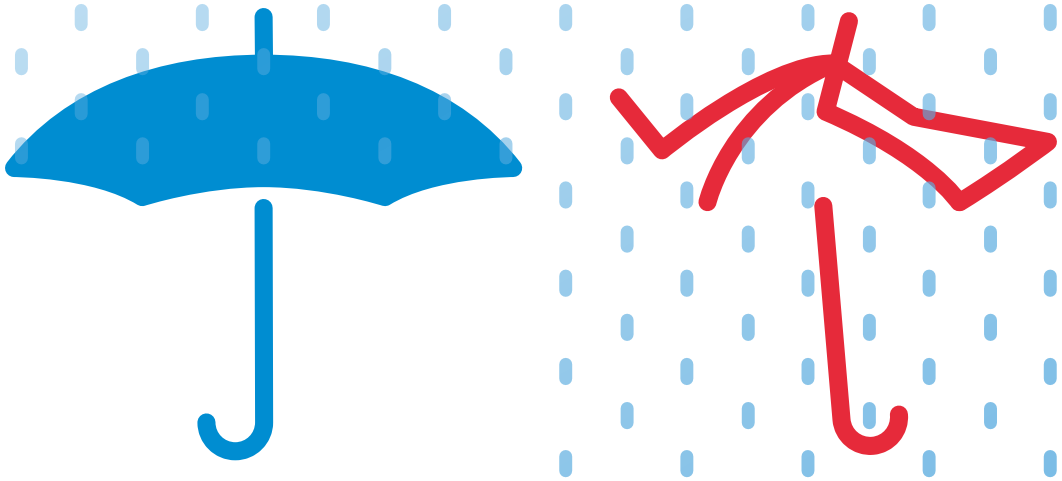
World Health Organization

European Region

Can people afford to pay for health care?

New evidence on financial protection in Italy

Giovanni Fattore
Luigi M Preti



Italy

WHO Barcelona Office for Health Systems Financing

The WHO Barcelona Office is a centre of excellence in health financing for universal health coverage (UHC). It works with Member States in Europe and central Asia to promote evidence-informed policy making. It also offers training courses on health financing.

A key part of the work of the Office is to assess country and regional progress towards UHC by monitoring affordable access to health care (financial protection). Financial protection is a core dimension of health system performance, an indicator for the Sustainable Development Goals, part of the European Pillar of Social Rights and central to the European Programme of Work, WHO European Region's strategic framework. The Office supports countries to strengthen financial protection through tailored technical assistance, including analysis of country-specific policy options, high-level policy dialogue and the sharing of international experience.

The Office disseminates country-specific and internationally comparable data and policy analysis through UHC watch, a digital platform tracking progress on affordable access to health care in Europe and central Asia.

Established in 1999, the Office is supported by the Government of the Autonomous Community of Catalonia, Spain. It is part of the Division of Country Health Policies and Systems of the WHO Regional Office for Europe.

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Abstract

This review is part of a series of country-based studies generating new evidence on affordable access to health care (financial protection) in health systems in Europe. Financial protection is central to universal health coverage and a core dimension of health system performance. Catastrophic health spending is higher in Italy than in many other European Union countries. It is heavily concentrated in households with low incomes, households in the southern region and households headed by pensioners. It is mainly driven by outpatient medicines and outpatient care in poorer households and by dental care in richer households. There is also a significant gap in unmet need for care between the richest and poorest people. Efforts to improve financial protection should focus on addressing long waiting times; reducing co-payments; expanding coverage of dental care and medical products; reviewing the equity and efficiency of the 19% tax rebate on out-of-pocket payments; reducing regional inequalities in access to health care; and extending entitlement to adult undocumented migrants. To meet equity and efficiency goals now and in the future (particularly in the context of population ageing) the Government should ensure that levels of public spending on health are sufficient and carefully targeted to reduce financial hardship and unmet need for households with low incomes and find ways to improve equity across regions.

Keywords

AFFORDABLE ACCESS
COVERAGE POLICY
FINANCIAL PROTECTION
HEALTH FINANCING
ITALY
OUT-OF-POCKET PAYMENTS
POVERTY
UNIVERSAL HEALTH COVERAGE
USER CHARGES (CO-PAYMENTS)

About the series

This series of country-based reviews monitors financial protection in European health systems. Financial protection – ensuring access to health care is affordable for everyone – is central to universal health coverage and a core dimension of health system performance.

What is the policy issue? Out-of-pocket payments can create a financial barrier to access, resulting in *unmet need*, and lead to *financial hardship* for people using health services. People experience financial hardship when out-of-pocket payments – formal and informal payments made at the point of using any health care good or service – are large in relation to a household's ability to pay. Out-of-pocket payments may not be a problem if they are small or paid by people who can afford them, but even small out-of-pocket payments can cause financial hardship for poor people and those who have to pay for long-term treatment such as medicines for chronic illness. Where health systems fail to provide adequate financial protection, people may not have enough money to pay for health care or to meet other basic needs. As a result, lack of financial protection can undermine health, deepen poverty and exacerbate inequalities. Because all health systems involve a degree of out-of-pocket payment, unmet need and financial hardship can occur in any country.

How do country reviews assess financial protection? Each review is based on analysis of common indicators used to monitor financial protection: the share of people foregoing health care due to cost (*unmet need*) and the share of households experiencing financial hardship caused by out-of-pocket payments (*impoverishing* and *catastrophic health spending*). These indicators are generated using household survey data.

Why is monitoring financial protection useful? The reviews identify the health system factors that strengthen and undermine financial protection; highlight implications for policy; and draw attention to areas that require further analysis. The overall aim of the series is to provide policy-makers and others with robust, context-specific and actionable evidence that they can use to move towards universal health coverage.

How are the reviews produced? Each review is produced by one or more country experts in collaboration with the WHO Barcelona Office for Health Systems Financing, part of the Division of Country Health Policies and Systems of the WHO Regional Office for Europe. To facilitate international comparison, the reviews follow a standard template, draw on similar sources of data and use the same equity-sensitive methods. Every review is subject to external peer review. Results are also shared with countries through a consultation process held jointly by

WHO headquarters and the WHO Regional Office for Europe. The country consultation includes regional and global financial protection indicators. The UHC watch website has more information on methods and indicators.

What is the basis for WHO's work on financial protection in Europe?
Affordable access to health care is a Sustainable Development Goal and is one of the principles of the European Pillar of Social Rights. It is also at the heart of the European Programme of Work, 2020–2025 – "United Action for Better Health in Europe" – the WHO Regional Office for Europe's strategic framework. Through the European Programme of Work, WHO supports national authorities to reduce financial hardship and unmet need for health care (including medicines) by identifying gaps in health coverage and redesigning coverage policy to address these gaps. The Tallinn Charter: Health Systems for Health and Wealth and resolution EUR/RC65/R5 on priorities for health systems strengthening in the WHO European Region include a commitment to work towards a Europe free of impoverishing out-of-pocket payments. Other regional and global resolutions call on WHO to provide Member States with tools and support for monitoring financial protection, including policy analysis and recommendations.

Comments and suggestions for improving the series are most welcome and can be sent to euhsf@who.int.

UHC watch

5 things to know about UHC watch

A digital platform tracking progress on affordable access to health care in Europe and central Asia

#1

Indicator explorer for the latest numbers and charts

#2

Policy explorer for up-to-date analysis of coverage policy

#3

Country pages with data, policy options and resources

#4

Country-level and comparative analysis

#5

Examples of good practice

UHC watch
apps.who.int/dhis2/uhcwatch

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Authors
Giovanni Fattore
Luigi M Preti

Editors
María Serrano Gregori
Sarah Thomson

Series editors
Sarah Thomson
Jonathan Cylus
Tamás Evetovits
Triin Habicht

Abbreviations

AGENAS	National Agency for Regional Health Services
AIFA	Italian Medicines Agency [Agencia Italiana del Farmaco]
COICOP	Classification of Individual Consumption According to Purpose
COVID-19	coronavirus disease
ECOICOP	European Classification of Individual Consumption According to Purpose
EHIS	European Health Interview Survey
EU	European Union
EU14	EU Member States from 1 January 1995 to 30 April 2004, excluding the United Kingdom
EU27	EU Member States as of 1 February 2020
EU-SILC	European Union Statistics on Income and Living Conditions
GDP	gross domestic product
GP	general practitioner
ISTAT	Italian National Institute of Statistics
LEA	Benefits package [Livelli essenziali di assistenza]
NHS	National Health Service
OECD	Organisation for Economic Co-operation and Development
OECD26	OECD member countries as of 1961
OTC	over-the-counter
VHI	voluntary health insurance

Countries

ALB	Albania
ARM	Armenia
AUT	Austria
BEL	Belgium
BIH	Bosnia and Herzegovina
BUL	Bulgaria
CRO	Croatia
CYP	Cyprus
CZH	Czechia
DEN	Denmark
DEU	Germany
EST	Estonia
FIN	Finland
FRA	France
GEO	Georgia
GRE	Greece
HUN	Hungary
IRE	Ireland
ISR	Israel
ITA	Italy
LTU	Lithuania
LUX	Luxembourg
LVA	Latvia
MAT	Malta
MDA	Republic of Moldova
MKD	North Macedonia
MNE	Montenegro
NET	Netherlands (Kingdom of the)
POL	Poland
POR	Portugal
ROM	Romania
SPA	Spain
SRB	Serbia
SVK	Slovakia
SVN	Slovenia
SWE	Sweden
SWI	Switzerland
TJK	Tajikistan
TUR	Türkiye
UKR	Ukraine
UNK	United Kingdom

Executive summary

This review assesses the extent to which people in Italy face financial barriers to access or experience financial hardship when they use health care. It covers the period from 2005 to 2025 using data from household budget surveys from 2005 to 2022, data on unmet need for health care up to 2024 (the latest available year) and information on coverage policy (population coverage, service coverage and user charges) up to June 2025.

The review's main findings are as follows.

- Financial hardship caused by out-of-pocket spending on health care is higher in Italy than in many European Union (EU) countries. In 2022 8.6% of households experienced catastrophic health spending and 3.7% of households were impoverished or further impoverished after out-of-pocket payments. These levels have grown over time.

- Catastrophic health spending is heavily concentrated in households with low incomes and in households headed by retired people and households in the southern regions of Italy. The incidence of catastrophic health spending is much higher than average in the poorest consumption quintile (27% in 2022) and higher than average in households headed by economically inactive people, older people living alone, people in the south of the country, unemployed people, retired people and households with two or more children.

- Catastrophic health spending is mainly driven by outpatient medicines and outpatient care in poorer households and by dental care in richer households.

- European Health Interview Survey data indicate that unmet need is greater for dental care than for health care or prescribed medicines. There is significant income inequality in unmet need for all three types of care.

Coverage policy in Italy has some strengths.

- It is generally less complex than in many other EU countries.

- Entitlement to services under the National Health Service (NHS) is based on residence and refugees, asylum seekers and undocumented migrant children (aged under 18 years) are entitled to all NHS benefits. As a result, the NHS covers virtually the whole population.

- Although all regions apply reference pricing to outpatient prescribed medicines, 9 out of 21 NHS regions do not apply additional co-payments to medicines. All regions avoid the use of percentage co-payments – a type of co-payment that lowers transparency and financial certainty for people.

Gaps and weaknesses in coverage persist, however. The current design of coverage policy does not seem to be effective in protecting people with low incomes from financial hardship or unmet need, particularly for outpatient medicines, dental care, other outpatient care and medical products.

There are weaknesses in the design and application of user charges (co-payments) for NHS care. These include:

- widely applied co-payments without exemptions for most working-aged people with low incomes and without any cap on co-payments;
- very few people are exempt from "avoidable co-payments" caused by reference pricing (applied in all regions) or other co-payments for outpatient prescribed medicines (applied in 12 out of 21 NHS regions);
- significant regional variation in co-payment design, which exacerbates regional inequalities, especially since the poorest regions have less fiscal space to reduce co-payments;
- the tax rebate of 19% on any out-of-pocket payments over €129 a year, which favours people with higher incomes; and
- VHI sometimes covers co-payments, which is also likely to favour richer households.

Out-of-pocket payments for outpatient prescribed medicines are driven by spending on non-covered medicines (mainly prescription and over-the-counter medicines in class C), private purchases of covered medicines, "avoidable co-payments" caused by reference pricing and other co-payments. Financial protection for outpatient care is likely to be undermined by co-payments and long waiting times for outpatient specialist visits and diagnostic tests, which have increased over time.

The NHS does not cover non-emergency dental care for working-aged adults. Financial protection may also be undermined by the exclusion of dental prostheses and implants from NHS coverage and long waiting times for covered services.

Recent national and regional efforts have tried to reduce waiting times and to protect people from co-payments, but they have not been sufficient to reduce financial hardship and unmet need, particularly for households with lower incomes.

To address key gaps in coverage and lower financial hardship and unmet need, the Government can consider the following measures;

- address long waiting times for outpatient specialist visits and diagnostic tests;
- improve the design of co-payments – especially for households with low incomes – by reducing regional variation, introducing a cap on all co-payments (ideally, the cap would be linked to household income) for the whole population, and extending current co-payment exemptions to all working-aged people with low incomes and to co-payments for outpatient prescribed medicines (including those derived from reference pricing);
- reduce "avoidable co-payments" caused by reference pricing by encouraging greater use of generics through stronger prescribing and dispensing policies; extending protection from co-payments (e.g. exemptions) from "avoidable co-payments"; and introducing educational campaigns for users;
- review the equity and efficiency of the 19% tax rebate on out-of-pocket payments, which tends to favour people with higher incomes;
- expand NHS coverage of dental care and medical products, including hearing aids and optical care, particularly for people with low incomes;
- address inequalities in access to health care across regions – options include improving care quality in the worst-performing regions and covering travel costs for people with low incomes who need highly specialized care in other regions (especially for cancer and rare diseases); and
- close gaps in population coverage by extending entitlement to NHS benefits to adult undocumented migrants; reducing administrative barriers to entitlements; and better monitoring.

To meet equity and efficiency goals now and in the future (particularly in the context of population ageing), the Government should ensure that levels of public spending on health are sufficient and carefully targeted to reduce financial hardship and unmet need for households with low incomes. It should also find ways to improve equity across regions.

1. Introduction

This review assesses the extent to which people in Italy experience financial hardship when they use health services, including medicines. It covers the period from 2005 to the present day, drawing on annual data from the household budget surveys from 2005 to 2022, data on unmet need for health care up to 2023 and information on coverage policy – the way in which health coverage is designed and implemented – up to June 2025. It focuses on three key dimensions: population entitlement, service coverage and user charges (co-payments).

Research shows that financial hardship is more likely to occur when public spending on health is low relative to gross domestic product (GDP) and out-of-pocket payments account for a relatively high share of total spending on health (Xu et al., 2003; Xu et al., 2007; WHO, 2010; WHO Regional Office for Europe, 2019, 2023). Increases in public spending or reductions in out-of-pocket payments are not in themselves guarantees of better financial protection, however. Policy choices are also important.

Governance of the Italian National Health Service (NHS) is shared between national and regional NHS authorities in 19 regions and two autonomous provinces. Funding mainly comes from a mix of regional and national taxes and the regions and provinces are responsible for health care delivery.

Italy was hit hard by the economic crisis that followed the global financial crisis, experiencing a severe and prolonged recession and a sharp increase in unemployment between 2008 and 2013. In response to the crisis the health budget was cut and user charges (co-payments) were increased. Public spending on health per person declined steadily between 2010 and 2017, pushing up the out-of-pocket payments share of current spending on health from 21% in 2011 to a peak of 24% in 2017 (WHO, 2025).

The coronavirus disease (COVID-19) pandemic induced another sharp fall in GDP in 2020. Public spending on health per person rose in response to the health shock but in 2023 (the latest available year of international comparable data on health spending in Italy) it was still low compared to most other countries in western Europe and lower than expected for a country with Italy's GDP (WHO, 2025).

As a result, Italy continues to rely relatively heavily on out-of-pocket payments to finance its health system. In 2023 out-of-pocket payments accounted for 23% of current spending on health in Italy compared to a European Union (EU)14[1] average of 17% and an EU27[2] average of 19% in 2022 (WHO, 2025).

This is the first comprehensive analysis of financial protection in Italy. Earlier analysis has used older data or different methods from this study or focused on older people (using different data sources to this study), usually as part of multi-country studies (Xu et al., 2007; Maruotti, 2009; Scheil-Adlung & Bonan, 2013; Arsenijevic et al., 2016; Palladino et al., 2016; Yerramilli, Fernández & Thomson, 2018; d'Angela & Spandonaro, 2023).

1. EU Member States from 1 January 1995 to 30 April 2004, excluding the United Kingdom.

2. EU Member States as of 1 February 2020.

The review is structured as follows. Section 2 sets out the analytical approach and sources of data used to measure financial protection. Section 3 provides a brief overview of coverage policy. Sections 4 and 5 present the results of the statistical analysis, with a focus on out-of-pocket payments in section 4 and financial protection in section 5 (covering both financial hardship and unmet need for health care). Section 6 provides a discussion of the results of the financial protection analysis and identifies factors that strengthen and undermine financial protection. Section 7 highlights implications for policy.

2. Methods

This section summarizes the study's analytical approach and main data sources. More detailed information can be found on the Methods page of UHC watch (2025).

The analysis of financial protection in this study is based on an approach developed by the WHO Regional Office for Europe (Cylus, Thomson & Evetovits, 2018; WHO Regional Office for Europe, 2019), building on established methods of measuring financial protection (Wagstaff & van Doorslaer, 2003; Xu et al., 2003).

2.1 Financial hardship linked to out-of-pocket payments

Financial hardship is measured using two main indicators: impoverishing and catastrophic health spending. Table 1 summarizes the key dimensions of each indicator.

Table 1. Key dimensions of impoverishing and catastrophic spending on health

Impoverishing health spending	
Definition	The share of households *impoverished* or *further impoverished after out-of-pocket payments*
Poverty line	A *basic needs line*, calculated as the average amount spent on food, housing (rent) and *utilities* (water, electricity and fuel used for cooking and heating) by households between the 25th and 35th percentiles of the household *consumption* distribution who report any spending on each item, respectively, adjusted for household size and composition using OECD equivalence scales; these households are selected based on the assumption that they are able to meet, but not necessarily exceed, *basic needs* for food, housing and utilities; this standard amount is also used to define a household's *capacity to pay for health care* (see below)
Poverty dimensions captured	The share of households further impoverished, impoverished and at *risk of impoverishment after out-of-pocket payments* and the share of households not at risk of impoverishment after out-of-pocket payments; a household is impoverished if its total consumption falls below the basic needs line after out-of-pocket payments; further impoverished if its total consumption is below the basic needs line before out-of-pocket payments; and at risk of impoverishment if its total consumption after out-of-pocket payments comes within 120% of the basic needs line
Disaggregation	Results can be disaggregated into household *quintiles* by consumption and by other factors, where relevant, as described above
Data source	Microdata from national *household budget surveys*
Catastrophic health spending	
Definition	The share of households with out-of-pocket payments that are greater than 40% of household capacity to pay for health care
Numerator	Out-of-pocket payments
Denominator	A household's capacity to pay for health care is defined as total household consumption minus a standard amount to cover basic needs; the standard amount is calculated as the average amount spent on food, housing and utilities by households between the 25th and 35th percentiles of the household consumption distribution, as described above; this standard amount is also used as a *poverty line* (basic needs line) to measure impoverishing health spending
Disaggregation	Results are disaggregated into household quintiles by consumption per person using OECD equivalence scales; disaggregation by place of residence (urban–rural), age of the head of the household, household composition and other factors is included where relevant
Data source	Microdata from national household budget surveys

Notes: see the Glossary provided by UHC watch (2025) for definitions of words in italics. OECD: Organisation for Economic Co-operation and Development.

