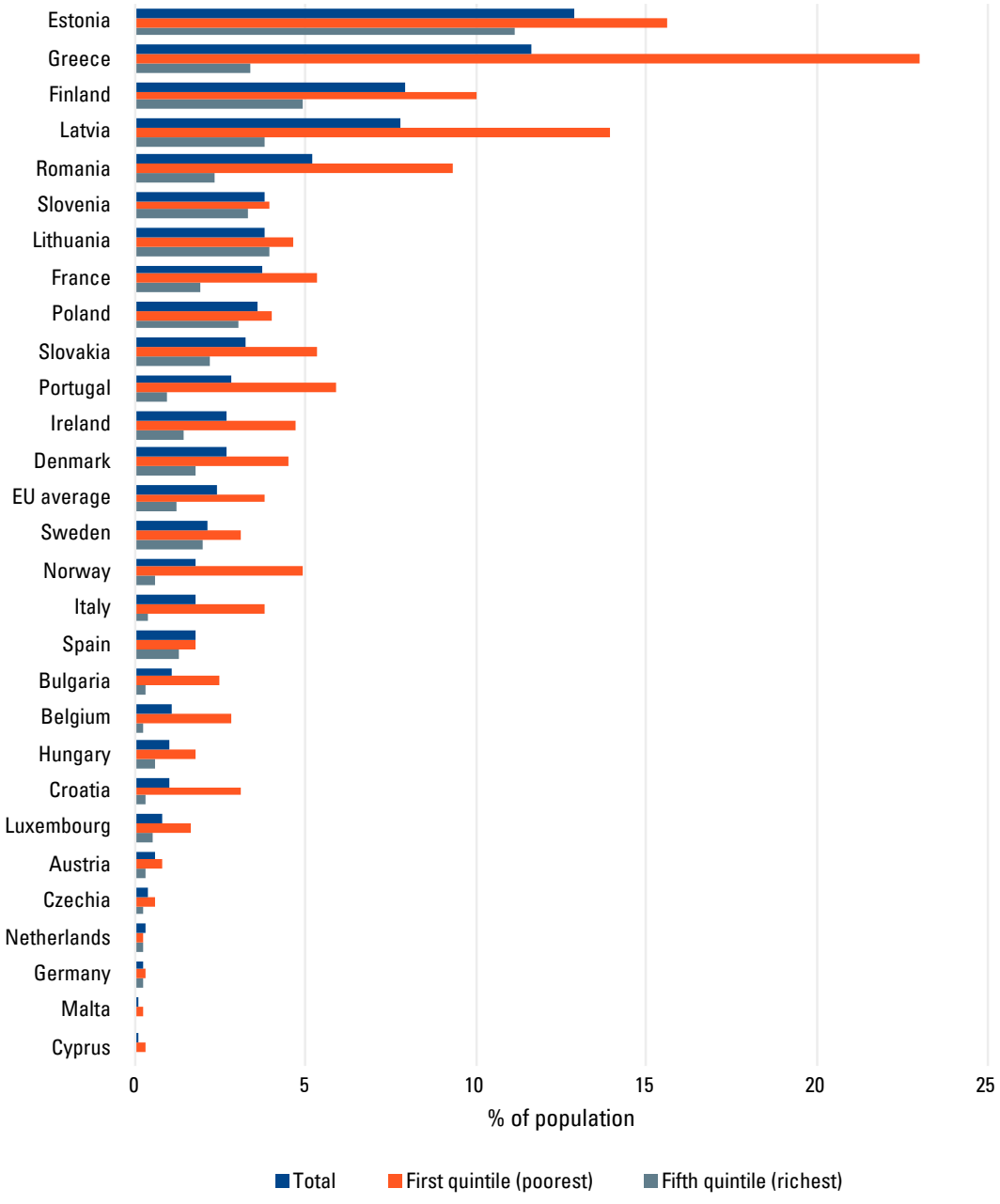
The national policy agenda has become increasingly aware of the importance of performance monitoring and accountability, implementing several initiatives in these areas, including improving existing information systems and making data available to the public. Health system performance measurement strongly relies on both the National Outcomes Programme and the New Guarantee System, which is complemented by quarterly monitoring and evaluation of the adequate delivery of the national benefits package.

