European Commission

State of Health in the EU

Italy

Country Health Profile 2023

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

The *Country Health Profile* Series

The *State of Health in the EU*'s *Country Health Profiles* provide a concise and policy-relevant overview of health and health systems in the EU/European Economic Area. They emphasise the particular characteristics and challenges in each country against a backdrop of cross-country comparisons. The aim is to support policy makers and influencers with a means for mutual learning and voluntary exchange. For the first time since the series began, the 2023 edition of the Country Health Profiles introduces a special section dedicated to mental health.

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

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Data and information sources

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

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

This profile was finalised in September 2023, based on data that were accessible as of the first half of September 2023.

Demographic and socioeconomic context in Italy, 2022

Demographic factors	Italy	EU
Population size	59 030 133	446 735 291
Share of population over age 65 (%)	23.8	21.1
Fertility rate[1] (2021)	1.3	1.5
Socioeconomic factors		
GDP per capita (EUR PPP[2])	33 688	35 219
Relative poverty rate[3] (%)	20.1	16.5
Unemployment rate (%)	8.1	6.2

1. Number of children born per woman aged 15-49. 2. Purchasing power parity (PPP) is defined as the rate of currency conversion that equalises the purchasing power of different currencies by eliminating the differences in price levels between countries. 3. Percentage of persons living with less than 60 % of median equivalised disposable income. Source: Eurostat Database.

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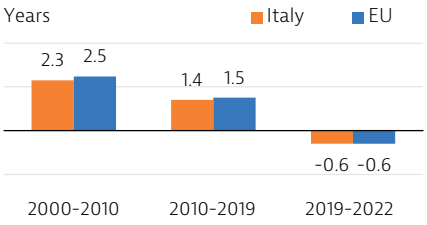
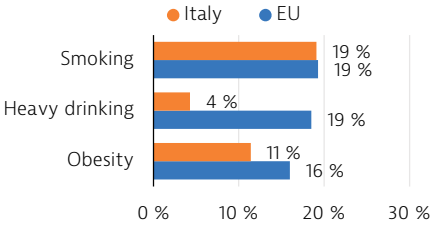
1 Highlights



Changes in life expectancy at birth

Health Status

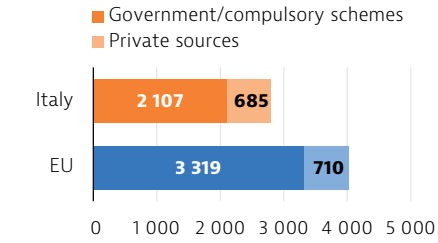
Over the two decades before the pandemic, Italy's life expectancy at birth grew broadly in line with the EU average. After falling by 1.3 years in 2020, life expectancy recovered to 83.0 years in 2022 – one of the highest levels in the EU, but still six months below its pre-pandemic level. Circulatory diseases remain the leading cause of death in Italy, followed by cancer.



% of adult population, 2019

Risk Factors

In 2022, Italy's adult smoking rate was slightly higher than the EU average at 19.6 %, marking a resurgence of smoking during the pandemic following a decade of gradual declines. Rates of both alcohol consumption and regular heavy drinking are below the EU averages, as is prevalence of obesity. However, high rates of physical inactivity, particularly among adolescents, indicate potential risks of increases in the obesity rate in the future.



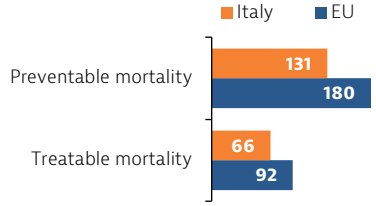
EUR PPP per capita, 2021

Health System

In 2021, Italy's health expenditure stood at 9.4 % of GDP – over 1.5 percentage points below the EU average. Between 2019 and 2021, health expenditure per capita increased by nearly 7 %, driven exclusively by increased public expenditure to tackle the pandemic. Approximately three quarters of health expenditure is publicly funded – a lower proportion than the EU average of 81 %.

Effectiveness

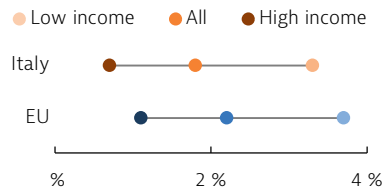
In 2020, Italy's mortality rates from generally preventable and treatable causes were over 27 % lower than their respective EU averages. COVID-19 emerged as the leading single cause of preventable death, while ischaemic heart disease and colorectal cancer collectively accounted for one third of potentially treatable mortality.



Age-standardised mortality rate per 100 000 population, 2020

Accessibility

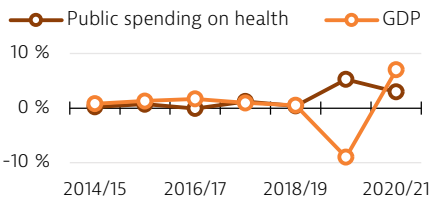
In 2022, 1.8 % of Italians reported experiencing unmet needs for medical care – a lower share than the EU average and in line with Italy's rate of unmet medical needs prior to the pandemic. Among individuals in the lowest income quintile, 3.3 % reported unmet medical care needs, compared to less than 1 % of individuals in the highest quintile.