Source: WHO Regional Office for Europe (2019).

Financial hardship indicators are generated by analysing data from household budget surveys. This study analyses anonymized microdata from the Italian household budget survey carried out annually by the Italian National Institute of Statistics (ISTAT).

The sample size and design of the Italian household budget survey has varied every three years depending on technical factors and the available budget (SISTAN, 2025). The sample size was 24 000 households from 2005 to 2007, 23 000 from 2008 to 2010, 22 000 from 2011 to 2013, 16 000 from 2014 to 2016, 18 000 from 2017 to 2019 and 30 000 from 2020 to 2022.

The following changes were made to the Italian survey in 2014 (ISTAT, 2025).

- The number of interviews was increased from two to three.
- The reporting period for the recording of daily expenses was extended from 7 to 14 days (including records of spending on outpatient medicines and single-use medical products, such as syringes and bandages).
- The reporting period for inpatient and outpatient care, paramedical and dental care and durable medical products (such as dental prostheses and glasses) was extended from one to three months.
- Spending on outpatient care and inpatient care was merged into a single item due to the low volume of out-of-pocket payments for inpatient care.

Household budget surveys typically collect information on health spending in a structured way, dividing it into six broad categories: medicines, medical products (including medical and assistive products), outpatient care, dental care, diagnostic tests (which also included paramedical services and patient emergency transportation until 2021) and inpatient care. These categories are agreed at international level through the Classification of Individual Consumption According to Purpose (COICOP) and the European Classification of Individual Consumption According to Purpose (ECOICOP) systems..

Data are collected and coded according to the COICOP. Since 2022 Italy has used the updated COICOP 2018 classification system to ensure greater comparability and relevance. In the case of data on household spending on health, the COICOP 2018 update allows data to be collected in alignment with the International Classification of Health Accounts (United Nations Department of Economic and Social Affairs, 2018; ISTAT, 2023).

This update led to the following changes in the health spending categories.

- In dental care: dentures were moved from medical products to dental care and outpatient dental care was grouped under dental care.
- In inpatient care: overnight dental care was shifted to inpatient care.

- In diagnostic tests: medical analyses and X-rays were moved from inpatient care to diagnostic tests.

- In outpatient care, several changes came into effect:

  – immunization, preventive care and general medical services provided in hospitals (without an overnight stay) were moved from inpatient care to outpatient care;

  – laboratory and imaging services for preventive care, when billed with health workers' time and skills, were moved from diagnostic tests to outpatient care;

  – some outpatient curative and rehabilitative care, like physical, psychological and speech therapy were moved from paramedical services (diagnostic tests) to outpatient care.

Due to these changes in the Italian household budget survey, data before and after 2014 are not comparable and data for 2022 should be compared to earlier data with caution. These breaks in series are signalled in the figures in sections 4 and 5.

The review reports household spending on outpatient care and inpatient care as a single item (under outpatient care) throughout the study period. This has few practical implications, as household spending on inpatient care is very modest in Italy (see section 3.3).

Out-of-pocket payments reported in the Italian household budget survey reflect the monthly amount households pay at the point of use, before any retrospective reimbursement through voluntary health insurance (VHI) or tax credits. This could lead to an overestimation of out-of-pocket spending in Italy, but mainly in households with high incomes because both VHI and the tax credit are concentrated in richer households (Brenna, 2017; Di Novi, Marenzi & Rizzi, 2018). As a result, any overestimation is unlikely to have any significant effect on the incidence of catastrophic health spending, which is heavily concentrated in poorer households.

The Italian household budget survey found that only 4.2% of households reported annual spending on VHI premiums in 2022, which is much lower than administrative data indicate (see section 3.4 for details), so this analysis does not draw on these survey data to assess household spending on VHI premiums. The main reason for this underestimation is that the Italian survey only accounts for VHI premiums paid by households but most VHI premiums in Italy are paid by employers or professional organizations.

Finally, like household budget surveys in other countries, the Italian survey does not differentiate between direct payments to private health care providers and user charges (co-payments) for publicly funded health care; nor does it distinguish between household spending on outpatient prescribed medicines and over-the-counter (OTC) medicines.

All currency units in the study are presented in euros (€).

2.2 Unmet need for health care

Unmet need for health care due to cost, distance and waiting time (health system factors) is measured using data from European or national surveys (Box 1).

Box 1. Unmet need for health care

Unmet need is defined as instances in which people need health services but do not receive the care they need because of access barriers. Self-reported data on unmet need should be interpreted with caution, especially across countries. However, analysis has found a positive relationship between unmet need and a subsequent deterioration in health (Gibson et al., 2019) and between unmet need and the out-of-pocket payment share of current spending on health (Chaupain-Guillot & Guillot, 2015), which suggests that unmet need can be a useful indicator of affordable access to health care.

Every year EU Member States collect data on unmet need for health care (medical examination or treatment) and dental care (dental examination or treatment) through the EU Statistics on Income and Living Conditions (EU-SILC) (Eurostat, 2025a). EU Member States also collect data on unmet need through the European Health Interview Survey (EHIS), carried out every 5–6 years (Eurostat, 2025b). The third wave of this survey was launched in 2019. EU-SILC typically provides information on unmet need as a share of the population but in recent years it has started to provide this information among people reporting a need for care for a limited number of years. EHIS provides information on unmet need among people reporting a need for health care and asks households about unmet need for prescribed medicines, in addition to health care and dental care (Ingleby & Guidi, 2024).

Financial protection analysis that does not account for unmet need could be misleading. A country may have a relatively low incidence of catastrophic health spending because many people face barriers to access and are unable to use the health services they need. Conversely, reforms that increase the use of health care can increase people's out-of-pocket payments – through, for example, user charges – if protective policies are not in place; in such instances, reforms might improve access to health care but at the same time increase financial hardship.

Sources: adapted from WHO Regional Office for Europe (2019, 2023).

A change in the EU-SILC survey instrument used in Italy in 2017 led to a significant drop in the share of people reporting unmet need. In 2017 the filter question for unmet need for health care was split into two questions: the first one to assess if the respondent "really" needed the visit or treatment and the second one to assess if the need had been met or not (Eurostat, 2025a). This break in series is signalled in the figures in section 5.

3. Coverage policy

This section describes the three main dimensions of publicly financed health coverage – population entitlement, service coverage and user charges (co-payments) – and reviews the role played by VHI. It draws on information from UHC watch (2025).

The Italian NHS was established in 1978 to guarantee universal access to health care for all residents. Governance of the NHS is shared between national and regional authorities, represented and steered by the State-Regions Standing Committee [Conferenza Permanente Stato-Regioni].

NHS funding is defined through an annual agreement between the regions and approved by the Committee. Public funding comes mainly from a mix of regional and national taxes, with the pooling of these funds managed at national level. The Ministry of Health re-allocates funds using a capitation formula agreed annually by the Committee; the formula is adjusted for population size and age, health care use by age, mortality and a deprivation index based on rates of poverty, education and unemployment. For each region, the estimated resources needed to deliver the benefits package are compared to the revenue raised from local sources and any difference between resources needed and local revenue is covered by the national Government through an equalization fund financed by national VAT. Some regions and provinces with autonomous status (e.g. Friuli Venezia Giulia) are funded differently due to their greater fiscal autonomy.

The 21 NHS regional authorities in 19 regions and two autonomous provinces (referred to in the review as 21 NHS regions) are responsible for health care delivery through local health authorities, independent public hospitals and research centres and private accredited providers. Regional autonomy in defining who provides services contributes to local variation in health care delivery.

The main changes to coverage policy are summarized in Table 2.

Table 2. Changes to coverage policy, 2000–2025

Source: UHC watch (2025).

Year	Month	Coverage policy area	Policy change
2000	-	User charges	Abolition of national fixed co-payments for outpatient (class A) medicines: including life-saving medicines and treatment for chronic conditions), but regions can opt to introduce regional co-payments.
2001	-	Service coverage (benefits package)	Definition in law of the benefits package [Livelli essenziali di assistenza (LEA)].
2005	-	Service coverage	Introduction of a new committee [Comitato LEA] to monitor and assess regional variation in health care delivery. Regions achieving higher performance scores benefit from additional public funding, equivalent to 0.25% of the regional budget.
2011	September	User charges	Introduction of a new user charge, the "super-ticket", an additional fixed co-payment of €10 typically applied to outpatient specialist care visits, diagnostic tests and inappropriate access to emergency departments (determined through triage) to raise revenue for the health system in response to the Italian sovereign debt crisis.
2017	January	Service coverage (benefits package)	Revision and expansion of the benefits package; including an update of covered medical products and expanded coverage of new technologically advanced services, health care for rare and chronic conditions, vaccines and diagnostics tests for neonatal conditions.
2017	January	VHI	Expansion of tax incentives for employers and employees buying supplementary VHI (in place since 1997): the limit on VHI premiums that can be deducted from taxable income is increased to €6615 (from €3615).
2019	-	Service coverage (waiting times)	Introduction of a national plan for waiting times: maximum waiting times are set at 3, 10, 30, or 120 days according to the urgency of the required care.
2020	September	Service coverage (benefits package)	Introduction of services related to COVID-19 into the benefits package (COVID-19 vaccine and tests, mobile home care teams and telemedicine).
2020	March	User charges	Abolition of the "super-ticket" (an additional fixed co-payment for outpatient specialist care and diagnostic tests introduced in 2011).
2020	-	Population coverage	Extension of coverage of COVID-19 health care services to previously non-covered groups (mainly undocumented migrants).
2022	-	VHI	Introduction of new reporting requirements to enhance the transparency of VHI health funds: health funds are required to report a list of indicators to the Ministry of Health. The policy has not yet been implemented at the time of writing.
2024	January	Service coverage	Replacement of financial incentives for generic dispensing in pharmacies (previously set at €0.12 per generic package dispensed at the reference price) by an incentive of €0.10 for all dispensed medicines from the so-called "transparency lists" (including both generics and branded medicines on the class A positive list).
2025	January	Service coverage (benefits package)	Addition of new benefits for specialist care (visits and diagnostic tests) and prosthetic care to the benefits package and revision of prices per service.
2025	March	Service coverage (waiting times)	Introduction of new policies to manage waiting times, with a focus on reducing waiting times for specialist visits and scheduled hospital admissions and enhancing transparency and accessibility in anticipation of a new national waiting time plan (which will update the previous 2019–2021 plan).
2025	June	Service coverage (waiting times)	The national platform to monitor waiting times for outpatient care [Piattaforma Nazionale Liste di Attesa in Italian (PNLA)] is made publicly available online.

3.1 Population entitlement

Entitlement to the NHS is based on legal residence, as defined by the Italian Parliament. People holding a permanent or temporary residence permit (including refugees and asylum seekers) are entitled to all publicly financed health care.

Migrants, refugees and asylum seekers need a valid residence permit to enrol in the NHS through a local health authority unit. Obtaining the residence permit should not take longer than 60 days for a standard residence permit; waiting time guarantees for permits are established in law but are often breached (Ferrarella, 2023).

Undocumented migrant children (aged under 18 years) are entitled to all NHS benefits. Unaccompanied minors are registered with the NHS under the legal responsibility of the Government. Since 1998, adult undocumented migrants have been entitled to publicly financed emergency care, public health programmes and maternity care.

Temporary visitors from outside the EU can access health care provided by the NHS but must pay the full price; prices vary by region.

There is no systematic monitoring of population coverage. Information on the number of non-covered people (mainly adult undocumented immigrants) is scarce and collected by nongovernmental organizations. A recent report suggests that about 500 000 undocumented migrants (including children) live in Italy (Cesareo, 2023).

No administrative requirements or documentation are needed to access emergency care and other services available to non-covered people. Health professionals are not required to report a patient's administrative status to any Government authority. Nongovernmental organizations provide outpatient care for people excluded from coverage or facing barriers to accessing NHS care.

3.2 Service coverage

The publicly financed benefits package [Livelli essenziali di assistenza (LEA)] was introduced in 1992, legally regulated in 2001 and further specified by Government decree in 2017. The package is defined by the national Ministry of Health through a combination of positive and negative lists with different levels of detail and transparency. Although the process for expanding the benefits package is clearly set out (see UHC watch (2025) for details), assessment criteria are not extensively detailed.

The benefits package covers a broad range of services (see UHC watch (2025) for details) and is generally considered to be generous, except for coverage of dental care and some mental health services (as discussed below).

The Italian Medicines Agency [Agencia Italiana del Farmaco (AIFA)] is responsible for defining and updating the coverage of medicines. The NHS covers class A (outpatient) and class H (inpatient) medicines but the vast majority of people have to pay fully out of pocket for medicines in class C (OTC medicines and some prescription medicines, including selected medicines for mental health conditions, such as most benzodiazepines, new lithium formulations and sleeping pills). Other class C medicines are only covered in inpatient settings.

The benefits package includes limited coverage of some medical products, such as orthopaedic prostheses and long-term care products. Hearing, vision and mobility aids are generally not covered, except for some benefits for people in vulnerable situations (eligible groups are defined by regional health authorities).

Dental care is the main gap in the benefits package. There is very limited coverage of dental care for most adults and adolescents (a first dental visit and emergency dental care only). Children aged under 14 years, adults aged over 65 years and some groups of people in vulnerable situations are entitled to a limited set of additional dental services (excluding things like implants or prostheses) but often experience long waiting times for treatment (Allin et al., 2020).

Mental health care is covered for most severe mental health conditions, including treatment for alcohol or drug or gambling abuse, eating disorders and child and adolescent neuropsychiatry. Coverage of care for mild and moderate mental health conditions is limited and varies significantly across regions.

The benefits package includes long-term health care (not social care) such as home care and medical equipment and a financial contribution to nursing homes to cover medical costs. Other long-term care is provided as social benefits in cash or in-kind by the social security agency [Instituto Nazionale della Previdenza Sociale], regions or municipalities but does not form part of the benefits package. A social care reform is currently under parliamentary discussion.

Non-emergency patient transport costs are generally not covered by the NHS and may represent an access barrier for people with lower incomes.

The benefits package was updated in 2025 – the first major update of the benefits package and tariffs for specialist and prosthetic care in two decades. Coverage was expanded to include uniform access to assisted reproductive care at the national level, genomic testing, enhanced diagnostics for coeliac disease and rare conditions, and advanced imaging diagnostics.

Primary care is mainly provided by general practitioners (GPs). Access to inpatient care and specialist outpatient care and diagnostic tests requires a referral from a GP or from a consultant working for the NHS. Access to covered outpatient medicines requires a prescription. A prescription is also mandatory for some outpatient medicines that are not included in the benefits package (e.g. benzodiazepines). People can access NHS care in any accredited public or private facility in Italy, regardless of their place of residence.

Waiting times are a long-standing challenge for non-urgent inpatient and outpatient specialist care and diagnostic services (particularly elective surgery and imaging services) and increased even further during the COVID-19 pandemic (Landi, Ivaldi & Testi, 2021; Cozzi et al., 2022; Federconsumatori, 2024). A 2019 national plan introduced maximum waiting times set at 3, 10, 30 or 120 days, according to the urgency of the care needed; required regions to develop measures to meet these standards; defined the types of health care subject to mandatory monitoring by the National Agency for Regional Health Services (AGENAS); and required public and private facilities to publish waiting times on their websites to enhance transparency and accountability (De Rosis et al., 2020). Not all providers comply with this last requirement, however, so data availability varies across regions (Landi, Ivaldi & Testi, 2021). The AGENAS recently launched a project to enhance and improve the monitoring of waiting times across NHS organizations.

To tackle ongoing challenges, the Ministry of Health is about to launch a new national waiting time plan (2025–2027), with a focus on reducing waiting times for specialist visits and hospital admissions. The 2024 national budget allocated €1 billion to support this effort, including funds to increase wages, purchase more care from accredited private providers and finance regional initiatives. The 2025 budget increased spending caps for these purchases and introduced performance-based rewards from 2026 for regions reducing waiting times.

Regional variations in service coverage – mainly due to differences in regional organizational and staff capacity – result in significant inequality between regions in the north and the south of the country. Regional variations have been monitored by an evaluation committee [Comitato LEA] since 2005. Regions that score well on selected quality-of-care indicators benefit from access to a small amount of additional funding (equivalent to 0.25% of the current regional budget). Regions that score less well tend to be those with lower levels of GDP per person and higher unemployment (De Belvis et al., 2022), resulting in patient flows from the south to the north (AGENAS, 2024). Anecdotal evidence suggests that lower perceived and actual quality of care (particularly for outpatient care) may lead to higher private spending, as those who can afford it will opt to pay out of pocket for privately provided care.

The shortage of health care professionals worsened during the COVID-19 pandemic and is particularly problematic in intensive care and emergency care (OECD, 2025).

Geographical barriers to outpatient specialist and inpatient care have worsened since small hospitals were closed under the 2016 reform (Furnari & Ricci, 2016).

3.3 User charges (co-payments)

The national Government and regional governments are responsible for defining user charges. Co-payments are applied to most outpatient care services, including outpatient medicines (reference pricing in all regions and

fixed co-payments in 12 out of 21 NHS regions) and outpatient specialist care, dental care, diagnostic services and non-urgent visits to emergency departments (in all regions) (see Table 3).

Regions can determine their own policy on user charges (co-payments). National legislation defines a minimum set of exemptions from co-payments and regions can expand them using their own funds. Some regions may choose to limit the use of co-payments due to their administrative complexity and the cost of collecting them – especially when payments are made after treatment or must be recovered from people who wrongly claimed exemptions.

National co-payments for class A medicines were abolished in 2000 but regions were allowed to introduce their own co-payments. All regions apply "avoidable co-payments" caused by reference pricing for class A medicines. The reference price should be at least 20% lower than the price of the original medicine. Unless there is a specific indication from the prescribing physician, medicines are prescribed by International Nonproprietary Name and pharmacies must ask users if they prefer the branded product or its generic equivalent. There are no overall exemptions from "avoidable co-payments" caused by reference pricing. However, it is waived in the case of medicine shortages and for specific groups of people in some regions (e.g. refugees are exempt in Piedmont).

