

NATIONAL REPORT - ITALY

Executive Summary

Italy's National Health Service (Servizio Sanitario Nazionale — SSN) was established in 1978 as a universal, tax-funded healthcare system founded on the principles of universality, equity and solidarity. For decades, it has represented an important European model of broad-based access to healthcare.

The system is now facing a structural sustainability challenge. Two developments are increasingly interconnected: persistent pressure on public healthcare financing and a growing crisis in the medical workforce, particularly among hospital physicians with clinical and managerial responsibilities.

Public healthcare expenditure remains below the levels observed in most comparable European countries. According to the latest GIMBE analysis, public healthcare spending represented 6.2% of GDP in 2025, compared with an OECD and European average of 7.1%, placing Italy last among the G7 countries on this measure. (GIMBE Press)

Regarding the sustainability of the Italian Health System, it should not be overlooked that the latest study on tax revenues by the *Itinerari Previdenziali* Research Centre - presented on September 24, 2026, at the CNEL (National Council for Economics and Labour) - highlighted that in Italy, a mere 30.22% of citizens pay 78.67% of the total national income tax (IRPEF).

At the same time, households are bearing an increasing share of healthcare costs, while private insurance and supplementary healthcare funds have expanded significantly. This is contributing to the emergence of an increasingly hybrid public-private healthcare model. Institutional analysis has raised concerns that part of this private expenditure is no longer simply complementary to the SSN, but is increasingly substituting for services traditionally delivered by the public system.

Access pressures are particularly visible in persistent waiting lists. The European Commission's 2026 assessment of Italy highlights increasing waiting times, out-of-pocket expenditure above the EU average, significant territorial disparities and shortages of healthcare personnel. (EUR-Lex)

The workforce dimension is equally critical. Staff shortages, an ageing medical workforce, comparatively low remuneration, high taxation, administrative burdens, professional-liability exposure, workplace violence and burnout are increasingly affecting the attractiveness and sustainability of hospital medical careers.

The resulting dynamic risks becoming self-reinforcing: underinvestment contributes to capacity constraints; capacity constraints increase waiting times; longer waiting times encourage patients to seek private care; and the expansion of private alternatives may further weaken the relative role and attractiveness of the public system.

The issue is therefore not simply one of healthcare expenditure. It is increasingly a question of system capacity, workforce sustainability and the long-term ability of the SSN to maintain universal and equitable access to care.

1. A Universal System Under Increasing Financial Pressure

The Italian SSN remains fundamentally based on universal access and public financing. However, the level of resources allocated to healthcare has increasingly diverged from the pressures generated by demographic change, technological development, rising healthcare needs and workforce costs.

GIMBE's most recent analysis estimates that public healthcare spending amounted to 6.2% of GDP in 2025, significantly below the 7.1% average for both the OECD and European countries. Italy also ranked last among G7 countries in per-capita public healthcare expenditure. (GIMBE Press)

The issue is not only the level of current expenditure but also the medium-term relationship between projected healthcare needs and available public resources. GIMBE's analysis of the 2026 Public Finance Document identifies a widening gap between projected healthcare expenditure and the National Health Fund, reaching an estimated €30.6 billion over 2027–2029.

This suggests that the central challenge is increasingly structural rather than cyclical: the resources available to the SSN may not be keeping pace with the expenditure required to maintain existing levels of service provision.

GIMBE has warned that the combination of progressive public underfunding and the expansion of private intermediation is creating increasing pressure on the sustainability of the SSN.

2. Waiting Lists and Access to Care

Waiting times have become one of the most visible indicators of pressure on the Italian healthcare system.

Demand is particularly concentrated in specialties such as ophthalmology, dermatology, cardiology, orthopaedics and otorhinolaryngology. Although successive governments have introduced measures intended to reduce waiting times and improve monitoring, implementation remains uneven.

The problem extends beyond officially recorded waiting lists. A significant number of patients may never enter the formal waiting-list system because they are unable to obtain an appointment, postpone care indefinitely or turn directly to private providers.

This creates a potential feedback loop:

capacity constraints → longer waiting times → increased private demand → expansion of private provision
→ reduced relative attractiveness of public provision.

The European Commission's 2026 assessment confirms that access to healthcare in Italy has deteriorated in recent years, specifically identifying increasing waiting lists, above-average out-of-pocket expenditure, territorial disparities and healthcare staff shortages as key structural issues. (EUR-Lex)

2.1 Out-of-Pocket Expenditure and Forgone Care

Out-of-pocket (OOP) expenditure is the clearest financial signal that access to the SSN is being partially shifted onto households. According to GIMBE's 8th Report on the National Health Service (October 2025), direct household spending on healthcare reached €41.3 billion in 2024, equal to 22.3% of total health expenditure. Italy has now remained above the 15% threshold indicated by the World Health Organization — beyond which the risk of financial hardship and catastrophic spending increases — for more than a decade.