% reporting unmet medical care needs, 2022

Resilience

After a substantial decline during the sovereign debt crisis, Italy's government spending on health returned to growth in 2014, trailing the country's modest GDP growth. The pandemic upended this trend, and public spending increased by 5.2 % against a 9 % decline in GDP in 2020. As GDP rebounded by 7 % in 2021, government spending rose by 2.9 %.



Annual change in real terms

Mental Health

About one in six Italians were estimated to have had a mental health disorder in 2019 – a share equal to the EU average. Anxiety disorders were the most common, affecting over 6 % of the population, followed by depressive disorders. Differences in the prevalence of depression between Italians on low and high incomes were much less pronounced than in most other EU countries. As in other southern European countries, depression was disproportionately reported by women.

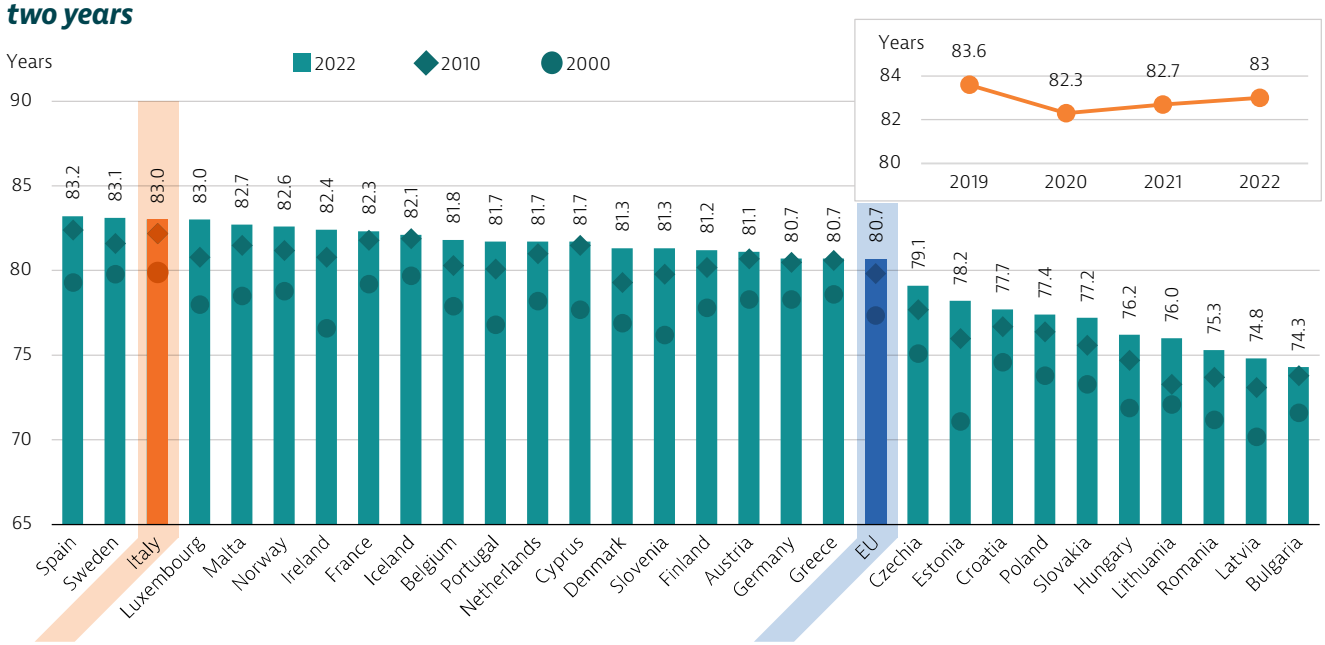
2 Health in Italy

Italy's life expectancy remains consistently among the highest in the EU

In 2022, Italy's life expectancy at birth was the third highest in the EU at 83.0 years, exceeding the EU average by 2.3 years (Figure 1). Throughout the decade preceding the COVID-19 pandemic, Italy's life expectancy increased at a rate comparable to the EU average, despite already holding the second-highest life expectancy in the EU in 2010. However, in 2020 Italy experienced a large, above-average drop in life expectancy of 1.3 years, resulting from the large number of COVID-19 deaths in the first year of the pandemic. Over the subsequent two years, Italy's life expectancy rebounded by 0.7 years, surpassing the EU average increase of 0.3 years. Despite this above-average rebound, in 2022 the life expectancy of the Italian population was still over 6 months below its pre-pandemic level.

As in other European countries, men in Italy tend to have shorter lifespans than women. In 2022, the average life expectancy of women was 85 years – over four years longer than that of men (80.9 years). This gender gap in life expectancy was nevertheless narrower than the EU average, which stood at nearly five and a half years.

