THE ITALIAN NATIONAL HEALTH SERVICE

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Historical evolution

1948 → Art. 32 of Italian Constitution : «The Republic protects health as a fundamental right of the individual and in the interest of the community and guarantees free medical care to the indigent.»

Until 1978 → Healthcare was very uneven: specific categories of workers (labourers, civil servants) were enrolled in "mutual aid funds" ("*Casse Mutue*", forms of insurance and social security protection), while the weaker segments of the population could only count on charitable organizations.

Law n° 833/1978 → the Italian National Health Service was borne

Supplemento ordinario alla "Gazzetta Ufficiale", n. 360 del 28 dicembre 1978

Spedizione in abbonamento postale - Gruppo I

GAZZETTA UFFICIALE

DELLA REPUBBLICA ITALIANA

PARTE PRIMA Roma - Giovedì, 28 dicembre 1978

LEGGE 23 dicembre 1978, n. 833.

Istituzione del servizio sanitario nazionale.

Tina Anselmi,
Italian Minister of health in 1978

Key principles of Italian NHS

UNIVERSALITY → Extension and guarantee of healthcare services to **the entire population**

EQUALITY → Access to healthcare services **without distinction** about individual, social or economic conditions

EQUITY → Ensuring **equal access to equal health needs**

How is the NHS financed?

The National Health Requirement (NHR)

or "Fabbisogno Sanitario Nazionale (FSN)"

💰 Each year the central government, in accordance with Italian Regions, establishes **ex ante** the **amount of public resources** needed to guarantee Essential Levels of Care (LEA)

💰 Starting point to determine **how much funding each region should receive** (established through standard criteria --> **National Standard Health Requirement (NSHR)** or "Fabbisogno Sanitario Nazionale Standard (FSNS)")

The Essential Levels of Care are a set of healthcare services that the NHS **must guarantee uniformly** across the country in an efficient way.

Trend of NHR 2010-2028

(absolute terms)

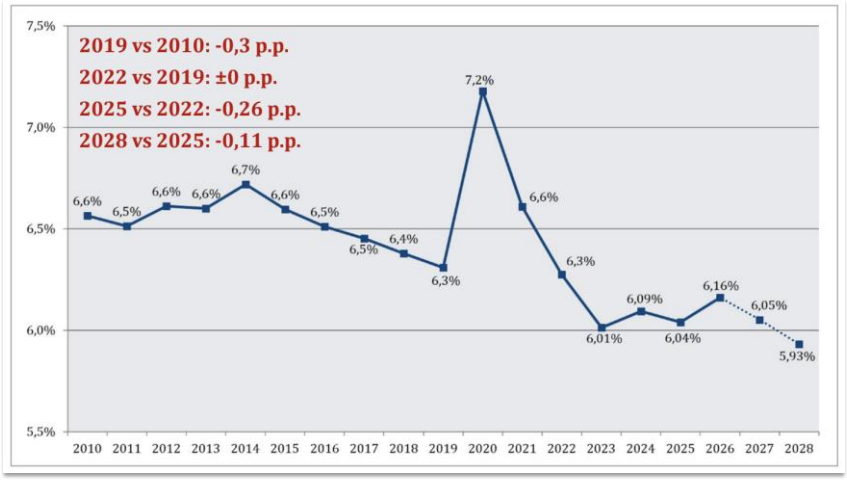
Sources: VIII Rapporto Gimbe (2025), DdL Bilancio 2026

Huge increase if we look at absolute terms :

- 2010-2025: + € 30,9 bln
- Important growth during Covid 19 pandemic
- Forecasted expansion also for the next 3 years

Trend of NHR 2010-2028

(% GDP)



Sources: VIII Rapporto Gimbe (2025), DdL Bilancio 2026

When expressed in terms of % of GDP:

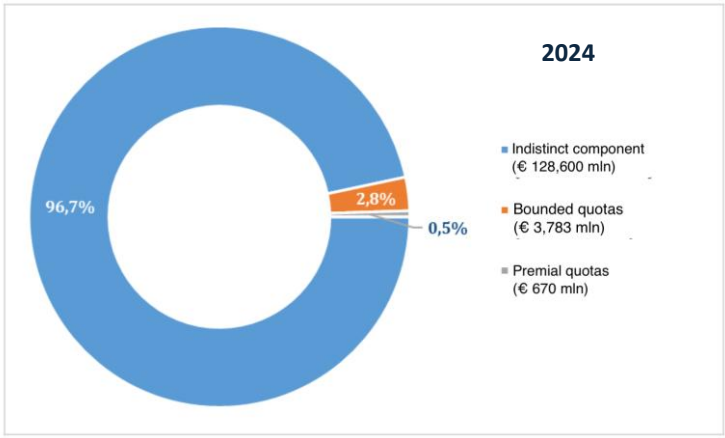
- Decreasing trend across all years (only exception during Covid-19)
- 2028 forecast: 5.9% of GDP
- Gradual but constant **erosion of investment in healthcare sector**

How is the NHR composed?