For the past decade, Italy has been working on the implementation of electronic medical records (*Cartella Clinica Elettronica*), which are equivalent to inpatient or outpatient medical records, and electronic health files (*Fascicolo Sanitario Elettronico*), which include all clinical records, preventive diagnostic assessments and all elements of a patient's health history. Implementation, however, remains fragmented for both, despite all regions being actively engaged in their development. E-prescriptions have now been widely adopted for pharmaceuticals but are less often used for referrals for outpatient visits.

# Accessibility and financial protection

Accessibility of services is generally high, and although the total level of unmet needs is less than the EU average, those from the poorest households report significantly higher unmet needs than those from the richest income group (Fig. 8). Moreover, citizens from poorer regions in the south of Italy are more likely to report unmet medical care needs than those living in wealthier regions in the north, due to financial reasons, waiting times or travel distances. Primary and inpatient care are totally free at the point of use for everyone. Although there are several exemption categories (such as by age or income level) for services that do incur cost-sharing, there is no overall annual cap on co-payment spending or other major financial protection mechanisms. The health system cannot always protect citizens from financial hardship. Excessive waiting times are one of the reasons citizens use their savings or incur debts to cover private health care expenses.

**Fig. 8** Unmet needs for a medical examination (due to cost, waiting time or travel distance), by income quintile, EU/EEA countries, 2023




**Source:** Eurostat, 2024.

# Health care quality

Key indicators of the quality of primary care, such as avoidable hospital admissions for ambulatory-sensitive chronic conditions, including chronic obstructive pulmonary disease (COPD) and asthma, congestive heart failure and diabetes show good results for Italy (Fig. 9). These are defined as admissions for medical problems that are potentially avoidable if effectively managed in outpatient settings. The country also performs well in terms of the effectiveness of secondary care, with 30-day mortality after admission from acute myocardial infarction among the lowest in Europe (OECD, 2024).

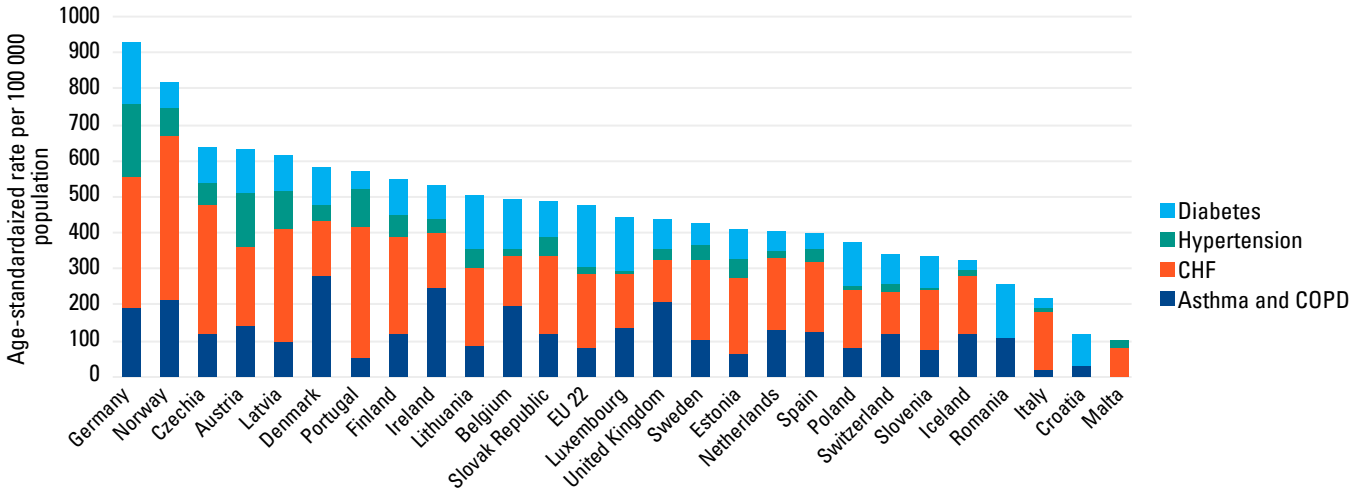
Recent surveys highlight variable results on how satisfied people are with health care services; while many Italians are generally satisfied with the quality of healthcare, there are significant regional differences, with higher satisfaction in northern areas compared to the south and the islands (Box 6).