Figure 1. Following a large decline in 2020, Italy's life expectancy partially recovered in the subsequent two years



Notes: The EU average is weighted. The 2022 data are provisional estimates from Eurostat that may be different from national data and may be subject to revision. Data for Ireland refers to 2021.
Source: Eurostat Database.

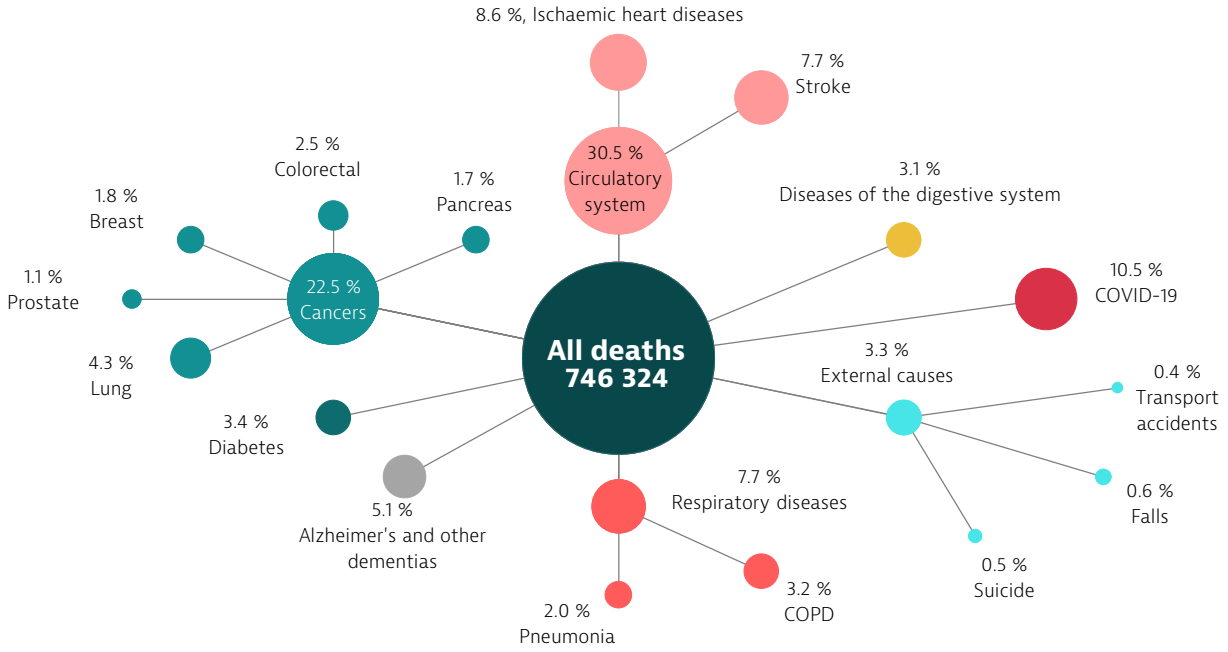
COVID-19 was the main single cause of death in Italy in 2020

Over the last decade, Italy's advancements in life expectancy primarily stemmed from reductions in mortality related to circulatory diseases and, to a lesser extent, cancer. Nonetheless, circulatory diseases remained the leading cause of death in Italy in 2020, and were responsible for over 30 % of all fatalities. Cancer was the second leading cause of mortality in 2020, accounting for 22.5 % of all deaths. Lung cancer continued to be the primary cause of cancer-related mortality, accounting for nearly one fifth of all cancer deaths in Italy (Figure 2).

With regard to single causes of death, COVID-19 emerged as the main driver of mortality in Italy during the first year of the pandemic, accounting for over 78 600 deaths – over one in every ten deaths recorded in Italy in 2020. Of these deaths, 43 % occurred among individuals aged 85 and over – a proportion on a par with the EU average.

The indicator of excess mortality, defined as deaths that occurred (regardless of their cause) above a baseline derived from pre-pandemic levels – provides a more complete picture of the pandemic's mortality impact. The more than 227 000 excess deaths that occurred in Italy between 2020 and 2022 account for a level 12.2 %