Twelve NHS regions[3] also have fixed co-payments for outpatient prescribed medicines, ranging from €2 to €4 per item to €5 to €10 per prescription, with exemptions for selected groups of people (see Table 3). Nine NHS regions do not apply additional co-payments.[4]

Medical products covered by the NHS are provided without co-payments but are limited to orthopaedic prostheses and long-term care products. Other products covered in some regions for people in vulnerable situations (e.g. hearing, vision and mobility aids) are generally also provided without co-payments.

For other outpatient care services (outpatient specialist visits, diagnostic tests and dental care), regions determine the level of the fixed co-payment (known as the "ticket" in Italian) to be applied per outpatient visit or diagnostic test; this ranges across regions from a few cents to about €36. Users typically have to pay the fixed co-payment for each visit or test, but for selected specialties and services a single co-payment can include up to eight interventions (e.g. different lab tests) within the same area (e.g. cardiology). People must pay the full price out of pocket to access health care without a GP referral.

Between 2011 and 2020, in addition to the fixed co-payment for outpatient care, an additional fixed co-payment of €10 per visit or test (the "super-ticket") was applied in all regions to all outpatient care services already subject to the ticket to raise revenue for the NHS in response to the Italian sovereign debt crisis. Some people with low incomes were exempt from this. In March 2020 the "super-ticket" was abolished.

3. Abruzzo, Calabria, Campania, Lazio, Liguria, Lombardy, Molise, Province of Bolzano, Puglia, Sicily, Valle d'Aosta and Veneto.

4. Basilicata, Emilia Romagna, Friuli Venezia Giulia, Marche, Piedmont, Sardinia, Trento Autonomous Province, Tuscany and Umbria.

Table 3. User charges for publicly financed health care, 2025

Note: NA: not applicable.

Source: UHC watch (2025).

Type of health care	User charges apply	Type of user charge	Reduced user charges	Exemptions from user charges	Cap on user charges
Outpatient primary care visits	No	**No user charges**	NA	NA	NA
Outpatient specialist visits Diagnostic tests	Yes	**Fixed co-payment** varies by region from a few cents to €36	No	**People in all regions** Income: • children < 6 and > 65 in low-income households (annual gross income < €36 152) • unemployed people in low-income households (annual gross income ranging from < €8263 for single households to €12 910 for households with 3+ children) • pensioners > 60 in low-income households (annual gross income ranging from < €8263 for single households to €12 910 for households with 3+ children) • people with a social security pension (a benefit for older people who are not entitled to an ordinary pension) Other: people harmed by irreversible complications from mandatory vaccinations, transfusions, or blood products, victims of terrorism and organized crime, and people harmed in the line of duty **Services in all regions** Care for disabilities, selected chronic or rare conditions, and health care during pregnancy and childbirth Regional governments can establish additional exemption criteria for selected groups of people and services	No
Emergency care	Yes	**No user charges** for appropriate access to emergency departments (determined through triage) and for emergency transport **Fixed co-payment** for inappropriate access to emergency departments (determined through triage): €25 per visit and an additional fixed co-payment that varies depending on the care delivered (ranging from < €1 to €36)	No	No	No

Table 3. (contd.)

Type of health care	User charges apply	Type of user charge	Reduced user charges	Exemptions from user charges	Cap on user charges
Outpatient prescribed medicines	Yes	**Fixed co-payment** varies by region: €0 in nine regions (Basilicata, Emilia Romagna, Friuli Venezia Giulia, Marche, Piedmont, Sardinia, Trento Autonomous Province, Tuscany and Umbria) and a range from €2 to €4 per item to €5 to €10 per prescription in other regions **Reference pricing** for medicines in all regions: users pay the difference between the retail price and the reference price	No	**People in all regions** (for fixed co-payments): people harmed by irreversible complications from mandatory vaccinations, transfusions, or blood products and victims of terrorism and organized crime, and people harmed in the line of duty Regional governments can establish additional exemption criteria based on health status and income **Services:** reference pricing is waived in the case of medicine shortages and for specific groups of people in some regions (e.g. refugees are exempt in Piedmont).	No
Medical products	No	**No user charges** but NHS coverage of medical products is limited to orthopaedic prostheses and long-term care products	NA	NA	NA
Dental care visits	Yes	**Fixed co-payment** varies by region from a few cents to €36 but NHS coverage of dental care is limited to a first dental visit and emergency treatment for the general population and a small range of other treatment for children < 14, people > 65 and other groups in vulnerable situations, which differ between regions	No	**People in all regions** Income: • children < 6 and > 65 in low-income households (annual gross income < €36 152) • unemployed people in low-income households (annual gross income ranging from < €8263 for single households to €12 910 for households with 3+ children) • pensioners > 60 in low-income households (annual gross income ranging from < €8263 for single households to €12 910 for households with 3+ children) • people with a social security pension (a benefit for older people who are not entitled to an ordinary pension) Health status: people with severe disabilities Regional governments can establish additional exemption criteria for selected groups of people and services	No
Dental care treatment	**Yes**	**Fixed co-payments** vary by region from a few cents to €36 but NHS coverage of dental care is limited to emergency treatment for the general population and a small range of other treatment for children < 14, people > 65 and other groups of people in vulnerable situations (these groups vary across regions)	No		No
Inpatient care	No	**No user charges** for covered inpatient care **Extra billing** for enhanced accommodation (0.5% of all hospital admissions in 2019) or choice of physician (0.3% of all hospital admissions in 2019); these charges vary across regions and providers	NA	NA	NA
Inpatient medicines	No	No user charges	NA	NA	NA

Every year the government tax agency [Agenzia delle Entrate] provides GPs with a list of people who are exempt from co-payments on the basis of income. Unemployed people and people who are not required to submit a tax return (e.g. employees with an annual income of less than €8176 or pensioners with an annual income of less than €8500 (in 2023)) must self-declare their status to their local health authority to qualify for the exemption. People must apply for health status exemptions, and applications must be certified by an NHS care provider and processed by the local health authority. Most exemptions are valid indefinitely.

Selected outpatient care services (including for disabilities, selected chronic or rare conditions, and health care provided during pregnancy, abortion and childbirth) are available to the entire population without co-payments. In 2021 23% of outpatient specialist visits and 30% of outpatient imaging services were provided without co-payments (Del Vecchio et al., 2023).

There is no overall cap on co-payments. People can claim an annual tax refund equal to 19% of any out-of-pocket payments for health care above €129, including co-payments and out-of-pocket payments for non-covered health care. This policy favours people with higher incomes (Brenna, 2017; Di Novi, Marenzi & Rizzi, 2018).

New changes to the benefits package introduced in 2025 are expected to increase co-payments by 5.8% at national level, amounting to an additional €90.3 million. The impact could vary significantly across services and regions, with the southern regions potentially facing higher increases, while some northern regions may experience a decrease in co-payments (Ministry of Health, 2024).

3.4 The role of VHI

VHI plays a relatively minor role in the health system. Its main role is supplementary, offering people faster access to treatment and greater choice of provider. It also plays a much smaller complementary role covering co-payments and services not covered by the NHS. It accounted for 2% of current spending on health in 2023 (WHO, 2025) and is sold by two groups: non-profit-making health funds and commercial profit-making insurers.

Non-profit-making health funds were introduced in 1992 and conceived as a second pillar of the health system, alongside the NHS. They are regulated by the Ministry of Health, typically linked to employment and managed at industry or company level, with employee representation through trade unions.

In 2023 there were 324 health funds offering supplementary VHI and13 offering complementary VHI covering co-payments and excluded services (Giannetti et al., 2024). Health funds managed by employers generally play a supplementary role and covered over 16 million people (27% of the population) in 2023 (up from 7 million in 2013), largely fuelled by tax incentives (Giannetti et al., 2024). These estimates – although uncertain –

are substantially larger than those reported in previous studies (Sagan & Thomson, 2016; Donatini, 2020). The average annual health fund contribution per person was €279 in 2021 and health fund resources amounted to €3.2 billion in 2023 (Del Vecchio et al., 2023; Giannetti et al., 2024). Regional disparities are significant, ranging from 30% of taxpayers covered by heath funds in north-eastern regions to fewer than 15% in southern regions in 2022 (Del Vecchio et al., 2023).

Health funds are encouraged by the Government though open enrolment (employer-based health funds cannot reject applications if the applicant belongs to the company or the category of worker associated with the health fund); community-rated premiums (the premium is the same for all members of a particular fund) defined by employers and unions; and tax incentives (employees can deduct VHI premiums provided by non-profit-making insurers from their taxable income). To qualify for the tax incentives, health funds must be listed in the national register and must allocate at least 30% of their spending (up from 20% in 2010) to covering services that the NHS does not cover (e.g. selected specialist outpatient care services and dental care and, to a lesser extent, long-term care).

Although health funds are widespread, the benefits they offer are generally modest, comprising access to some specialist outpatient care, diagnostic imaging tests and preventive dental care. Medicines are rarely covered. Health fund coverage may include some social benefits not covered by the NHS because the funds were partly established to play a role in enhancing coordination between health and social care.

People covered by health funds tend to be of working age and live in areas with higher employment levels. Coverage can usually be extended to family members for an additional fee. Around 74% of people covered by health funds in 2016 were employees or self-employed people, 20% were family members and 7% were pensioners and their family members (Fondazione GIMBE, 2019).

Commercial VHI provided by private profit-making insurers plays a smaller, mainly complementary role, offering access to non-covered health care, including dental care, other types of outpatient care, inpatient care and long-term care. Some commercial insurers also cover NHS co-payments. Premiums amounted to €4.2 billion in 2023, up from under €3.1 billion in 2019 (ANIA, 2024; Celidone & Rebba, 2024). This total includes commercial VHI premiums sold either directly to individuals (around €1.2 billion in 2023) or through health funds that purchase coverage on behalf of their members.

Although regulated by the Institute for the Supervision of Insurance, there are no reliable data on the share of the population with commercial VHI. Anecdotal evidence suggests that individuals buying commercial VHI – which is relatively expensive – tend to come from richer households.

Table 4 highlights key issues in the governance of coverage, summarizes the main gaps in publicly financed coverage and indicates the role of VHI in filling these gaps.

Table 4. Gaps in publicly financed and VHI coverage

Source: UHC watch (2025).

Coverage dimension	Main gaps in publicly financed coverage	Are these gaps covered by VHI?
Population entitlement	Entitlement to publicly financed health care is based on residence, which means all registered residents (including refugees and asylum seekers) are automatically covered. Undocumented adults only have access to publicly financed emergency care, public health programmes and maternity care. A recent report indicates that about 500 000 undocumented migrants live in Italy (Cesareo, 2023).	No. VHI does not usually fill gaps in population coverage.
Service coverage	The publicly financed benefits package does not cover most dental care for adults. Coverage of dental care for children and medical products is limited. Procedures and deadlines for updating the benefits package (the *Livelli Essenziali di Assistenza* in Italian, or the LEA) are specified in law but rarely followed, so the benefits package is not regularly updated. Waiting times are a major issue for non-urgent inpatient and outpatient specialist care and diagnostic services. There is significant inequality in access to quality health care between regions in the north and the south of the country. Health systems in more deprived regions tend to perform less well than those in richer regions.	No. Although VHI provides people with faster access to treatment and access to care not covered by the NHS (mainly dental care and other outpatient care), the benefits offered are generally modest. VHI covered about a third of the population and accounted for only 2% of current spending on health in 2023. VHI is also more likely to be taken up by richer households.
User charges (co-payments)	User charges (co-payments) vary across regions. All regions apply co-payments to medical products, outpatient specialist visits, diagnostic tests and dental care. For outpatient prescribed medicines, all regions apply reference pricing ("avoidable co-payments") and 12 out of 21 NHS regions also apply fixed co-payments. Although there are exemptions in place for several groups of people with low incomes, including very young children, pensioners and unemployed people, there are none for workers with low incomes or to mitigate "avoidable co-payments" caused by reference pricing and there is no overall cap on co-payments. People can claim an annual tax refund equal to 19% of any out-of-pocket payments above €129 but this policy favours people with higher incomes.	No. Although VHI sometimes covers co-payments, it covered about a third of the population and accounted for only 2% of current spending on health in 2023. VHI is also more likely to be taken up by richer households.

3.5 Summary

Entitlement to NHS benefits is based on legal residence. People with a permanent or temporary residence permit (including refugees and asylum seekers) and undocumented migrant children (aged under 18 years) are entitled to all NHS benefits. Access to health care for adult undocumented migrants is limited to emergency care, public health programmes and maternity care.

Although the NHS benefits package is relatively comprehensive, most dental care for adults is excluded and coverage of dental care for children, medical products and care for mild and moderate mental health conditions are limited. With the exception of the positive list for medicines, the benefits package is not regularly updated.

Waiting times are a major issue for non-urgent inpatient and outpatient specialist care and diagnostic services.

There is significant inequality in access to health care between regions in the north and the south of the country; NHS organizations in more deprived regions tend to perform less well than those in richer regions.

User charges (co-payments) vary across regions. All regions apply co-payments to medical products, outpatient specialist visits, diagnostic tests and dental care. For outpatient prescribed medicines, all regions apply reference pricing and 12 out of 21 NHS regions also apply fixed co-payments.

Although there are exemptions in place for several groups of people with low incomes, including very young children, pensioners and unemployed people, there are none for most working-aged people with low incomes, nor for "avoidable co-payments" caused by reference pricing and there is no overall cap on co-payments. People can claim an annual tax refund equal to 19% of any out-of-pocket payments above €129 but this policy favours people with higher incomes.

New changes to the benefits package in 2025 are expected to increase co-payments overall, but with higher increases expected in the southern regions.

VHI plays a relatively minor role, mainly offering people faster access to treatment and greater choice of provider. Although it covers about a third of the population, it only accounted for 2% of current spending on health in 2023 and tends to favour richer households.

4. Household spending on health

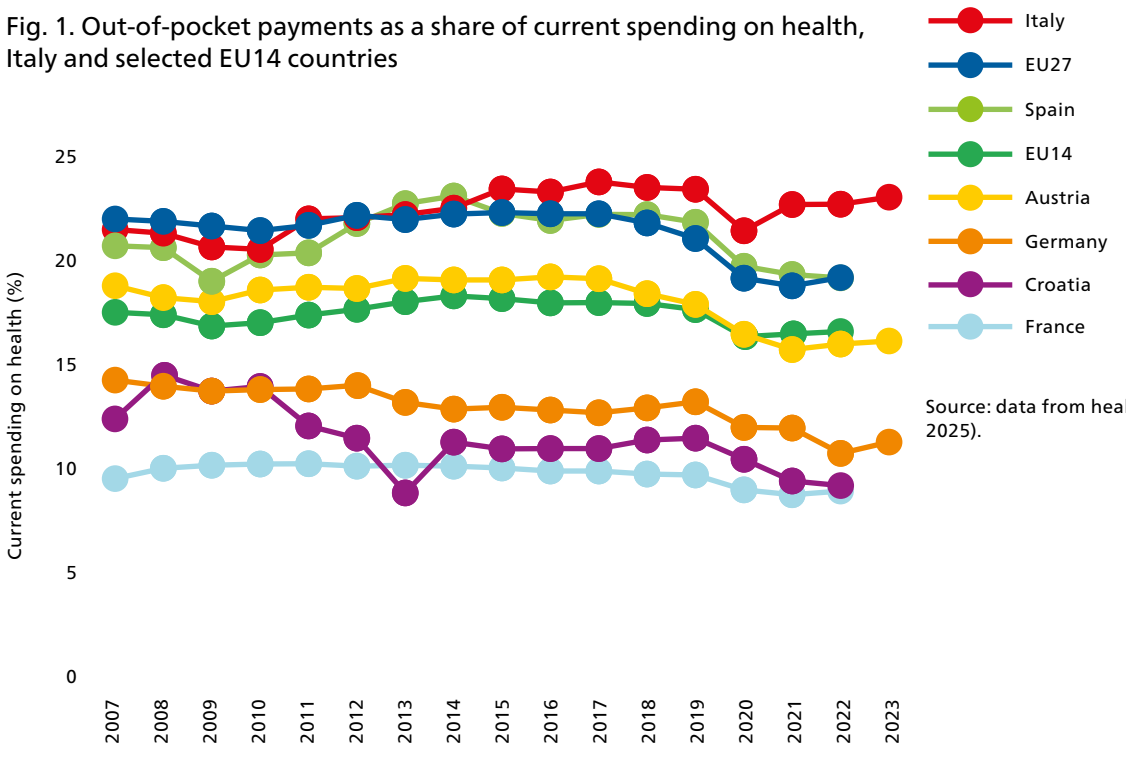
The first part of this section uses data from national health accounts[5] to present patterns in public and private spending on health. The second and third parts use household budget survey data to review household spending through out-of-pocket payments (the formal and informal payments made by people at the time of using any good or service delivered in the health system) (ISTAT, 2025). The fourth part considers the role of informal payments.

5. The latest available year in terms of WHO data varies by indicator: 2023 for some indicators and 2022 for others (WHO, 2025).

4.1 Public and private spending on health

Data from national health accounts indicate that Italy relies relatively heavily on out-of-pocket payments to finance its health system. In 2023 (the latest available year of internationally comparable data for Italy) out-of-pocket payments accounted for 23.1% of current spending on health in Italy compared to an EU14 average of 16.6% and an EU27 average of 19.2% in 2022 (Fig. 1).

