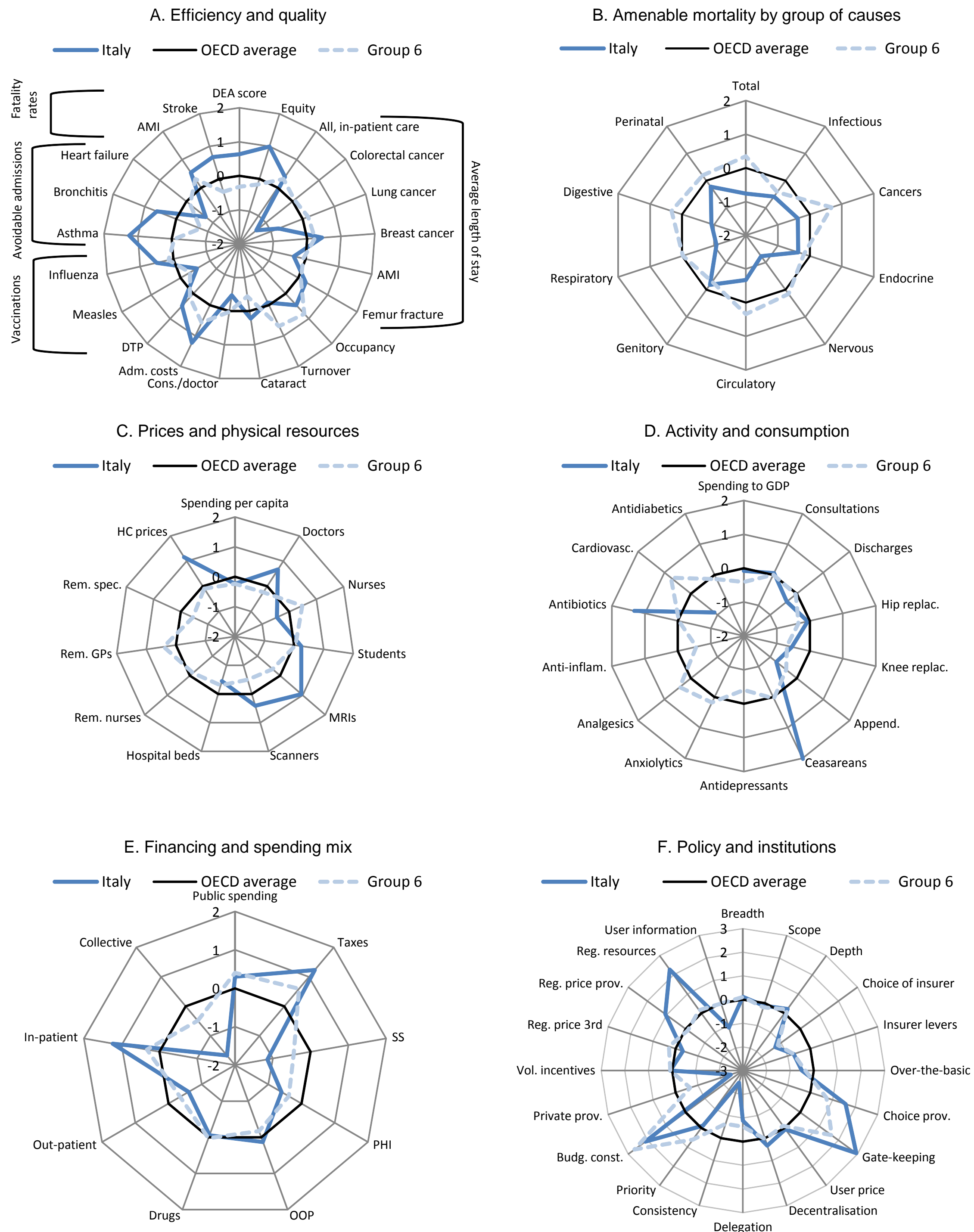


*Note:* Country groups have been determined by a cluster analysis performed on policy and institutional indicators. In all panels except Panel A, data points outside the average circle indicate that the level of the variable for the group or the country under scrutiny is higher than for the average OECD country (e.g. Australia has more scanners than the OECD average country).
In Panel A, data points outside the average circle indicate that the group or the country under scrutiny performs better than the OECD average (e.g. administrative costs as a share of total health care spending are lower in Australia than on average in the OECD area).
In all panels except Panel F, data represent the deviation from the OECD average and are expressed in number of standard deviations.
In Panel F, data shown are simple deviations from the OECD average.

*Source*: OECD Health Data 2009; OECD Survey on Health Systems Characteristics 2008-2009; OECD estimates based on Nolte and Mc Kee (2008).

**ITALY**

**GROUP 6:** Mostly public insurance. Health care is mainly provided by a heavily regulated public system, with strict gate-keeping, little decentralisation and a tight spending limit imposed *via* the budget process.

| Efficiency and quality | Prices and physical resources | Activity and consumption | Financing and spending mix | Policies and institutions | Weaknesses and policy inconsistencies emerging from the set of indicators |
|---|---|---|---|---|---|
| High DEA score, low amenable mortality rate and low inequa-lities in health status | | | Higher tax-financed share | | |
| Mixed signals on output/acute care efficiency | More doctors and medical students; less nurses | Slightly less hospital discharges *per capita* | Higher in-patient share | Less private provision (in particular for specialist services) and less information on the quality and prices of services | Strategies to increase efficiency in the in-patient care sector should be devised. Options to consider include: the publication of information on quality and price of services and the reform of payment systems for in-patient specialists |
| Rather high quality of out-patient and preventive care | Less acute care beds *per capita* but more high-tech equipment | | | More gate-keeping and more choice of providers | |
| Low administrative costs | | | | Low consistency of responsibility assignment across government levels. More regulation of provider prices and resources | Efforts to increase consistency in the allocation of resources across government levels could contribute to raise spending efficiency |