Figure 2. COVID-19 alone accounted for over one in every ten deaths in 2020



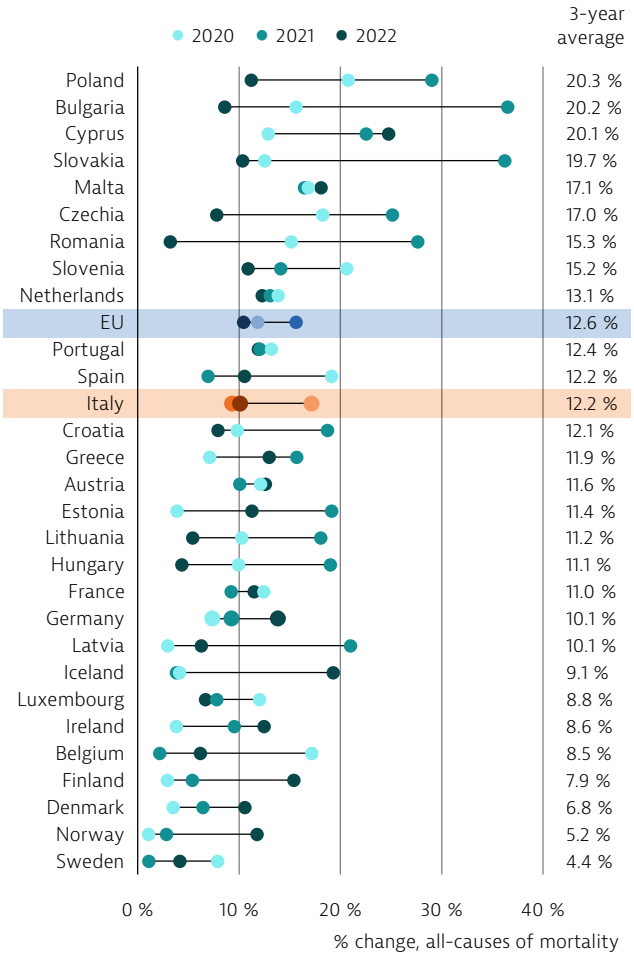
Note: COPD refers to chronic obstructive pulmonary disease.
Source: Eurostat Database (data refer to 2020).

above their historic baseline, which is slightly below the 12.6 % excess mortality observed on average in the EU (Figure 3).

Throughout the three years of the pandemic, Italy witnessed a relatively unusual pattern of excess mortality. Following its peak in 2020, excess mortality declined in 2021, only to experience a slight increase in 2022. The increase occurred despite a year-on-year decline of over 15 % in the number of reported COVID-19 deaths in 2022 (Figure 4). This unexpected occurrence can be partially attributed to the elevated number of fatalities resulting from a severe heatwave that struck the country during the summer of 2022, with approximately one third of the total excess mortality for that year concentrated in the months of July and August (ISTAT, 2023).

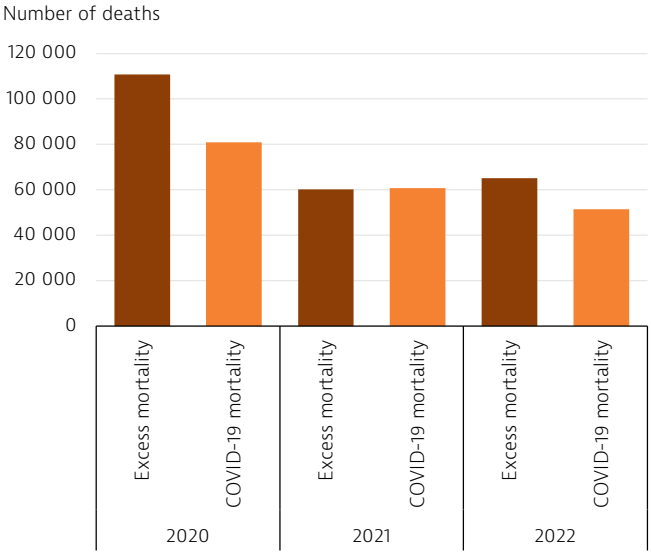
Additional factors that may have contributed to this development include prolonged disruptions in healthcare service access in the aftermath of the acute phase of the COVID-19 pandemic, as well as the impact of delayed diagnoses and treatments in 2020 that aggravated the severity of unresolved conditions (Spadea et al., 2021).

Figure 3. Excess mortality in Italy peaked at 17 % in the first year of the pandemic



Note: Excess mortality is defined as the number of deaths from all causes above the average annual number of deaths over the previous five years before the pandemic (2015-19).
Source: OECD Health Statistics based on Eurostat mortality data (last updated on 30 June 2023).

Figure 4. Despite continuous declines in the number of COVID-19 deaths, excess mortality in Italy increased in 2022



