State of Health in the EU

ITALY

Country Health Profile 2025

European Commission

OECD
BETTER POLICIES FOR BETTER LIVES

European Observatory on Health Systems and Policies
a partnership hosted by WHO

The Country Health Profiles series

The *State of Health in the EU*'s Country Health Profiles provide a concise and policy-relevant overview of health and health systems in the EU/European Economic Area. They emphasise the particular characteristics and challenges in each country against a backdrop of cross-country comparisons. The aim is to support policy makers and influencers with a means for mutual learning and knowledge transfer. The 2025 edition of the Country Health Profiles includes a special section dedicated to pharmaceutical policy.

The profiles are the joint work of the OECD and the European Observatory on Health Systems and Policies, in co-operation with the European Commission. The team is grateful for the valuable comments and suggestions provided by the Observatory's Health Systems and Policy Monitor network, the OECD Health Committee and the EU Expert Group on Health Systems Performance Assessment (HSPA).

Contents

Data and information sources

The data and information in the Country Health Profiles are based mainly on national official statistics provided to Eurostat and the OECD, which were validated to ensure the highest standards of data comparability. The sources and methods underlying these data are available in the Eurostat Database and the OECD health database. Some additional data also come from the Institute for Health Metrics and Evaluation (IHME), the European Centre for Disease Prevention and Control (ECDC), the Health Behaviour in School-Aged Children (HBSC) surveys, the Survey of Health, Ageing and Retirement in Europe (SHARE), the European Cancer Information System and the World Health Organization (WHO), as well as other national sources.

The calculated EU averages are weighted averages of the 27 Member States unless otherwise noted. These EU averages do not include Iceland and Norway.

This profile was finalised in September 2025, based on data that was accessible as of the first half of September 2025.

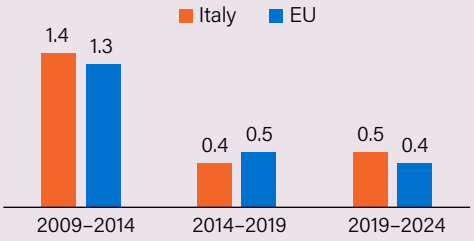
Demographic and socioeconomic context in ITALY, 2024

Demographic factors	Italy	EU
Population size	58 971 230	449 306 184
Share of population over age 65	24 %	22 %
Fertility rate 2023[1]	1.2	1.4
Socioeconomic factors		
GDP per capita (EUR PPP)[2]	38 863	39 675
At risk of poverty or social exclusion rate[3]	23.1 %	20.9 %

1. Mean number of children born per woman aged 10-54.
2. Purchasing power parity (PPP) is defined as the rate of currency conversion that equalises the purchasing power of different currencies by eliminating the differences in price levels between countries.
3. At risk of poverty or social exclusion (AROPE) is the percentage of people who are either at risk of poverty, severely materially and socially deprived, or living in a household with very low work intensity.

Source: Eurostat Database.

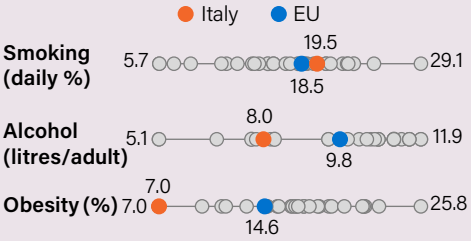
1 Highlights



Changes in life expectancy at birth

Health Status

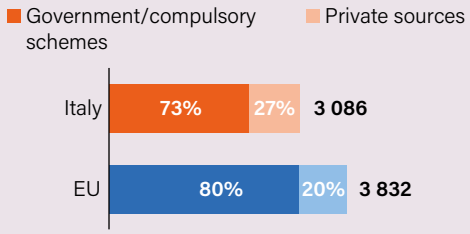
In 2024, Italy's life expectancy rose to a record 84.1 years, the highest in the EU alongside Sweden, exceeding its pre-pandemic level by six months. Cardiovascular disease and cancer account for over half of all deaths, while preventable deaths are concentrated in lung cancer, COVID-19 and ischaemic heart disease. Despite a rapidly ageing population, older Italians generally have better health outcomes than the EU average, though challenges remain, including widespread undiagnosed or untreated hypertension and rising smoking rates



Adults, 2022 (or nearest year)

Risk Factors

While adult smoking has plateaued just below 20 %, a concerning 27 % of 15-year-olds report smoking in the past month, the third-highest rate in the EU. Alcohol consumption is modest overall, though heavy episodic drinking affects 10 % of adults and one in six young Italians. Adult obesity remains low, but high child overweight rates and low adolescent physical activity signal future upward pressure on weight-related health issues.



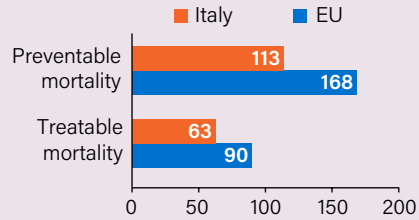
Health spending per capita (EUR PPP), 2023

The Health System

In 2023, Italy's health spending was 8.4 % of GDP, with public sources covering 73 % - both below EU averages. Outpatient care and pharmaceuticals accounted for over half of total spending, while long-term care made up just 10 %, reflecting heavy reliance on family-based care. While physician density ranks among the highest in the EU, the health system faces nursing shortages due to limited training and uncompetitive pay. Amid structural disincentives and an ageing workforce, general practice is contracting, with northern regions experiencing the most acute capacity gaps.

Health System Performance

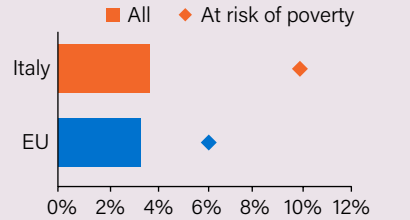
Effectiveness



Age-standardised rate per 100 000 population, 2022

Italy excels at preventing avoidable deaths and has the EU's lowest hospital admission rates for chronic conditions. However, its prevention performance is mixed: while infant measles vaccination rates are high, gaps remain in adult immunity and HPV vaccination coverage. Moreover, cancer screening participation has yet to recover from pandemic disruptions and suffers from significant regional disparities.

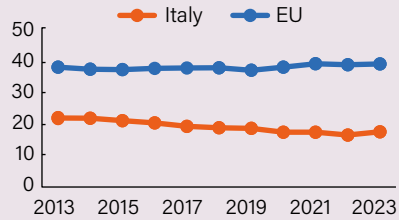
Accessibility



% reporting unmet medical care needs, 2024

Long waiting lists are the main barrier in Italy's healthcare system, causing over 7 % of the population to forgo needed medical care in 2023. Compounded by relatively low public coverage for outpatient and dental services, patients often pay out-of-pocket for faster access to private providers. This creates stark inequality: adults at risk of poverty were over 2.5 times more likely to report unmet needs for medical care than the general population in 2024.

Resilience



Nursing graduates per 100 000 population

Italy has successfully expanded its medical training pipeline, achieving graduate outputs 9 % above the EU average in 2023. In contrast, the nursing pipeline has deteriorated sharply: annual graduate numbers have dropped to less than half the EU average since 2020, and the applicant-to-place ratio has fallen to near parity, effectively eliminating competitive selection.

Spotlight: pharmaceuticals

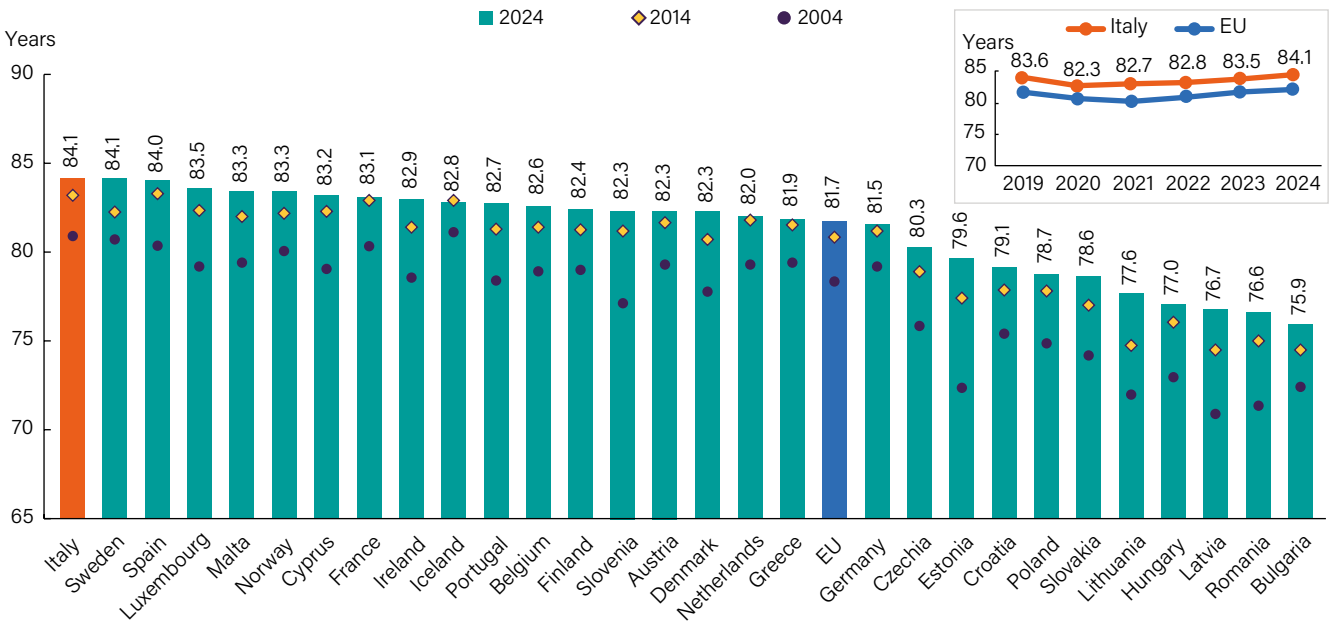
Italy's pharmaceutical system is dominated by hospital procurement, which accounts for about three-quarters of total expenditure - nearly double the EU average of 41 %. While this centralised model enables effective price negotiations and strong biosimilar uptake, it generates persistent budgetary overruns which in 2024 exceeded EUR 4 billion. The retail sector presents relatively low generic medicines' penetration and high reliance on out-of-pocket spending, which in 2023 represented 6.5 % of total health expenditure compared to 3.9 % across the EU. Nevertheless, Italy maintains rapid access to innovative medicines and demonstrates pharmaceutical innovation capacity despite relatively modest R&D investment.

2 Health in Italy

Italy boasts the highest life expectancy at birth in the EU

In 2024, life expectancy at birth in Italy reached 84.1 years, the highest level in the European Union alongside Sweden. This represents a 0.6-year increase from the previous year, setting a new record and placing Italy nearly two and a half years above the EU average. The latest figure also marks a full recovery from the impact of the COVID-19 pandemic, with life expectancy now exceeding its 2019 pre-pandemic level by six months (Figure 1). Consistent with wider EU trends, the gender gap in life expectancy in Italy continues to narrow. In 2024, women lived on average 4.0 years longer than men, significantly below the EU average gender gap of 5.2 years. Both Italian men and women maintain a clear longevity advantage compared to their EU peers: men can expect to live almost three years longer, while women live 1.6 years longer than the respective EU averages.

Figure 1. Italy's life expectancy at birth surpassed its pre-COVID level in 2024



Notes: The EU average is weighted. 2024 data for Ireland pertains to 2023.
Source: Eurostat (demo_mlexpec).

Mortality patterns reflect the sustained epidemiological impact of SARS-CoV-2

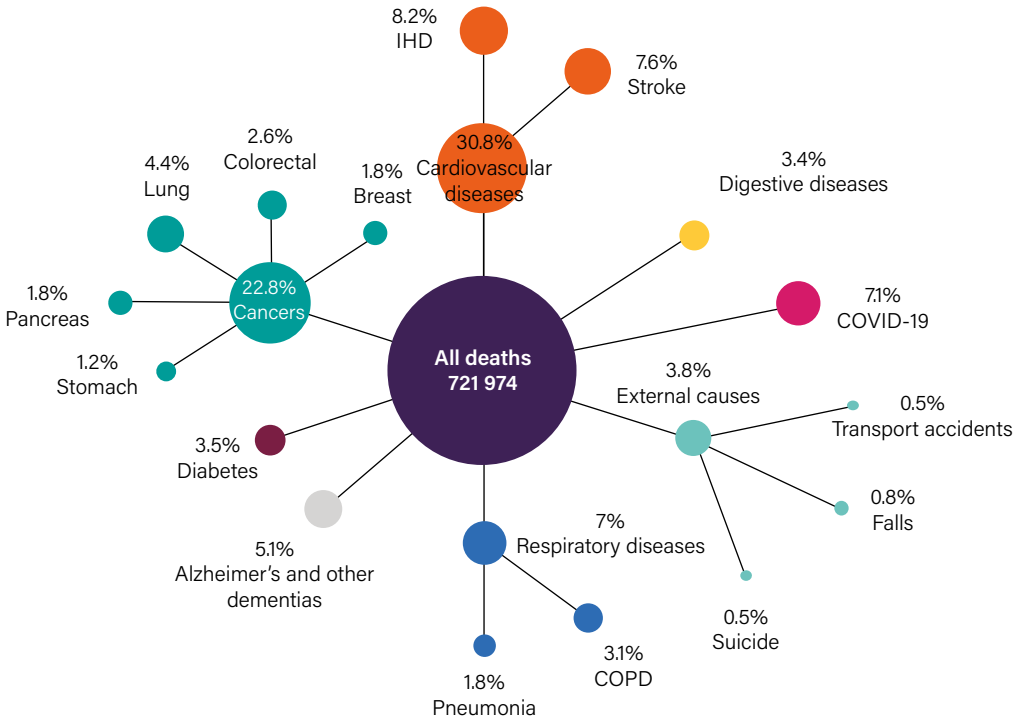
Between 2004 and 2024, life expectancy at birth in Italy increased by 3.2 years, just two and a half months less than the EU average, despite Italy's already high baseline. This steady improvement was mainly driven by significant declines in cardiovascular mortality, supported by substantial advancements in cancer prevention, early diagnosis and treatment. In 2022, Italy recorded around 722 000 deaths, accounting for 14 % of all deaths in the EU while representing 13.2 % of the EU population. This slight overrepresentation reflects Italy's older age structure, as it has the highest share of people aged 65 and over in the EU (24 %, compared to the EU average of 21 %). Cardiovascular diseases (31 %) and cancer (23 %) remained the two leading causes of death, together accounting for more than half of all fatalities; COVID-19 was the third leading cause at approximately 7 % (Figure 2). Although this share was more than 30 % lower than the pandemic peak in 2020, it illustrates the continued epidemiological impact of SARS-CoV-2 during the endemic transition period. This persistence occurred despite extensive vaccination uptake, with over 90 % of Italians aged 60 and above having received a booster dose by January 2023.

Although Italy is ageing more rapidly than the EU average, older adults report comparatively good health outcomes

Italy's population is aging rapidly, with its median age rising by four years to 48.7 over the past decade, a rate significantly above the EU average increase of 2.2 years. Projections indicate the proportion of Italians aged 65 and over will rise from 24 % in 2024 to approximately 34 % by 2050, the highest share among EU countries.