**Box 6** What do patients think of the care they receive?

A survey conducted in 2023 by the Piepoli Institute for FNOMCeO (the National Federation of the Orders of Surgeons and Dentists) reveals that over three quarters of Italians believe healthcare should be publicly provided. For 90% of citizens, healthcare should be a government priority in the Financial Bill, and for 37% it should be the top priority. According to the survey, more than half of Italians (54%) tend to report being satisfied with their regional health service, but with large territorial disparities. Satisfaction rates peak at 69% in the northern parts of the country, but drop to 41% in the south and on the islands. A greater proportion of citizens feel the need to seek better care in regions outside of where they live, with peaks of 79% in the south and the islands. While 67% are satisfied with the quality of health care, many believe that services are managed in line with budgetary needs than rather than health needs. Among the actions to be taken to improve care, 55% of those who are dissatisfied suggest increasing healthcare personnel, 42% advocate for more funding, and 38% suggest improving organisational structures (FNOMCeO, 2023).

A 2023 Harvard survey of 1000 adults in Italy used a new instrument, called The People's Voice Survey, that measures health system performance from the population's perspective. This survey found that 34% of respondents rated the quality offered by private health systems as excellent, compared with 21% for public healthcare. In general, for primary and secondary care, Italians are more satisfied with the quality of care received from private than from public providers. Furthermore, 64% of respondents are confident that they will receive and be able to afford good quality of care if they are ill (Harvard T. H. Chan School of Public Health, 2023).

**Fig. 9** Avoidable hospital admission rates for asthma and chronic obstructive pulmonary disease, congestive heart failure and diabetes, 2021




**Notes:** CHF: congestive heart failure; COPD: chronic obstructive pulmonary disease. Croatia and Romania: no data for CHF or hypertension; Malta: no data for Asthma & COPD or diabetes.