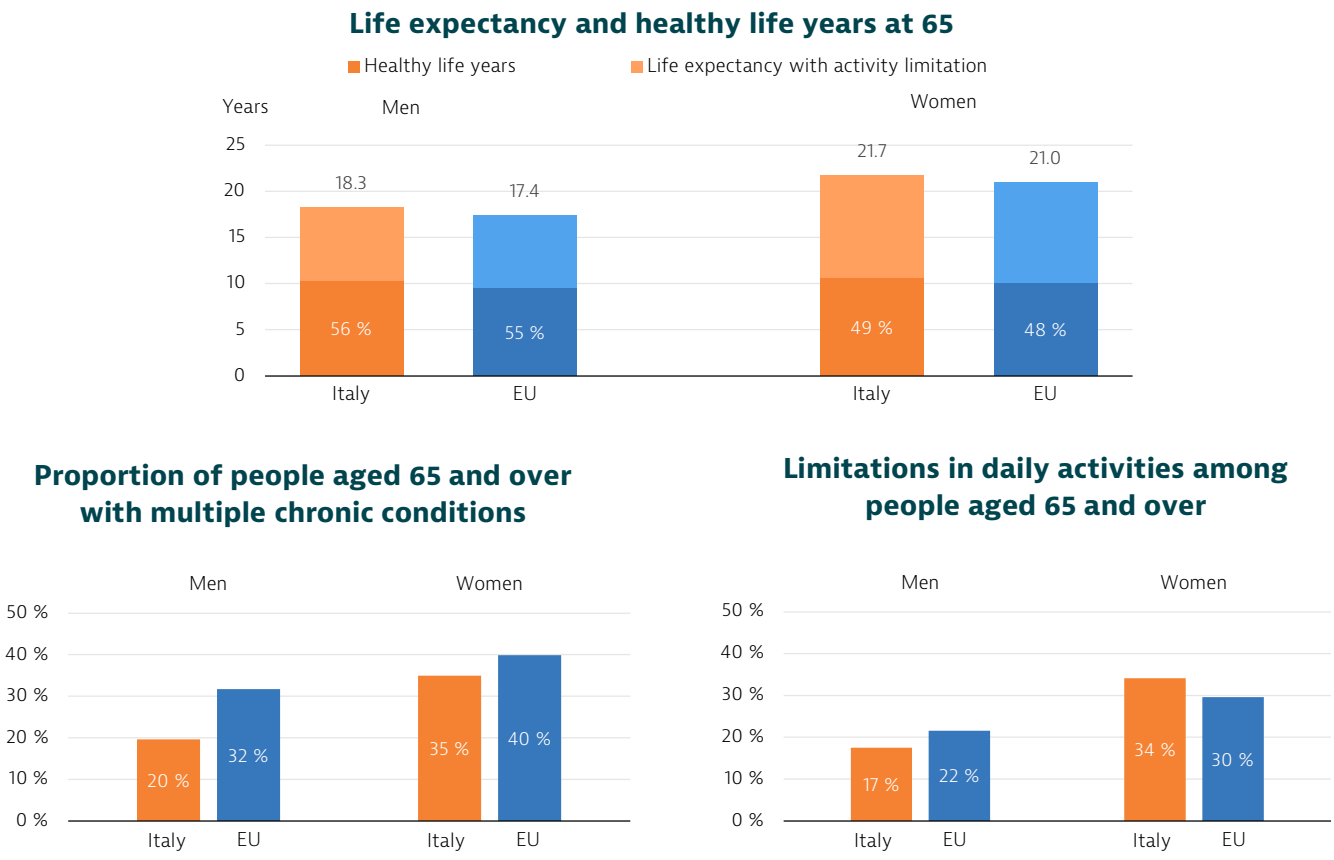
Note: Excess mortality is defined as the number of deaths from all causes above the average annual number of deaths over the previous five years before the pandemic (2015-19).
Sources: OECD Health Statistics 2023 based on Eurostat data.

Italian women bear a higher burden of illness in old age than men

As in other EU countries, Italy has undergone a demographic shift towards an older population over the past two decades. The proportion of its population aged 65 and older rose from 18 % in 2000 to 23 % in 2021 – slightly surpassing the EU average of 21 %. This share is projected to increase to 34 % by 2050 – one of the highest in the EU.

In 2020, women in Italy at the age of 65 could anticipate living an additional 21.7 years, while men could expect 18.3 years – 0.7 and 0.9 years above their respective EU averages. In addition to enjoying above-average life expectancies, both Italian men and women at 65 could anticipate spending a marginally greater portion of their remaining lives after 65 in good health compared to the EU average (Figure 5). Italy's gender gap in healthy life expectancy at age 65 was about four months in favour of women, reflecting the fact that while women tend to outlive men, they also tend to experience more years with some health-related limitations in functioning.

Figure 5. Italians in old age have slightly longer healthy life expectancies and report lower rates of multimorbidity than in most other EU countries



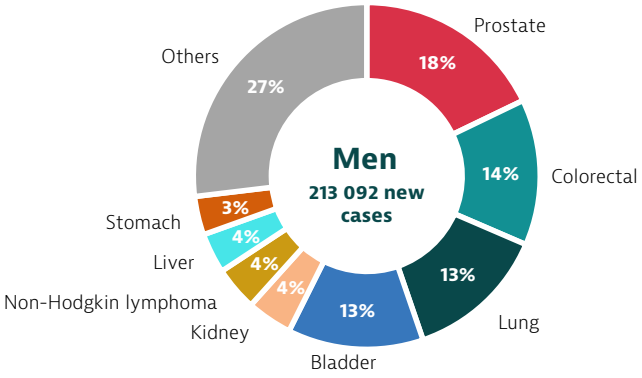
Sources: Eurostat Database (for life expectancy and healthy life years) and SHARE survey wave 8 (for multiple chronic conditions and limitations in daily activities). All the data refer to 2020.

In 2020, Italians aged 65 and older not only enjoyed a higher-than-average life expectancy, but they were also less likely to report suffering from multiple chronic conditions. The gap with the EU average in the prevalence of multiple chronic conditions among those aged 65 and above was particularly significant for Italian men, who were also slightly less likely to report experiencing health-related limitations in their basic activities of daily life. In contrast, Italian women aged 65 and above also reported lower rates of multimorbidity compared to the EU average, but a higher-than-average prevalence of health-related limitations in daily activities.