«indistinct» component → assigned to the delivery of the Essential Level of Care (most relevant part of the NHR)

«bounded» quotas → assigned to specific policy goals (e.g. prevention, development of innovative medicines)

«premial» quotas → resources set aside and distributed based on agreements within the State–Regions Conference = incentives for good management and performance



Source: VIII Rapporto Gimbe (2025)

How is the NHR distributed among Regions?

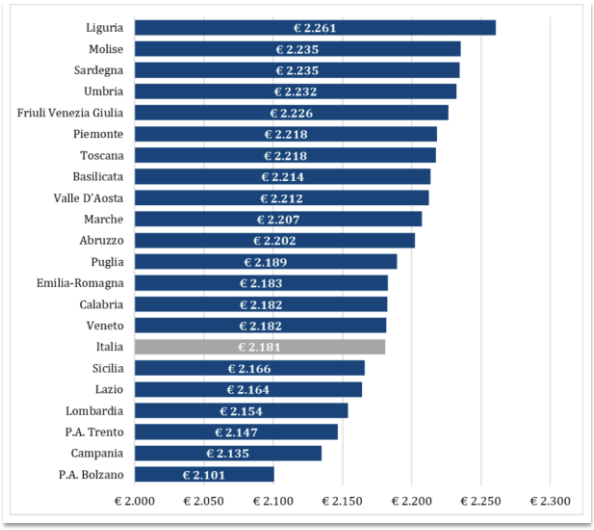
The **indistinct component** is distributed following **these allocation criteria** (State-Regions Agreement December 21 2022):

- 98.5% based on the criterion of **resident population** and frequency of **healthcare consumption by age group**;
- 0.75% based on **the mortality rate** of the population under the age of 75;
- 0.75% based on **indicators of territorial deprivation** affecting healthcare needs (i.e. the incidence of relative poverty, the incidence of low educational attainment among 15+ and unemployment rate)

EQUITY CONCERS: little weight to **premature mortality and** to **socioeconomic determinants** of health compared to **huge weight** to **resident population** and **age structure** –> shift of resources toward Regions with older populations

How is the NHR distributed among Regions?

Per capita funding of indistinct component of the NSHR in 2024



Source: VIII Rapporto Gimbe (2025)

📌 Liguria received the highest per-capita allocation → Region with highest old-age index (277 people aged 65+ per 100 residents aged 0–14)

📌 Sicilia, Lazio e Lombardia obtained a per capita funding lower than the national average → younger and most populated Regions

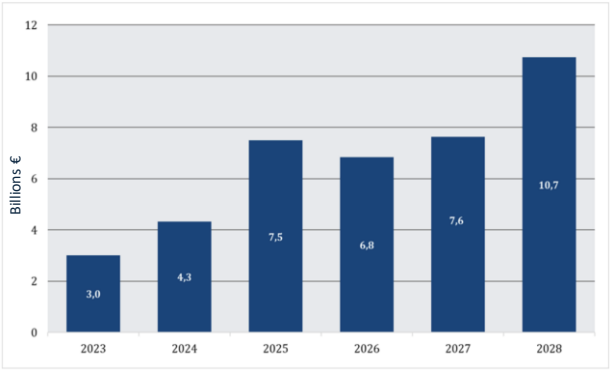
📌 **Campania** represents an emblematic case: the youngest Region (154 people aged 65+ per 100 resident aged 0-14) received the lowest funding, despite important health needs (lowest life expectancy at birth)

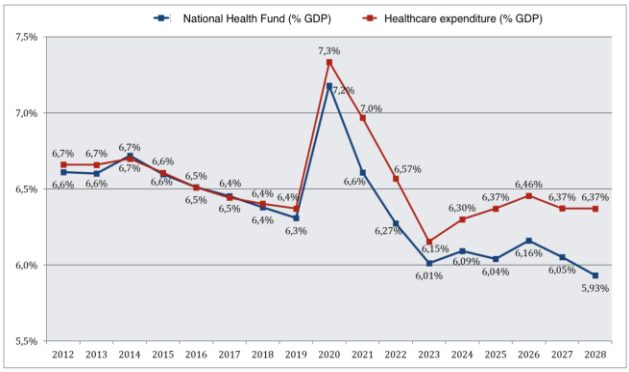
⚠ **Misalignment** between the "standard" need as measured by these allocation criteria and the real needs of Italian population.

Funding sources of NHS: where the money comes from

- State Budget through the Regions' sharing of VAT
- Regions' general taxation, i.e., IRAP and the regional surcharge on the personal income tax (IRPEF)
- Own revenues of NHS entities (proceedings from intramoenia, copayments) → (marginal component)
- Sharing of State taxes enjoyed by the Special-Statute Regions (RSS)