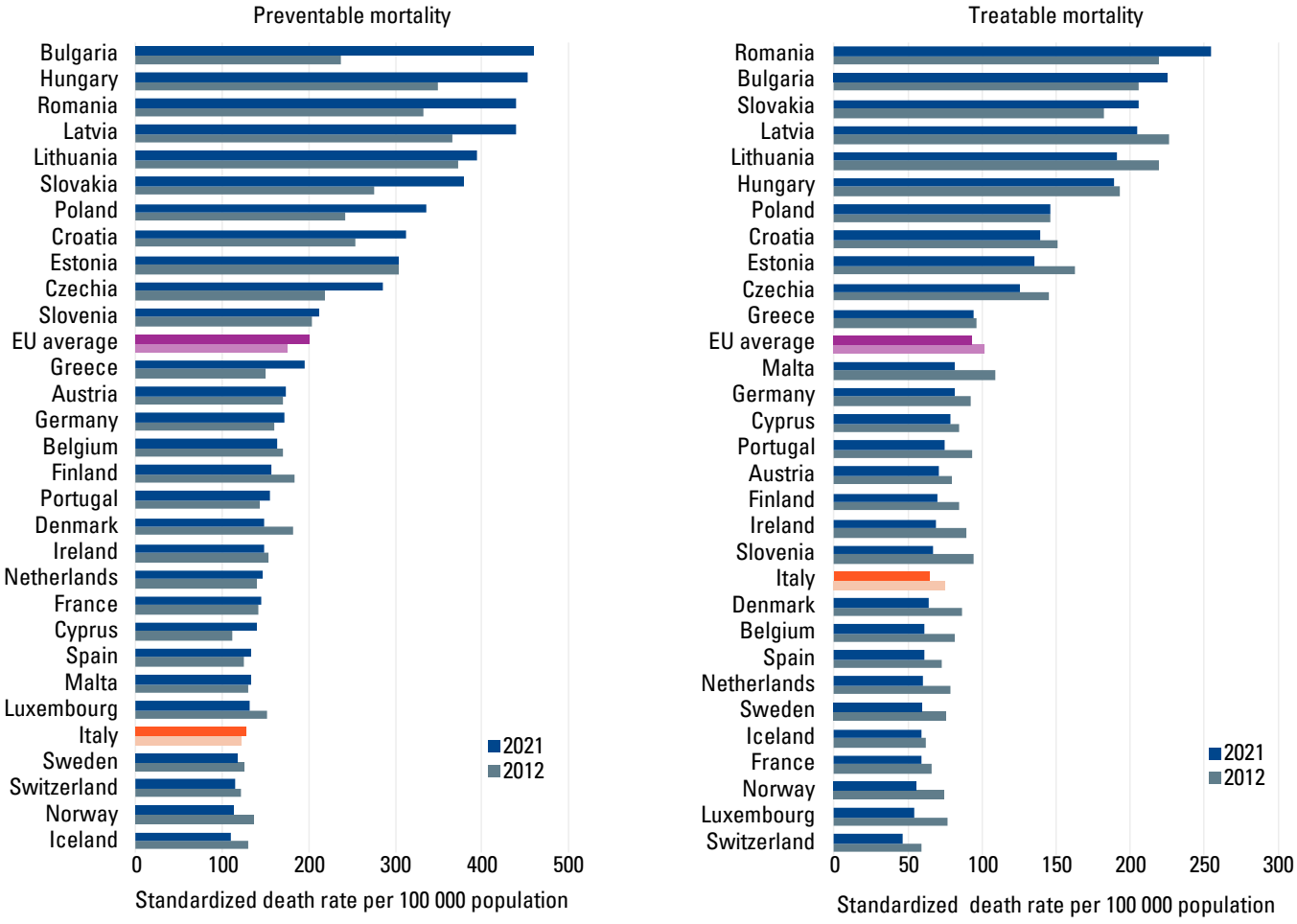
**Source:** OECD, 2024

# Health system outcomes

Mortality from treatable causes refers to deaths in people under 75 years old which should not occur if people have access to timely and effective health care interventions and treatment. The treatable mortality rate in Italy has reduced by 14% since 2012, and in 2021 was 64.4 per 100 000 population, well below the EU27 average of 93.2 (Fig. 11).

Preventable mortality is broader and includes deaths in those under 75 which could have been avoided through public health interventions focusing on the wider determinants of public health, such as behaviour and lifestyle factors, socioeconomic status and environmental factors. The preventable mortality rate had been declining steadily in Italy since 2012, falling to 101 deaths per 100 000 population in 2019. As in most other European countries, the rate increased in 2021 due to the fact that COVID-19 deaths are classified as preventable deaths (since COVID-19 vaccines became available from the end of 2020). Nevertheless, in Italy the rate of deaths from preventable causes remained significantly below the EU average in 2021 (128 compared to 201 per 100 000 population) and ranks among the best performing Member States (Fig. 11). Several national screening plans have been put in place over the past decade to promote screening for common types of cancer such as breast, cervical and colorectal cancers, contributing to these results. In addition, strong public health measures, such as tobacco and alcohol control policies, may partly explain Italy's low rate of preventable deaths (Box 7).

**Fig. 10** Mortality from preventable and treatable causes 2012 and 2021




**Note:** After 2020, deaths due to COVID-19 are counted as preventable deaths, resulting in an increase in mortality from preventable causes for most countries.

**Source:** Eurostat, 2024.

**Box 7** Are public health interventions making a difference?

The smoking rate in Italy has declined incrementally from nearly one quarter of adults in 2000 to just under one fifth (19%) in 2021. A nationwide indoor smoking ban in public places and workplaces was implemented in 2005 (Mele & Compagni, 2010), and increases in cigarette prices were subsequently enforced, although they remain low compared with other European countries. In 2013, stricter rules on tobacco access among young people were also introduced: the minimum purchase age was raised to 18 years; higher fines were imposed on tobacco retailers who sold cigarettes to minors; automatic age-detection systems were installed in tobacco vending machines; a smoking ban was extended to the outdoor premises of schools; and a ban on the sale of electronic cigarettes to minors was implemented. In addition, in 2016, a new law regulated the combination of images and warnings on cigarette packs and introduced a smoking ban in cars (in the presence of pregnant women and minors) and on the outdoor premises of hospitals.