Fig. 1. Out-of-pocket payments as a share of current spending on health, Italy and selected EU14 countries



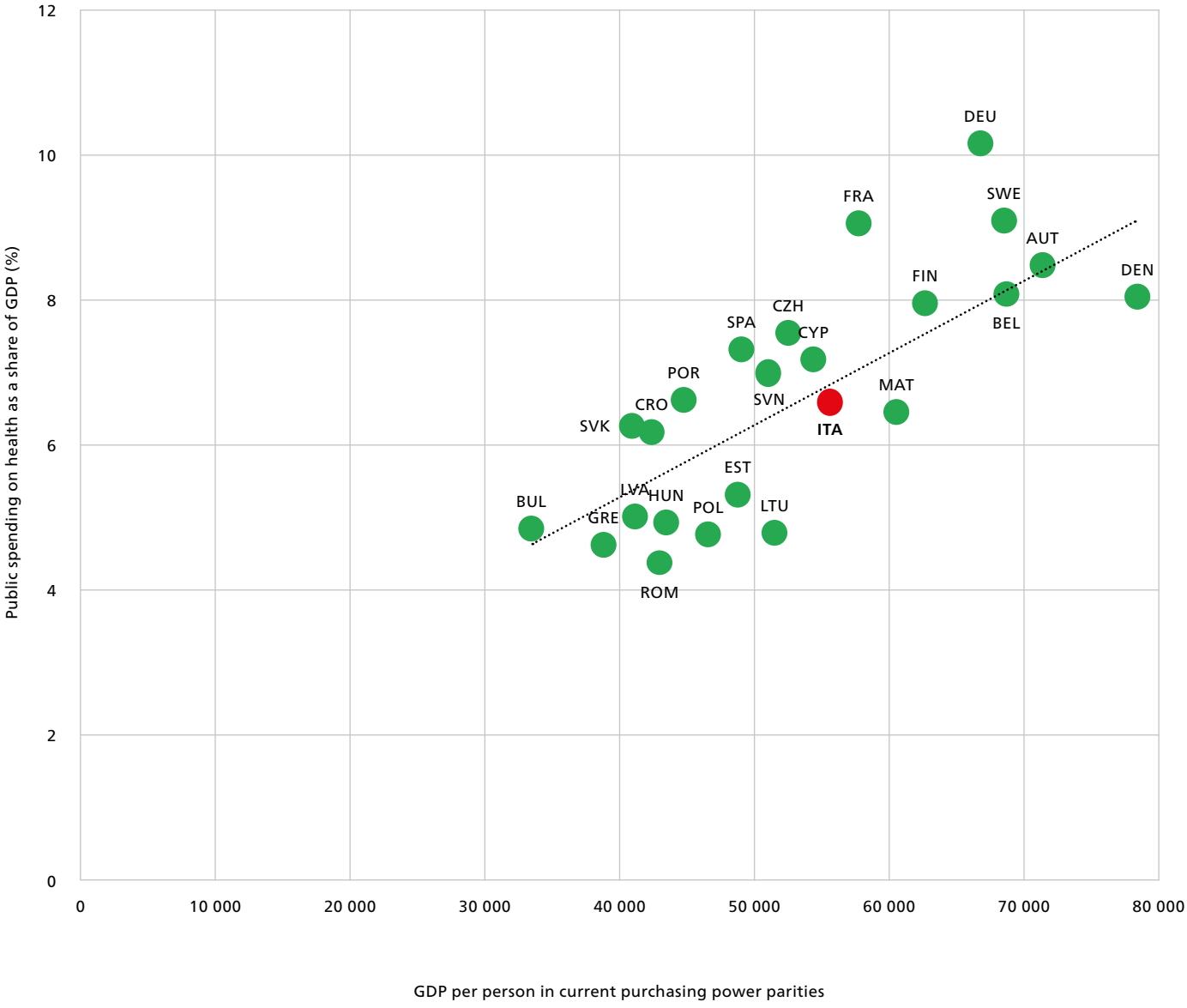
Source: data from health accounts (WHO, 2025).

Heavy reliance on out-of-pocket payments reflects a relatively low level of public spending on health. In 2023 public spending on health accounted for 6.3% of GDP in Italy (WHO, 2025). In 2022 it was 6.7%, on a par with the EU27 average (6.5%) and the EU14 average (6.6%), but lower than in every other EU14 country except Greece and Portugal and lower than expected given the size of GDP per person in Italy (Fig. 2).

Fig. 2. Public spending on health and GDP per person, EU countries, 2022

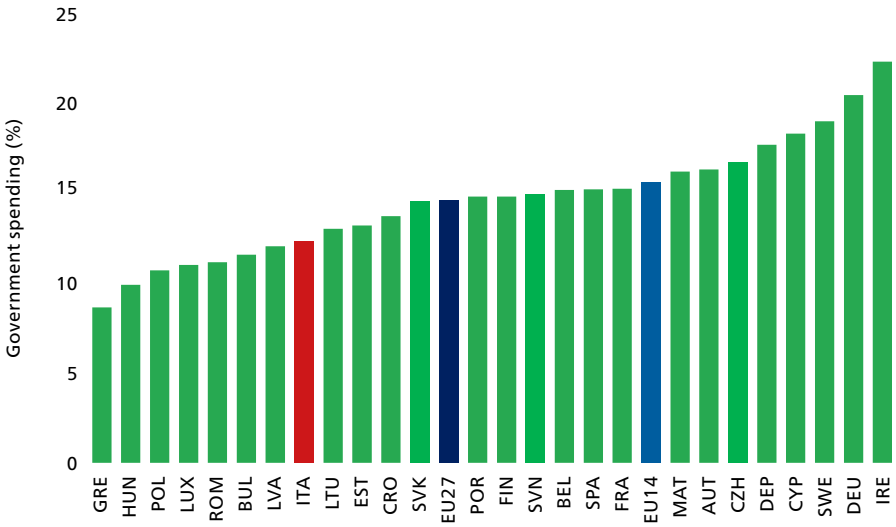
Notes: Italy is shown in red. The figure excludes Ireland and Luxembourg because they are outliers in terms of GDP per person and Netherlands (Kingdom of the) because Dutch data on public spending on health are not internationally comparable. A list of country codes is available in the preliminary pages.

Source: data from health accounts (WHO, 2025).



This level of public spending on health reflects the priority given to health in allocating the government budget. In 2022 the share of government spending allocated to health in Italy (12.3%) was below the EU27 average (14.6%) and well below the EU14 average (15.6%) (Fig. 3).

Fig. 3. Public spending on health as a share of the government budget, EU countries, 2022



Notes: the figure excludes Netherlands (Kingdom of the) because Dutch data on public spending on health are not internationally comparable. A list of country codes is available in the preliminary pages.

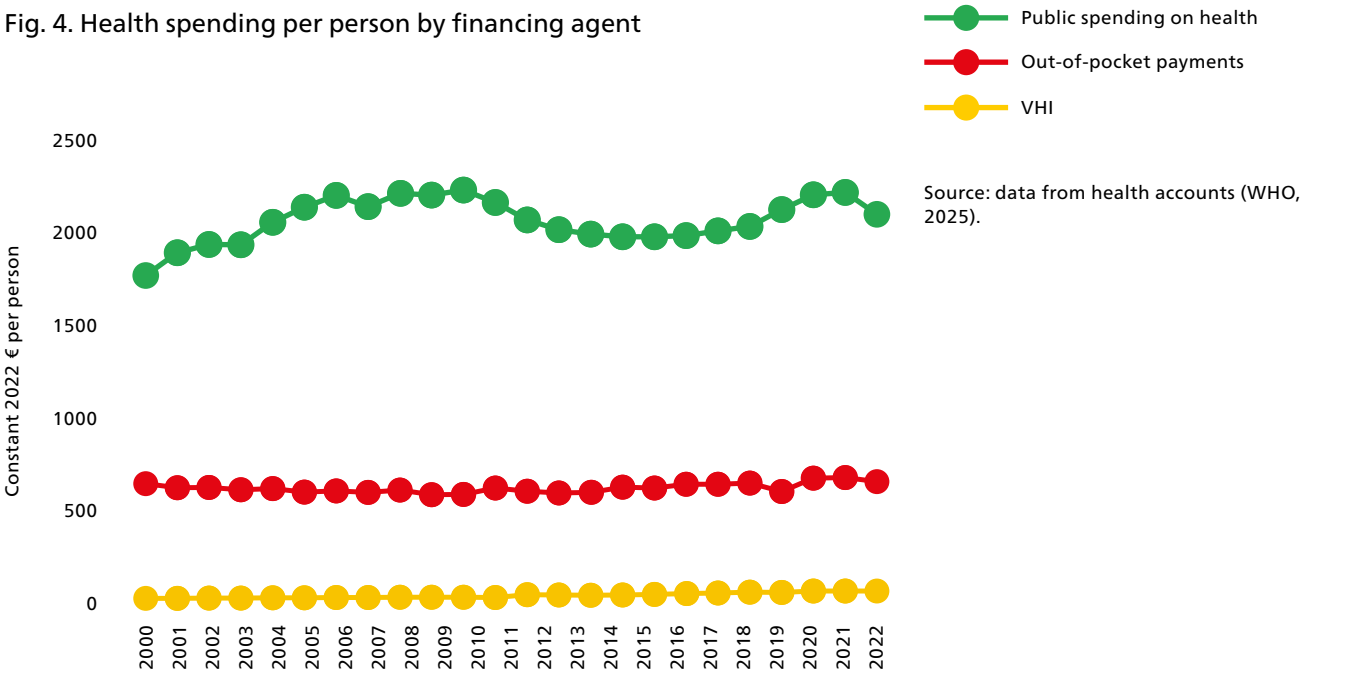
Source: data from health accounts (WHO, 2025).

Public spending on health per person steadily declined in the aftermath of the global financial crisis of 2008 and the economic crisis in Italy. It grew very slowly (by less than 1% a year in real terms) between 2016 and 2019, followed by a higher increase in 2020 and 2021 in response to the COVID-19 pandemic and a relatively sharp drop in 2023 (Fig. 4).

Out-of-pocket spending per person has been stable over time (Fig. 4), so it was the decline in public spending on health per person in the early 2010s that pushed up the out-of-pocket payment share of current spending on health from a low of 21% in 2011 to a peak of 24% in 2017 (Fig. 1).

Per person spending on VHI has more than doubled over the last two decades but from a very low base (Fig. 4).

Fig. 4. Health spending per person by financing agent



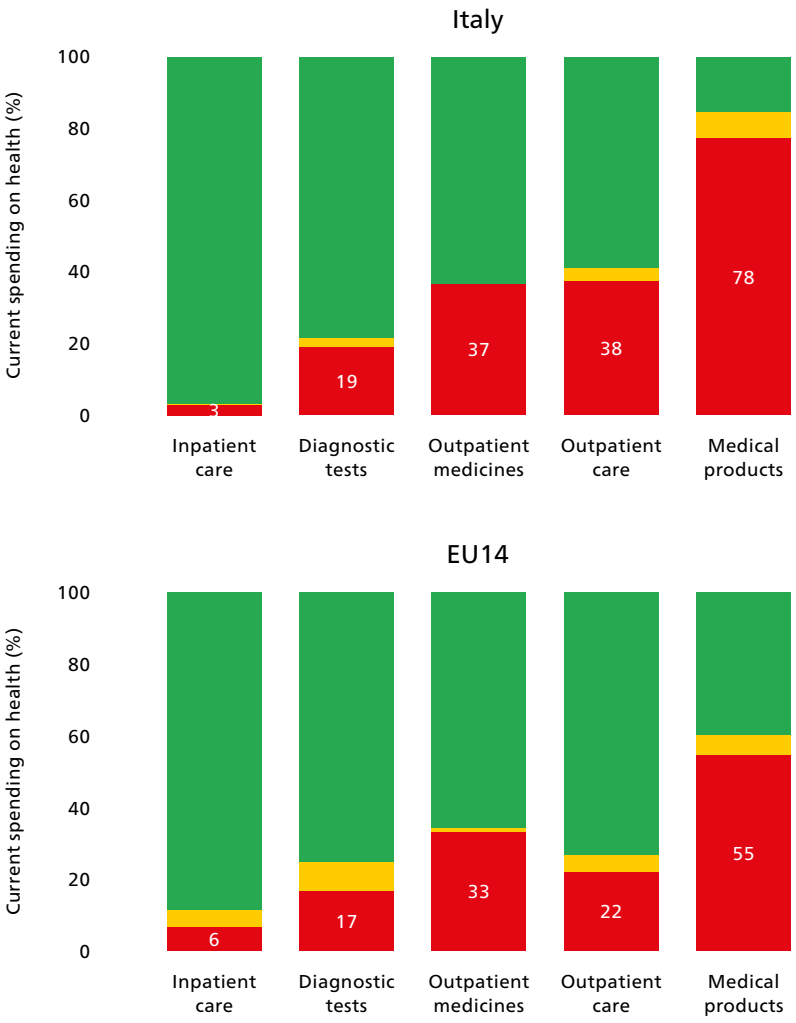
Source: data from health accounts (WHO, 2025).

Broken down by type of care, the out-of-pocket payment share of current spending on health is highest in Italy for medical products (78%: far above the EU14 average of 55%) and outpatient care (38%: well above the EU14 average of 22%). It is relatively close to the EU14 average for outpatient medicines (37% in Italy vs 33% for EU14 countries) and diagnostic tests (19% in Italy vs 17%) and lower than the EU14 average for inpatient care (3% in Italy vs 6%) (Fig. 5).

National data on out-of-pocket payments for outpatient medicines in Italy indicate that in 2023 around two thirds of this spending was on non-covered class C medicines (36% on prescription medicines and 28% on OTC medicines) and a third on covered medicines: private purchases of class A medicines (19%), "avoidable co-payments" caused by reference pricing (10%) and fixed co-payments (4%) (AIFA, 2024). Focusing on the 12 out of 21 NHS regions with co-payments for outpatient prescribed medicines, the co-payment share was higher: 11% through reference pricing and 6% through co-payments.

Out-of-pocket spending due to co-payments has remained relatively stable over the last eight years but spending on class C prescription medicines grew from €2.8 billion in 2017 to €3.8 billion in 2023 and spending on privately purchased class A medicines grew from €1.3 to 2.0 billion in the same period (AIFA, 2024).

Fig. 5. Breakdown of current spending on health by type of care and financing agent, Italy and EU14 countries, 2022



Notes: dental care spending in Italy is included under outpatient care and cannot be disaggregated and presented separately. EU14 averages are calculated accordingly.

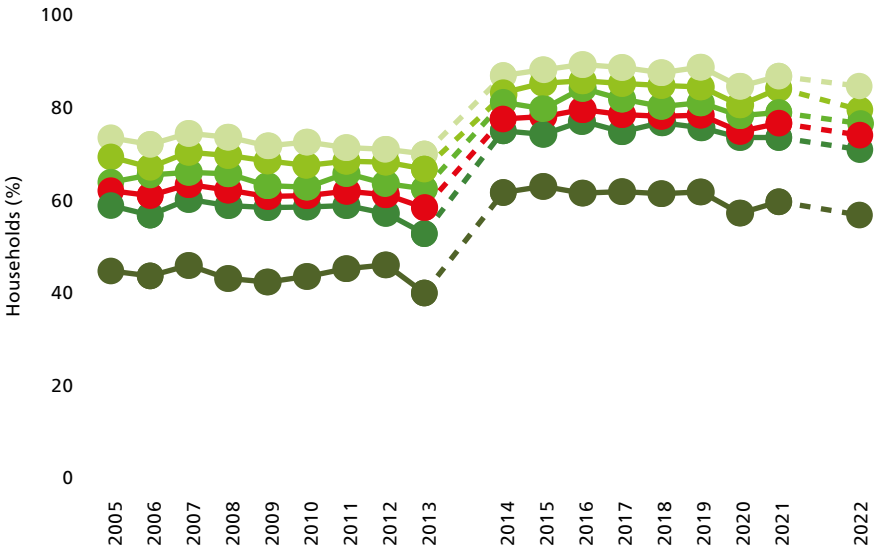
Source: data from national health accounts (OECD, 2025).

4.2 Out-of-pocket payments

Household budget survey data indicate that, on average, 74% of households incurred out-of-pocket payments in 2022 (Fig. 6). Richer households are consistently more likely to report out-of-pocket spending than poorer households.

The decline in the average amount spent between 2007 and 2009 may reflect the impact of the economic crisis. There was a fall in spending in 2020 – the first year of the COVID-19 pandemic (Fig. 7).

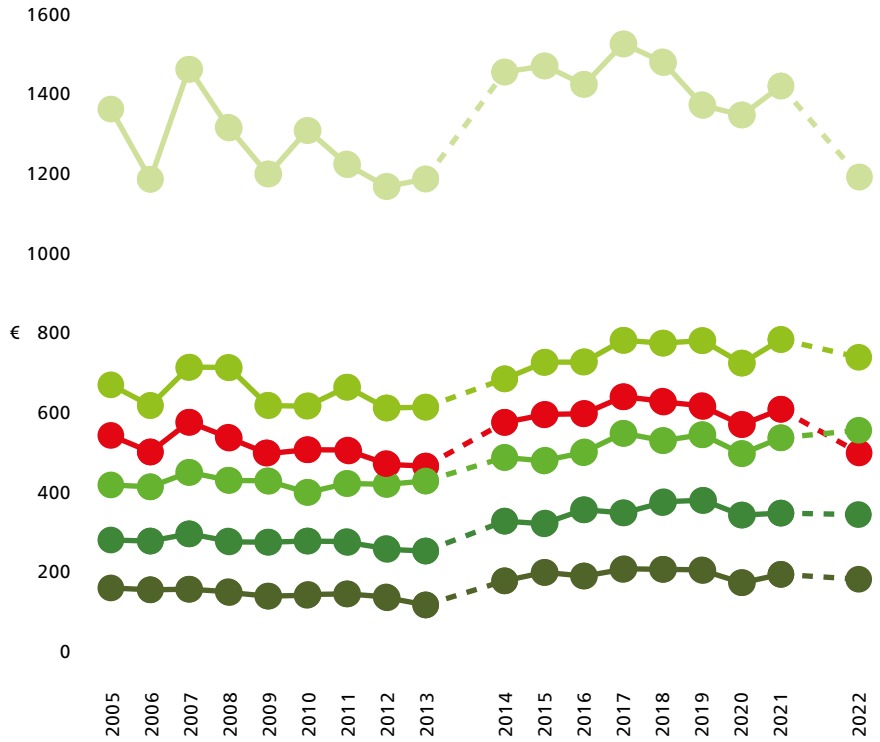
Fig. 6. Share of households with out-of-pocket payments by consumption quintile



Notes: quintiles are based on per-person consumption, adjusted for household size and composition using OECD equivalence scales. Breaks in the series in 2014 and 2022 reflect changes in the Italian survey; data from different series are not comparable.

Source: authors, based on household budget survey data (ISTAT, 2025).

Fig. 7. Annual out-of-pocket spending on health care per person by consumption quintile

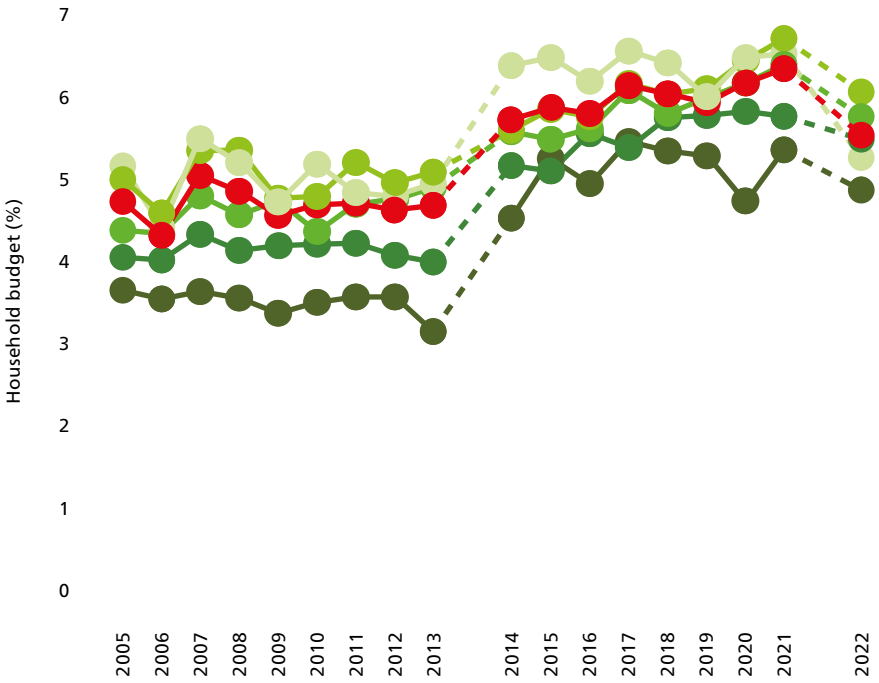


Notes: amounts are shown in real terms (base year 2020). Breaks in the series in 2014 and 2022 reflect changes in the Italian survey; data from different series are not comparable.