Gap between what is financed and what is actually spent



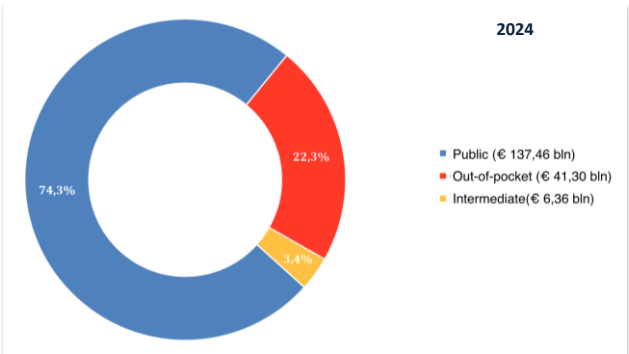


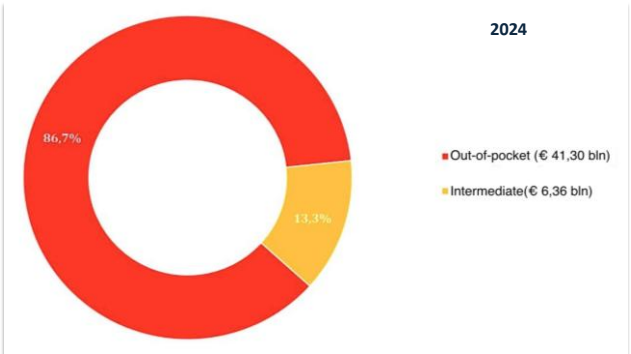
Sources: VIII Rapporto Gimbe (2025), Public Finance Document (2025)

⚠ **Actual expenditure persistently outpaces planned resources**, creating a structural gap that is around 7 billion in 2025 and will grow up to more than 10 billions in 2028 →
Key contributor to the ongoing crisis of the public health system, undermining its capacity to guarantee equitable and adequate care.

Healthcare expenditure

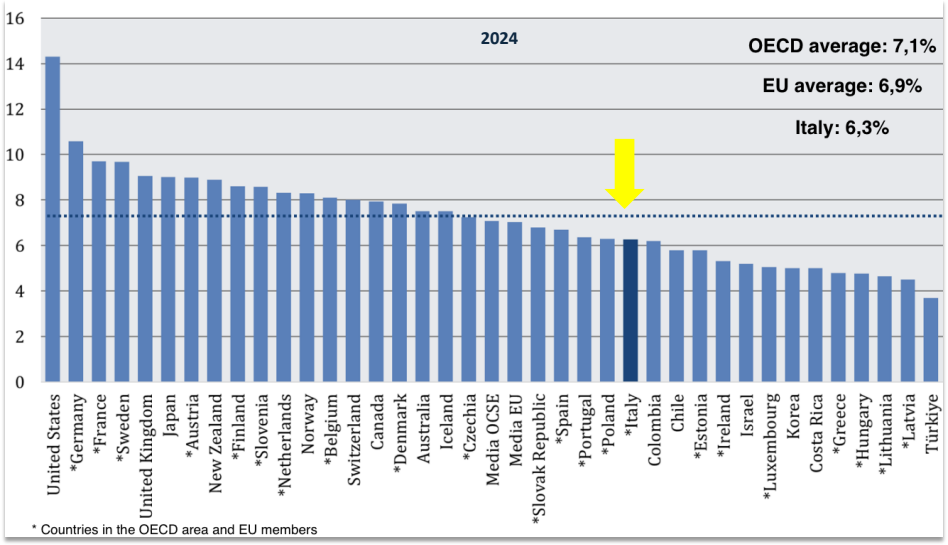
In 2024, the **total healthcare expenditure has been 185,12 billions of €,** composed by:
💰 **Public** component → incurred by public administrations to meet the collective needs
💰 **Private** component which can be represented by:
💸 **Out-of-pocket** expenses → directly borne by citizens to purchase healthcare services or goods
💸 **Intermediate** spending → spending covered by insurers or other collective payers





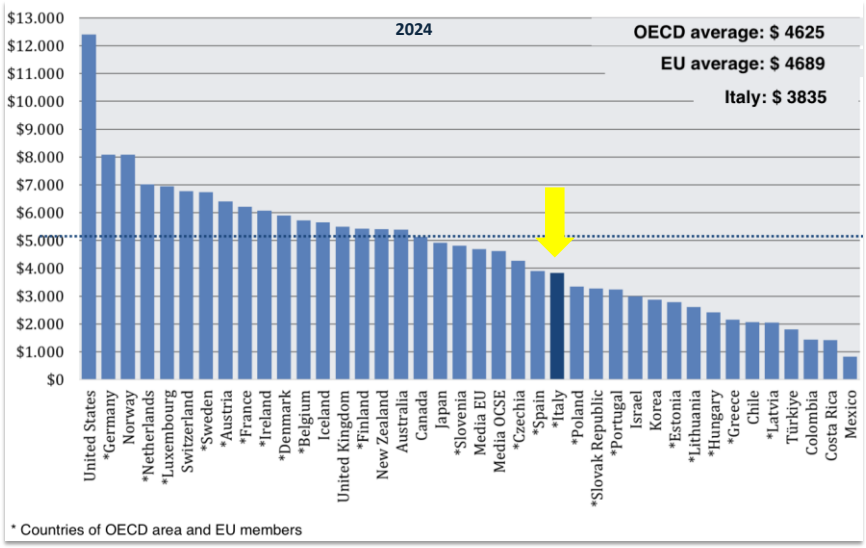
Source: VIII Rapporto Gimbe (2025)

Public healthcare expenditure: international comparison (% GDP)