Recent health indicators for older adults show mixed outcomes but generally positive longevity figures compared to the EU average. In 2022, Italian women aged 65 could expect to live an additional 21.9 years, with approximately 10 years (45 %) spent in good health. Men aged 65 could anticipate 19 additional years, with a slightly longer duration of 10.4 years (55 %) spent in good health. While women's overall

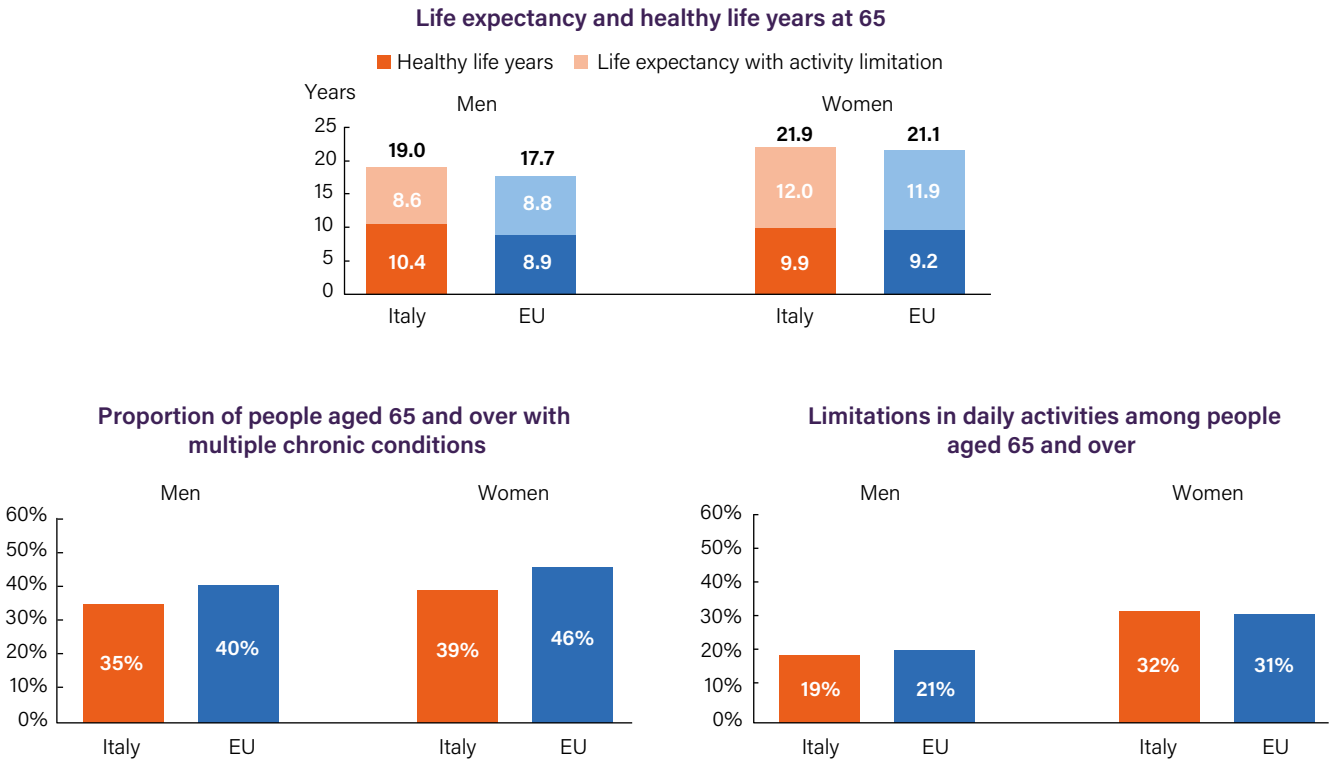
Figure 2. Cardiovascular diseases and cancer accounted for over half of all deaths in Italy in 2022



Notes: IHD = ischaemic heart diseases; COPD = chronic obstructive pulmonary disease.
Source: Eurostat (hlth_cd_aro); Data refer to 2022.

life expectancy at age 65 exceeded men's by 2.9 years, men maintained a six-month advantage in healthy life expectancy. This disparity suggests that women's additional years are frequently accompanied by greater health limitations (Figure 3). This pattern extends to chronic disease prevalence: in 2021/2022, 39 % of women and 35 % of men aged 65 and over reported multiple chronic conditions - rates below the respective EU averages of 46 % and 40 %.

Figure 3. Italy's older population enjoys longer life expectancy and relatively better health status than most other EU countries



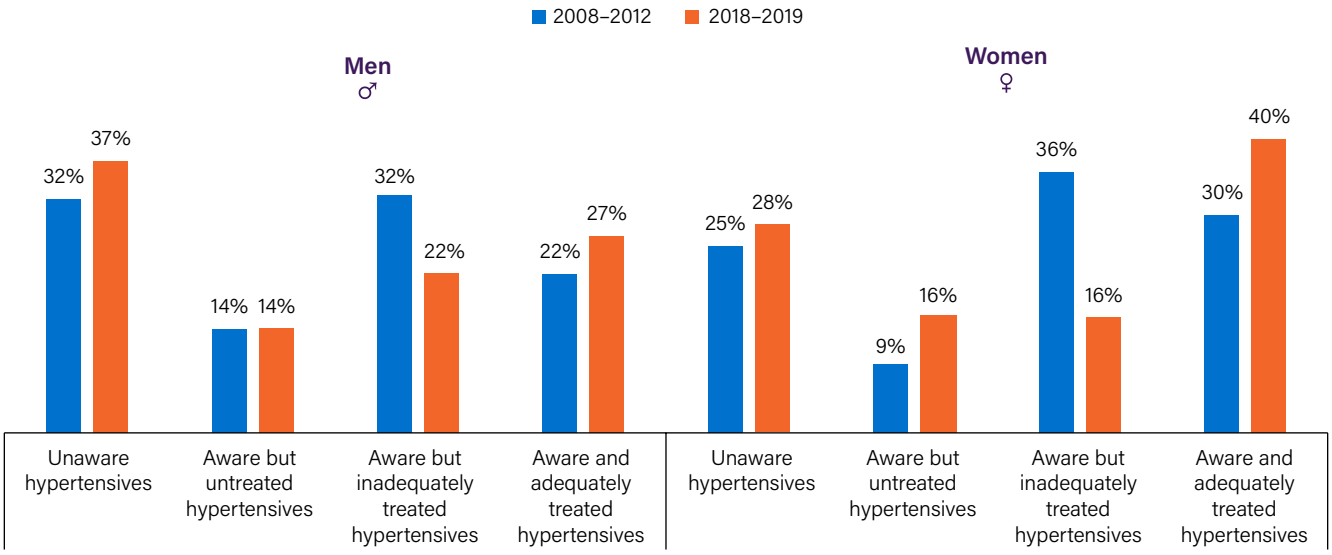
Notes: The EU average is unweighted and based on 26 EU countries (Ireland does not participate in the SHARE survey).
Source: Eurostat for healthy life years (demo_mlexpec) and SHARE survey (for chronic diseases and limitations in daily activities). Data refer to 2022 and 2021-22, respectively.

Despite lower reported rates of multimorbidity, functional limitations remain common: about 19 % of men and 32 % of women aged 65 and over face restrictions in daily activities, close to the EU mean. This reflects Italy's older age profile, with 7.6 % of the population aged 80 and above compared with 6.1 % across the EU. As limitations increase sharply after age 80, this demographic structure raises overall rates. Disabling but often underdiagnosed conditions such as frailty and cognitive decline further contribute, impairing functioning without necessarily increasing recorded chronic disease prevalence. Against this backdrop, regional disparities are pronounced: older adults in Trentino-Alto Adige and Lombardy report the longest healthy life expectancy and lowest limitation rates, while those in Campania and Calabria face substantially higher levels of chronic disease and functional impairment. These north-south divides mirror broader inequalities in economic resources, healthcare capacity and access to preventive services (Naghavi, Zamagni, et al., 2025).

Cardiovascular diseases drive a major burden of illness in Italy

As in most EU countries, cardiovascular diseases (CVDs) are both the leading cause of death and a major source of morbidity in Italy. In 2021, the Institute for Health Metrics and Evaluation (IHME) estimated around 810 000 new CVD cases, with more than 9.1 million people - over 15 % of the population - living with a cardiovascular condition. By 2022, CVDs accounted for nearly one in six hospitalisations, the largest share of any disease group and ahead of cancer (11 %), underscoring their heavy impact on the health system. When adjusted for age, Italy's CVD burden is broadly in line with the EU average: the incidence rate was 1 142 per 100 000 population, slightly below the EU average of 1 157, while the prevalence rate of 12 672 per 100 000 was also marginally lower than the EU figure of 12 965. Much of this burden is attributable to modifiable risk factors, with hypertension management illustrating both progress and persisting challenges. National surveillance data comparing 2008-2012 with 2018-2019 show that treatment effectiveness among diagnosed patients improved, particularly for women, who recorded a 10-percentage-point increase in adequate blood pressure control. Yet these gains were offset by declining diagnosis and treatment initiation. Over the same period, the share of undiagnosed hypertension rose to 37 % among men and 28 % among women. Particularly concerning is the near doubling of women who were aware of their condition but remained untreated, highlighting persistent barriers to care (Figure 4).

Figure 4. About half of Italy's hypertensive patients are either unaware of their condition or untreated despite diagnosis



Note: Data are age-standardised to the European Standard Population 2013.
Source: National Institute of Health, CuoreData project (https://www.cuore.iss.it/indagini/CuoreData)

Against the backdrop of enhanced early detection and treatment, cancer poses a major public health challenge in Italy

Cancer remains a major public health challenge in Italy, ranking as the second leading cause of death after cardiovascular diseases. The European Cancer Information System (ECIS) estimated around 407 000 new cancer diagnoses in 2022, a figure expected to rise further as the population ages (Figure 5). Although Italy's age-adjusted incidence rate is broadly in line with the EU average, prevalence is 9 % higher, reflecting strong survival linked to early detection and advances in treatment. The age-standardised cancer mortality rate is nearly 7 % below the EU average, following a 15 % decline since 2011 - faster than the EU average reduction of 12 %. This progress has contributed to a 17 % fall in potential years of life lost, driven mainly by lower mortality from lung and breast cancer (OECD/European Commission, 2025). The cancer burden varies significantly by gender: among men, incidence rates were 2 % below the EU average, with prostate, colorectal and lung cancer the most common sites. Among women, incidence rates were 4 % higher, largely due to breast cancer, which accounts for nearly

Figure 5. Almost 6 % of Italy's population is estimates to be living with a cancer diagnosis

407 240

New cases in 2022

Incidence rate (age-standardised), 576 per 100 000 population (572 in the EU)

3.5 MILLION

Living with the condition in 2020

Prevalence rate (age-standardised), 5 184 per 100 000 population (4 767 in the EU)

Notes: These are estimates that may differ from national data. Cancer data includes all cancer sites except non-melanoma skin cancer.
Source: European Cancer Information System (estimates refer to 2022 for incidence data and 2020 for prevalence).

one-third of all new female malignancies. Many cases remain preventable, yet tobacco use, the leading avoidable cause of cancer mortality, continues to pose a major challenge. After years of decline, adult smoking rates are rising again, while smoking rates among adolescents are among the highest in the EU (see Section 3).

3 Risk factors

Nearly a quarter of all deaths in Italy are amenable to behavioural risk factors

Behavioural risk factors remain major contributors to premature mortality in Italy. In 2021, the Institute for Health Metrics and Evaluation estimated that smoking, harmful alcohol use, poor diet and physical inactivity together caused about 167 000 deaths – about 24 % of all deaths, a share close to the EU average (IHME, 2023). Poor diet was the leading contributor, accounting for nearly half of all behaviour--related deaths, followed by tobacco use (37 %), alcohol consumption (13 %) and physical inactivity (6 %). Environmental risks also weighed heavily on population health: exposure to fine particulate matter ($PM_{2.5}$) was linked with approximately 33 200 additional deaths, nearly half the toll from smoking. Combined, behavioural risks and air pollution accounted for around 29 % of total mortality, underscoring the need for stronger and more comprehensive public health measures.

Relatively low childhood overweight rates hide large regional variations and the EU's lowest youth physical activity levels

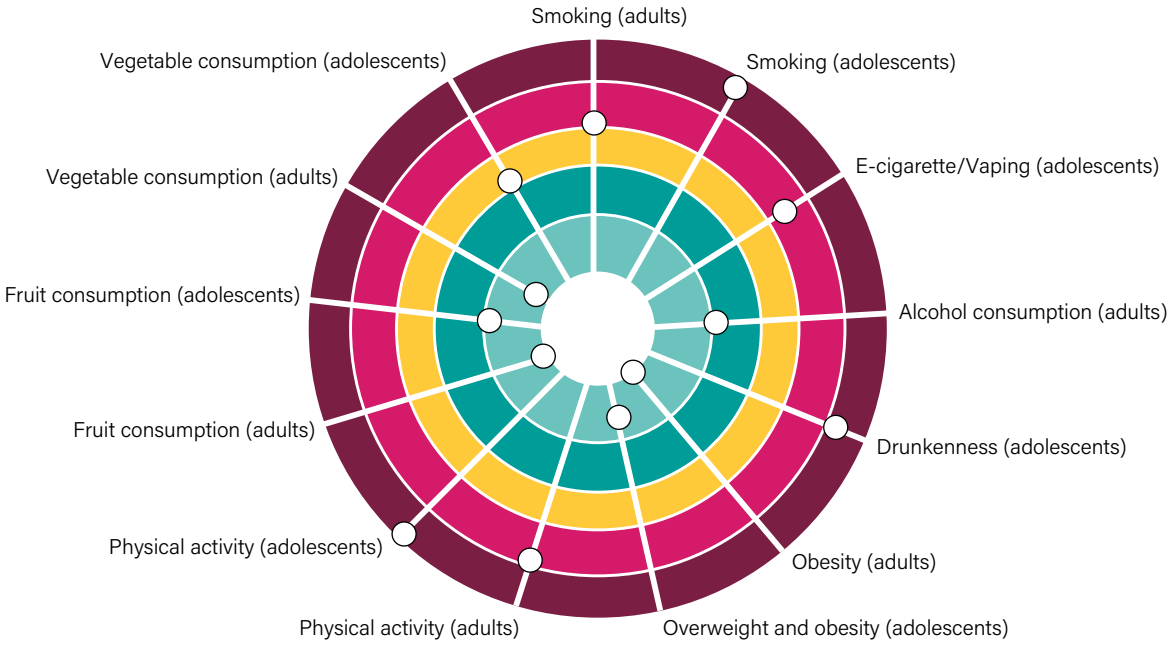
Given its strong link to adult obesity and non-communicable diseases, childhood obesity is a critical public health concern. In this regard, Italy performs relatively well within the EU: in 2022, about 18 % of adolescents were classified as overweight or obese, three percentage points below the EU average and among the lowest in the EU. However, this advantage is offset by extremely low physical activity levels: only 5 % of Italian teenagers reported at least one hour of daily moderate-to-vigorous activity - the lowest rate in the EU and far below the EU average of 15 % (Figure 6). Boys are disproportionately affected, with higher excess weight prevalence (25 % compared to 11 % for girls) and lower activity levels (3 % compared to 7 %).

Recent data point to further risks: a 2023 national survey using International Obesity Task Force (IOTF) criteria found that among Italian 8-9 year-olds, 19 % were overweight and nearly 10 % obese, suggesting possible deterioration in younger cohorts. A persistent north-south gradient also remains, with Southern regions showing higher prevalence. Structural drivers include widespread availability of energy-dense food, limited access to safe recreational spaces and socioeconomic barriers to healthy choices. Parents' failure to accurately recognise their child's weight status remains a key barrier: 45 % of mothers with overweight or obese children consider their child's weight normal; 60 % believe inactive children are sufficiently active; and 73 % view their dietary intake as appropriate (Italian National Institute of Health, 2024). This perceptual gap hampers early behavioural change, underscoring the need for school-based prevention.

Italy's adult smoking rates stalled during the pandemic, while youth nicotine consumption has reached alarming levels

In 2022, just under 20 % of Italian adults smoked daily, about two percentage points above the EU average. After a 20 % decline between 2009 and 2019 driven by higher tobacco taxes and awareness campaigns, progress stalled during the pandemic, with smoking rates rising by one percentage point between 2019 and 2022. At the same time, new nicotine products are gaining ground, with adult use of heated tobacco products climbing from 1 % in 2018 to nearly 5 % in 2024 (Italian National Institute of Health, 2025). The trend is particularly concerning among adolescents: in 2022, nearly 27 % of 15-year-olds reported smoking in the past month, ten percentage points above the EU average, with girls (31 %) reporting higher rates than boys (22 %). E-cigarette use has also surged, rising from 13 % in 2019 to 23 % among 15- to 16-year-olds in 2022. National survey data

Figure 6. Italian children show low overweight rates, yet remain the least active in the EU



Note: The closer the dot is to the centre, the better the country performs compared to other EU countries. No country reaches the white target area, indicating that all countries have room for improvement in all areas.
Sources: OECD calculations based on HBSC survey 2022 for adolescents indicators; Eurostat based on EU-SILC and OECD Data Explorer for adults indicators (2022 or nearest year).

from 2023–2024 show that 30 % of students aged 14-17 had used a tobacco or nicotine product in the previous 30 days, with multi-product use nearly doubling over two years.

This surge in youth nicotine use is facilitated by weak enforcement, as most adolescents report purchasing products directly from retailers with minimal age verification. Low parental awareness compounds the problem: only one-third of parents know about their child's nicotine use, and tolerance is often higher for newer products than for conventional cigarettes (Italian National Institute of Health, 2025).