Source: authors, based on household budget survey data (ISTAT, 2025).

Out-of-pocket payments accounted for 5.5% of total household consumption on average in 2022, ranging from 5% in the poorest quintile to 6% in the fourth quintile (Fig. 8). This share fell in the years of the economic crisis and grew quite sharply during the pandemic.

Fig. 8. Out-of-pocket payments for health care as a share of total household spending (the household budget) by consumption quintile

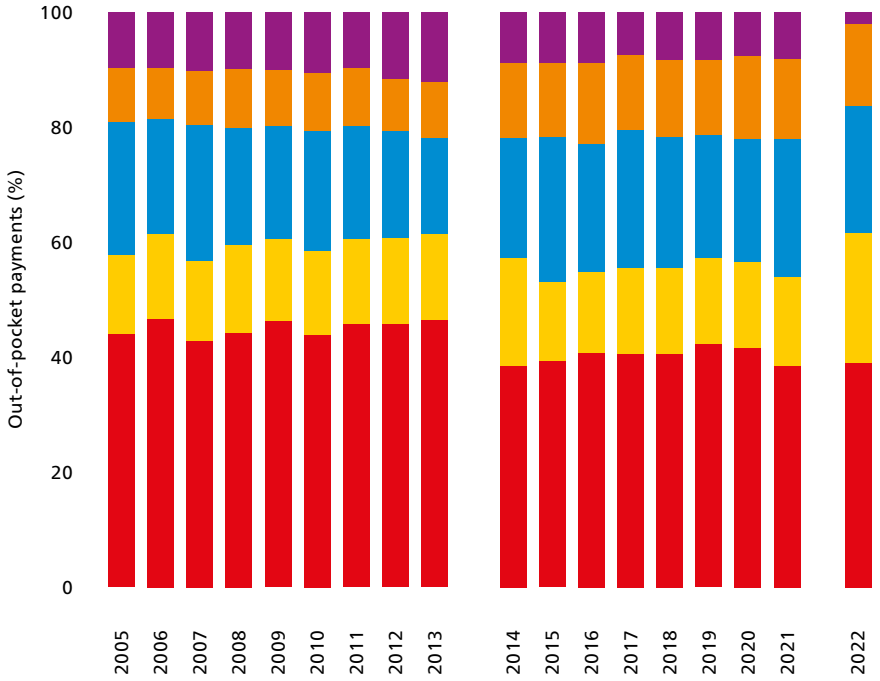


Notes: quintiles are based on per-person consumption, adjusted for household size and composition using OECD equivalence scales. Breaks in the series in 2014 and 2022 reflect changes in the Italian survey; data from different series are not comparable.

Source: authors, based on household budget survey data (ISTAT, 2025).

In 2022 out-of-pocket payments were on average driven mainly by spending on outpatient medicines (39%), followed by outpatient care (23%), dental care (22%) and medical products (14%) (Fig. 9). Over time the share spent on outpatient medicines rose from 39% in 2014 to a peak of 42% in 2019 before falling back to 38% by 2021. Other shares did not change much.

Fig. 9. Breakdown of total out-of-pocket spending by type of care



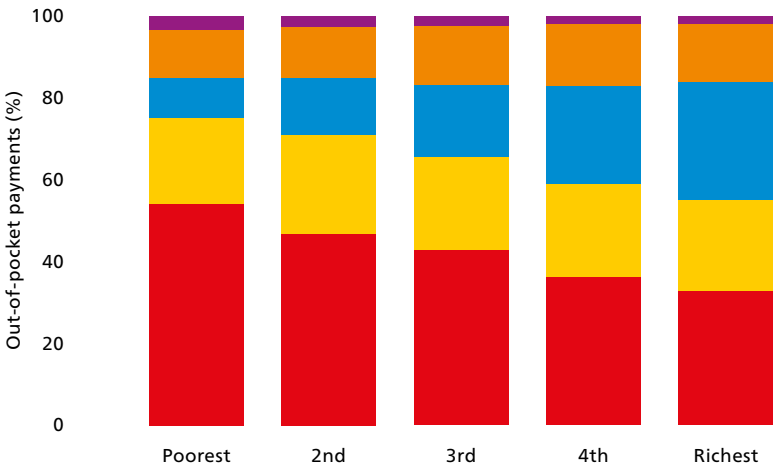
Notes: outpatient care includes inpatient care, due to negligible spending on inpatient care. Breaks in the series in 2014 and 2022 reflect changes in the Italian survey; data from different series are not comparable.

Source: authors, based on household budget survey data (ISTAT, 2025).

There is a consistent social gradient in out-of-pocket spending on outpatient medicines and dental care (Fig. 10): outpatient medicines are a larger driver of out-of-pocket payments in poorer households (54% in the poorest quintile in 2022 vs 33% in the richest), while dental care is a larger driver in richer households (10% in the poorest quintile in 2022 vs 29% in the richest). Households with lower incomes are less likely to be able to afford to pay out of pocket for dental care, resulting in higher levels of unmet need for dental care (see section 5.3). There is little variation across quintiles in the shares spent on other types of care.

The average amount spent on outpatient medicines, dental care, outpatient care and medical products declined during the economic crisis, while spending on diagnostics remained more stable (Fig. 11). The average amount spent on dental care also declined in the years before the COVID-19 pandemic and during the pandemic (Fig. 11), driven mainly by a fall in spending in the richest quintile (data not shown). In 2020 there was a decline in the average amount spent on all types of health care (Fig. 11).

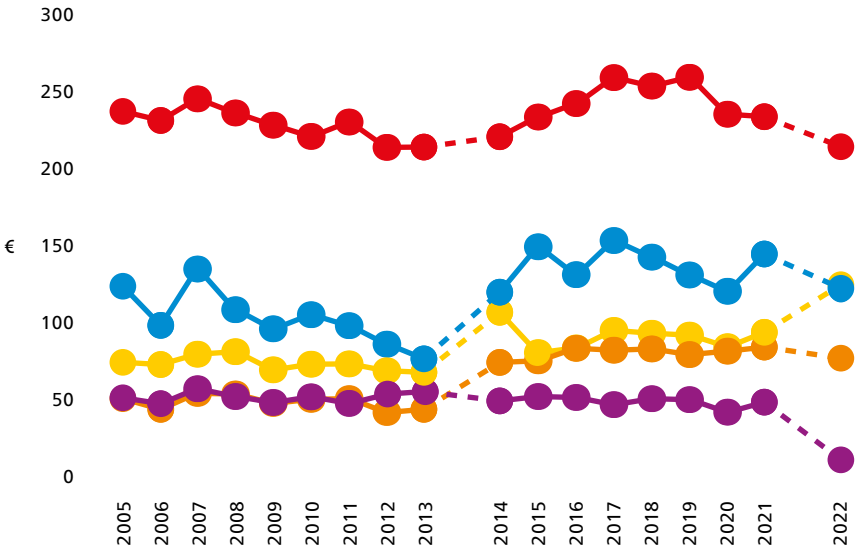
Fig. 10. Breakdown of total out-of-pocket spending by type of care and consumption quintile, 2022



Notes: outpatient care includes inpatient care, due to negligible spending on inpatient care. Quintiles are based on per-person consumption, adjusted for household size and composition using OECD equivalence scales.

Source: authors, based on household budget survey data (ISTAT, 2025).

Fig. 11. Annual out-of-pocket spending on health care per person by type of care



Notes: amounts are shown in real terms. Outpatient care includes inpatient care, due to negligible household spending on inpatient care. Breaks in the series in 2014 and 2022 reflect changes in the Italian survey; data from different series are not comparable.

Source: authors, based on household budget survey data (ISTAT, 2025).

4.3 Informal payments

Informal payments are not a salient issue in Italy. The 2024 Special Eurobarometer survey on corruption reported that 2% of respondents in Italy who had visited a public health care provider in the previous 12 months reported having made an extra payment or given a valuable gift to a nurse or doctor or donations to a hospital, below the EU average of 4% (European Commission & Kantar, 2024).

Anecdotal evidence suggests that informal payments are infrequent and mainly enable health care providers to evade taxes – for example, some health professionals may offer patients a reduced fee in exchange for an informal arrangement. The fact that people can claim an annual tax refund equal to 19% of any out-of-pocket payments over €129 may serve as a disincentive to pay informally, however.

Tax evasion by health care providers is a challenge: according to the latest ISTAT annual report on the unobserved economy (ISTAT, 2024), underreported revenue in the education, health and social care sectors accounted for 2.5% of the overall value produced.

4.4 Summary

Data from national health accounts indicate that Italy relies relatively heavily on out-of-pocket payments. In 2023 out-of-pocket payments accounted for 23% of current spending on health in Italy compared to an EU14 average of 17% and an EU27 average of 19% in 2022.

This partly reflects the level of public spending on health as a share of GDP, which was lower in Italy in 2022 than almost every other EU14 country and lower than expected given the size of GDP per person in Italy. This in turn reflects the very low priority given to health in allocating the government budget.

Public spending on health per person steadily declined in the aftermath of the global financial crisis of 2008 and the economic crisis in Italy, which pushed up the out-of-pocket payment share of current spending on health.

Broken down by type of care, the share of spending through out-of-pocket payments in Italy in 2022 was higher than the EU14 average for medical products (78% in Italy vs 55% in EU14 countries), outpatient care (38% vs 22%) and outpatient medicines (37% vs 33%).

In 2023 around two thirds of out-of-pocket payments for outpatient medicines in Italy were spent on non-covered class C medicines (36% on prescription medicines and 28% on OTC medicines) and a third on covered medicines – private purchases of class A medicines (19%), reference pricing (10%) and fixed co-payments (4%) (AIFA, 2024). The co-payment

share was higher in the 12 out of 21 NHS regions with co-payments for outpatient prescribed medicines: 11% through reference pricing and 6% through
co-payments.

Household budget survey data show that 74% of households reported out-of-pocket payments in 2022. Richer households are consistently more likely to report out-of-pocket payments than poorer households, reflecting their greater capacity to pay for health care.

Out-of-pocket payments accounted for 5.5% of household budgets on average in 2022, ranging from 5% in the poorest quintile to 6% in the fourth quintile. This share fell in the years of the economic crisis and grew quite sharply during the COVID-19 pandemic.

Out-of-pocket payments are mainly driven by outpatient medicines (in all quintiles), followed by outpatient care, dental care and medical products. There is a clear social gradient in out-of-pocket spending on outpatient medicines and dental care: outpatient medicines are a larger driver of out-of-pocket payments in poorer households, while dental care is a larger driver in richer households – the latter reflecting their greater capacity to pay for dental care.

Informal payments are not considered to be a major issue in Italy, but there is evidence to suggest that tax evasion and avoidance by private health care providers is a challenge.

5. Financial protection

This section uses data from the Italian household budget survey to assess the extent to which out-of-pocket payments result in financial hardship for households who use health services. It looks at household capacity to pay for health care, the relationship between out-of-pocket spending on health and poverty – impoverishing health spending – and the incidence, distribution and drivers of catastrophic health spending. The section also draws on other survey data to assess unmet need for health services.

5.1 Household capacity to pay for health care

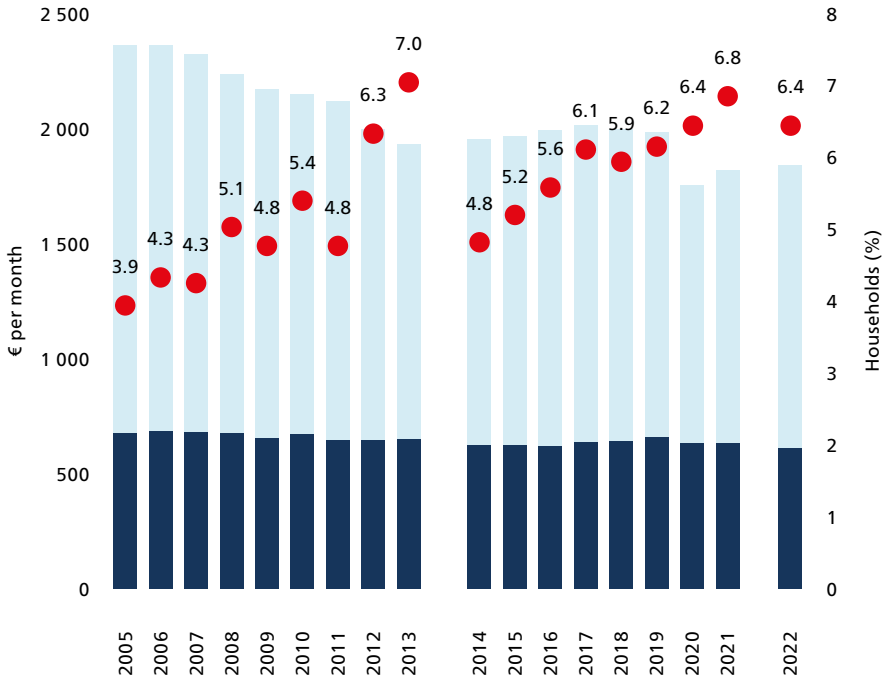
Household capacity to pay for health care is what is left of a household's budget after deducting a normative amount to cover spending on basic needs. Basic needs are defined as the average cost of spending on food, housing and utilities (water, electricity and heating) among a relatively poor part of the Italian population (households between the 25th and 35th percentiles of the consumption distribution), adjusted for household size and composition. In this study, consumption is calculated net of rent because rent is not available in the household budget survey. In 2022 the monthly cost of meeting these basic needs (the basic needs line) was €612 and 6.4% of households were living below the basic needs line (Fig. 12). This is low when compared to other measures of poverty – for example, 23% of the population was considered to be at risk of poverty or social exclusion in 2024, slightly above the EU27 average of 21% and the EU14 average of 20% (Fig. 13) (Eurostat, 2025c).

While the cost of meeting basic needs remained relatively stable during the study period, household capacity to pay for health care fell sharply in the years following the economic crisis, pushing the share of households living below the basic needs line to a peak of 7% in 2013. The share of households living below the basic needs line steadily increased from 4.8% in 2014 to 6.8% in 2021 and household capacity to pay for health care fell sharply in 2020, the first year of the COVID-19 pandemic.

Italy experienced its longest and most serious economic downturn since the Second World War between 2008 and 2015 (World Bank, 2025). Unemployment rates more than doubled during this time, rising from 6% in 2007 to 13% in 2014, before slowly falling (data not shown) (Eurostat, 2025c). The increase in unemployment was particularly severe among young people (Saraceno, Benassi & Morlicchio, 2020). Poverty rates were initially slow to rise (Fig. 13) because many young people were able to rely on family support, as demonstrated by a sharp decline in the propensity to save in those years (data not shown) (Saraceno, Benassi & Morlicchio, 2020). However, from 2011 poverty rates rose sharply and remained well above the EU27 average for the following decade (Fig. 13).

GDP fell again in 2020 in response to the COVID-19 pandemic (World Bank, 2025), but did not have such a large effect on poverty rates, which was closer to the EU27 average in 2023 (Fig. 13).

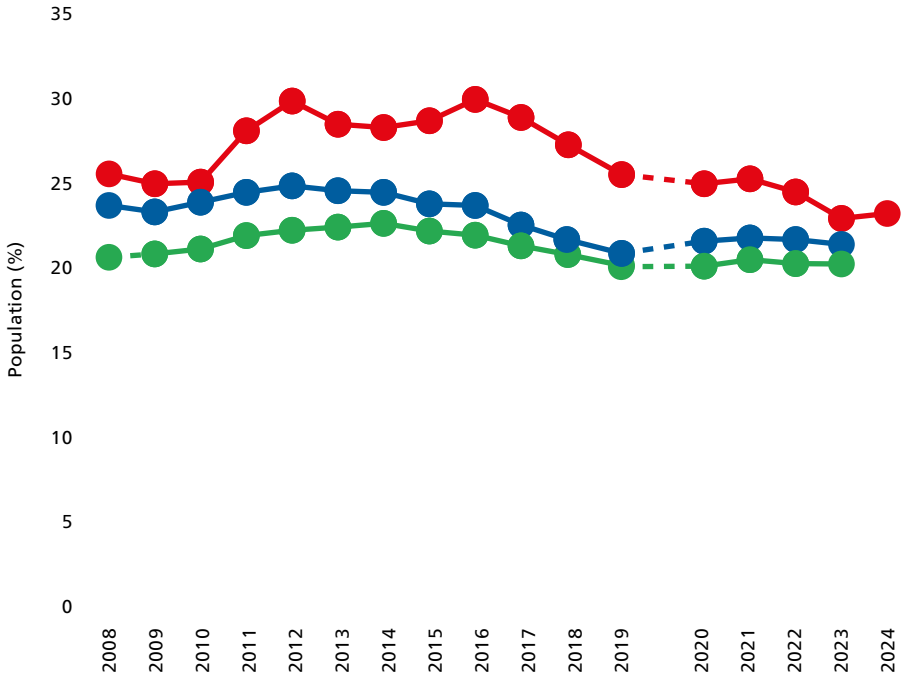
Fig. 12. Changes in the cost of meeting basic needs, capacity to pay and the share of households living below the basic needs line



Notes: amounts are shown in real terms (base year 2020). Capacity to pay is measured as a household's consumption minus a normative (standard) amount to cover basic needs such as food, housing and utilities. Breaks in the series in 2014 and 2022 reflect changes in the Italian survey; data from different series are not comparable.

Source: authors, based on household budget survey data (ISTAT, 2025).

Fig. 13. Share of the population at risk of poverty or social exclusion, Italy and the EU



Note: break in the series in 2020.