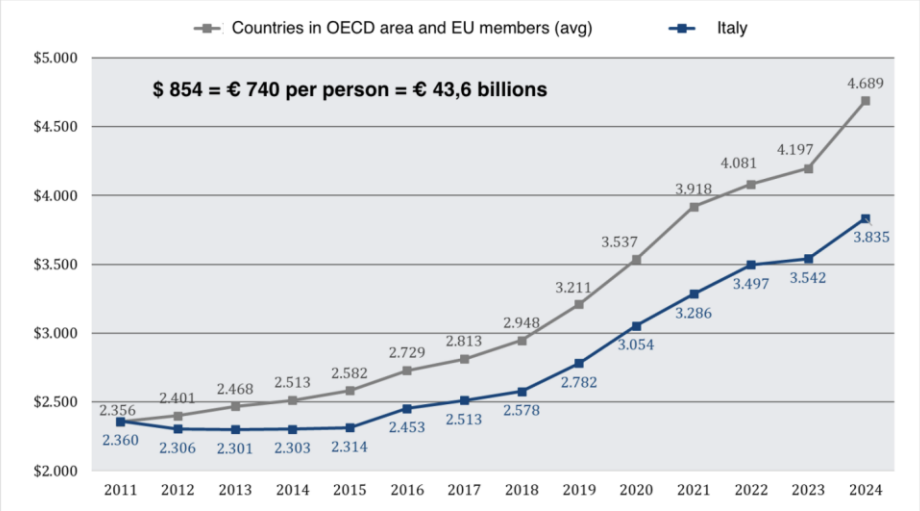
Source: VIII Rapporto Gimbe (2025)

Public healthcare expenditure: international comparison (per capita terms)



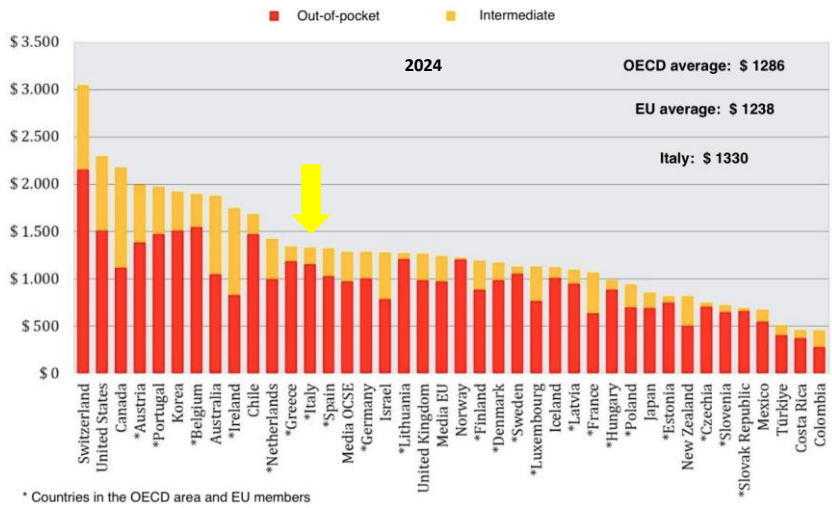
Source: VIII Rapporto Gimbe (2025)

Public healthcare expenditure: international comparison (per capita terms)



Source: VIII Rapporto Gimbe (2025)

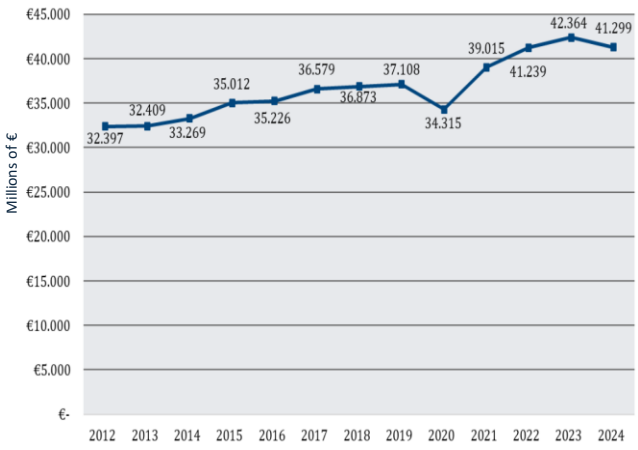
Private healthcare expenditure: international comparison (per capita terms)



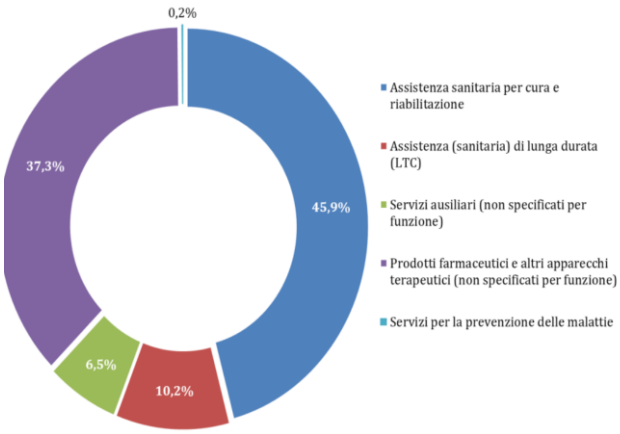
Source: VIII Rapporto Gimbe (2025)