Per capita alcohol consumption among those 15 years and older decreased from 12.4 litres to 7.7 litres between 1990 and 2019. Alcohol control policies introduced during this period included setting a minimum legal age of 18 to buy alcohol; establishing legal blood alcohol concentrations for drink–driving; launching legal regulations on alcohol sponsorship and sales promotion; and creating a national alcohol and health plan starting in 2007.

## Health system efficiency

Given its level of health expenditure, which is significantly below the EU average, the Italian SSN has shown that it is generally efficient and capable of delivering access to high-quality treatment at a reasonably low cost, albeit with major variability among regions. Italy appears to be achieving good health outcomes in terms of treatable mortality, given its moderate level of health expenditure (Fig. 11).

In terms of technical efficiency, some instructive indicators show that the use of day hospitalizations, including day surgery for specific scheduled procedures, has been promoted over the past few decades and has seen sharp increases. The average length of stay in hospitals in Italy in 2022 (7.24 days) increased slightly from the level in 2013 (6.75 days). This increase may be due to more patients requiring low-intensity care being treated through ambulatory care; with the result that the remaining inpatient cases are likely to require more complex care and longer stays. Moreover, despite significant improvements in the emergency care system over the past 20 years, there has been a progressive increase in emergency admissions, many of which are due to inappropriate use by patients seeking treatment for minor illnesses or conditions that could be treated within primary care, thereby contributing to driving up costs and increasing inefficiencies, such as longer waiting times.

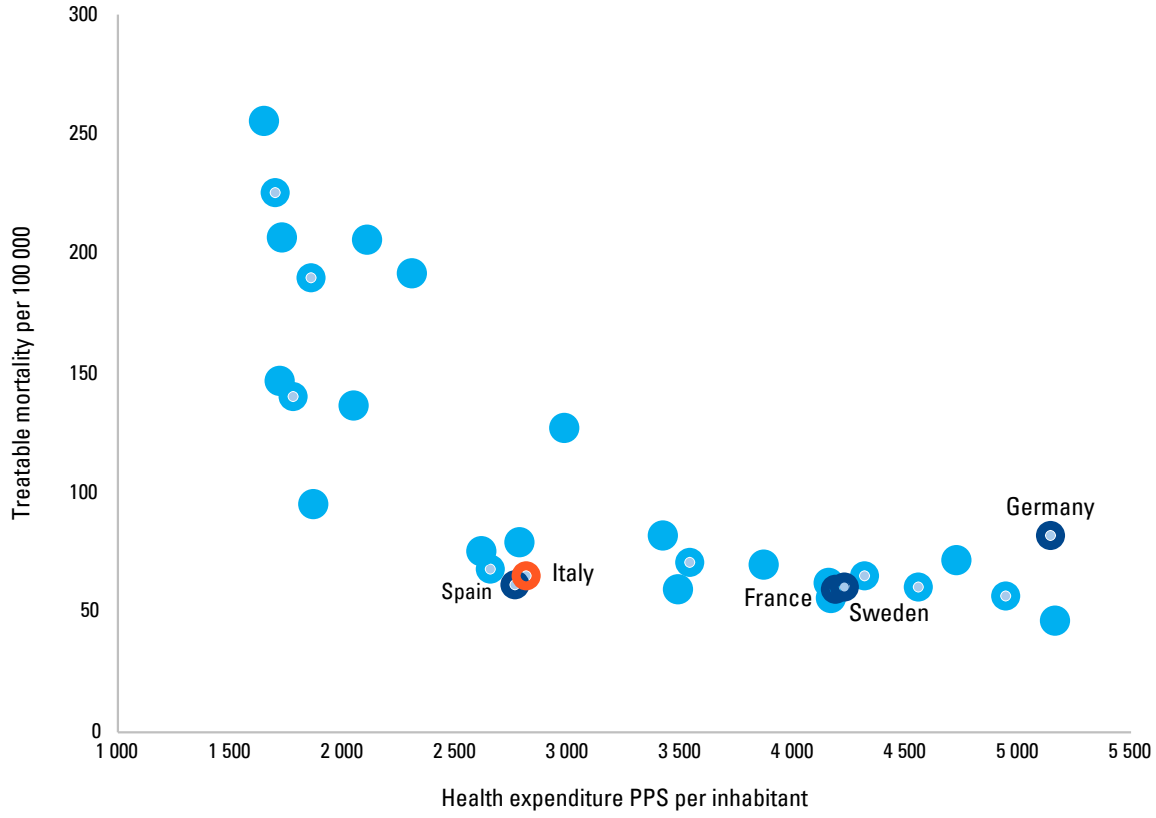
Since 2010, major initiatives have been launched to improve government purchasing, operational efficiency and appropriateness of care in hospital. Ministerial Decree 70/2015 set new standards that require minimum capacity volumes of care for hospitals, forcing regions to close some small hospitals and implement mergers. Additionally, in order to monitor the dynamics of pharmaceutical expenditure and GP prescriptions, a comprehensive information system called *Sistema*