While alcohol consumption among adults is low, the share of teenagers reporting multiple instances of intoxication increased in recent years

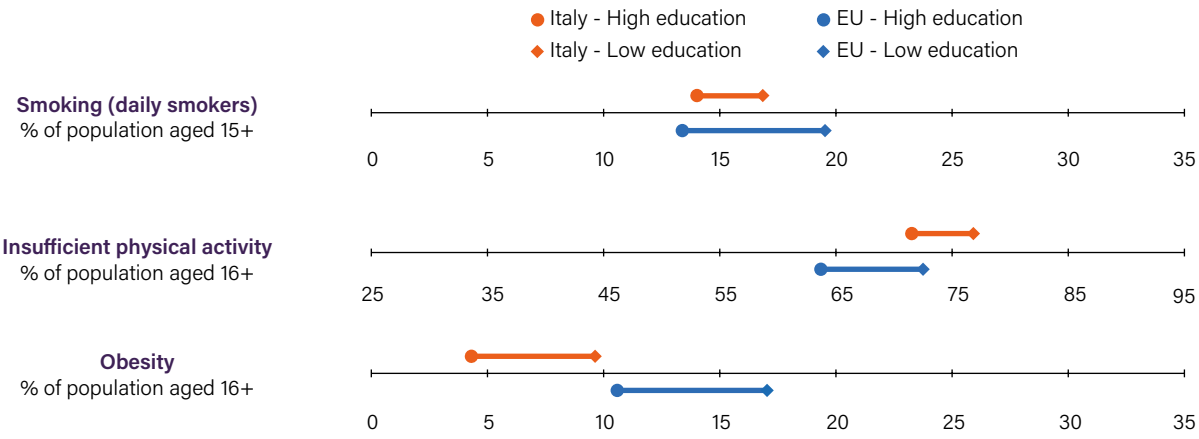
Although average per capita consumption of pure alcohol in Italy remains over one sixth below the EU average, heavy episodic drinking[1] poses a significant public health concern. In 2022-2023, nearly 10% of adults reported engaging in this behaviour, with substantial variation across demographic groups. The prevalence peaks among young adults aged 18 to 24, reaching almost 16%, and men engage in heavy episodic drinking at more than twice the rate of women. Unlike most other behavioural risk factors, this pattern is more common among people with higher levels of education: 11 % of university graduates reported heavy episodic drinking compared with only 4 % of those with primary education or less. Over the past decade, heavy episodic drinking has remained relatively stable overall, with a gradual decline among men and a rise among women have significantly narrowed the gender gap (Italian National Institute of Health, 2025).

Most behavioural risk factors in Italy are more prevalent among the less educated

In Italy, as across the EU, adults with lower education tend to face higher behavioural risks, though the steepness of this social gradient varies by risk factor. In 2019, daily smoking was 20 % more prevalent among adults with low education than among those with tertiary education, a gap smaller than the EU average of over 40 %. A similar pattern emerges for physical activity: in 2022, 23 % of adults with lower education reported exercising outside work at least three times per week, compared with 28 % of those with higher education - a narrower difference than the EU average (Figure 7). By contrast, obesity shows a much sharper divide: in 2022, adults with low education were more than twice as likely to be obese as those with higher education, compared with an EU average difference of about 60 %.

[1] "Heavy episodic drinking" is defined as consuming ≥5 alcohol units over a short space of time for men, ≥4 for women.

Figure 7. Italy's obesity burden is more concentrated in lower-educated groups than other behavioural risks



Note: Low education is defined as the population with no more than lower secondary education (levels 0-2), whereas high education is the population with tertiary education (levels 5-8). Low physical activity is defined as people doing physical activity 3 times or less per week.
Source: Eurostat based on EHIS 2019 for smoking (hlth_ehis_sk1e) and EU-SILC 2022 for physical activity and obesity (ilc_hch07b, ilc_hch10).

4 The health system

Italy's decentralised healthcare system combines national oversight with regional autonomy to ensure universal access to care

Italy's National Health Service (*Servizio Sanitario Nazionale - SSN*) is a universal, publicly financed system administered by 19 Regions and two Autonomous Provinces. The Ministry of Health sets strategic priorities, allocates tax revenues through block grants and audits regional performance through the *New Guarantee System* (NSG), which monitors compliance with the *Livelli Essenziali di Assistenza* (LEA), the nationally defined basket of essential services guaranteed to all residents (see Section 5.2). Regional governments are responsible for health planning and service delivery, contracting with Local Health Authorities (*Aziende Sanitarie Locali - ASLs*), which manage budgets and provide preventive, primary and hospital care within their jurisdictions. General practitioners (GPs) and paediatricians act as gatekeepers to specialist and hospital services, and acute care is provided by a mix of public and accredited private facilities, with the balance varying widely across regions.

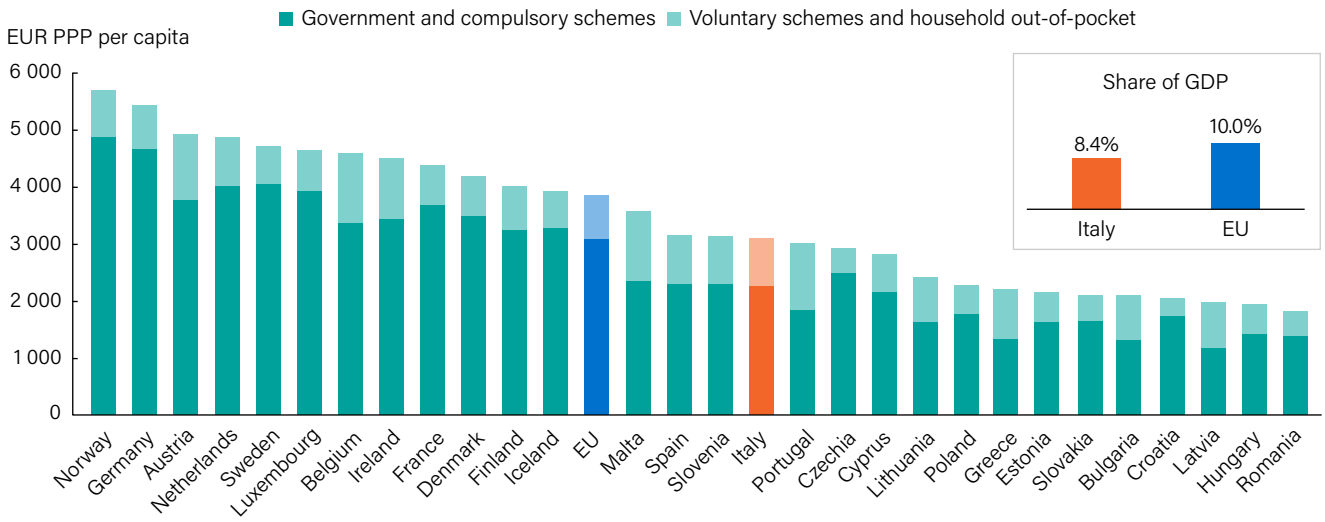
Several national agencies, including the *Istituto Superiore di Sanità*, AIFA and AGENAS, support the Ministry of Health by overseeing quality assurance, pharmaceutical regulation and research coordination. Italy has also established a National System for Health Prevention from Environmental and Climate Risks (*Sistema Nazionale Prevenzione Salute dai rischi ambientali e climatici - SNPS*). Operational since 2023, the SNPS coordinates prevention and treatment strategies for diseases linked to environmental pollution and climate change, bringing together health authorities, environmental agencies and regional health departments in a unified network.

Post-pandemic, Italy's health spending reverted back to 2019 levels in real terms

In 2023, Italy's current health expenditure amounted to 8.4 % of GDP, 1.6 percentage points below the EU average. After adjusting for purchasing power, per capita health spending reached EUR 3 086, about 19 % lower than the EU average of EUR 3 832. This gap reflects lower public spending, which was 27 % below the EU average per capita, partially offset by higher private expenditure, which was 8 % above the EU average (Figure 8). Following strong increases between 2019 and 2021, when health spending rose by over 8 % in real terms due to pandemic-related costs, expenditure growth has since normalised. Real per capita spending declined thereafter but in 2023 remained nearly 3 % above its 2019 level, with preliminary estimates pointing to a further real increase of about 1.5 % in 2024. The financing structure has remained broadly stable since 2019: public sources covered just over 73 % of total spending in 2023, below the EU average of 80 %. The remaining 27 % was financed privately, almost 90 % of which came from direct out-of-pocket (OOP) payments.

The publicly covered benefits package includes primary and preventive care, hospital services in public and accredited private facilities, specialist consultations and essential pharmaceuticals. Cost-sharing applies in most regions for specialist visits, diagnostic tests and, depending on regional policy, certain pharmaceuticals. However, this cost-sharing represents only a small proportion of total OOP expenses, with the vast majority stemming from direct payments for private alternatives to public services, particularly in regions with more limited public service capacity (see Section 5.2).

Figure 8. Italy's healthcare spending is lower than the EU average both as a share of GDP and on a per capita basis

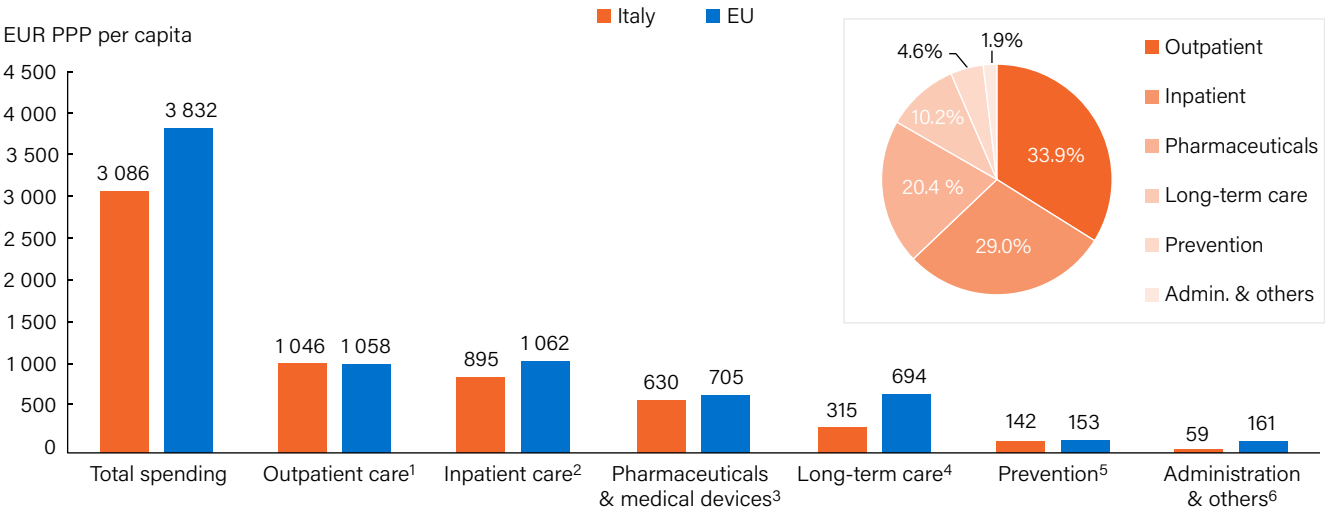


Note: The EU average is weighted (calculated by OECD).
Sources: OECD Data Explorer (DF_SHA); Eurostat Database (demo_gind). Data refer to 2023.

High outpatient spending contrasts with underdeveloped long-term care in Italy

In 2023, Italy's health spending composition revealed significant divergences from the average EU pattern. Outpatient care services absorbed nearly 34 % of current health spending, almost six percentage points higher than the EU average. Remarkably, Italy's per capita outpatient spending virtually matched the EU average despite the country's overall health expenditure being almost one-fifth lower. Spending on retail pharmaceuticals and medical devices showed a similar pattern: while per capita expenditure was 11 % lower than the EU average, it represented over 20 % of Italy's total health budget, slightly above the EU average share of 18 % (Figure 9). The starkest divergence lies in long-term care (LTC), which accounted for only about 10 % of total health expenditure compared with approximately 18 % across the EU. This gap largely reflects Italy's heavy reliance on family-based care, reinforced by a system in which roughly half of public LTC funding is delivered via cash benefits, which often incentivise private arrangements. Consequently, public investment in structured LTC remains limited: only a small fraction of older Italians live in LTC facilities or receive formal home care. Capacity constraints are sizeable, with many households reporting unmet LTC needs owing to gaps in publicly provided services (Santini et al., 2025).

Figure 9. Long-term care absorbs one tenth of Italy's health expenditure



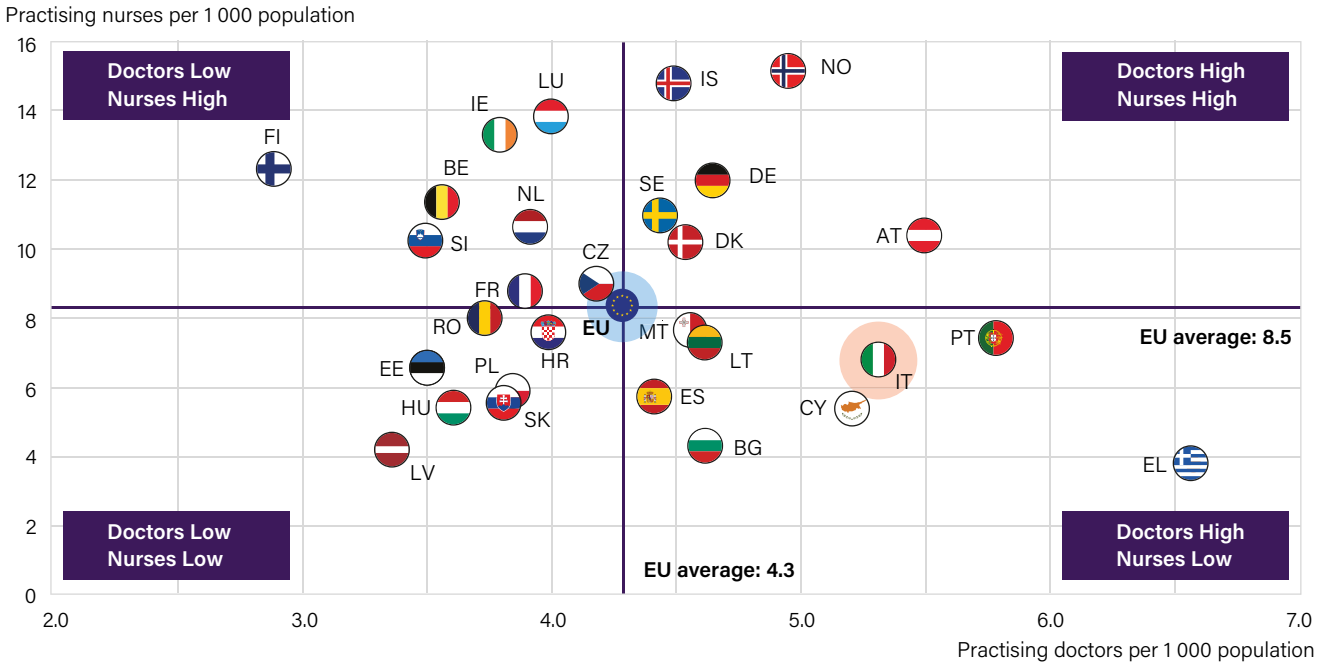
Notes: 1. Includes home care and ancillary services (e.g. patient transportation); 2. Includes curative-rehabilitative care in hospital and other settings; 3. Includes only the outpatient market; 4. Includes only the health component; 5. Includes only spending for organised prevention programmes; 6. Includes health system governance and administration and other spending. The EU average is weighted (calculated by the OECD).
Sources: OECD Data Explorer (DF_SHA). Data refer to 2023.

While Italy's doctor density is high, persistent nurse shortages and structural obstacles undermine progress towards integrated care

In 2023, Italy reported one of the highest densities of doctors in the EU, with 5.4 per 1 000 population, more than 25 % above the EU average. In contrast, the density of practising nurses was 6.9 per 1 000 population, over 20 % below the EU average of 8.4, resulting in a nurse-to-doctor ratio of just 1.3, among the lowest in the EU (Figure 10). This imbalance reflects longstanding difficulties in expanding the nursing workforce, compounded by growing demand from population ageing and workforce attrition due to retirements, emigration and declining numbers of new graduates. The profession's attractiveness is further undermined by uncompetitive remuneration: while nurses in most EU countries earn around 20 % more than the national average wage, Italian nurses are paid roughly at parity. The nursing shortage poses a structural barrier to transitioning towards more integrated and cost-effective models of care. It is further exacerbated by rigidities in health workforce planning and deployment, as Italy's 31 legally recognised health professions contribute to a segmented system that limits interoperability and complicates coordinated workforce planning.

Geographic disparities compound these challenges, with recruitment substantially more difficult in rural and remote areas. Policy options under consideration include consolidating training pathways, adjusting university admission quotas to better reflect labour market needs, and reforming curricula to support more flexible career trajectories (Camera dei Deputati, 2025).

Figure 10. Italy's density of nurses is over 20 % lower than the EU average



Note: The EU average is unweighted. The data on nurses include all categories of nurses (not only those meeting the EU Directive on the Recognition of Professional Qualifications). In Portugal and Greece, data refer to all doctors licensed to practice, resulting in a large overestimation of the number of practising doctors. In Greece, the number of nurses is underestimated as it only includes those working in hospital.
Source: OECD Data Explorer (DF_PHYS, DF_NURSE). Data refer to 2023 or nearest year.

Since 2018, Italy has significantly expanded medical school intake and increased the number of specialist training contracts, effectively resolving the long-standing bottleneck in postgraduate medical education. However, this growth has been accompanied by a shift in student preferences away from system-critical specialties, such as emergency medicine and anaesthesiology, towards fields offering better work-life balance and stronger private sector opportunities (Conference of the Regions and Autonomous Provinces, 2025). In contrast, the inflow of new nurses has declined sharply over the past decade, with nursing graduate numbers falling by more than 3 % per year between 2013 and 2022. Between 2020 and 2022, this trend resulted in fewer nurses than doctors entering the workforce annually. A modest recovery was observed in 2023, when the number of nursing graduates once again exceeded that of medical graduates, an encouraging sign for strengthening nursing capacity in the years ahead (see Section 5.3).