Private healthcare expenditure:
Out-of-pocket expenses

Trend of OOP expenses 2012-2024



Composition of OOP expenses in 2024



Source: VIII Rapporto Gimbe (2025)

Current challenges faced by the Italian NHS

LOW PUBLIC INVESTMENTS + HIGH PRIVATE EXPENDITURE → PEOPLE MAY FACE **FINANCIAL HARDISHIP** AND **DIFFICULTIES IN HEALTHCARE ACCESS**

CHALLENGES FOR THE NHS IN ENSURING THE **ESSENTIAL LEVEL OF CARE**

Essential Level of Care
or "Livelli Essenziali di Assistenza" (LEA)

- Set of health services that the NHS **must guarantee to all citizens** (free or with co-payment) using public tax funding
- Most of the resources financed by the Government are devoted to the delivery of the LEA

- Originally defined in 2001, renewed in 2017(DPCM 12 January 2017) but the update planned in 2017 is **still not fully operational** 8 years later

- Organised in three macro-areas:

1. **Prevention** area → vaccinations, screening programmes, environmental and occupational health, food safety
2. **District** (territorial) area → primary care, emergency care, outpatient specialist care
3. **Hospital** area → emergency departments, inpatient and day-hospital care, rehabilitation, long-term care

Monitoring system of LEA: "Griglia LEA"
Until 2019

Until 2019, LEA provision was monitored through the **"Griglia LEA"**:

- **34 indicators** across the three macro-areas of care

- the minimum score that a Region should have reach to be "**compliant**" was 160 (on average) → **compensation across macro-areas**


Ministero della Salute
DIREZIONE GENERALE DELLA PROGRAMMAZIONE SANITARIA
UFFICIO VI

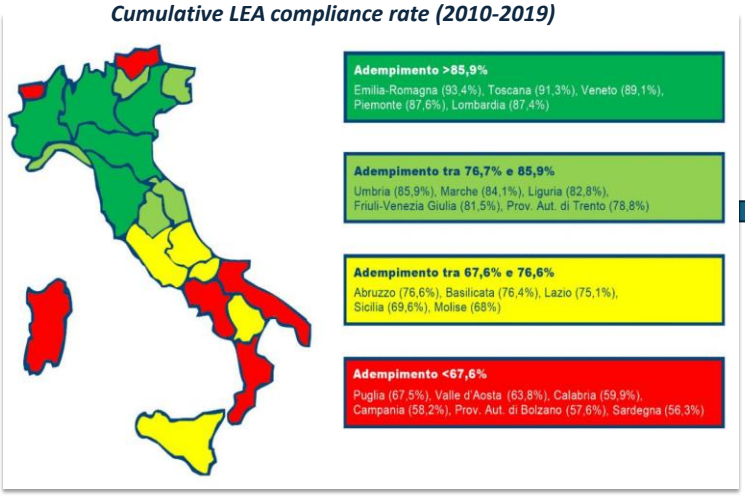
Monitoraggio dei LEA attraverso la cd. Griglia LEA

Metodologia e Risultati dell'anno 2019

Maggio 2021

Monitoring system of LEA: "Griglia LEA"
Until 2019

Cumulative LEA compliance rate (2010-2019)



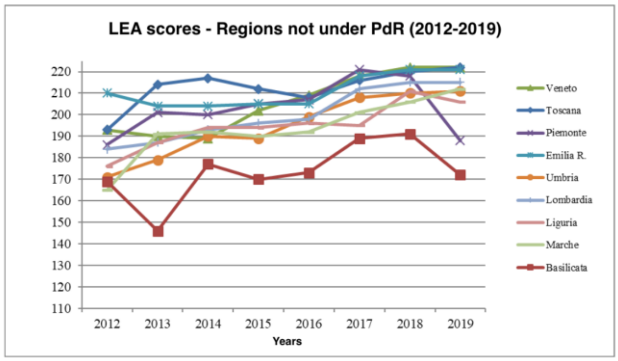
High compliance: Norther Regions
Low compliance: Southern Regions

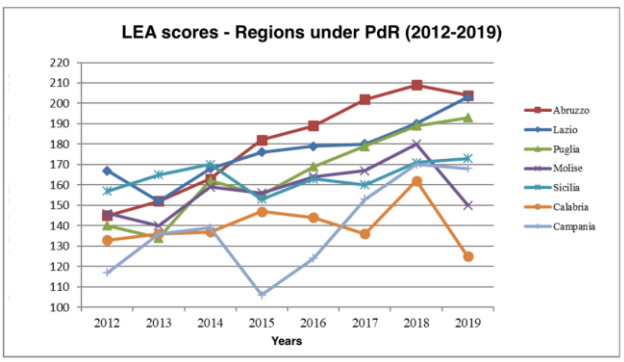
Some have been under the **Health Financial Recovery Plans** (or "Piano di Rientro" (PdR)) which had an impact on their ability to deliver the LEA

Source: VIII Rapporto Gimbe (2025)

Monitoring system of LEA: "Griglia LEA"
Until 2019

Health Financial Recovery Plan (or "Piano di Rientro" (PdR)) → agreements between the Italian central government and regions with **large healthcare deficits**, imposing extraordinary measures (e.g. hospital closures, new staff hiring freezes) to **restore the financial sustainability** of the regional healthcare system.