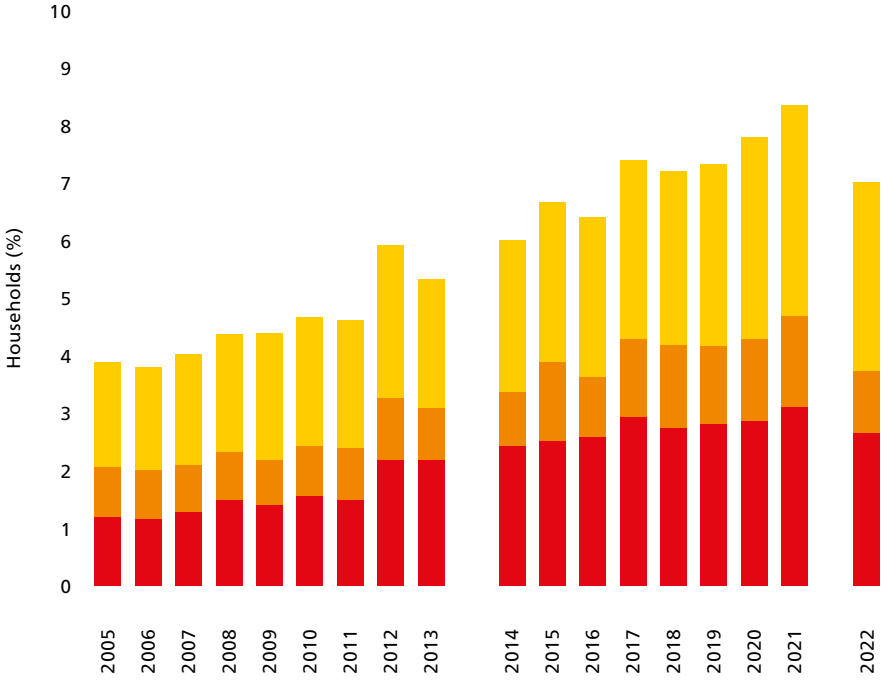
Source: Eurostat (2025c).

5.2 Financial hardship

How many households experience financial hardship?

Impoverishing health spending is defined in this study as out-of-pocket payments that push people into poverty or deepen their poverty. Just under 4% of households in Italy were impoverished or further impoverished after out-of-pocket payments in 2022 (Fig. 14). This share has grown over time, driven by a sharp increase in the share of further impoverished households in 2012 – a year marked by a relatively large fall in GDP and the implementation of austerity measures – and growth in all three risk categories between 2014 and 2021.

Fig. 14. Share of households at risk of impoverishment after out-of-pocket payments

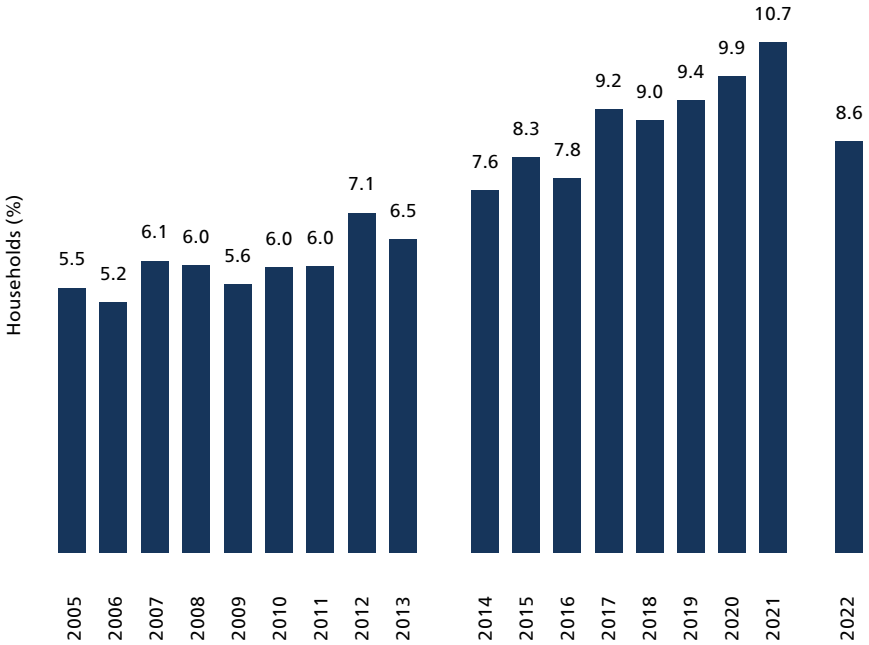


Notes: a household is impoverished if its total spending falls below the basic needs line after out-of-pocket payments; further impoverished if its total spending is below the basic needs line before out-of-pocket payments; and at risk of impoverishment if its total spending after out-of-pocket payments comes within 120% of the basic needs line. Breaks in the series in 2014 and 2022 reflect changes in the Italian survey; data from different series are not comparable.

Source: authors, based on household budget survey data (ISTAT, 2025).

Households with catastrophic health spending are defined in this study as those who spend more than 40% of their capacity to pay for health care out of pocket. This includes households who are impoverished after out-of-pocket payments (because they no longer have any capacity to pay) and further impoverished (because they had no capacity to pay before paying out-of-pocket for health care). Over 8% of households experienced catastrophic health spending in 2022 (Fig. 15). The incidence of catastrophic health spending doubled during the study period, rising from 5.2% to 7.1% between 2006 and 2012 and from 7.6% to 10.7% between 2014 and 2021.

Fig. 15. Share of households with catastrophic health spending



Note: breaks in the series in 2014 and 2022 reflect changes in the Italian survey; data from different series are not comparable.

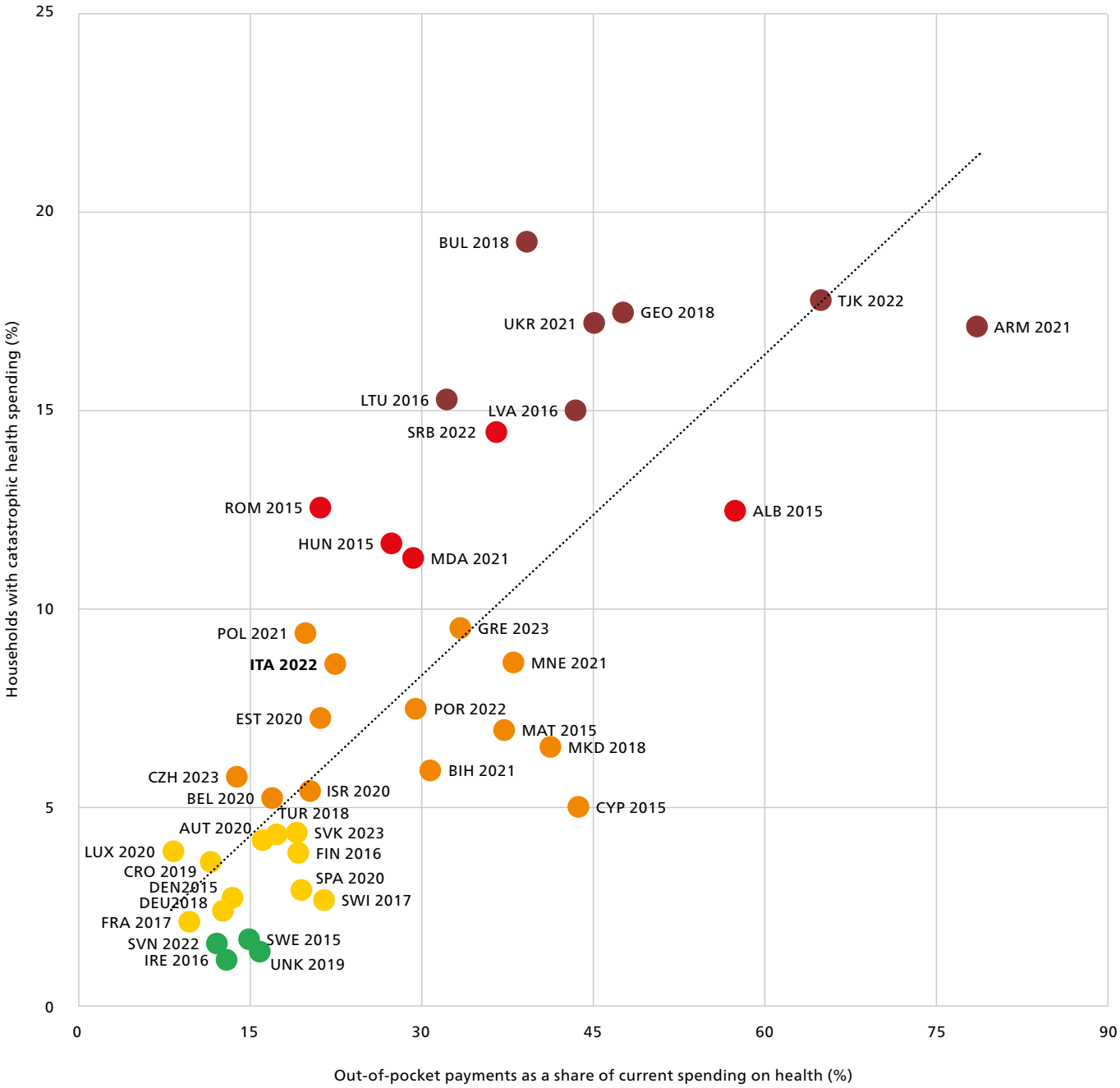
Source: authors, based on household budget survey data (ISTAT, 2025).

Levels of catastrophic health spending in Italy are higher than every other country in western Europe except Portugal, including many European Union (EU) countries with similar levels of out-of-pocket payments (Fig. 16).

Fig. 16. Incidence of catastrophic health spending and the out-of-pocket payment share of current spending on health in the WHO European Region, latest available year

Notes: data on catastrophic health spending and out-of-pocket payments are from the same year, except for Greece and Slovakia, for which data on out-of-pocket payments are from 2022. A list of country codes is available in the preliminary pages.

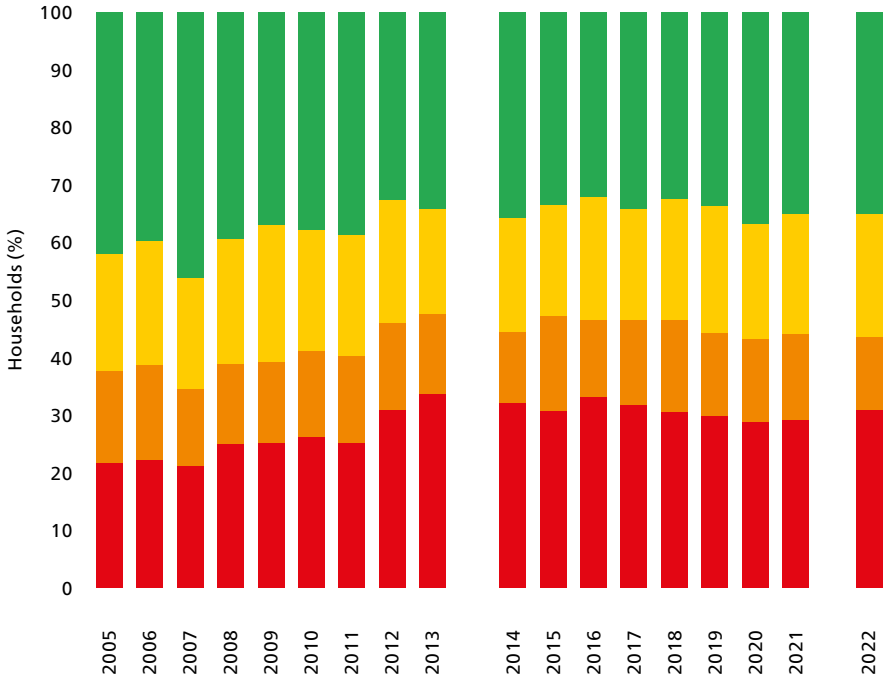
Source: UHC watch (2025).



Who experiences financial hardship?

In 2022 about two thirds of households with catastrophic health spending were further impoverished, impoverished or at risk of impoverishment after out-of-pocket payments (Fig. 17). This share has increased slightly over time, driven mainly by an increase in further impoverished households.

Fig. 17. Breakdown of households with catastrophic health spending by risk of impoverishment

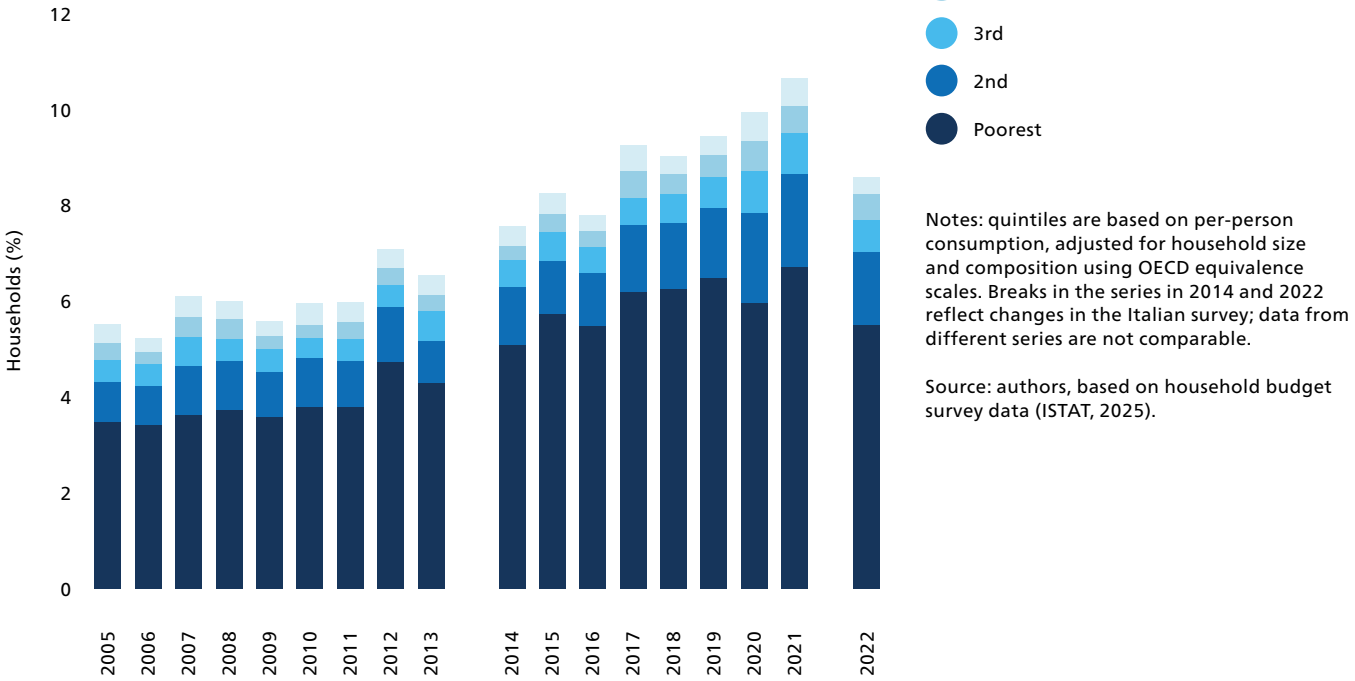


Note: breaks in the series in 2014 and 2022 reflect changes in the Italian survey; data from different series are not comparable.

Source: authors, based on household budget survey data (ISTAT, 2025).

Catastrophic health spending is heavily concentrated in the poorest quintile (Fig. 18). Households in the poorest quintile consistently account for about two thirds of all households with catastrophic health spending. The incidence of catastrophic health spending ranged from 27.5% of households in the poorest quintile in 2022 to only 1.6% in the richest. The incidence in the poorest quintile rose in both study periods, from 17% in 2006 to 33% in 2021 (data not shown).

Fig. 18. Share of households with catastrophic health spending by consumption quintile



Notes: quintiles are based on per-person consumption, adjusted for household size and composition using OECD equivalence scales. Breaks in the series in 2014 and 2022 reflect changes in the Italian survey; data from different series are not comparable.

Source: authors, based on household budget survey data (ISTAT, 2025).

Broken down by other factors, around half of all households with catastrophic health spending are headed by people who are retired, aged over 65 years and living in the south of the country (Fig. 19).

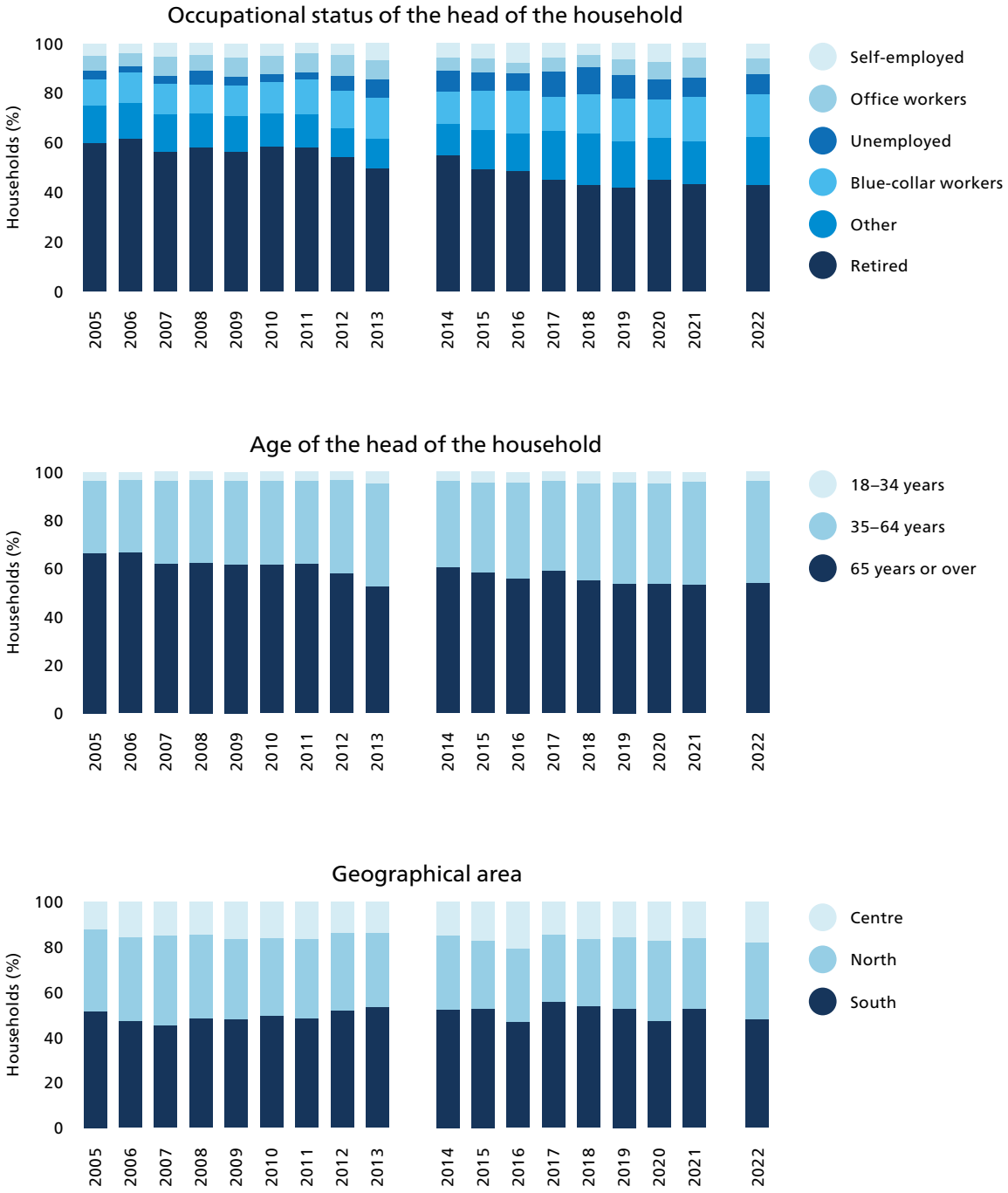
In 2022 the incidence of catastrophic health spending was higher than average (8.6%; see Fig. 15) in households headed by economically inactive people (people with domestic responsibilities, students and other unspecified categories: 18%); households headed by people aged over 65 years living alone (13%); households living in the south of the country (13%, compared to only 6% in households living in the north); unemployed people (12%); retired people (11%); and households with two or more children (11%) (data not shown).