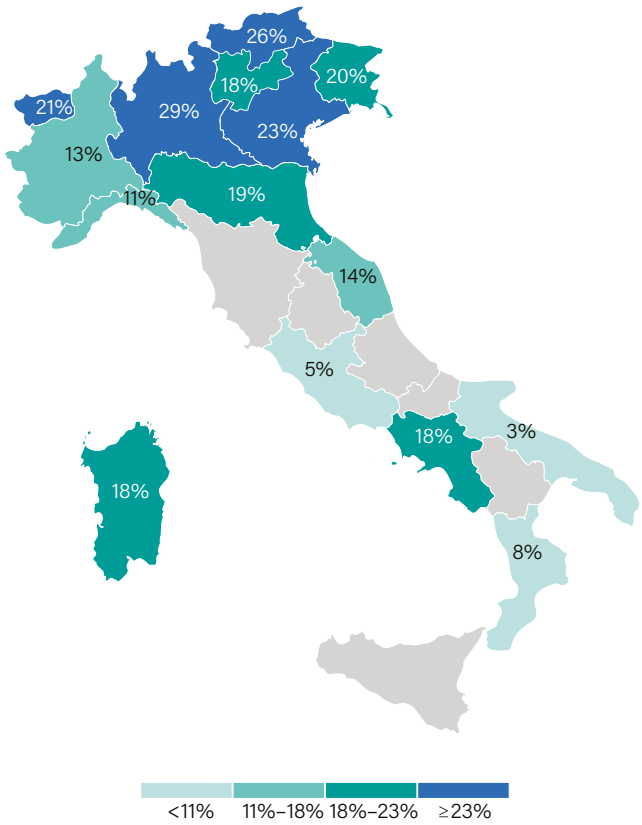
General practice is shrinking due to structural disincentives and an ageing workforce

While Italy's overall physician density has grown by more than 1 % annually over the past decade, the density of general practitioners (GPs) has declined by approximately 13 % over the same period. This contraction has led to growing workload pressures: in 2023, nearly 52 % of GPs were caring for more than 1 500 patients, the maximum caseload set by the binding National Collective Agreement. The shortfall is estimated at between 2 910 and 5 897 GPs nationwide, equivalent to deficits of 8 % to 16 % depending on whether the benchmark used is the contractual ceiling or a more sustainable ratio of 1 350 patients per GP. Regional

disparities are pronounced, particularly in the North: in Lombardy alone, a 20 % expansion of the GP workforce would be required to comply with contractual thresholds (Figure 11). In response, several regions have introduced temporary mitigation measures, such as extending the retirement age to 72 and deploying hospital physicians in community settings. The declining attractiveness of general practice reflects long-standing disincentives embedded in both training and employment frameworks. Unlike other specialties, GP training has traditionally been delivered through extra-university regional programmes with less favourable conditions than university-based specialist training, including bursaries around 50 % lower and heavy administrative workloads that limit clinical practice time. The substantial expansion of university-based specialist training places has likely created a substitution effect, with graduates increasingly opting for other fields.

Another structural barrier has been the lack of formal equivalence between GP diplomas and university specialisation degrees: legislative reforms currently progressing through Parliament aim to address these issues by recognising GP training as a formal specialisation school, aligning it with other specialties through more structured training, improved remuneration for trainees and closer integration into local health services. The demographic profile of the GP workforce compounds these challenges: in 2023, 68 % of practising GPs had graduated more than 27 years earlier, with the share exceeding 75 % in southern regions (Ministry of Health, 2025). Projections for the next five years, accounting for expected retirements and inflows of newly qualified GPs, indicate that GP density will decline most sharply in the South, particularly in Campania, Apulia and Sicily.

Figure 11. Italy's shortages of general practitioners are concentrated in the northern regions



Note: The map illustrates the estimated regional shortfall of GPs, calculated as the percentage increase in the GP workforce needed to reach a target ratio of 1 350 patients per GP. This target represents 90 % of the contractual maximum caseload of 1 500 patients per GP set by the National Collective Agreement. Calculations are based on total regional population and are not age-weighted. Grey indicates no calculated shortfall.
Source: Calculations based on Ministry of Health (2025). Data pertain to 2023.

5 Performance of the health system

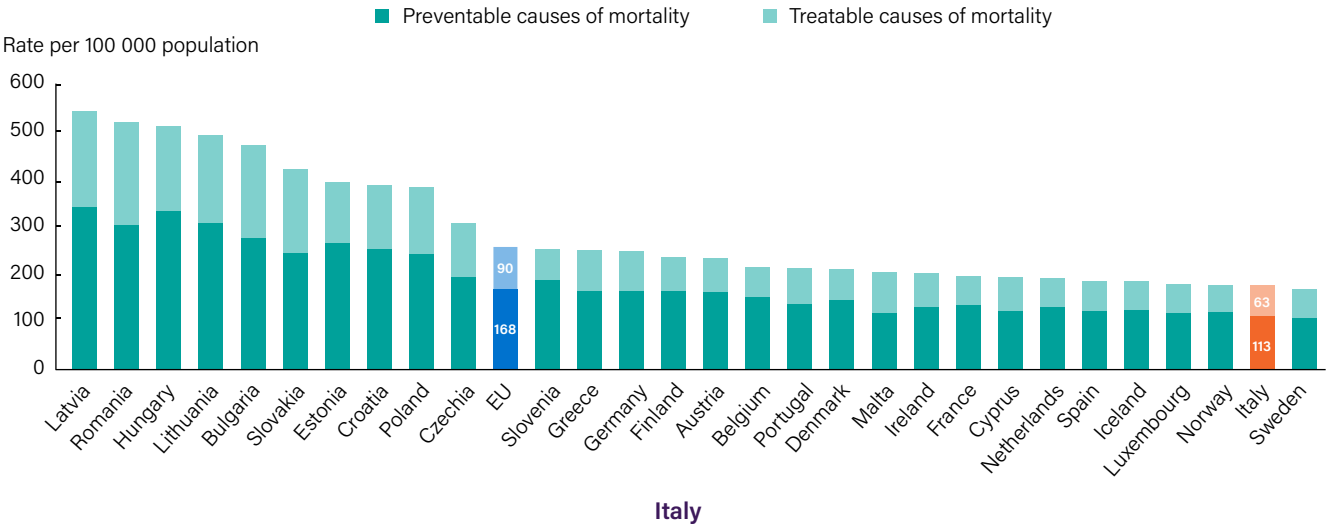
5.1 Effectiveness

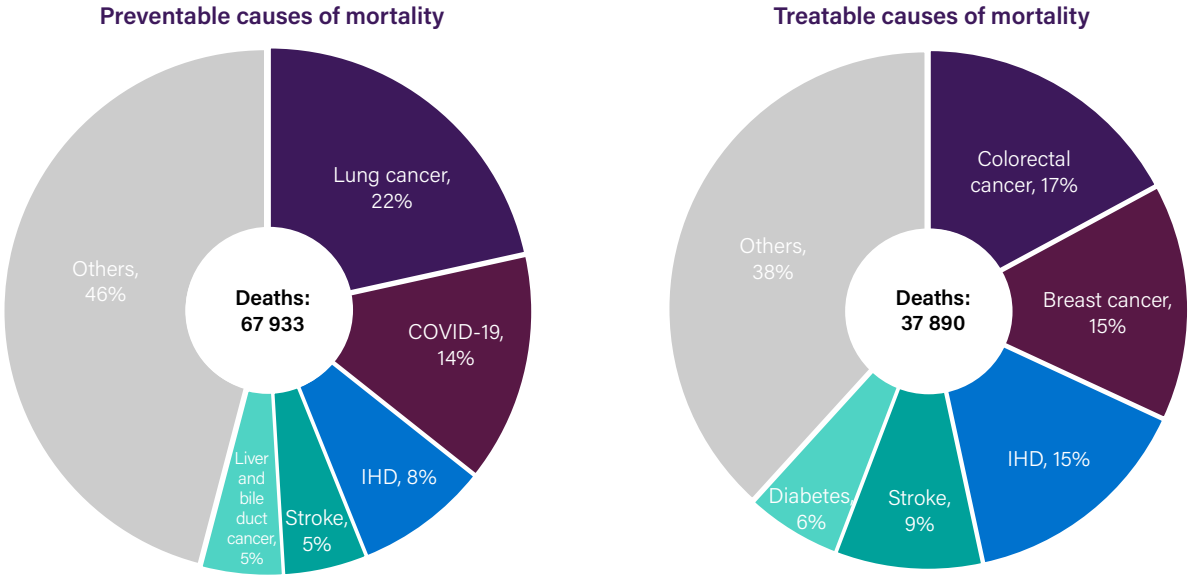
Italy is broadly successful at preventing premature deaths

In 2022, Italy recorded the second-lowest preventable mortality rate in the EU, with deaths from potentially preventable causes accounting for 9 % of all fatalities, about one third below the EU average (Figure 12). This strong performance was temporarily affected by the pandemic: while the EU's preventable mortality rate rose by 17 % in 2020, Italy experienced a sharper 29 % increase, reflecting its disproportionately high COVID-19 death toll. By 2022, Italy's preventable mortality remained 12 % higher than in 2019, compared with a 9 % increase in the EU as a whole; COVID-19 accounted for 14 % of preventable deaths that year, ranking second only to lung cancer (22 %).

Italy demonstrates similar strength in treatable mortality; in 2022, its age-standardised rate of deaths amenable to timely and effective healthcare was about 30 % below the EU average, largely owing to substantially lower mortality from ischaemic heart disease, colorectal and breast cancer. These three conditions together accounted for nearly half of all potentially treatable deaths, around 17 800 lives lost.

Figure 12. Italy's mortality rate from potentially avoidable causes is the second lowest in the EU





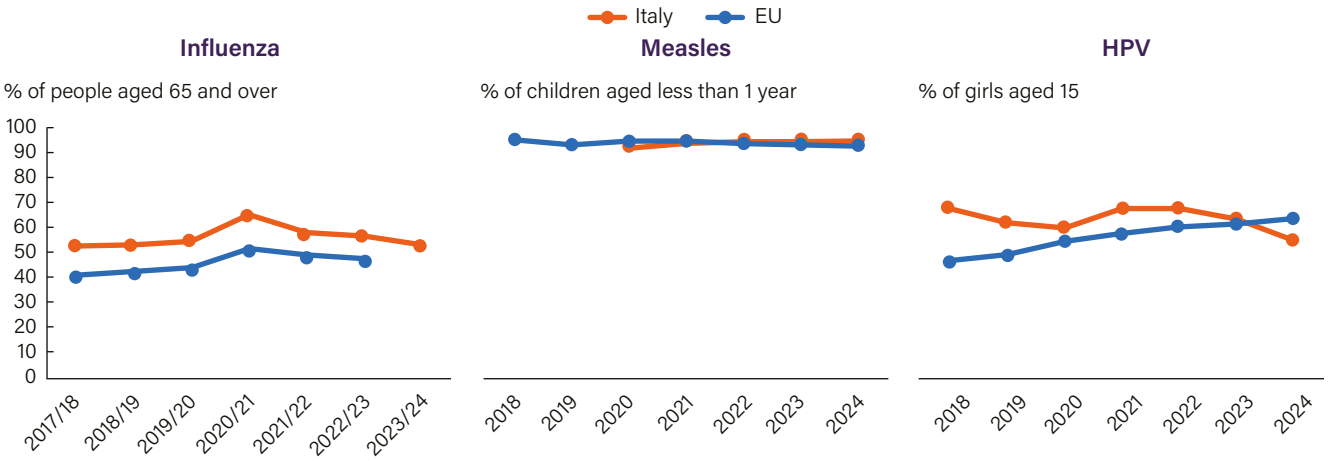
Note: Preventable mortality is defined as death that can be mainly avoided through public health and primary prevention interventions. Treatable (or amenable) mortality is defined as death that can be mainly avoided through health care interventions, including screening and treatment. Both indicators refer to premature mortality (under age 75). The lists attribute half of all deaths for some diseases (e.g. ischaemic heart diseases, stroke, diabetes and hypertension) to the preventable mortality list and the other half to treatable causes, so there is no double-counting of the same death. IHD refers to ischaemic heart diseases.
Source: Eurostat (hlth_cd_apr) (data refer to 2022).

Influenza vaccination coverage remains high, yet gaps in HPV and adult measles immunisation persist

Uptake of influenza vaccination among adults aged 65 and over remains comparatively high in Italy, supported by long-standing policies offering free immunisation to at-risk groups. Coverage peaked at 65 % during the 2020-21 influenza season, largely due to heightened awareness during the COVID-19 pandemic, before gradually declining in subsequent years. By the 2023-24 season, it had fallen to around 53 %, though remaining consistently above the EU average (Figure 13). Uptake of human papillomavirus (HPV) vaccination has proven more challenging to sustain: although the vaccine is free and strongly recommended from age 11, coverage among 15-year-old girls has stagnated between 60 % and 70 % over the past five years. Having once exceeded the EU average, Italy's coverage has slipped in relative terms as uptake rose in other countries: in 2024, 55 % of 15-year-old girls in Italy had completed the full HPV schedule compared with 63 % across the EU.

Since the introduction of mandatory childhood vaccination in 2017, Italy has achieved substantial gains in measles immunisation: first-dose coverage among children under 12 months reached 95 % in 2024, above the EU average of 92 %. However, this progress has not prevented a resurgence of measles in line with broader EU trends: more than 1 000 cases were reported in Italy in 2024, a tenfold increase compared with 2020 (ECDC, 2025). The median age of cases in Italy exceeded 30 years, compared with 5 years across the EU, and over 95 % of those infected were unvaccinated. These data reveal substantial immunity gaps among older cohorts, underscoring the need for targeted catch-up campaigns.

Figure 13. Italy has struggled to sustain the high flu vaccination rates among people aged 65+ reached during COVID-19



Notes: The EU average is weighted for influenza (calculated by Eurostat) and unweighted for measles and HPV.
Sources: Eurostat (hlth_ps_immu) and WHO/UNICEF Joint Reporting Form on Immunization (JRF).

Cancer screening participation has yet to fully recover from pandemic-related disruptions

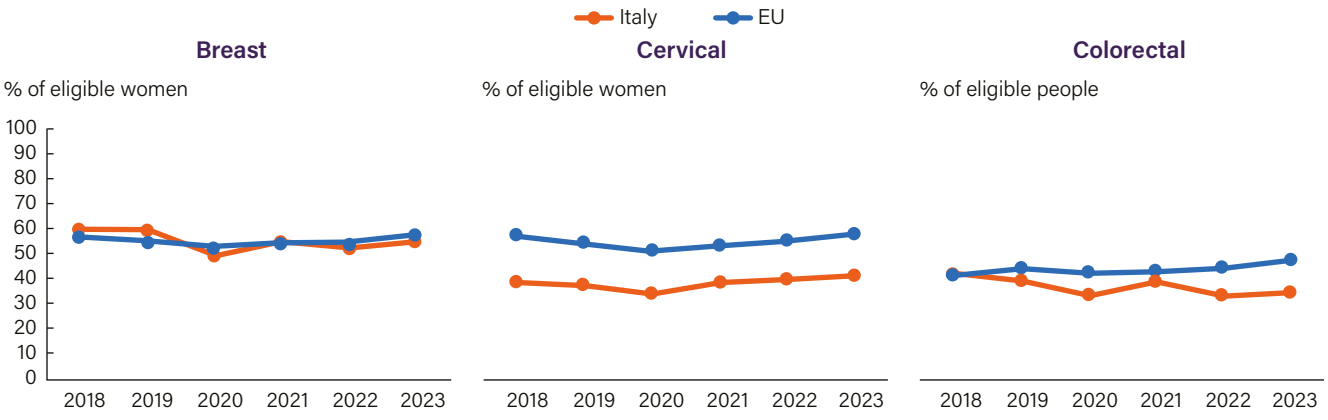
In 2023, participation in Italy's population-based cancer screening programmes remained below pre-pandemic levels, reflecting an incomplete recovery from the disruptions caused by COVID-19. Among women aged 50-69, breast cancer screening coverage stood at 55 % in 2023, down from approximately 61 % in 2019; after dropping to 51 % in 2020, coverage rebounded to 56 % in 2021 but has since stalled. Colorectal cancer screening followed a similar pattern of partial recovery: coverage fell from 40 % in 2019 to 34 % in 2020, rose to 39 % in 2021, but then declined again to 35 % in 2023. Cervical cancer screening, by contrast, showed stronger momentum; coverage among women aged 25-64 recovered from 34 % in 2020 to 41 % in 2023, surpassing its 2019 baseline. Despite this progress, which coincides with Italy's ongoing transition from pap smears to HPV-DNA testing, cervical screening coverage remains well below the EU average of 58 % (Figure 14).

These national figures obscure stark regional inequalities; in many southern regions, large segments of the target population remain outside organised screening pathways. In 2022, fewer than 12 % of eligible women in Calabria participated in organised breast cancer screening, compared to nearly 50 % in several northern regions. Similar geographic disparities affect both colorectal and cervical cancer screening, underscoring a persistent north-south divide in access to and uptake of secondary prevention services (OECD/European Commission, 2025).