Source: Ministero della Salute (2019)

Monitoring system of LEA: Nuovo Sistema di Garanzia
From 2020

From 2020, **new monitoring system → "Nuovo Sistema di Garanzia" (NSG):**

🔍 it includes **88 indicators** regarding the 3 macro-areas of care (prevention, district and hospital care) + context and need, social equity and 10 PDTA indicators for 6 major conditions

-there is a "**CORE subset"** of indicators related to prevention, district and hospital care

🔍 the CORE subset is used to **summarise LEA fulfilment** and to assign scores to Regions → to be "compliant" a Region must obtain a **score between 60-100 in all** the 3 macro-area.

Monitoring system of LEA: Nuovo Sistema di Garanzia
From 2020

Some examples of the indicators in the CORE subset for the 3 macro areas

a) Prevenzione collettiva e sanità pubblica

N° Indicatore	Descrizione Indicatore	Valorizzazione Indicatore (x=valore indicatore; y=punteggio indicatore)
P01C	Copertura vaccinale nei bambini a 24 mesi per ciclo base (polio, difterite, tetano, epatite B, pertosse, Hib)	y = 0, x ∈ [0-90) y = 30 * x - 2700, x ∈ [90-92) y = 13,3333 * x - 1166,6667, x ∈ [92-95) y = 100, x ∈ [95-100) Soglia: (92, 60) Soglia di significatività: 0,1 Verso: CRESCENTE
P02C	Copertura vaccinale nei bambini a 24 mesi per la 1° dose di vaccino contro morbillo, parotite, rosolia (MPR)	y = 0, x ∈ [0-90) y = 30 * x - 2700, x ∈ [90-92) y = 13,3333 * x - 1166,6667, x ∈ [92-95) y = 100, x ∈ [95-100) Soglia: (92, 60) Soglia di significatività: 0,1 Verso: CRESCENTE

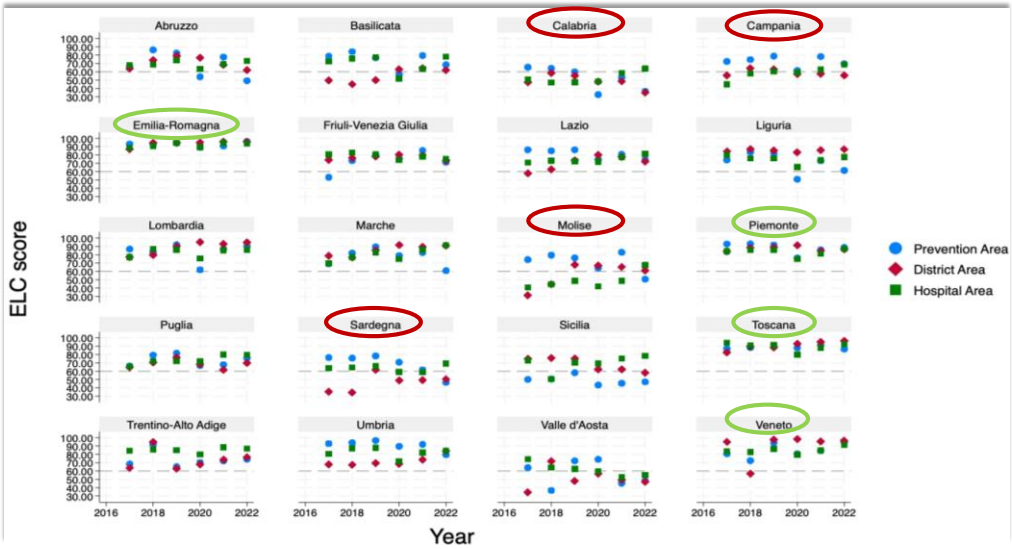
b) Assistenza distrettuale

N° Indicatore	Descrizione Indicatore	Valorizzazione Indicatore (x=valore indicatore; y=punteggio indicatore)
D03C*	Tasso di ospedalizzazione standardizzato (per 100.000 ab.) in età adulta (≥ 18 anni) per complicanze (a breve e lungo termine) per diabete, BPCO e scompenso cardiaco	y = 100, x ∈ [0-343) y = - 1,3333 * x + 557,3333, x ∈ [343-418) y = 0, x ∈ [418-550) Soglia: (373, 60) Soglia di significatività: 0,1 Verso: DECRESCENTE
D10Z	Percentuale di prestazioni, garantite entro i tempi, della classe di priorità B in rapporto al totale di prestazioni di classe B	y = 0, x ∈ [0-50) y = 6 * x - 300, x ∈ [50-60) y = 1,3333 * x - 20, x ∈ [60-90) y = 100, x ∈ [90-100) Soglia: (60, 60) Soglia di significatività: 0,1 Verso: CRESCENTE

c) Assistenza ospedaliera

N° Indicatore	Descrizione Indicatore	Valorizzazione Indicatore (x=valore indicatore; y=punteggio indicatore)
H01Z	Tasso di ospedalizzazione (ordinario e diurno) standardizzato in rapporto alla popolazione residente	y = 100, x ∈ [0-140) y = - 2 * x + 380, x ∈ [140-160) x = 160, x ∈ [160-160) y = 0, x ∈ [160-200) Soglia: (160, 60) Soglia di significatività: 0,1 Verso: DECRESCENTE

Monitoring system of LEA: Nuovo Sistema di Garanzia Trend 2017-2022



Interregional healthcare mobility

Italian citizens have the right to seek and receive care in facilities located outside their Region of residence.