**Box 8** Is there waste in pharmaceutical spending?

Despite a significant increase in consumption (from 12% in 2010 to 27% in volume in 2021), the use of generic medicines in Italy is still lower than other EU countries, such as Belgium (36%), Portugal (50%) and Slovakia (64%) (OECD, 2024), especially in southern regions. There are a number of possible reasons. Firstly, although the pharmacist is required to offer the customer any available cheaper generic, doctors can still specify the prescribed medicine as non-substitutable. Secondly, customers can still decide to purchase the branded medicine, paying out of pocket for the price difference between the generic and the prescribed medicine. Despite TV information campaigns (e.g. Health For All 2012), many patients do not fully understand how the system works or prefer to rely on branded drugs which are well known in the market. Thirdly, pharmacy staff often do not help patients to choose between branded and generics as they have no financial incentives to do so (European Commission, 2019).

*Tessera Sanitaria* has been implemented, which keeps track of e-prescriptions and other health data at the patient level (see also Box 8).

**Fig. 11** Treatable mortality per 100 000 population versus health expenditure per capita, Italy and selected countries, 2021




**Note:** PPS: purchasing power standard.

**Source:** Eurostat, 2024.

# Summing up

Italy's health system faces challenges such as shortages in the health workforce, infrastructure that requires modernization and the need to strengthen primary and community care. Addressing the persistent inequalities across regions also remains a concern

Italy's regionalized SSN offers universal coverage, with most services provided free of charge at the point of delivery, although some services and goods require co-payments. Overall, the health system delivers high-quality, effective care at a relatively low cost. However, significant regional disparities exist in health indicators, per capita spending, the distribution of healthcare professionals, and the quality of services.

The COVID-19 pandemic exposed several pre-existing issues that need to be addressed to improve the sustainability and resilience of the health system. Key challenges include tackling long-standing underinvestment in the health workforce, modernizing outdated infrastructure and equipment, and enhancing information infrastructure. Italy's National Recovery and Resilience Plan outlines specific health sector priorities aimed at reinforcing the SSN, including strengthening primary and community care, increasing capital investment and funding the digitalization of the healthcare system. Other critical tasks involve addressing inequalities in health outcomes and significant disparities in access to care across regions, as well as improving the governance framework to enhance coordination between central and regional authorities.

## Population health context

### Key mortality and health indicators

| Life expectancy (years) | 2023 |
|---|---|
| Life expectancy at birth, total | 83.8 |
| Life expectancy at birth, male | 81.7 |
| Life expectancy at birth, female | 85.8 |
| **Mortality** | **2021** |
| All causes (SDR per 100 000 population) | 899.26 |
| Circulatory diseases (SDR per 100 000 population) | 266.89 |
| Malignant neoplasms (SDR per 100 000 population) | 221.53 |
| Communicable diseases (SDR per 100 000 population) | 18.43 |
| External causes (SDR per 100 000 population) | 34.32 |
| Infant mortality rate (per 1 000 live births) | 2.7 |
| Maternal mortality per 100 000 live births (modelled estimates) | 4.6 |

**Notes:** Maternal mortality data is for 2020.
**Sources:** Eurostat, 2024; WHO Regional Office for Europe, 2024.

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