A strong primary care system enables Italy to maintain exceptionally low hospital admission rates for chronic conditions

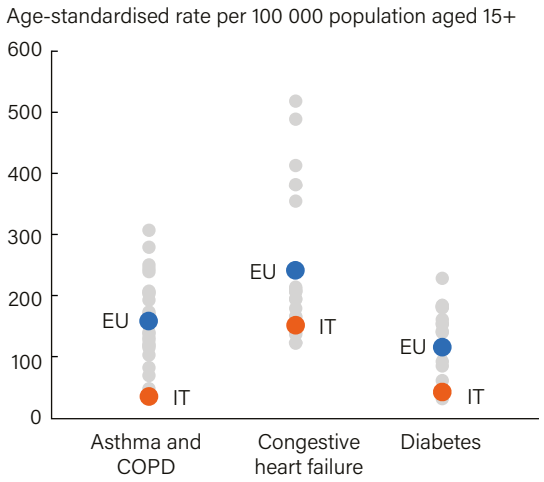
A key measure of a primary healthcare system's success is its ability to manage chronic diseases in the community, thereby avoiding costly hospital admissions. By this standard, Italy stands out as a top performer in the EU. In 2023, its combined hospital admission rate for diabetes, congestive heart failure (CHF), asthma and chronic obstructive pulmonary disease

Figure 14. Italy's cervical cancer screening recovered above pre-pandemic levels, but still trails the EU average by nearly 15 percentage points



Notes: All data refer to programme data. Colorectal programme data are based on national programmes that may vary in terms of age group and frequency. The EU average is unweighted.
Sources: OECD Data Explorer (DF_KEY_INDIC) and Eurostat database (hlth_ps_prev).

Figure 15. Italy's avoidable hospitalisation rates for key chronic conditions are the lowest in the EU



Note: Admission rates are not adjusted for differences in disease prevalence across countries. The data pertain to 2023.
Source: OECD Data Explorer (DF_HCQO).

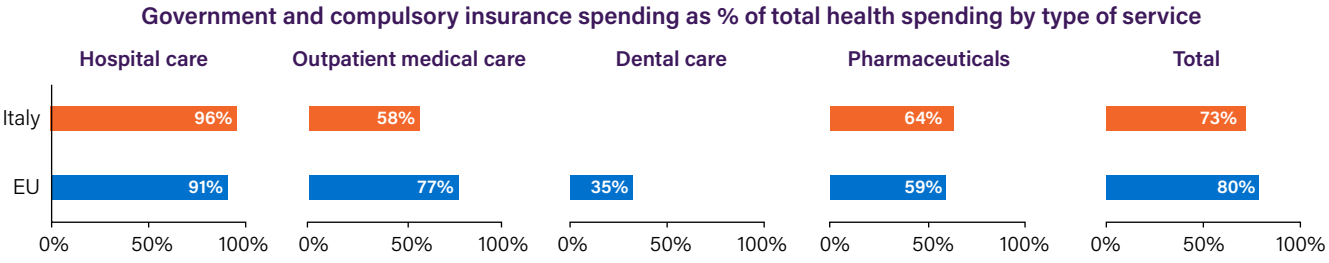
(COPD) was the lowest in the EU at less than half the EU average (Figure 15). This strong performance is rooted in the strength of the country's primary care system, where 70 % of general practitioners (GPs) operated in group practices by 2023 (Ministry of Health, 2025). The system's effectiveness is particularly evident in diabetes management: despite having a higher prevalence of the disease than most other peer countries, Italy reports the lowest diabetes-related hospital admission rate in the EU.

5.2 Accessibility

Public coverage of healthcare services in Italy prioritises hospital care and essential medicines

In 2023, public financing accounted for 96 % of hospital expenditure in Italy, above the EU average of 91 %, effectively shielding patients from the high costs associated with inpatient care. Public coverage for retail medicines was also slightly more generous than the EU average at 63 %, reflecting a robust reimbursement system for essential medicines (Figure 16). However, public financing remains notably limited in other areas of care. Publicly funded dental care is largely confined to children under 14 and selected vulnerable groups, making it a major driver of out-of-pocket (OOP) expenditure for most households. The impact is particularly severe for disadvantaged populations: in 2024, 12.5 % of individuals at risk of poverty[2] who needed dental care reported unmet need due to cost, distance or waiting times compared to 4.6 % in the general population, a nearly threefold gap (Figure 18). Outpatient medical services face similar coverage shortfalls: in 2023, only 58 % of related costs were publicly financed, below the EU average of 77 %. This gap is partly tied to long waiting times for specialist consultations, which frequently push patients to seek faster access through privately paid services.

Figure 16. Public finances cover the cost of nearly all hospital care services in Italy



Notes: Outpatient medical services mainly refer to services provided by generalists and specialists in the outpatient sector. Pharmaceuticals include prescribed and over-the-counter medicines as well as medical non-durables. N/A means data not available. The EU average is weighted.
Source: OECD Data Explorer (DF_SHA). The data pertain to 2023.

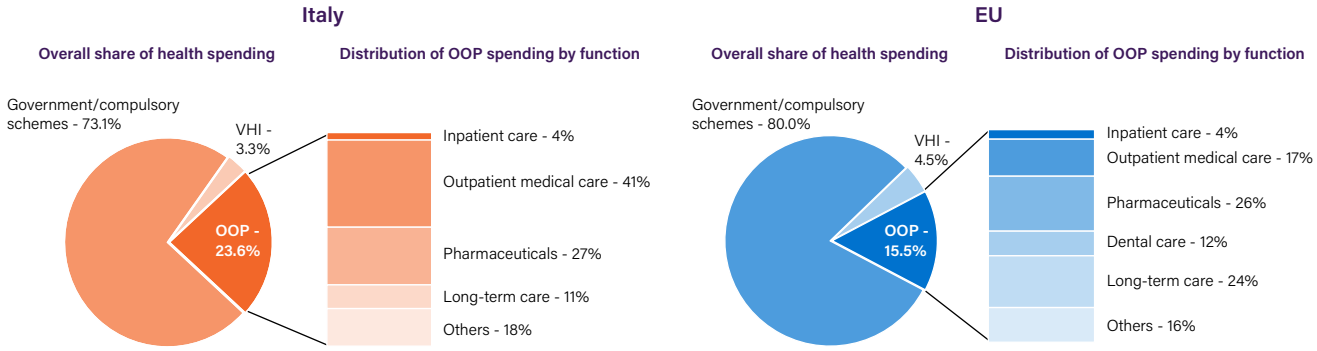
High private spending reflects direct purchases from private providers rather than cost-sharing within the public system

In 2023, private sources accounted for nearly 27 % of Italy's total health expenditure, seven percentage points above the EU average. The bulk of this private spending came from out-of-pocket (OOP) payments at 24 %, with voluntary health insurance (VHI) contributing a further 3 % (Figure 17). Italy's high OOP share is driven primarily by direct payments for privately delivered services rather than by formal cost-sharing within the SSN; in 2023, statutory co-payments (ticket) on specialist consultations and medicines accounted for only 7.4 % of total OOP spending, including EUR 1.71 billion for specialist services and EUR 1.48 billion for pharmaceuticals. Moreover, exemption schemes based on income, age, and clinical vulnerability covered about 28 % of all specialist outpatient services delivered in 2023, limiting the reach of co-payments. The role of formal cost-sharing has remained broadly unchanged since the 2020 abolition of the *Superticket*, a fixed EUR 10 surcharge on most outpatient consultations and diagnostic tests (General State Accounting Department, 2024). Direct private purchases dominate Italy's OOP expenditure: nearly half (47 %) of total OOP spending in 2023 was allocated to specialist consultations and interventions, with dental services

[2] People at risk of poverty are defined as people with an equivalised income below 60 % of the national median income.

alone representing approximately 30 % within this category. Private pharmaceutical spending not covered by the SSN was broadly in line with the EU average, while expenditure on inpatient and long-term care services remained negligible. The concentration of OOP payments in privately purchased services translates into significant financial strain for many households. In 2022, Italy recorded the highest rate of catastrophic health spending in Western Europe: an estimated 8.6 % of households incurred OOP costs exceeding 40 % of their capacity to pay (defined as total spending net of subsistence needs). The burden fell disproportionately on the poorest: households in the lowest income quintile accounted for 60 % of all catastrophic health expenditure.

Figure 17. Specialist outpatient care accounts for Italy's higher-than-average private health expenditure



Note: VHI also includes other voluntary prepayment schemes. The EU average is weighted.
Source: OECD Data Explorer (DF_SHA). The data pertain to 2023.

Unmet healthcare needs remain moderate overall, but reveal substantial socioeconomic disparities

In 2024, 3.8 % of Italian adults who reported a need for medical care also reported being unable to access it due to excessive costs, distance or waiting times, close to the EU average of 3.6 %. However, this aggregate figure masks pronounced socioeconomic disparities: individuals at risk of poverty were 2.6 times more likely to report unmet medical needs than the general population, a gap substantially wider than the EU average ratio of 1.6 (Figure 18). Access barriers were even more pronounced for dental care, reflecting its limited public coverage. In 2024, 4.6 % of adults with a self-reported need for dental care were unable to obtain it, below the EU average of 6.3 %. Yet here too, inequalities remained stark: adults at risk of poverty faced unmet dental needs at 2.7 times the rate of the general population, compared with an EU average ratio of 2.2. These patterns suggest that while Italy's health system maintains relatively equitable access at the aggregate level, gaps in public coverage, particularly for dental care, create disproportionate barriers for disadvantaged groups.

More regions meet the LEAs, but southern and smaller regions still lag in key service areas

Since 2020, Italy's SSN has monitored regional compliance with legally mandated minimum service levels (*Livelli Essenziali di Assistenza, LEA*) through the New Guarantee System (*Nuovo Sistemi di Garanzia, NSG*). This framework scores each region a set of core indicators across three macro-areas - prevention, community care and hospital services. Regions must achieve at least 60 out of 100 points in each area; those falling short must implement corrective action plans and risk losing access to performance-related national funding. The 2023 NSG results show gradual overall improvement, but substantial interregional disparities persist (Figure 19). Thirteen regions met or exceeded the minimum standard across all three areas, while eight fell short in at least one: Valle d'Aosta, Abruzzo, and Sicily underperformed in two areas, and five others failed to meet the standard in one. Deficits are concentrated in prevention and community-based care, and disproportionately affect smaller southern regions. While the number of fully compliant regions has increased since 2020, the continued low performance in several territories underscores the need for targeted investment, strengthened governance and enhanced stewardship to ensure equitable access to LEA across the country.

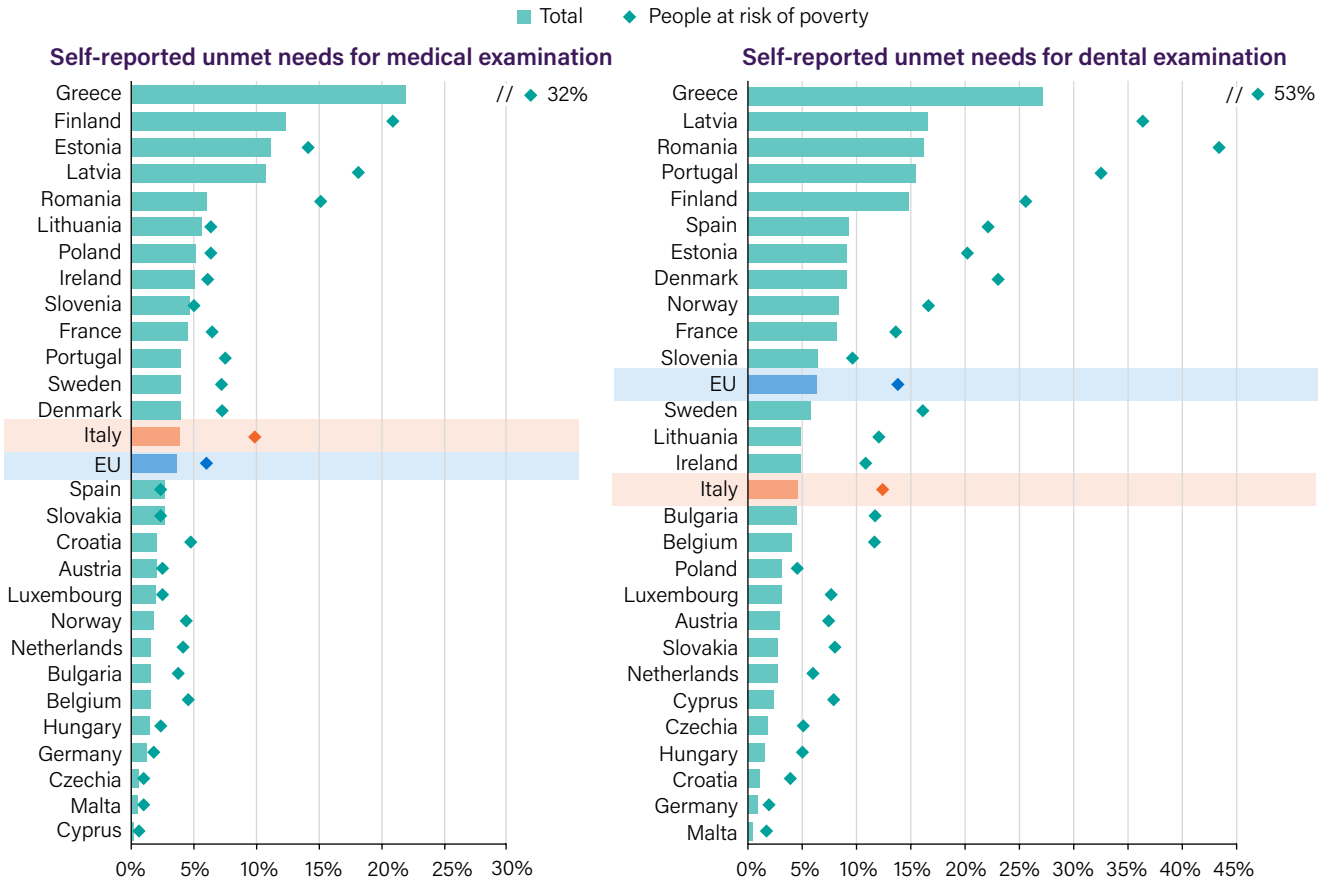
5.3 Resilience

Health system resilience - the ability to prepare for, manage (absorb, adapt and transform) and learn from shocks and structural changes - has become central to policy agendas. Key priorities include easing pressures on service delivery, strengthening health infrastructure and workforce capacity, adapting crisis preparedness strategies, supporting digital innovation, and safeguarding long-term sustainability.

While efforts to improve care appropriateness advance, hospital activity volumes remain below pre-pandemic levels

Italy's acute care capacity is leaner than in most other EU countries. In 2023, hospital bed density stood at three beds per 1 000 population, 40 % below the EU average, and hospital discharge rates were 36 % lower, reflecting a long-standing strategy to reduce avoidable admissions. While discharge volumes rebounded from their 2020 low, they remained over 6 % below their 2019 level in 2023. Average bed occupancy rose to 75 % in 2023, above the EU average and up from 68 % in 2020, although still below its pre-pandemic level of around 79 % (Figure 20).

Figure 18. Unmet healthcare needs in Italy are more concentrated among low-income individuals than the EU average



Notes: The EU average is weighted. Data refer only to individuals who reported having medical care needs. People at risk of poverty are defined as those with an equivalised disposable income below 60% of the national median disposable income.
Source: Eurostat database (hlth_silc_08b, hlth_silc_09b). Data refer to 2024.

Alongside capacity reductions, Italy has made progress in concentrating hospital resources on more complex cases. Between 2013 and 2023, the average case-mix index for acute admissions, a measure of clinical complexity, increased by 15 %, while in 2023 alone, hospitals recorded a 4 % reduction in potentially inappropriate surgical discharges. Despite these gains, challenges remain: one-day hospital stays, often indicative of admissions that could be managed in outpatient settings, accounted for 40 % of all hospitalisations in 2023. Additionally, admissions for diagnosis-related groups more appropriately treated in ambulatory settings rose from 1.63 million in 2022 to 1.71 million in 2023 (Ministry of Health, 2024).