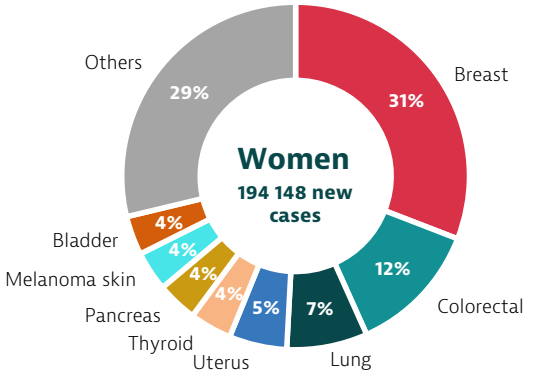
The burden of cancer in Italy is comparable to the EU average

According to incidence estimates from the Joint Research Centre based on historical trends, Italy witnessed approximately 407 200 new cancer cases in 2022.[1] Cancer incidence among Italian men was expected to be about 30 % higher than among women – a comparatively smaller gap, reflecting a slightly below-average projected cancer incidence among Italian men and a cancer incidence rate among Italian women about 4 % above its respective EU average. Prostate cancer was projected to be the single most common cancer site among men, comprising nearly one fifth of all new cancers in 2022. For women, breast cancer was expected to account for over 30 % of all new cancer cases. Both among Italian men and women, colorectal and lung cancers were anticipated to be the second and third most frequent cancer sites (Figure 6). Cancer prevention is one of the main priorities of the five-year National Prevention Plan introduced in Italy in August 2020 (Ministry of Health, 2020) and of the National Oncology Plan 2023-2027 (Box 1) (Ministry of Health, 2023).

Figure 6. More than 407 000 new cancer cases in Italy were estimated in 2022



Age-standardised rate (all cancer): 668 per 100 000 population
EU average: 684 per 100 000 population



Age-standardised rate (all cancer): 508 per 100 000 population
EU average: 488 per 100 000 population

Notes: Non-melanoma skin cancer is excluded; uterine cancer does not include cervical cancer.
Source: European Cancer Information System.

Box 1. Italy's National Oncology Plan aims to reduce interregional disparities in cancer care

In January 2023, Italy adopted its National Oncology Plan (NOP) 2023-2027. Aligned with the objectives outlined in Europe's Beating Cancer Plan, the NOP sets out a strategic framework to guide regions in formulating detailed 5-year action plans to address disparities in the accessibility and quality of cancer care both within and between regions. The NOP encompasses a wide range of objectives, including the promotion of healthy lifestyles, the expansion of age groups for screenings included in the basic benefits package (see Section 5.2) and the intensification of efforts to identify individuals at familial cancer risk through dedicated clinical pathways. Other notable goals include completing the establishment of the National Cancer Registry and supporting innovative oncological research activities.

To enable the implementation of regional improvement plans, a total allocation of 50 million EUR will be distributed to regions using a mixed capitation formula. To access the funds, regions will be required to submit annual progress reports documenting the achievement of the annual objectives defined in their plans.

1 *According to estimates from the Italian National institute of Health (2022a), 390 700 new cancer cases arose in Italy in 2022. This figure is 4 % lower than the estimated count by the Joint Research Centre.*

3 Risk factors

Behavioural and environmental risk factors are major drivers of mortality

Around one third of all deaths in Italy registered in 2019 can be attributed to behavioural risk factors, such as tobacco smoking, dietary risks, alcohol consumption and low physical activity. Environmental issues like air pollution also contribute to a sizeable number of deaths each year (Figure 7). Some 15 % of all deaths in 2019 can be attributed to tobacco smoking (including direct and second-hand smoking) – this share is lower than the EU average, but tobacco smoking still causes 96 000 deaths. Dietary risks (including low fruit and vegetable intake, and high sugar and salt consumption) are estimated to account for about 14 % of all deaths (87 000 deaths). About 5 % of all deaths (30 000) can be attributed to alcohol consumption, while about 3 % (18 000) are related to low physical activity. Air pollution in the form of fine particulate matter ($PM_{2.5}$) and ozone exposure alone accounted for about 4 % of all deaths (28 000) in 2019, mainly from cardiovascular diseases, respiratory diseases and some forms of cancer.

Figure 7. Tobacco and dietary risks are major contributors to mortality in Italy

Notes: The overall number of deaths related to these risk factors is lower than the sum of each one taken individually, because the same death can be attributed to more than one risk factor. Dietary risks include 14 components such as low fruit and vegetable intake, and high sugar-sweetened beverages consumption. Air pollution refers to exposure to $PM_{2.5}$ and ozone.
Source: IHME (2020), Global Health Data Exchange (estimates refer to 2019).