The incidence rose in unemployed people during the economic crisis and in retired people throughout the study period (data not shown), even though the share of retired people with catastrophic health spending declined over time (Fig. 19).

Fig. 19. Breakdown of households with catastrophic health spending by occupational status, age of the head of the household and geographical area

Notes: the category "Other" in the classification by occupational status includes people with domestic responsibilities, students and other unspecified categories that cannot be further disaggregated. Breaks in the series in 2014 and 2022 reflect changes in the Italian survey; data from different series are not comparable.

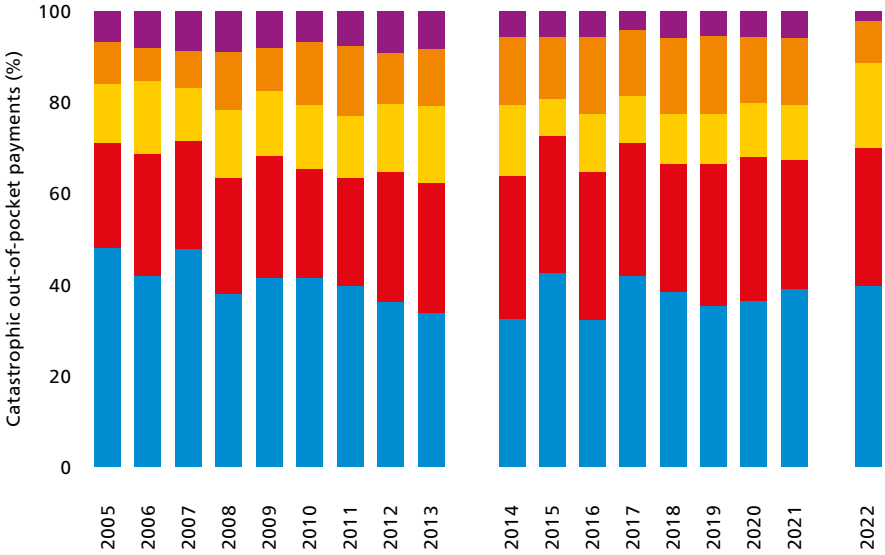
Source: authors, based on household budget survey data (ISTAT, 2025).



Which health services are responsible for financial hardship?

Catastrophic health spending is driven mainly by dental care (40% in 2022), followed by outpatient medicines (30%), outpatient care (19%) and medical products (9%) (Fig. 20). These patterns have been relatively consistent over time, although the dental care share fell between 2005 and 2013.

Fig. 20. Breakdown of catastrophic health spending by type of care, 2022

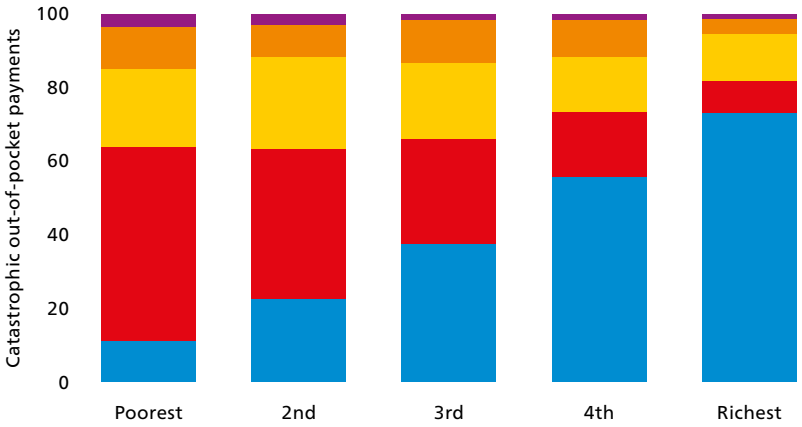


Notes: outpatient care includes inpatient care, due to negligible household spending on inpatient care. Breaks in the series in 2014 and 2022 reflect changes in the Italian survey; data from different series are not comparable.

Source: authors, based on household budget survey data (ISTAT, 2025).

Dental care is the largest single driver of catastrophic health spending in the three richest quintiles (Fig. 21). In the two poorest quintiles, however, catastrophic health spending is mainly driven by outpatient medicines, followed by outpatient care, medical products and dental care (Fig. 21). There is a social gradient for all types of care: while dental care is a much stronger driver in richer households (reflecting their greater capacity to pay for such care), outpatient medicines, outpatient care and medical products are stronger drivers in poorer households.

Fig. 21. Breakdown of catastrophic health spending by type of care and consumption quintile, 2022



Note: outpatient care includes inpatient care, due to negligible household spending on inpatient care.

Source: authors, based on household budget survey data (ISTAT, 2025).

How much financial hardship?

Among households with catastrophic health spending, the average amount spent on health as a share of total household spending consistently rises progressively with income (data not shown).

On average, further impoverished households spend around 7% of their budget on health care (data not shown). This is much higher than the average share of household budgets spent on health (5.5% in 2022) and the share spent in the poorest quintile (4.9%) (see Fig. 8 in section 4.2).

5.3 Unmet need for health care

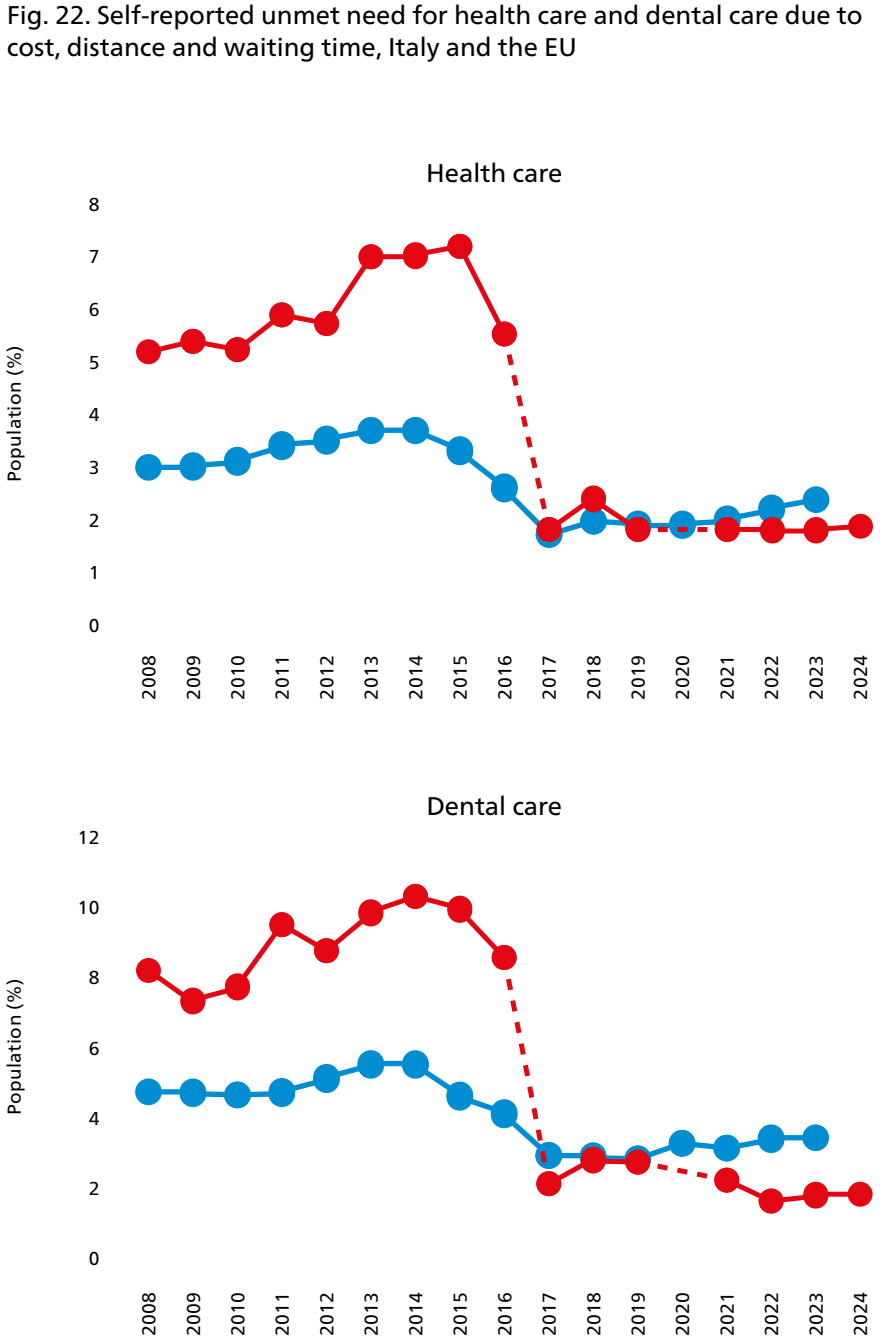
Data on unmet need due to cost, distance and waiting time (see Box 1 in section 2.2) show that in 2023 unmet need for health care and dental care in Italy was slightly below the EU average (Fig. 22). The EU-SILC question on unmet need was changed for Italy in 2017 (Eurostat, 2025a). Before that, the figures for unmet need for both health care and dental care were much higher in Italy than the EU average.

When looking specifically at people needing health care, as opposed to the whole population, the share of people experiencing unmet need in 2024 rose from 1.9% to 3.8% for health care and from 1.8% to 4.6% for dental care (data not shown) (Eurostat, 2025a). These shares fell from 4.5% for health care and 6.1% for dental care in 2021 (data not shown).

There is significant income inequality in unmet need for both types of care and particularly for dental care (Fig. 23). Cost is the main reason for unmet need for dental care and cost followed by waiting time are the main reasons for unmet need for health care (data not shown).

EHIS data on unmet need for health care, dental care and prescribed medicines show that, on average, unmet need is highest for dental care (Fig. 24). There is significant income inequality for all three types of care; unmet need is consistently higher than average in the poorest quintile and much higher than average in the richest quintile. In 2019 unmet need in Italy was above the EU average for health care and prescribed medicines but similar to the EU average for dental care (Fig. 24).

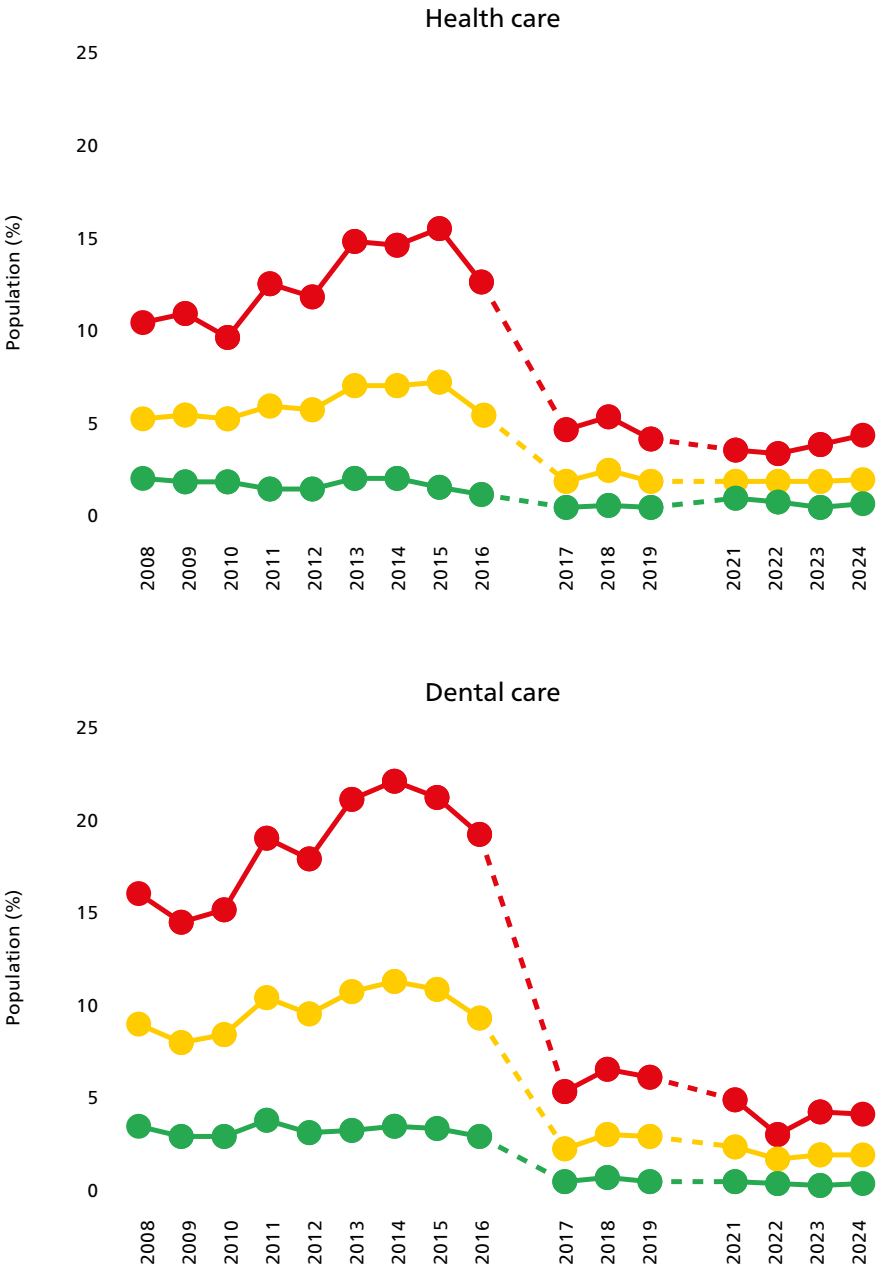
Fig. 22. Self-reported unmet need for health care and dental care due to cost, distance and waiting time, Italy and the EU



Notes: population is people aged 16 years and over. Break in the series in 2017 in Italy due to a change in the EU-SILC question on unmet need. The EU-SILC survey was not conducted in Italy in 2020.

Source: EU-SILC data from Eurostat (2025a).

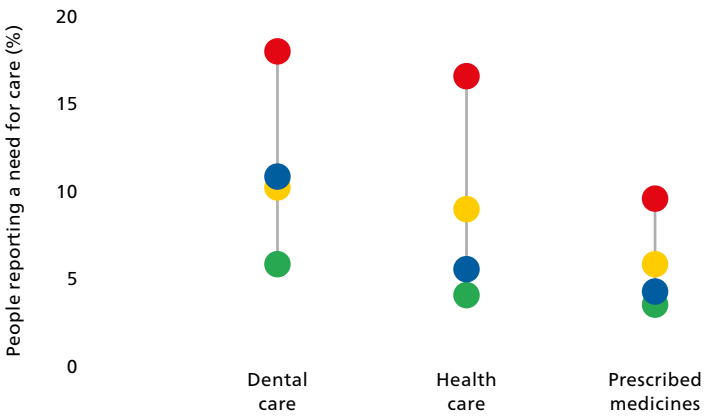
Fig. 23. Income inequality in unmet need for health care and dental care due to cost, distance and waiting time



Notes: population is people aged 16 years and over. Break in the series in 2017 in Italy due to a change in the EU-SILC question on unmet need. The EU-SILC survey was not conducted in Italy in 2020.

Source: EU-SILC data from Eurostat (2025a).

Fig. 24. Income inequality in unmet need for health care, dental care and prescribed medicines due to cost, 2019



Note: people reporting a need for care refers to people aged 15 years and over.

Source: EHIS data from Eurostat (2025b).

5.4 Summary

Just under 4% of households were impoverished or further impoverished due to out-of-pocket payments in 2022. This share has grown over time, driven by a sharp increase in the share of further impoverished households in 2012 – a year marked by a relatively large fall in GDP and the implementation of austerity measures – and growth in all three risk categories (at risk of impoverishment, impoverished and further impoverished) between 2014 and 2021.

In 2022 over 8% of households in Italy experienced catastrophic health spending, up from 5% in 2006 but lower than a peak of 11% in 2021. Levels of catastrophic health spending in Italy are high compared to many EU countries and higher than every other country in western Europe except Portugal.

Catastrophic health spending is heavily concentrated in households with low incomes and households headed by people who are retired, aged over 65 years and living in the south of the country. Within population groups, the incidence of catastrophic health spending is much higher than average in the poorest consumption quintile (27% in 2022) and higher than average in households headed by economically inactive people, older people living alone, people in the south, unemployed people, retired people and households with two or more children.

In the poorest quintile catastrophic health spending is mainly driven by outpatient medicines, followed by outpatient care. Dental care is the largest single driver of catastrophic health spending on average and in the three richest quintiles.

EHIS data indicate that unmet need is greater for dental care than for health care or prescribed medicines, but there is significant income inequality in unmet need for all three types of care.

6. Factors that strengthen and undermine financial protection

This section considers factors within the health system that may be responsible for financial hardship caused by out-of-pocket payments in Italy and which may explain the trend over time.

6.1 Coverage policy

Coverage policy in Italy has some strengths.

- It is generally less complex than in many other EU countries.
- Entitlement to care under the NHS is based on residence and refugees, asylum seekers and undocumented migrant children (aged under 18 years) are entitled to all NHS benefits. As a result, the NHS covers virtually the whole population.
- Although all regions apply reference pricing to outpatient prescribed medicines, 9 out of 21 NHS regions do not apply additional co-payments to medicines. All regions avoid the use of percentage co-payments – a type of co-payment that lowers transparency and financial certainty for people (WHO Regional Office for Europe, 2023).

However, the current design of coverage policy does not seem to be effective in protecting people with low incomes from financial hardship or unmet need, particularly with regard to outpatient medicines, dental care, other outpatient care services and medical products. Gaps in the coverage of these types of care persist, reflecting weaknesses in coverage policy design and other factors.