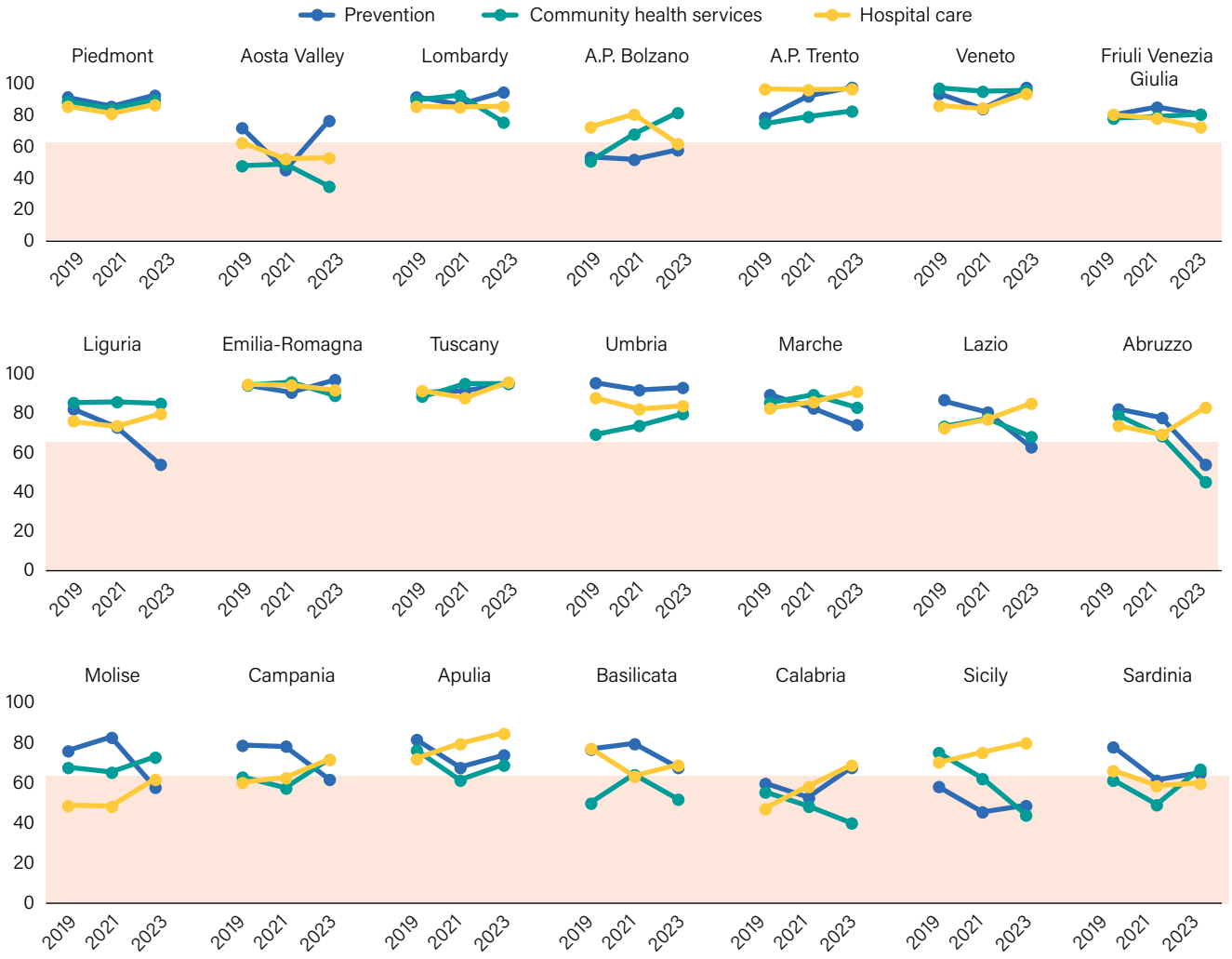
These pressures coincide with marked interregional disparities that drive substantial patient mobility. In 2023, over 8 % of acute care admissions occurred outside patients' region of residence, with much higher rates in the South: 21 % in Calabria, 29 % in Basilicata and 32 % in Molise. While proximity to regional borders explains some mobility, persistently high outbound flows highlight gaps in local hospital infrastructure. In 2023, patients seeking care outside their home region generated nearly EUR 3 billion billion in spending across 668 145 hospitalisations, with 84 % directed toward northern regions.

Despite short surgical delays, long wait times for specialist consultations and diagnostics remain a major barrier to medical care

Waiting times for healthcare services represent a major challenge in Italy: in 2023, 7.6 % of the population reported forgoing medical care due to long waiting lists, cost or access difficulties. Waiting lists were the most frequently cited barrier, affecting 2.7 million people, nearly twice the 1.5 million recorded in 2019, highlighting how the pandemic has exacerbated a long-standing issue. The delays are concentrated at the entry points to specialist care: initial consultations and diagnostic tests accounted for over 60 % of all waiting-time-related access barriers, far exceeding problems with subsequent treatment stages (ISTAT, 2024).

International comparisons offer a more nuanced perspective: for a specific basket of elective surgeries including cataract removal, hip and knee replacement, Italy reported an average waiting time of just 74 days in 2022, among the shortest in the EU and well below levels in countries with comparable per capita health spending, such as Spain and Portugal (Figure 21). However, these figures reflect only the interval from placement on the surgical list to the procedure itself, excluding the often lengthy delays in accessing the prerequisite consultations and diagnostic assessments

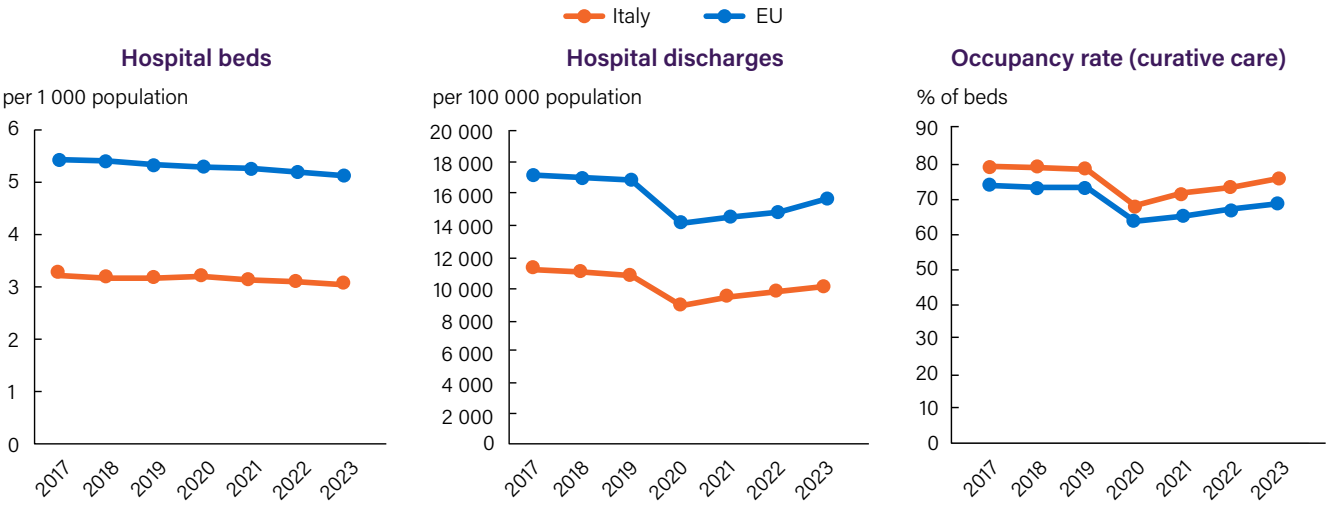
Figure 19. Across regions, LEA shortfalls tend to be clustered in prevention and community care



Notes: Composite scores for prevention, community health services and hospital care measure each region's ability to deliver Essential Levels of Care, using a set of 24 core indicators. A score of 100 denotes optimal performance, while any score below 60 (shaded in red) is deemed insufficient.
Source: Ministry of Health (2023)

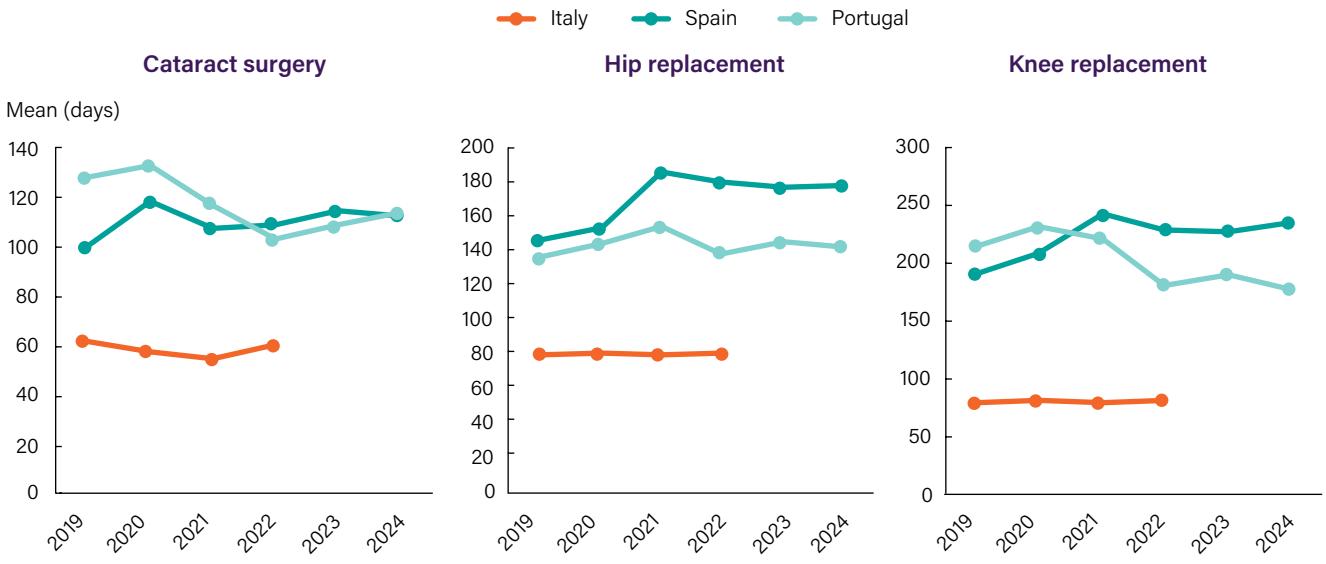
required before patients can even be placed on surgical lists. This discrepancy points to the diagnostic and referral stage as a key bottleneck in Italy's care pathway, rather than actual surgical delivery. In response, the government has adopted a *National Plan for Waiting List Management* (PNGLA) set for implementation in 2025-2027 (Box 1).

Figure 20. Hospital activity is still trending below pre-COVID levels



Note: The EU average is weighted for hospital beds and hospital discharges.
Source: Eurostat (hlth_rs_bds1) and OECD Data Explorer (DF_KEY_INDIC).

Figure 21. Once patients are placed on the list, Italy continues to report some of the shortest waiting times for elective surgeries in the EU



Source: OECD Data Explorer (DF_WAITING).

Box 1. Italy's new *National Plan for Waiting List Management*

To combat growing wait times, Italy launched the *National Plan for Waiting List Management* (2025-2027). The plan's cornerstone is the *National Waiting List Platform* (PNLA), a unified monitoring dashboard that became operational in July 2025. Initial data from the first half of 2025 indicates that while urgent services (mandated within three days) are delivered effectively, the system is struggling to manage less urgent care, which constitutes over 75 % of demand. While performance is strong in areas like oncology, significant delays persist elsewhere. For instance, deferrable cardiology consultations, which have a 30-day target, saw only 75 % of lists cleared after an average of 90 days.

To close these performance gaps, the plan introduces legally binding "patient protection pathways." These require local health authorities (ASLs) to offer patients timely alternatives when a service cannot be provided within the guaranteed timeframe, including referrals to other public or accredited providers or purchasing services from the private sector at public expense. This is backed by a dedicated national budget of EUR 50 million in 2025, rising to EUR 100 million annually from 2026. These funds are distributed as performance-based incentives for regions to hire staff, extend service hours or contract with private providers. The reform is further reinforced by dedicated regional oversight, mandatory system integration for all providers and penalties for missed appointments.

Source: Ministry of Health (2025)

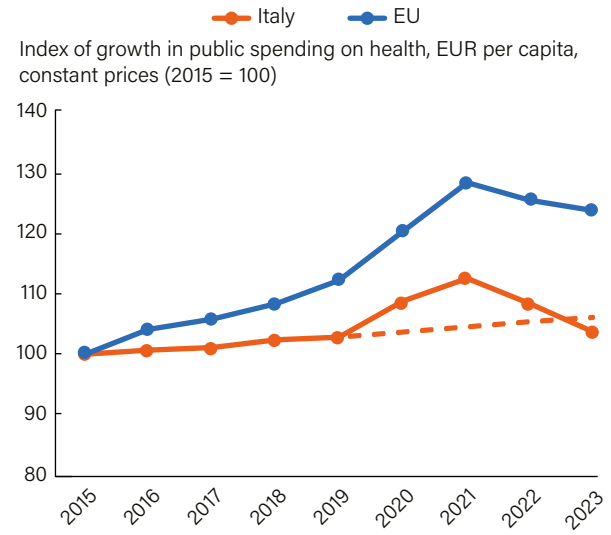
Amid competing fiscal demands, Italy's public health spending reverted to pre-pandemic levels in 2023

Between 2015 and 2019, Italy's real public health spending per capita grew by just 0.7 % per year, well below the EU average of 2.9 %. This modest growth reflected broader constraints on public expenditure, with healthcare's share of total government spending remaining stable at around 14 %. The COVID-19 pandemic temporarily reversed this trend: between 2019 and 2021, per capita public health spending increased by more than 9 % in real terms, driven largely by vaccine procurement and other emergency-related costs. However, real spending fell by 3.5 % in 2022 and by a further 4.5 % in 2023, bringing per capita expenditure back to its 2019 level and below the trajectory implied by the pre-pandemic trend (Figure 22). Despite real per capita spending returning to pre-pandemic levels, healthcare's share of total government expenditure dropped to an unprecedented low of 12 % in 2023 due to a sharp expansion of other public spending lines, primarily driven by tax credits for building renovations and rising interest payments on public debt, which effectively reduced healthcare's relative budgetary weight. While the planned discontinuation of energy and housing bonuses may create some fiscal space, healthcare will continue facing strong competition from pensions, debt servicing and other priority spending commitments (Ministry of Economy and Finance, 2024).

Italy receives substantial EU funding to support reforms and health system resilience

Italy is a major beneficiary of EU funding for health, drawing on three complementary instruments: the *Recovery and*

Figure 22. Italy's public healthcare spending per capita returned to its pre-COVID level in 2023



Notes: The EU average is weighted, calculated by the OECD. The dashed line represents the projected trend based on pre-pandemic (2015-2019) data.
Source: OECD Data Explorer (DF_SHA).

Resilience Plan (PNRR), the *Cohesion Policy* funds, and the *EU4Health* programme. While differing in scale and scope, these mechanisms share the objective of modernising health infrastructure and enhancing system resilience. The PNRR is by far the largest source, allocating EUR 16 billion to health between 2021 and 2026, equivalent to over 8 % of Italy's total Plan. These resources support structural reforms by upgrading infrastructure and digital systems, expanding community care through telemedicine and strengthening the health workforce. The 2021-2027 *Cohesion Policy* funds provide an additional EUR 1 billion, largely to reinforce healthcare capacity. Around 60 % of this allocation co-finances investments in health infrastructure, medical equipment and digitalisation, with the remainder directed at improving health system accessibility, efficiency and resilience. Finally, the *EU4Health* programme contributed EUR 136 million over 2021-2025; reflecting its focus on cross-border health threats, funding was concentrated on crisis preparedness (37 %) and cancer care (31 %).[3]

Diverging trends in the training of doctors and nurses put Italy at risk of a future skill mix imbalance

Over the past decade, Italy has expanded significantly its medical workforce training pipeline. The number of medical graduates peaked in 2020 and reached 16.6 per 100 000 population in 2023, 9 % above the EU average. At the same time, targeted policy measures have largely resolved the long-standing bottleneck in postgraduate medical training: over 50 000 residency contracts were financed between 2020 and 2024, nearly closing the gap between the number of medical graduates and available specialty training positions. However, recruitment into system-critical specialties remains weak: In 2024, one-quarter of residency posts went unfilled, with especially low uptake in system-critical specialties such as emergency medicine (30 % vacancy rate) and clinical pathology (15 %). Attrition compounds the problem, as about 9 % of residents abandon training before completion (ALS, 2024). Looking ahead, Italy intends to expand undergraduate medical education capacity further and adopt an 'open-access' admissions model (Box 2).