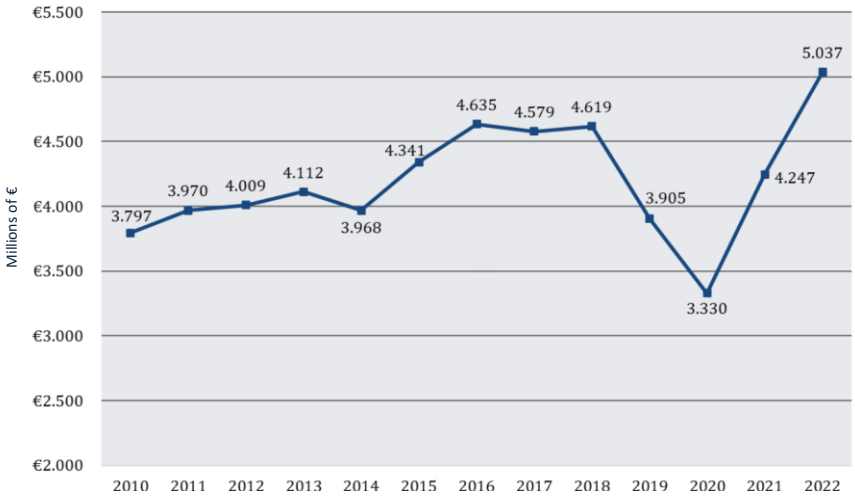
It can be:

Active mobility → credits for the Region that attracts patients (indicator of attractiveness)

Passive mobility →debits for the Region whose residents go elsewhere (indicator of "patient escape")

Interregional healthcare mobility:

Trend of 2010-2022 (mln €)



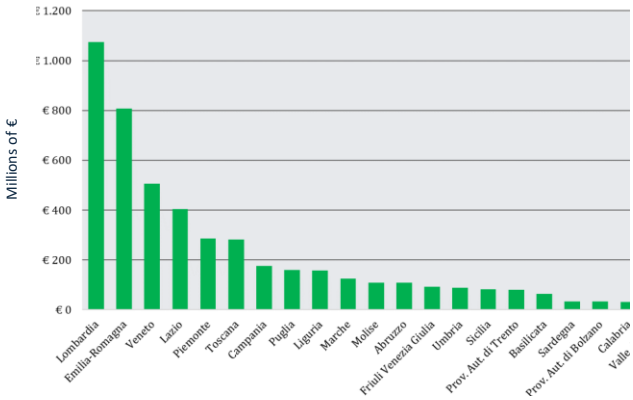
Source: VIII Rapporto Gimbe (2025)

In 2022, the value of healthcare mobility was €5,037 million, the highest level since 2010 (+18.6% wrt 2021)→ **relevant phenomenon**.

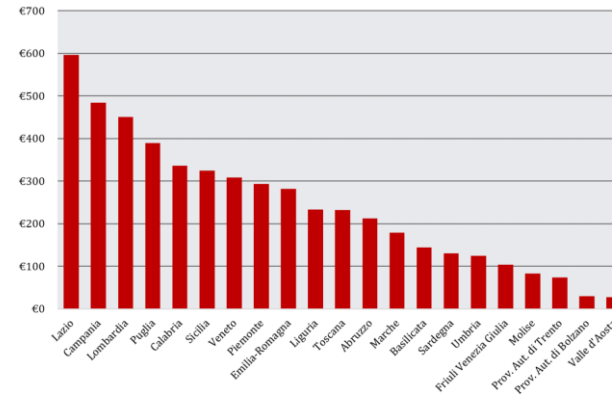
Interregional healthcare mobility:

active and passive flows

Credits for active healthcare mobility (2022)



Debts for passive healthcare mobility (2022)



Source: VIII Rapporto Gimbe (2025)

Interregional healthcare mobility balance:

Credits from active mobility – Debts from passive mobility

2022

Saldo positivo rilevante (oltre € 100 milioni)
Lombardia (€ 623,6 mln), Emilia-Romagna (€ 525,4 mln)
Veneto (€ 198,2 mln)

Saldo positivo moderato (da € 25,1 a € 100 milioni)
Toscana (€ 49,3 mln), Molise (€ 26,4 mln)

Saldo positivo minimo (da € 0,1 a € 25 milioni)
PA Trento (€ 7,1 milioni), PA Bolzano (€ 2,2 milioni)

Saldo negativo minimo (da -€ 0,1 a -€ 25 milioni)
Piemonte (-€ 6,3 mln), Friuli Venezia Giulia (-€ 11,8 milioni),
Valle d'Aosta (-€11,9 milioni)