After a decade of gradual declines, smoking rates increased during the pandemic

Following a gradual yet consistent decline in the decade leading up to the COVID-19 pandemic, Italy's adult smoking rate experienced a resurgence during the pandemic years. In 2019, over 18 % of Italian adults were smokers – a proportion close to the EU average. By 2022, the adult smoking rate had risen to 19.6 % – over 1 percentage point above the pre-pandemic rate. Concurrently, the adoption of alternative smoking products has gained popularity: the use of heated tobacco products surged from 1.1 % in 2019 to 3.3 % in 2022, and e-cigarette usage grew from 1.7 % in 2019 to 2.4 % in 2022 (Italian National Institute of Health, 2023). Although no increase was observed in smoking rates among teenagers during the same period, they nonetheless remain alarmingly high: in 2022, 27 % of 15-year-olds reported having smoked in the past month, one of the highest rates in the EU. In contrast to the higher prevalence of smoking observed among adult men, female adolescents reported a higher smoking rate (31 %) than boys (22 %). The use of e-cigarettes among adolescents was also significant, with 13 % of 15- and 16-year-olds reporting their use in 2019 – a figure close to the EU average of 14 %.

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

In 2019, alcohol consumption among Italian adults was 20 % below the EU average, and the proportion of adults reporting regular heavy drinking[2] was lower than in nearly all other EU countries at 4.3 %. However, heavy drinking among Italian teenagers appears to have become more common in recent years. In 2022, 31 % of Italian 15-year-olds reported having been drunk at least twice in their lifetime – a significantly higher percentage than the EU average of 18 % and a notable rise from the 19 % reported by Italian teenagers in 2018.

While obesity rates are low, elevated levels of physical inactivity exacerbate the risk of obesity becoming more prevalent in the future

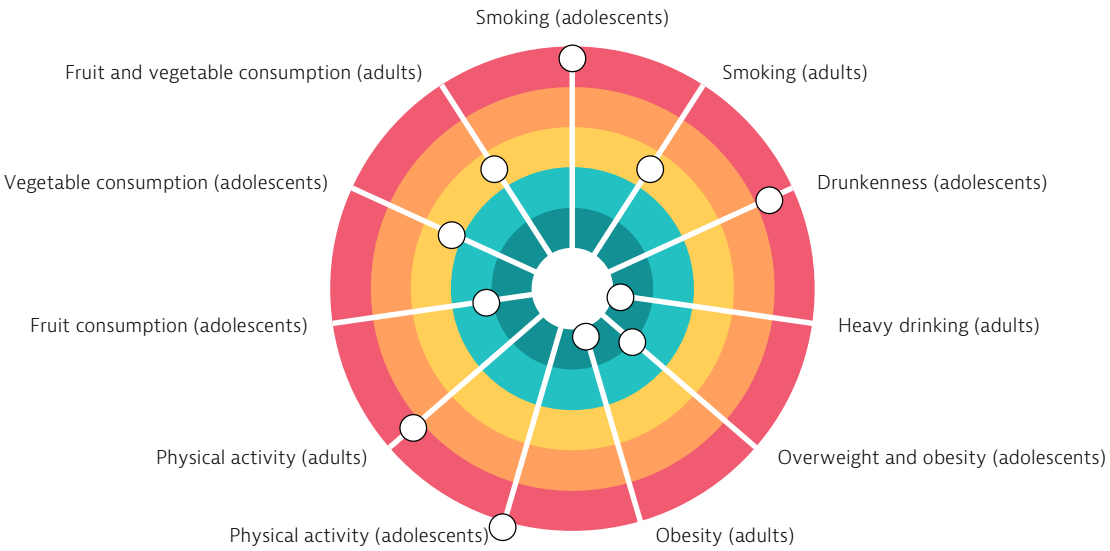
In 2019, Italy's obesity rate stood at 11.4 %, marking an increase of nearly 1 percentage point compared to 2014. While this was one of the lowest rates in the EU, high rates of lifestyle-related risk factors for obesity such as physical inactivity among Italians raises concerns about potential future increases. In 2019, less than 20 % of Italians reported engaging in at least 150 minutes of weekly exercise – a much lower share than the EU average of 33 % (Figure 8).

The pandemic appears to have had little effect on the prevalence of obesity among Italians aged 18 to 69. Between 2019 and 2021, the obesity rate among individuals in this age group experienced a marginal decrease from 10.9 % to 10.2 %. Obesity in Italy demonstrates a clear socioeconomic gradient: in 2021, nearly 23 % of Italians with a low level of education were classified as obese, in contrast to less than 6 % of those with a university degree. A steep geographical gradient in the prevalence of obesity to the detriment of southern regions is also evident in the data (Italian National Institute of Health, 2022b).

Overweight and obesity among children are a public health concern

Given its foresight into adult obesity trends, addressing child and adolescent obesity is a pivotal focus for public health efforts. According to data from the HSBC survey, in 2022 approximately 18 % of 15-year-olds in Italy were either overweight or obese – a proportion slightly below the EU average. However, another Europe-wide survey concentrating on primary school children reported that over 40 % of 8-year-olds in Italy were either overweight or obese in 2018-20 – one of the highest rates in Europe (WHO-Europe, 2022). Physical activity rates among Italian teenagers are also alarmingly low, with only 3 % of 15-year-old girls and 7 % of 15-year-old boys engaging in at least moderate daily physical exercise in 2022.