The nursing training pipeline, by contrast, is under growing strain. Since its 2013 peak, the annual output of nursing graduates has fallen steadily, dropping to a record low of 16.3 per 100 000 population in 2022 - less than half the EU average (Figure 23). This downward trend reflects a sharp decline in the profession's attractiveness: the applicant-to-place ratio for nursing programs fell from 1.6 in 2019 to just 1.04 in 2024, effectively eliminating selection pressure. High academic attrition worsens the shortfall, with first-year dropout rates reaching about 15 % in 2022-2023. Unless

Box 2. An ambitious plan to scale up medical education may shift bottlenecks downstream

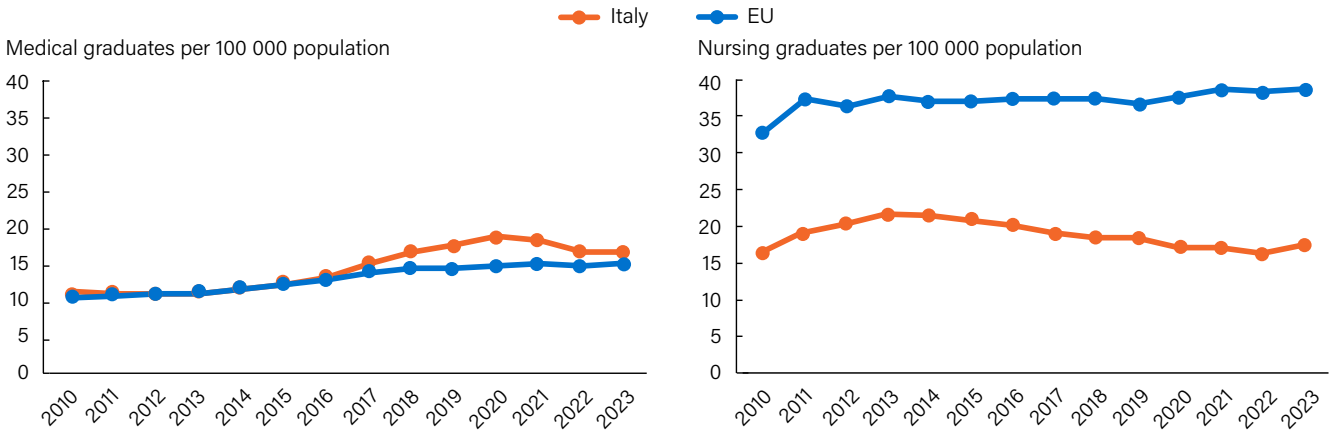
To meet projected workforce needs, Italian authorities announced a progressive scale-up of undergraduate medical education to produce 30 000 additional physicians by 2032 relative to a 'no-policy-change' trajectory, starting from about 20 900 entrants in 2023/24. At the same time, a comprehensive admissions overhaul began from the 2025 academic year: the long-standing multiple-choice entrance examination was replaced by an open-access first-semester track (the *semestre filtro*), where progression to the full medical curriculum depends on performance in a standardised national test at the semester's end.

While this reform should broaden opportunities and align supply with medium-term demand, stakeholder analyses identify three implementation risks. First, if postgraduate residency places do not expand in parallel with undergraduate capacity, the bottleneck may simply move from admission to specialisation, leaving surplus graduates unable to qualify as specialists. Second, a rapid increase in first-year cohorts could outpace available faculty and physical infrastructure, potentially affecting training quality. Finally, universities note that existing financing rules do not cover the incremental costs of larger student intakes, raising concern about unfunded budget pressures.

Sources: Ministry of University and Research (2025), SISM (2025).

[3] Data are based on the information available as of 20 September 2025; potential future amendments may affect these figures.

Figure 23. Since 2020, Italy has produced new nursing graduates at a rate less than half the EU average



Note: The EU average is weighted (calculated by the OECD). Data include graduates from all nursing programmes, not limited to those meeting the EU Directive for general nurses.
Source: OECD Data Explorer (DF_GRAD).

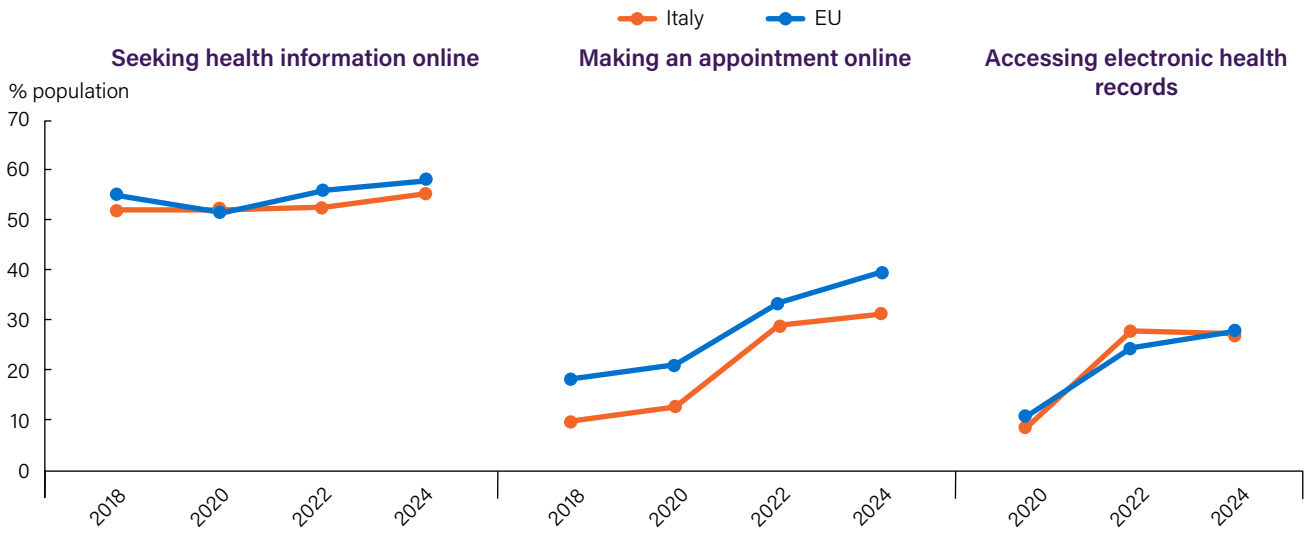
reversed, these divergent trajectories risk widening skill-mix imbalances just as Italy accelerates its shift towards community-based models of care that rely more heavily on nurses.

Italy has increased its investment in digital health in recent years, but progress remains constrained by persistent regional and digital skills gaps

Since the start of the pandemic, Italy has accelerated the digital transformation of its healthcare system, yet investment and public uptake remain below EU levels. Capital spending on digital health per capita has been about 30 % lower than the EU average since 2015, and public adoption of digital health tools is progressing unevenly: for example, in 2024, only 31 % of Italians reported booking a medical appointment digitally compared with 40 % across the EU. Conversely, the proportion of Italians accessing their electronic health records (EHRs) has grown rapidly, reaching the EU average of 28 % in 2024 (Figure 24). This progress reflects substantial investment under Italy's *PNRR*, which has funded the expansion of the country's core digital infrastructure, including the *Fascicolo Sanitario Elettronico* (FSE 2.0), the National Telemedicine Platform (*Piattaforma Nazionale di Telemedicina* - PNT) and the emerging Health Data Ecosystem (*Ecosistema Dati Sanitari* - EDS).

Although PNRR investments have scaled up the infrastructure of Italy's digital health system, with the FSE 2.0 covering 98 % of the population and almost all general practitioners connected by 2024, the decentralised governance of the SSN continues to create significant regional disparities in digital readiness. While northern regions generally lead in EHR interoperability and telemedicine deployment, actual user engagement rates remain uneven across the country, with several telemedicine initiatives remaining experimental or fragmented. These disparities highlight that, although strategic PNRR investments are successfully building core infrastructure, overcoming deeper barriers such as regional fragmentation and low digital literacy, with fewer than half of Italians possessing basic digital skills, is essential to realising the benefits of an integrated digital health system.

Figure 24. Italy's share of citizens accessing electronic health records matches the EU average

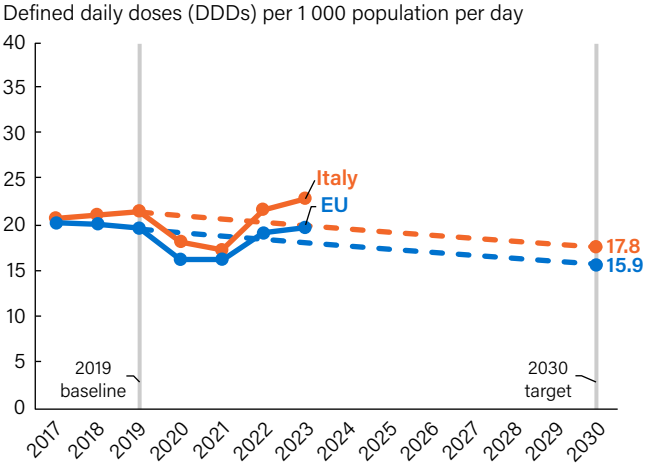


Source: Eurostat database (isoc_ci_ac_i).

Italy's antibiotic consumption remains high, posing a persistent challenge to AMR containment efforts

Excessive antibiotic use remains a major hurdle in Italy's fight against antimicrobial resistance (AMR). In 2023, consumption reached 23.1 defined daily doses (DDD) per 1 000 inhabitants per day - 16 % above the EU average and the largest gap in recent years. This consumption level places Italy off track from achieving the EU Council's target of an 18 % reduction from 2019 levels by 2030 (Figure 25). Regional disparities compound the challenge with community antibiotic use in northern regions being markedly lower than in southern regions, revealing uneven stewardship practices across the country. These elevated consumption levels correlate with Italy's adverse AMR profile: the ECDC's composite AMR index, which measures the proportion of bacterial isolates resistant to first-line pathogen-antibiotic pairs, ranks Italy sixth-worst in the EU. The problem extends beyond volume to prescription quality: only about half of antibiotic prescriptions fall into the WHO 'Access' group (antibiotics with lower resistance potential), well below the 65 % target. To address these challenges, Italy launched a new National Plan to Combat AMR 2022-2025, focusing on integrated surveillance, prevention of healthcare-associated infections, and promotion of judicious antibiotic use in both humans and animals (Ministry of Health, 2023).

Figure 25. Italy's antibiotic consumption is not on track to achieve its 2030 reduction target



Note: The EU average is weighted. The chart shows antibiotic consumption in hospital and the community. The dashed line illustrates the policy target pathway to meet the 2030 reduction targets.
Source: ECDC ESAC-Net.

6 Spotlight on pharmaceuticals

Private spending drives a relatively large share of pharmaceutical financing in Italy

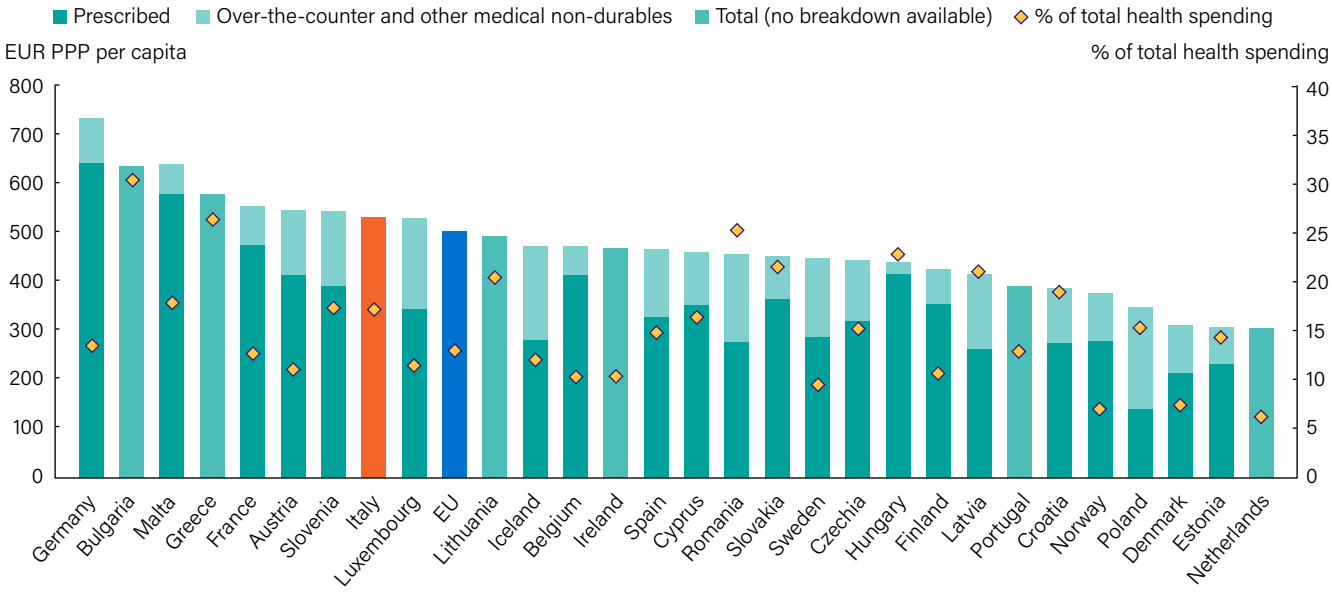
Italy's expenditure on retail medicines is only moderately above the EU average in per capita terms, but absorbs a significantly larger share of current health spending. In 2023, per capita spending on retail medicines reached EUR 539 (adjusted for differences in purchasing power), around 6 % above the EU average. However, this accounted for 17 % of Italy's current health expenditure compared to 13 % on average across the EU (Figure 26). OOP payments represent a comparatively large share of pharmaceutical spending in Italy: in 2023, OOP spending on retail medicines totalled EUR 10.6 billion, nearly 28 % of total pharmaceutical expenditure. This included about EUR 7.1 billion for non-reimbursed 'Class C' medicines and EUR 1.1 billion in price differentials paid by patients who chose originator drugs over reimbursed generics. These theoretically avoidable payments varied across regions, ranging from EUR 23.5 per capita in the South to EUR 13.3 in the North (AIFA, 2024). Taken together, private payments for retail medicines represented 6.5 % of Italy's total health expenditure, well above the EU average of 3.9 %.

Despite this high reliance on private financing, medicine prices in Italy remain relatively contained, reflecting a longstanding regulatory framework led by the Italian Medicines Agency (AIFA), which centrally evaluates reimbursable 'Class A' (for outpatient use) and 'Class H' (for hospital settings) medicines based on therapeutic benefit and cost-effectiveness. In early 2024, a unified Scientific and Economic Committee (CSE) was established to consolidate technical and pricing review functions, with the aim of streamlining decision-making and regulatory procedures.

Italy's total pharmaceutical spending is dominated by hospital procurement

Italy's pharmaceutical system is dominated by hospital-based procurement. In 2023, medicines acquired directly by hospitals or dispensed through the *distribuzione per conto* (DPC) scheme accounted for about three-quarters of total pharmaceutical expenditure, compared with an EU average of around 41 % (Figure 27). This pronounced skew reflects both the rising use of high-cost specialist medicines and a deliberate policy to channel many high-volume chronic-care drugs, such as new oral anticoagulants and modern antidiabetics, through hospital tenders, enabling public payers to negotiate lower prices and monitor prescribing more closely than in the retail sector. This classification 'inflates' Italy's apparent hospital share; for instance, non-vitamin K antagonist oral anticoagulants (NOACs) like apixaban and rivaroxaban are supplied via direct distribution or DPC in Italy and recorded as hospital expenditure, even though patients take them at home. In several other EU countries, the same products are dispensed through retail pharmacies (AIFA, 2024).

Figure 26. Retail medicines account for a greater share of health spending than the EU average



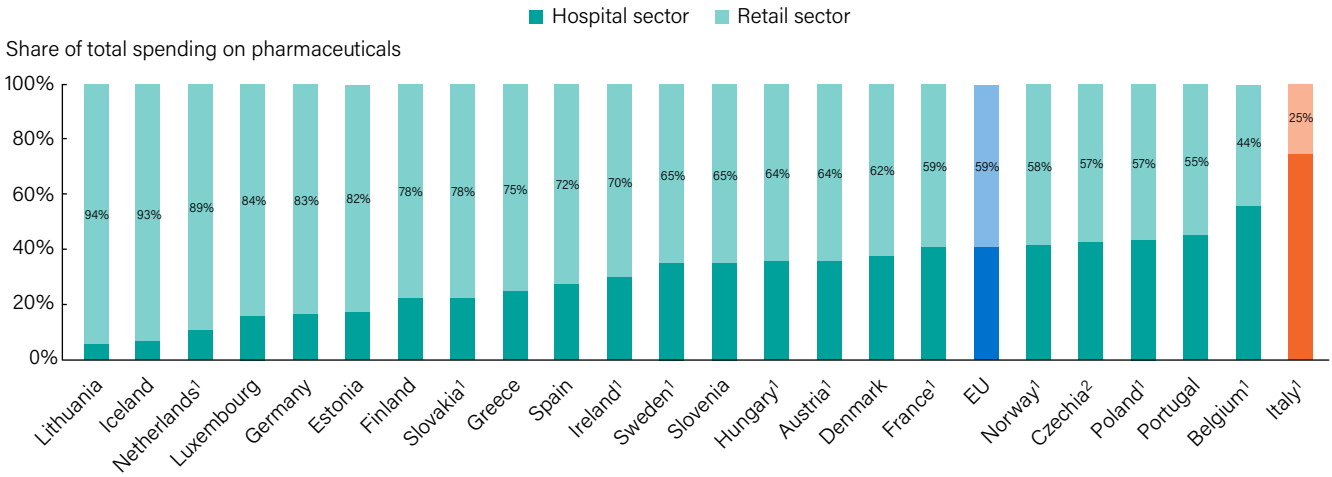
Note: This figure represents pharmaceutical expenditures dispensed through retail pharmacies for outpatient use only. It excludes medications administered in hospitals, clinics or physician offices.
Source: OECD Data Explorer (DF_SHA). Data pertain to 2023, except for Norway (2022).