Saldo negativo moderato (da -€ 25,1 a -€ 100 milioni)
Umbria (-€ 36,6 milioni), Marche (-€ 53,7 milioni), Liguria (-€ 74,6 milioni),
Basilicata (-€ 80,8 milioni), Sardegna (-€ 96,3 milioni),

Saldo negativo rilevante (oltre -€ 100 milioni)
Abruzzo (-€ 104,1 milioni), Lazio (-€ 193,4 milioni), Puglia (-€ 230,2 milioni),
Sicilia (-€ 241,8 milioni), Calabria (-€ 304,8) , Campania (-€ 308,4 milioni)

In 2022, the highest **positive balance** is concentrated in 3 large regions in the North (Emilia-Romagna, Lombardy, and Veneto), while the highest **negative balance** is concentrated in 5 regions in the South (Abruzzo, Calabria, Campania, Puglia, Sicily) and in Lazio.

Source: VIII Rapporto Gimbe (2025)

Private healthcare funding and provision:

Why private healthcare sector matters?

Pressure on the NHS
Public spending constraints and growing demand push citizens to use private tools to complement public coverage →**expansion of health funds**

Expansion of Private Providers
Accredited and non-accredited providers increasingly deliver services, especially in residential care and outpatient services.

Role of Tax Incentives
Fiscal benefits for health funds and OOP expenses shape how people access private healthcare.

Equity and Universalism
The growth of private funding raises questions about equity, territorial inequalities and the future of a universal, tax-funded NHS.

Private healthcare funding :

Supplementary health funds

1978

NHS Creation
Law 833 establishes a universal NHS and allows complementary mutual schemes, without public subsidies.

1992

«Differentiated care»
Reform that allowed Regions to organize alternative services for citizens willing to opt out of equivalent NHS services in exchange for greater choice or higher quality → **equity concerns**

1993-1999

«Integrative care»
Reforms that established the creation of health funds complementing - rather than replacing - NHS services

2000-2009

Tax incentives
Initially recognized only to type A funds but then also to type B → **huge development**

2016

Corporate welfare era
companies can offer **as corporate welfare benefits** health fund contributions, under favourable tax treatment → huge spread of contractual and company-level health funds

Parallel development of 2 types of health insurance funds:
- **Type A ("fondi doc")** → they can offer only services outside the LEA = **complementary services/integrative health funds** (in line with 1993-1999 Reforms)
- **Type B ("fondi non doc")** → they also offer services already included in the LEA

Private healthcare funding :

Supplementary health funds

Type A Health Funds

Members in Type A Funds

≈24 thousand

Enrolment has increased over the last decade, **but growth still limited**

Healthcare Spending

€1.2 billion

Total healthcare spending by Type A funds in 2022, all **devoted to services beyond the Essential Levels of Care** (dental care, social care).

Health funds have moved from marginal mutual schemes to a **central pillar of private welfare, often compensating for NHS access gaps** rather than simply offering extra services.

Type B Health Funds

Members in Type B Funds

≈16 million

Enrolment more than doubled in a decade, driven mostly by employees covered through contractual and company-level funds.

Healthcare Spending

€3.2 billion

Total healthcare spending by Type B funds in 2022, with **2/3 devoted to services already included in the Essential Levels of Care**.

Tax Exemptions

€3,615.20

Maximum annual amount of fund contributions exempt from taxable income under the Italian personal income tax code.

Private healthcare provision

In Italy, different types of healthcare services providers:
- **Fully public** → operating under the NHS
- **Non accredited private** → purely private, paid fully out of pocket or via health insurance
- **Accredited but not contracted private** → meet quality standards but do not receive public reimbursement until a contract is signed.
- **Accredited and contracted private** → provide services on behalf of the NHS within agreed budgets and tariffs

Shift in Public vs Private

In 2023, out of 29,386 registered healthcare facilities, 17,042 (**58%**) were accredited private entities and 12,344 (**42%**) were public ones.

Dominant in Some Sectors

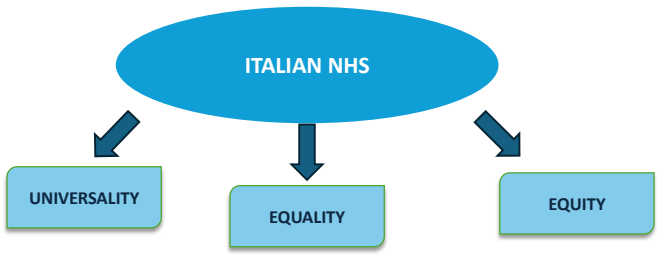
Accredited private providers are particularly important in **residential** care, **rehabilitation and specialist outpatient** services.

Beyond Public Oversight

Non-accredited providers are growing fast but are **not fully tracked in official registries**, making governance and equity assessment difficult.

Source: Annuario Statistico del Servizio Sanitario Nazionale – Anno 2023. Ministero della Salute

Summing up



But now relevant issues that threaten these pillars
→ **GROWING TENSION BETWEEN UNIVERSALISM AND MORE SELECTIVE AND STRATIFIED ACCESS TO CARE.**

- Constant erosion of public investment
- Regional inequalities in healthcare access
- Growth of private funds and private providers

THANKS FOR THE ATTENTION!

Any question?

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