The composition of this spending is revealing. In 2023, households spent about €12.1 billion in pharmacies, €10.6 billion on independent health professionals (of which €5.8 billion on dentists), €7.6 billion in private facilities accredited with the SSN and €7.2 billion in non-accredited private facilities. Spending in the purely private, non-accredited sector rose by 137% between 2016 and 2023, from roughly €3.05 billion to €7.23 billion. This is the segment most directly associated with patients leaving the public system because of waiting times.

The counterpart of rising OOP expenditure is forgone care. ISTAT data reported by GIMBE show that the number of people who gave up at least one healthcare service they needed, mainly because of long waiting times or cost, rose from 4.1 million in 2022 to 5.8 million in 2024 — roughly one resident in ten.

Out-of-pocket payments are the most regressive form of health financing: they weigh most heavily on lower-income households, older people and those with chronic conditions, and they widen the territorial gap between regions. A system in which more than one euro in five of health spending is paid directly by patients can remain formally universal while becoming progressively less equitable in practice.

2.2 Hospital Bed Capacity: Eurostat Data

Hospital capacity is a second structural constraint. According to Eurostat, Italy had 311.7 hospital beds per 100,000 inhabitants in 2024, compared with an EU average of 507 — around 39% below the EU level. Countries such as Germany (759) and Bulgaria (870) have more than twice Italy's bed density.

Italy's figure has declined over time, from 338.5 beds per 100,000 inhabitants in 2012 to 316.3 in 2019 and a low of 304.1 in 2023, before a slight recovery in 2024. Psychiatric beds are particularly scarce, at around 7.9 per 100,000 inhabitants. The reduction was driven largely by cost-containment policies and by the hospital standards set by Ministerial Decree 70/2015, which fixed a target of 3.7 beds per 1,000 inhabitants (3.0 for acute care and 0.7 for rehabilitation and long-term post-acute care); national availability now stands below that benchmark.

Bed numbers are falling across the EU as well (from 582 per 100,000 in 2009), reflecting the shift towards day surgery and outpatient care. Countries with low bed density, such as the Netherlands, Denmark and Sweden, however, generally rely on strong community and territorial care networks. In Italy, the territorial reform introduced by Ministerial Decree 77/2022 and financed by the National Recovery and Resilience Plan (Community Houses and Community Hospitals) is still being implemented and is itself constrained by staff shortages.

The practical consequences are visible in emergency departments: a shortage of available ward beds leads to patients remaining in the emergency department after admission has been decided (boarding), overcrowding and longer waiting times, further increasing the workload of hospital physicians.

3. The Medical Workforce: The Critical Constraint

Financial sustainability is only one side of the equation. The SSN ultimately depends on its ability to recruit, retain and motivate healthcare professionals.

Italy is facing a combination of immediate staffing shortages and longer-term demographic pressure.

A large proportion of Italian doctors are approaching retirement age, while the inflow of newly trained specialists is not sufficient to fully compensate for departures and growing healthcare demand.

Emergency medicine illustrates the scale of the problem particularly clearly. According to SIMEU's January 2026 survey, a substantial proportion of emergency departments were operating with staffing levels significantly below their estimated requirements.

The consequences extend beyond workload. Persistent understaffing can affect continuity of care, clinical organisation, working-time patterns, professional development and the ability of hospitals to provide services within reasonable timeframes.

3.1 Medical Plethora and Access to Medical School

The Italian workforce crisis presents an apparent paradox. According to the OECD/European Observatory Country Health Profile 2025, Italy's density of doctors is around 25% above the EU average, while hospitals, emergency departments and general practice report serious shortages. The problem is therefore not primarily the total number of doctors, but their distribution across specialties, sectors and regions, the age structure of the workforce and, above all, the declining attractiveness of employment in the SSN.

Italy has already experienced a "medical plethora" (plethora medica). Open access to medical faculties in the 1970s and 1980s produced a large surplus of graduates, with significant unemployment and underemployment among young doctors. This led to the introduction of a national limit on admissions (numerus clausus) with Law 264/1999. In the 2010s the main problem became the "training bottleneck" (imbuto formativo): many graduates could not access postgraduate specialty training, which is required for hospital employment. The number of specialty training contracts has since been increased substantially, to around 14,000 per year.

In recent years admissions to medicine have also been expanded sharply, roughly doubling over the past decade. From the 2025/26 academic year, following Law 26/2025 and Legislative Decree 71/2025, the entrance test has been replaced by an open-access "filter semester": all applicants can enrol, attend a common first semester and sit national exams in chemistry, physics and biology, with admission to the second semester based on a national merit ranking. In the first year, 17,278 places were available in medicine (24,026 including dentistry and veterinary medicine), and 22,688 students qualified for the ranking.

The reform does not abolish selection: the number of places remains limited and is still set at national level. It has, however, been criticised for moving selection from an entrance test to university exams, with high failure rates, particularly in physics, and considerable uncertainty for students and universities.