Even accounting for this classification difference, antineoplastic and immunomodulating agents remain the principal cost driver within Italy's hospitals, absorbing 44 % of their pharmaceutical budget in 2023. Spending rose over 6 % year-on-year, driven by 10 % higher consumption and a 2 % positive mix effect toward newer, costlier therapies, which offset a nearly 5 % decline in unit prices. This hospital-centric model is central to Italy's cost-containment strategy and complements its extensive use of Managed Entry Agreements (Box 3). However, recognising potential access barriers for chronic-condition patients, regulators have recently reclassified certain medicines, including oral antidiabetics such as gliflozins, for conventional pharmacy distribution.

Another key instrument in Italy's pharmaceutical policy is the Innovative Medicines Fund (IMF), a fiscally self-contained fund that supports access to high-cost, high-value therapies. A significant 2025 reform refined the process for granting 'innovative' status, creating a more stringent binary system of 'innovative' or 'not innovative', eliminating the previous 'conditionally innovative' category.

Under the new rules, innovative status is awarded on an indication-specific basis for a maximum of 36 months. To qualify, a therapy must undergo a comprehensive assessment and meet strict requirements for unmet therapeutic need, added therapeutic benefit and quality of evidence. The 36-month period is reserved for

Figure 27. Italy's pharmaceutical expenditure is concentrated in the hospital channel



Notes: The EU average is weighted. Data refer to 2023, except for Norway and Slovenia (2022). Hospital pharmaceutical sales data for the Netherlands are incomplete, leading to an overestimation of the share of retail pharmacy sales.
Sources: OECD Data Explorer (DF_SHA); [1]IQVIA and Swedish Dental and Pharmaceutical Benefits Agency, 2024; [2]Czech Institute of Health Information and Statistics.

Box 3. Italy is a European leader in the use of Managed Entry Agreements

To manage the clinical and financial uncertainty associated with high-cost novel therapies, Italy has become a leading user of Managed Entry Agreements (MEAs). These agreements aim to provide patient access to innovative drugs while ensuring the financial sustainability of the SSN. These agreements fall into two main categories:

- *Outcome-based* MEAs directly link reimbursement to a drug's real-world performance. The most prominent type is *payment-by-result*, where AIFA tracks individual patient outcomes against pre-agreed clinical endpoints. If a treatment fails to deliver the expected benefits, the manufacturer refunds the cost of the drug, transferring risk from the SSN to the company.
- *Financial-based* MEAs are designed to manage budgetary impact regardless of clinical outcome. They include patient-level agreements, such as cost-sharing, and population-level agreements, such as expenditure caps, where a firm annual budget ceiling is set for a specific drug. If sales exceed this cap, the manufacturer must pay back the overspend in full.

The implementation of patient-level agreements is enabled by AIFA's digital platform, which tracks over 300 active registries, primarily for high-cost drugs in oncology, immunology and rare diseases. In 2023, these agreements generated EUR 218 million in refunds and discounts, with 72 % coming from financial-based agreements.

Source: AIFA (2024)

first-in-class products, and subsequent medicines in the same class are only granted status for the remainder of the initial period. For the 2025 fiscal year, the fund's EUR 1.3 billion budget has been allocated to two main areas: EUR 1.2 billion for medicines meeting the full innovative criteria and a dedicated EUR 100 million for WHO-designated reserve antibiotics and those active against priority pathogens (Ministry of Economy and Finance, 2024).

Recurring breaches of the hospital pharmaceutical spending ceiling prompted a revision of budget control mechanisms

Persistent pharmaceutical overspending remains a major challenge for Italy's SSN, driven entirely by hospital procurement. In 2023, direct hospital purchases exceeded their 8.15 % allocation of the National Health Fund (NHF) by over EUR 3 billion, while retail pharmaceutical expenditure remained EUR 690 million below its ceiling. This imbalance triggered the payback mechanism, under which pharmaceutical manufacturers and regional authorities jointly cover the shortfall. The hospital overspending widened further in 2024 despite budgetary adjustments intended to mitigate it: even after raising hospitals' ceiling to 8.5 % of the NHF, the breach exceeded EUR 4 billion. This deterioration stemmed partly from transferring financing for certain innovative medicines from the IMF, which recorded a EUR 500 million surplus, to ordinary hospital budgets (AIFA, 2025).

The scale and persistence of these breaches have exposed limitations in the current framework, prompting the government to launch discussions in July 2025 on comprehensive pharmaceutical legislation reform through a new Consolidated Act (*Testo Unico*). The proposed reform seeks to move beyond incremental adjustments to spending ceilings by modernising the payback mechanism with sophisticated, data-driven tools that would transform it from a routine, reactive instrument into a true contingency measure activated only when preventive controls fail.

Italy's access times for new medicines are among the fastest in Europe

Italy ranks among Europe's fastest performers in providing access to new medicines, though this achievement requires careful interpretation. The 2024 EFPIA Patients WAIT Indicator Survey shows that medicines approved by the European Commission between 2020 and 2023 reached Italian patients in an average of 439 days, over four months faster than the EU average of 578 days, with 83 % of these medicines reimbursed, second only to Germany (Newton et al, 2025). Performance is particularly strong in oncology, where 86 % of cancer therapies gained reimbursement within an average of 441 days, approximately 140 days shorter than the EU average. Similarly, Italy reimbursed 70 % of approved orphan medicines, well above the EU average of 42 %, within 498 days compared with 611 days EU-wide. This reflects Italy's strategy of early but conditional access to high-cost therapies through instruments such as Managed Entry Agreements, with roughly three-quarters of reimbursed orphan medicines subject to conditional terms.

However, these headline mask significant on-the-ground complexities. Firstly, national reimbursement decisions are followed by regional authorisation requirements, which add an average of two months to patient access, with a notable north-south disparity in speed. More fundamentally, the WAIT indicator measures the time to a reimbursement decision, not actual patient uptake, which can be limited by prescribing restrictions and clinical practice. Finally, the timelines are also influenced by external factors, such as manufacturers' commercial launch strategies, meaning the data do not solely reflect the efficiency of Italy's national processes.

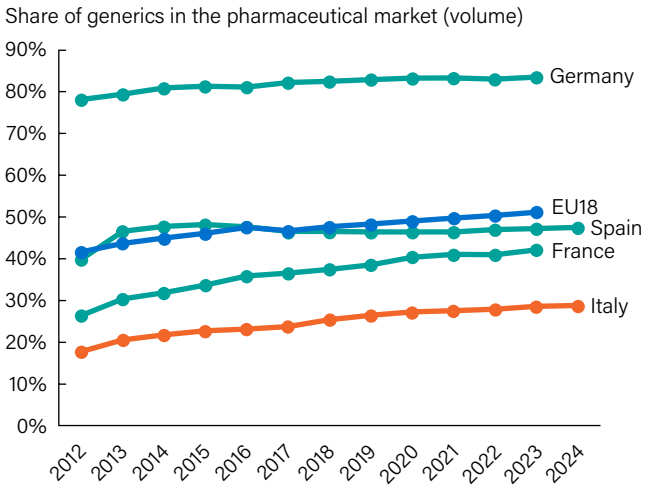
Italy has one of the highest adoption rates for biosimilars, yet the uptake of generics in its retail sector remains low

Italy's generic medicines market is significantly underdeveloped, generating significant inefficiencies for

both the national health service and households. In 2024, generics accounted for only 29 % of pharmaceutical volumes, well below the EU average of over 50 % (Figure 28). Italy's reference pricing system, which requires patients to pay the difference in price when choosing originator drugs over reimbursable generics, has not succeeded in changing behaviour at scale. In 2023, Italian patients incurred an estimated EUR 1.06 billion in avoidable out-of-pocket payments to cover price differences for branded medicines when generic equivalents were available.

Uptake also shows a marked territorial divide that reinforces existing inequalities: In 2023, generic spending represented 40 % of total spending on covered off-patent medicines in the north, compared with 23 % in the south and islands. This counterintuitive pattern stems from a combination of cultural, informational and policy factors; persistent mistrust of generics and a cultural preference for branded drugs remain widespread, particularly in the south, compounded by limited public awareness of the therapeutic equivalence of generic medicines.

Figure 28. Generic medicines have a low penetration rate in the Italian pharmaceutical market



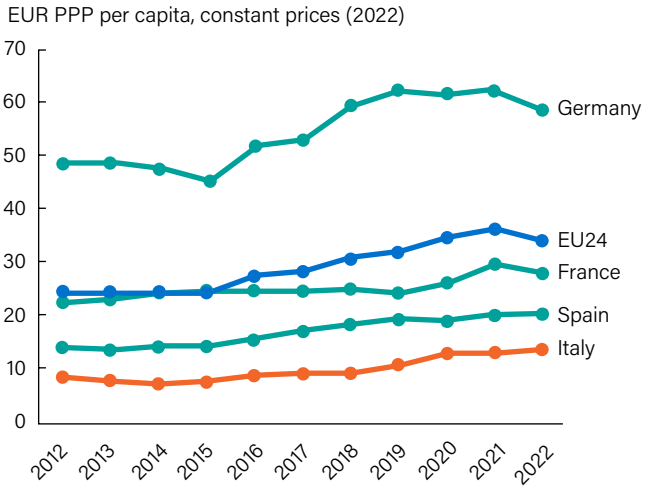
Note: The EU average is weighted.
Source: OECD Data Explorer (DF_GEN_MRKT).

To address these market barriers, Italy introduced a reformed pharmacy remuneration system in 2024. The previous model compensated pharmacies solely through percentage margins linked to retail prices, inadvertently incentivising the dispensing of higher-priced medicines. The new mixed scheme combines a fixed fee-per-pack with a lower ad-valorem margin, aligning financial incentives with expanding generic use. This weak retail performance contrasts sharply with Italy's success in promoting the use of biosimilars : centralised procurement and stringent governance have driven biosimilar penetration to about 67 % of the addressable market by volume, significantly above the EU average of approximately 32 % and placing Italy among the EU's top performers in this area (AIFA, 2024).

Italy's pharmaceutical sector converts modest R&D expenditure into robust innovation outputs

Italy's pharmaceutical sector represents a major force in EU manufacturing, with the second-largest pharmaceutical industry output after Ireland at EUR 52 billion in 2023, characterised by an efficient mix of research and industrial production. While business enterprise R&D has grown steadily, rising from approximately EUR 10 per capita before 2018 to a record EUR 14 in 2022, this figure remains modest in a European context, standing at less than half the EU average of EUR 35 per capita (Figure 29). Despite relatively low investment in R&D, Italy's innovation output remains competitive: the number of international pharmaceutical patent applications from applicants based in Italy rose from 137 in 2010 to nearly 200 in 2022, equivalent to 3.2 filings per million population, a rate in line with the EU average. This innovation capacity is also evident in clinical trial activity, which stabilised at approximately 16 trials per million population in 2024 - in line with the EU average and representing 11 % of all EU clinical trials. Regarding the structure of this research, recent national data indicates a predominance of industry sponsorship, with the majority of trials approved between 2020 and 2023 being industry-sponsored, while less than a quarter were no-profit studies. In other respects, Italy's research profile aligns with the EU average, with approximately 86 % of trials being international, half involving multi-country collaboration and a stable 40 % share consisting of early-phase trials.

Figure 29. Italy's private pharmaceutical R&D spending per capita is less than half the EU average



Note: The EU average is weighted (calculated by the OECD).
Source: OECD Data Explorer (DF_ANBERDi4).

A mix of financial incentives and strategic investments underpins this activity. Tax policy plays a central role, with a dedicated 20 % R&D tax credit for pharmaceutical and vaccine research in place from 2021 to 2030, complementing general R&D tax incentives and a "patent box" regime that offers deductions on income derived from patented innovations. Public investment is also channelled through direct grants supporting biotech clusters under the National Health Research Programme and the Research Projects of National Interest (PRIN). Italy's public investment bank (CDP) and regional authorities co-finance biotech start-ups, clinical research and manufacturing upgrades, often in collaboration with EU funding instruments.

7 Key findings

- In 2024, Italy's life expectancy reached 84.1 years, the highest in the EU, surpassing pre-pandemic levels for the first time following a rebound of 0.6 years from 2023. Cardiovascular diseases and cancer remain the leading causes of mortality, accounting for 31 % and 23 % of deaths respectively. These conditions contribute to a high burden of disease: over 15 % of the population lives with cardiovascular disease, more than 6 % has a history of cancer, and nearly half of adults with hypertension are either undiagnosed or untreated.
- Behavioural risk factors were linked with nearly one in four deaths in 2021; poor diet was the largest contributor, followed by tobacco use. While adult smoking rates have plateaued at just under 20 %, youth nicotine consumption is rising sharply, with 27 % of 15-year-olds reporting recent use - ten percentage points above the EU average. Although Italy's childhood overweight rates remain below the EU average, adolescent physical activity is the lowest in the EU and obesity rates are high.
- Italy's National Health Service provides universal health coverage through regionally-governed provider networks. Current health spending per capita is 19 % below the EU average, with a comparatively high share financed out-of-pocket. Resources are concentrated on outpatient care and pharmaceuticals, with only 10 % allocated to long-term care. While Italy reported 5.4 doctors per 1 000 population, exceeding the EU average by 25 %, nurse density stood at only 6.9 per 1 000, over 20 % below the EU average. General practice is under severe strain, with over half of GPs exceeding their maximum caseload of 1 500 patients per physician.
- Italy achieves strong health outcomes, with avoidable mortality rates significantly below the EU average and the lowest hospital admission rates for chronic conditions in the EU. Influenza vaccination coverage among older adults remains above the EU average at 53 %, but HPV vaccination rates among 15-year-old girls have declined to 55 %, falling below the EU average of 63 %. Cancer screening participation has yet to fully recover from the pandemic-induced disruption, with rates remaining markedly low for cervical cancer screening in southern regions.
- While virtually all hospital care costs are publicly funded, lower public financing rates for outpatient care services and nearly non-existent public coverage for dental care contribute to high out-of-pocket spending levels. These access barriers disproportionately affect lower-income groups, creating marked socioeconomic inequalities in unmet healthcare needs. Despite improving regional compliance with essential service standards, several southern and smaller regions continue to underperform in key areas.
- Waiting times pose a significant challenge to Italy's healthcare system. While waiting times for elective surgery are relatively short, access to diagnostics and specialist consultations remains limited, resulting in high rates of foregone care. While publicly-funded health spending has returned to 2019 levels, extensive EU funding has been mobilised to support investments in digitalisation and infrastructure upgrades. Diverging trends in medical and nursing training risk exacerbating workforce imbalances, as an increase in medical training contrasts with a decline in nursing graduates. High antibiotic consumption undermines ongoing efforts to control antimicrobial resistance.
- Retail medicines accounted for 17 % of Italy's health spending in 2023, four percentage points above the EU average. At the same time, Italy's pharmaceutical market is dominated by hospital procurement, accounting for three-quarters of total spending compared to 41 % across the EU. Although this approach enables tighter price control and greater negotiating leverage, hospital pharmaceutical spending often exceeds its budget, triggering industry payback mechanisms. Against this backdrop, Italy provides faster access to new medicines than most EU countries and leads in biosimilar adoption, although uptake of generics remains low. Despite modest R&D investment, Italy maintains competitive patent filing rates and clinical trial activity in line with EU averages.

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Country abbreviations

Austria	AT	Czechia	CZ	Germany	DE	Italy	IT	Netherlands	NL	Slovakia	SK
Belgium	BE	Denmark	DK	Greece	EL	Latvia	LV	Norway	NO	Slovenia	SI
Bulgaria	BG	Estonia	EE	Hungary	HU	Lithuania	LT	Poland	PL	Spain	ES
Croatia	HR	Finland	FI	Iceland	IS	Luxembourg	LU	Portugal	PT	Sweden	SE
Cyprus	CY	France	FR	Ireland	IE	Malta	MT	Romania	RO		

State of Health in the EU
Country Health Profiles 2025

The *Country Health Profiles* are a key element of the European Commission's *State of Health in the EU* cycle, a knowledge brokering project developed with financial support from the European Union.

These Profiles are the result of a collaborative partnership between the Organisation for Economic Co-operation and Development (OECD) and the European Observatory on Health Systems and Policies, working in tandem with the European Commission. Based on a consistent methodology using both quantitative and qualitative data, the analysis covers the latest health policy challenges and developments in each EU/EEA country.

The 2025 edition of the *Country Health Profiles* provides a synthesis of various critical aspects, including:

- the current state of health within the country;
- health determinants, with a specific focus on behavioural risk factors;
- the structure and organisation of the health system;
- the effectiveness, accessibility and resilience of the health system;
- an account of the pharmaceutical sector and policies within the country.

Complementing the key findings of the Country Health Profiles is the *Synthesis Report*.

For more information, please refer to: https://health.ec.europa.eu/state-health-eu_en

Please cite this publication as: OECD/European Observatory on Health Systems and Policies (2025), *Country Health Profile 2025: Italy*. *State of Health in the EU*, OECD Publishing, Paris/ European Observatory on Health Systems and Policies, Brussels.

BETTER POLICIES FOR BETTER LIVES

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