There are gaps in the NHS **benefits package** for dental care and medical products. NHS coverage of non-emergency dental care is very limited for working-aged adults (covering a first dental visit only) and the NHS only covers some hearing, vision and mobility aids for some people in vulnerable situations (with regional variation). NHS coverage of care for mild and moderate mental health conditions is also limited (again, with regional variation).

There are also the following limitations in the design and application of **user charges (co-payments)** for NHS care:

- co-payments are widely applied to most types of NHS care except primary care visits and inpatient care (see Table 3 in section 3.3 for details);
- mechanisms to protect people from co-payments are limited at national level – although some national exemptions from co-payments target people with low incomes (children, older people and some others), there are no national exemptions for most working-aged people with low incomes; very few national exemptions apply to co-payments for outpatient prescribed medicines; and not all exemptions are applied automatically;

- there is no cap on co-payments;
- significant regional variation in co-payment design is likely to exacerbate regional inequalities in affordable access to health care, especially since the poorest regions have less fiscal space to reduce co-payments;
- although all out-of-pocket payments (including co-payments) are eligible for a tax rebate of 19% on amounts over €129 a year, this policy is likely to favour people with higher incomes (Brenna, 2017; Di Novi, Marenzi & Rizzi, 2018); and
- VHI sometimes covers co-payments, which is also likely to favour richer households.

Catastrophic health spending is largely driven by household spending on **outpatient medicines** (see Fig. 20 and Fig. 21 in section 5.2). There is also considerable unmet need for prescribed medicines in the poorest households (see Fig. 24 in section 5.3). National administrative data on out-of-pocket payments for outpatient medicines show that around two thirds constitute spending on non-covered class C medicines: 36% on prescription medicines – of which benzodiazepines accounted for 16% in 2023 – and 28% on OTC medicines (AIFA, 2024). The remainder comes from spending on covered medicines: private purchases of covered medicines (class A: 19%), "avoidable co-payments" caused by reference pricing (10%) and, in the 12 out of 21 NHS regions with co-payments, fixed co-payments (6%) (AIFA, 2024). Unfortunately, these data cannot be disaggregated by household income.

Two factors are of note here.

- The relatively high share of out-of-pocket payments spent on private purchases of non-covered (class C) medicines and covered medicines (class A) could indicate a gap in the benefits package; problems accessing NHS prescriptions (for example, due to waiting times for outpatient visits); and challenges in enforcing prescription requirements. About 9% of Italians reported purchasing antibiotics without a prescription in 2018, above the EU average of 7% (European Commission & Kantar, 2018).
- The high share of "avoidable co-payments" caused by reference pricing in co-payments (65% in regions with additional fixed co-payments for outpatient prescribed medicines) suggests that not enough people are able to access medicines priced at the reference price – a problem that appears to be larger in poorer regions (AIFA, 2024).

OECD data show that Italy lags well behind other countries in the use of generics, which accounted for only 9% of the value and 27% of the volume of the total pharmaceutical market in Italy in 2021, compared to OECD26[6] averages of 27% and 54%, respectively (OECD, 2025). Regional differences are also significant in Italy: generic spending accounted for twice the share of total spending on covered patent-expired medicines in the north (40% in 2023) as in the south and the islands (23%) (AIFA, 2024).

6. OECD member countries as of 1961.

Even when pharmacists must offer branded or generic alternatives to users, users are more likely to purchase the branded option, which is likely to reflect inadequate awareness of the therapeutic equivalence between generics and branded medicines among users and perhaps also among health professionals (Piccinni, Fontolan & Zucconi, 2016; SWG, Cittadinanzattiva & Egualia, 2024).

In 2024 financial incentives for pharmacies to dispense generics were replaced with a new financial incentive: €0.115 per package (in 2025) targeting all medicines from the so-called "transparency lists" (including both generics and branded medicines from the class A positive list).

Dental care is the main driver of catastrophic health spending in richer households (see Fig. 21 and Fig. 22 in section 5) and levels of unmet need are higher for dental care than for other types of care and particularly high in poorer households (see Fig. 23 and Fig. 24 in section 5.3). This reflects the lack of NHS coverage of non-emergency dental care for working-aged adults (only one covered visit a year). It also reflects some gaps in coverage for those entitled to a more extensive range of NHS dental benefits (children aged under 14 years, adults aged over 65 years and some people in vulnerable situations) – for example, the NHS does not cover prostheses or implants and people often experience long waiting times for covered services (Allin et al., 2020). Italy has one of the lowest rates of dental visits in Europe, with a significant gap between income groups (OECD, 2019).

Outpatient care is the third-largest driver of catastrophic health spending overall and the second-largest driver for households in the two poorest quintiles (see Fig. 21 and Fig. 22 in section 5). This is likely to reflect two main factors: co-payments and long waiting times.

Co-payments have been applied to most outpatient visits (emergency care, outpatient specialist visits) and diagnostics tests since 2011 and vary across regions. In 2021 they were applied to 77% of outpatient specialist visits and 70% of outpatient imaging services (Del Vecchio et al., 2023). Although these co-payments were reduced in 2020 (with the abolition of the "super ticket"), they remain high in some regions (for example, €36 for several outpatient care services or €25 for use of an emergency department if the use is deemed to be inappropriate, plus up to €36 for any care provided). These are likely to be a barrier to access for most working-aged people with low incomes, who are not exempt (see Table 3 in section 3.3 for details). New changes to the benefits package introduced in 2025 are expected to increase co-payments by 5.8% at national level, with the southern regions potentially facing higher increases (Ministry of Health, 2024).

Long **waiting times** are a long-standing problem and push people to pay out of pocket for privately provided health care, especially for outpatient specialist visits and diagnostic tests. It is estimated that in 2022 48% of outpatient specialist visits were fully paid for by people (up from 41% in 2018), either through out-of-pocket payments (42%) or VHI (6%) (Del Vecchio et al., 2023). Despite the introduction of a national plan to address waiting times in 2019 (followed by a second national plan in 2025), they have continued to increase due to a range of factors: limited

public resources, a shortage of health workers, a lack of policies to better coordinate human resources, poor planning of specialist training in past decades and, more recently, the COVID-19 pandemic.

Administrative data show that growth in out-of-pocket payments since the mid-2010s has been driven mainly by growth in direct out-of-pocket payments (rather than growth in co-payments) (Del Vecchio et al., 2020). This may reflect increases in waiting times.

Health systems in more deprived regions tend to perform less well than those in richer regions, exacerbating **regional inequality in access to health care**, particularly between the north and the south of the country. Almost half of all households with catastrophic health spending live in the south, even though it has less than 40% of the population (see Fig. 19 in section 5.2). Although not explicitly considered in this study, patient mobility costs may represent a barrier to access and lead to financial hardship for households with lower incomes (Fattore, Petrarca & Torbica, 2014). Recent data show that people in southern regions accounted for 72% of all mobility hospitalizations and that more than half of all spending on patient mobility (58%) was concentrated in four southern regions (Calabria, Campania, Puglia and Sicily) (AGENAS, 2024). Anecdotal evidence suggests that lower perceived and actual quality of care (particularly in outpatient care settings) may lead to higher private spending, as those who can afford it will opt to pay out of pocket for privately provided care.

The NHS benefits package has not been updated regularly; the 2017 update was the first in 15 years. The most recent update (introduced in 2025) is expected to expand coverage of some health services but also to increase co-payments by 5.8% at national level, with southern regions potentially facing the highest increases – a change that may further widen the north–south divide (Ministry of Health, 2024).

6.2 Spending on health

Some of the factors undermining financial protection are linked to Italy's relatively low level of public spending on health compared to most other countries in western Europe and lower than what would be expected given the size of GDP per person in Italy.

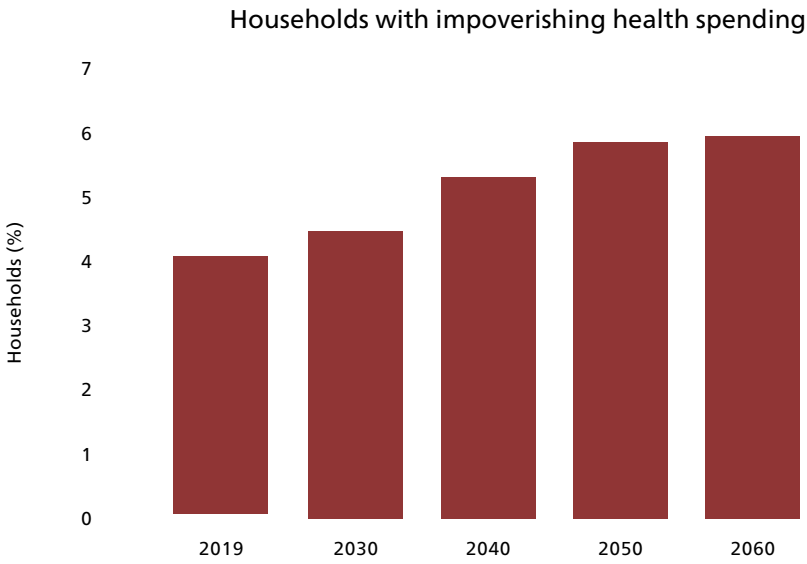
Public spending on health per person steadily declined in Italy in the context of austerity measures and recovery plans introduced during the economic crisis that followed the global financial crisis of 2008, pushing up the out-of-pocket payment share of current spending on health.

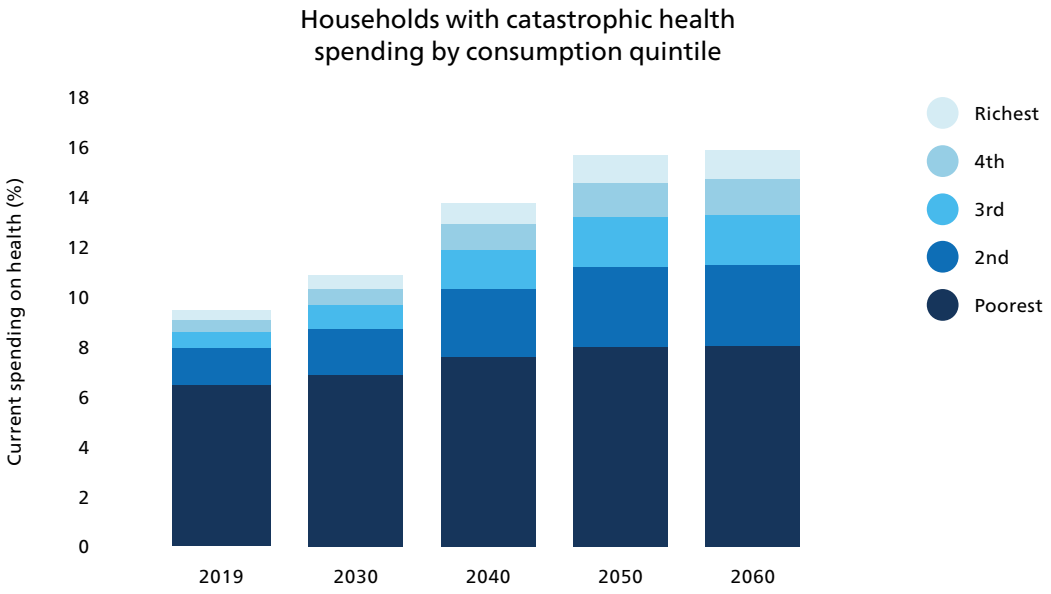
Health sector financial imbalances between regions (partly due to financial incentives for better performance that typically benefit regions with higher levels of GDP and partly due to differences in regional fiscal autonomy) have led to persistent deficits in the poorest regions and affected their ability to reduce co-payments.

Fig. 25. Projected increase in the share of households with impoverishing or catastrophic health spending in Italy between 2019 and 2060

Note: quintiles are based on per-person consumption, adjusted for household size and composition using OECD equivalence scales.

Source: Cylus et al. (2025).





Heavy reliance on out-of-pocket payments is particularly challenging for households in the context of Italy's relatively high rates of poverty and social exclusion, especially in the regions where these rates are higher – an issue that may be exacerbated by demographic shifts. Recent analysis has found that population ageing could lead to much higher levels of catastrophic health spending in Italy in the future if public spending on health does not increase to support ageing-related increases in per-person health spending (Cylus et al., 2025). Given the high incidence of catastrophic health spending in Italy, even a relatively modest increase in out-of-pocket payments between now and 2060 might lead to a large increase of catastrophic health spending over time (Fig. 25) (Cylus et al., 2025).

6.3 Summary

The current design of coverage policy does not seem to be effective in protecting people with low incomes from financial hardship or unmet need for health care, particularly in terms of outpatient medicines, dental care, other outpatient care services and medical products.

There are weaknesses in the design and application of user charges (co-payments) for NHS care:

- co-payments are widely applied – there are no exemptions for most working-aged people with low incomes and there is no cap on co-payments;
- very few people are exempt from "avoidable co-payments" caused by reference pricing (applied in all regions) or other co-payments for outpatient prescribed medicines (applied in 12 out of 21 NHS regions);
- significant regional variation in co-payment design exacerbates regional inequalities, especially since the poorest regions have less fiscal space to reduce co-payments; and
- the 19% tax rebate on any out-of-pocket payments over €129 a year favours people with higher incomes.

Out-of-pocket payments for outpatient prescribed medicines are driven by spending on non-covered medicines (mainly class C prescription medicines, including benzodiazepines, and OTC medicines), private purchases of covered medicines, "avoidable co-payments" caused by reference pricing and other co-payments.

The high share of co-payments due to reference pricing (65% in regions with additional fixed co-payments for outpatient prescribed medicines) suggests that not enough people are able to access medicines priced at the reference price – a problem that appears to be larger in poorer regions and reflects lower use of generics in Italy than in other EU countries.

The NHS does not cover non-emergency dental care for working-aged adults. Financial protection may also be undermined by the exclusion of dental prostheses from NHS coverage and long waiting times for covered services.

Financial protection for outpatient care is likely to be undermined by co-payments and long waiting times for outpatient specialist visits and diagnostic tests, which have increased over time.

Regional inequalities in access to health care may also play a part in inequalities in catastrophic health spending and unmet need.

Levels of public spending on health are below what would be expected given Italy's level of GDP and updates to the NHS benefits package planned for 2025 are expected to increase co-payments further and to widen the north–south divide.

Population ageing could lead to much higher levels of catastrophic health spending in Italy in the future if public spending on health does not increase to support ageing-related increases in per-person health spending (Cylus et al., 2025).

7. Implications for policy

Financial hardship caused by out-of-pocket payments is higher in Italy than in many EU countries. In 2022 8.6% of households experienced catastrophic health spending and 3.7% of households were impoverished or further impoverished after out-of-pocket payments. These levels have grown over time.

Catastrophic health spending is heavily concentrated in households with low incomes, households headed by retired people and households in southern regions. Broken down by groups, the incidence of catastrophic health spending is much higher than average in the poorest consumption quintile (27% in 2022) and higher than average in households headed by economically inactive people, older people living alone, people in the south, unemployed people, retired people and households with two or more children.

Catastrophic health spending is mainly driven by outpatient medicines, dental care and outpatient care; mainly by outpatient medicines and outpatient care in poorer households and by dental care in richer households.

There is substantial income inequality in unmet need for health care. EHIS data indicate that unmet need is greater for dental care than for health care or prescribed medicines, but there is significant income inequality in unmet need for all three types of care.

Coverage policy in Italy has some strengths. It is less complex than in many other EU countries, entitlement to care under the NHS is based on residence and refugees, asylum seekers and undocumented migrant children are entitled to all NHS benefits.

However, the current design of coverage policy does not seem to be effective in protecting people with low incomes from financial hardship or unmet need, particularly in terms of outpatient medicines, dental care, other outpatient care services and medical products. This is likely to reflect: gaps in the NHS benefits package for dental care and medical products; widespread co-payments, with significant regional variation and limited mechanisms to protect people from co-payments for outpatient prescribed medicines or to protect most working-aged people with low incomes from all co-payments; low use of generics compared to other EU countries; long and growing waiting times for outpatient care; and regional inequalities in access to health care.

Although implementing financial protection reforms may be challenging within Italy's highly regionalized health system, the Government can build on recent efforts (e.g. the abolition of some co-payments for outpatient care in 2020 – the "super-ticket"– and recent measures to tackle waiting times and the expansion of the NHS benefits package in 2025) to reduce financial hardship and unmet need, particularly for households with lower incomes.

Options to consider include the following actions.

- **Address long waiting times for outpatient specialist visits and diagnostic tests.** Although reducing waiting times is a high priority on the political agenda, further efforts should aim to expand capacity through additional financial resources and enhanced productivity, including reducing inappropriate use of care by establishing clear clinical guidelines for health care providers.

- **Improve the design of co-payments – especially for households with low incomes, as well as reducing regional variation.** Current co-payment exemptions should be extended to all working-aged people with low incomes and co-payments for outpatient prescribed medicines (including "avoidable co-payments" caused by reference pricing). The Government should also introduce a cap on all co-payments for the whole population – ideally, the cap would be linked to household income so that it is more protective for people with lower incomes and has less impact on the NHS budget (García-Ramírez et al., 2025).

- **Reduce "avoidable co-payments" for more expensive medicines when cheaper alternatives are available.** This could be achieved by encouraging greater use of generics through stronger prescribing and dispensing policies; educational campaigns for users; and extending protection from co-payments (e.g. exemptions) to "avoidable co-payments" caused by reference pricing.

- **Review the equity and efficiency of the 19% tax rebate on out-of-pocket payments**, which tends to favour people with higher incomes (Brenna, 2017; Di Novi, Marenzi & Rizzi, 2018).

- **Expand NHS coverage of dental care and medical products, including hearing aids and optical care, particularly for people with low incomes.**

- **Adress inequalities in access to health care across regions** – options include improving care quality in the worst-performing regions and covering travel costs for people with low incomes, who need highly specialized care in other regions (especially for cancer and rare diseases).

- **Close gaps in population coverage by extending entitlement to NHS benefits to adult undocumented migrants, reducing administrative barriers to entitlements, and better monitoring.** Countries like Spain and France offer examples of good practice in extending coverage to adult undocumented migrants (WHO Regional Office for Europe, 2023).

To meet equity and efficiency goals now and in the future (particularly in the context of population ageing), the Government should ensure that levels of public spending on health are sufficient and carefully targeted to reduce financial hardship and unmet need for households with low incomes. It should also find ways to improve equity across regions.

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7. All references were accessed on 28 March 2025.

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World Health Organization Regional Office for Europe

UN City, Marmorvej 51, DK-2100 Copenhagen Ø, Denmark
Tel.: +45 45 33 70 00 Fax: +45 45 33 70 01
Email: eurocontact@who.int
Website: www.who.int/europe

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