The Italian Association of Hospital Doctors (Anao Assomed) has warned that the combined effect of increased admissions and the reform risks creating a new medical plethora. Its projections estimate that about 109,000 doctors will retire by 2032, while about 141,000 are already in training, implying a surplus of more than 30,000 doctors; after the reform, Anao estimates that up to 60,000 doctors could be seeking employment by 2032. Students entering medical school in 2025 will complete specialty training only around 2035, too late to address current shortages.

The policy lesson is that increasing the number of medical students is not, by itself, a solution to the workforce crisis. Without improvements in remuneration, working conditions and career prospects in the public system, a larger supply of doctors risks producing both unemployment or underemployment and continued shortages in the SSN, with more young physicians choosing the private sector or leaving Italy. Workforce planning must align undergraduate places, specialty training posts and the actual needs of the health system.

4. From a Funding Problem to a System-Capacity Problem

The evidence suggests that the current challenges facing the SSN should not be interpreted solely as a question of insufficient funding.

The more fundamental issue is the interaction between financial resources, workforce capacity, organisational resilience and access to care.

A healthcare system can have formally universal coverage while experiencing growing barriers to effective access if patients face prolonged waiting times, geographical disparities or increasing out-of-pocket costs.

Similarly, increasing healthcare expenditure does not automatically translate into greater capacity if additional resources are not accompanied by adequate workforce planning, organisational reform and investment in infrastructure and digital systems.

The sustainability challenge facing the SSN is therefore multidimensional.

5. Strategic Implications

Five structural priorities emerge from this analysis:

1. Align public healthcare financing with projected demand.

Long-term financial planning should take into account demographic change, healthcare inflation, technological development and workforce costs rather than focusing exclusively on annual budget allocations.

2. Treat the medical workforce as strategic infrastructure.

Recruitment, retention, remuneration, career progression and working conditions should be considered core components of healthcare capacity.

3. Reduce the structural drivers of waiting lists.

Increasing short-term capacity without addressing workforce shortages, organisational inefficiencies and regional disparities is unlikely to provide a durable solution.

4. Rebalance public and private provision.

The expansion of private healthcare should be assessed not only in terms of additional capacity but also in terms of its impact on equity, affordability and the ability of the SSN to guarantee universal access.

Conclusion

Italy's National Health Service is not facing a single crisis but a convergence of structural pressures.

Public financing remains below the level observed in many comparable European systems; waiting times and out-of-pocket expenditure are increasing; regional disparities persist; and the healthcare workforce is under growing demographic, economic and organisational pressure.

The medical workforce is particularly important because it represents the link between financial resources and actual service capacity. Without sufficient numbers of adequately remunerated and supported physicians, additional financial resources alone cannot guarantee access to care.

Conversely, workforce shortages cannot be sustainably addressed without confronting the broader financial and organisational conditions under which doctors work.

The central challenge for the SSN is therefore to preserve the practical meaning of universal healthcare in an environment characterised by constrained public resources, growing private provision, international competition for medical talent and increasingly differentiated access to care.

The issue is ultimately not whether Italy should have a public or private healthcare system. The more immediate policy question is how to ensure that the public system retains sufficient financial, organisational and human capacity to fulfil its universal mandate.

Recent European-level assessments reinforce the urgency of this question: the European Commission has identified deteriorating access, waiting lists, above-average out-of-pocket expenditure, territorial disparities and healthcare staff shortages among Italy's key structural healthcare challenges. (EUR-Lex)

At the same time, GIMBE's latest analysis indicates that public healthcare expenditure stood at 6.2% of GDP in 2025 and remained well below the OECD and European averages. (GIMBE Press)

Taken together, these indicators point to a healthcare system under sustained structural pressure — where the sustainability of public financing, the retention of medical talent and the preservation of equitable access are increasingly inseparable policy challenges.

Selected sources

** Fondazione GIMBE, Public Healthcare Expenditure in Italy and OECD/EU Comparison, 2026.*

- * *Fondazione GIMBE, analysis of the 2026 Public Finance Document.*
- * *Itinerari Previdenziali Research Centre, 2024 tax returns: analysis of IRPEF and other direct and indirect taxes by amount, type of taxpayer, and region over the last 17 years.*
- * *Parliamentary Budget Office (UPB), analyses of public and private healthcare financing in Italy.*
- * *Italian Society of Emergency Medicine (SIMEU), Survey on Emergency Department Staffing, 2026.*
- * *Ministry of Health, data on violence against healthcare personnel.*
- * *OECD, Health Statistics.*
- * *European Federation of Salaried Doctors (FEMS), White Book, 2025.*
- * *Court of Auditors, reports on the financial management of the National Health Service.*
- * *European Commission, 2026 Country-Specific Recommendations for Italy.*
- * *Law No. 24/2017 (Gelli-Bianco).*