Figure 8. The share of Italians engaging in regular physical activity is among the lowest in the EU



Notes: The closer the dot is to the centre, the better the country performs compared to other EU countries. No country is in the white "target area" as there is room for progress in all countries in all areas.
Sources: OECD calculations based on HBSC survey 2022 for adolescents indicators; and EHIS 2019 for adults indicators (except smoking among adults, based on national survey data from 2021).

2 *Heavy drinking is defined as consuming six or more alcoholic drinks on a single occasion for adults.*

4 The health system

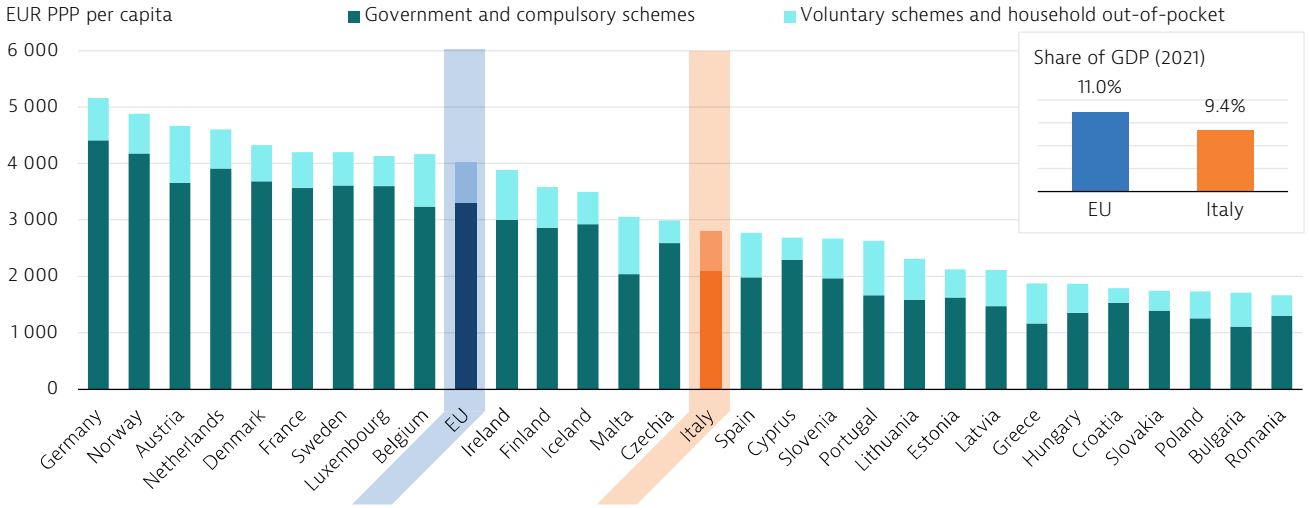
A decentralised health system is tasked with delivering health services uniformly across the country

Italy's National Health Service (NHS) operates on a regional basis and provides universal coverage to citizens and registered foreign residents. Undocumented migrants are entitled to access urgent and essential medical services. The central government allocates general tax revenues for publicly financed healthcare to regions, defines and supervises regional compliance with the delivery of the guaranteed benefits package (known as 'essential levels of care') and exercises overall stewardship. Regions are responsible for the organisation, planning and delivery of health services. A wide range of preventive, primary and community healthcare services is provided through local health authorities, with general practitioners (GPs) acting as gatekeepers to specialist and hospital care. Hospital and specialist ambulatory care are provided by a mix of public and accredited private providers, with significant variation across regions.

Italy spends less on health than the EU average

In 2021, Italy's health expenditure accounted for 9.4 % of GDP, a lower proportion than the EU average of 11 %. When measured per capita, Italy's spending on health stood at EUR 2 792 in 2021 – an amount nearly one third lower than the EU average (Figure 9). Between 2019 and 2021, government health spending surged by 8.3 % in real terms, while private health expenditure experienced a decline of over 1 %, reflecting disruptions in non-COVID-19 elective care provided by private providers and shifts in patient healthcare-seeking behaviour during the first two years of the pandemic. As a result, the proportion of health expenditure financed through private sources – of which 90 % consisted of out-of-pocket (OOP) spending by households – fell from 26.3 % in 2019 to 24.5 % in 2021. This proportion was nevertheless higher than the EU average of 18.9 %.

Figure 9. In per capita terms, Italy's health expenditure is almost one-third less than the EU average



Note: The EU average is weighted.
Source: OECD Health Statistics 2023 (data refer to 2021, except Malta (2020)).

Preliminary expenditure data for 2022 shows a notable year-on-year decline, with health spending per capita returning to a level approximately 2.6 % above its 2019 level. This decline results from a significant reduction in OOP expenditure (-6 %) and a more moderate decline in government health expenditure (-3.5 %), with the latter likely reflecting lower COVID-19-related expenses compared to 2021.

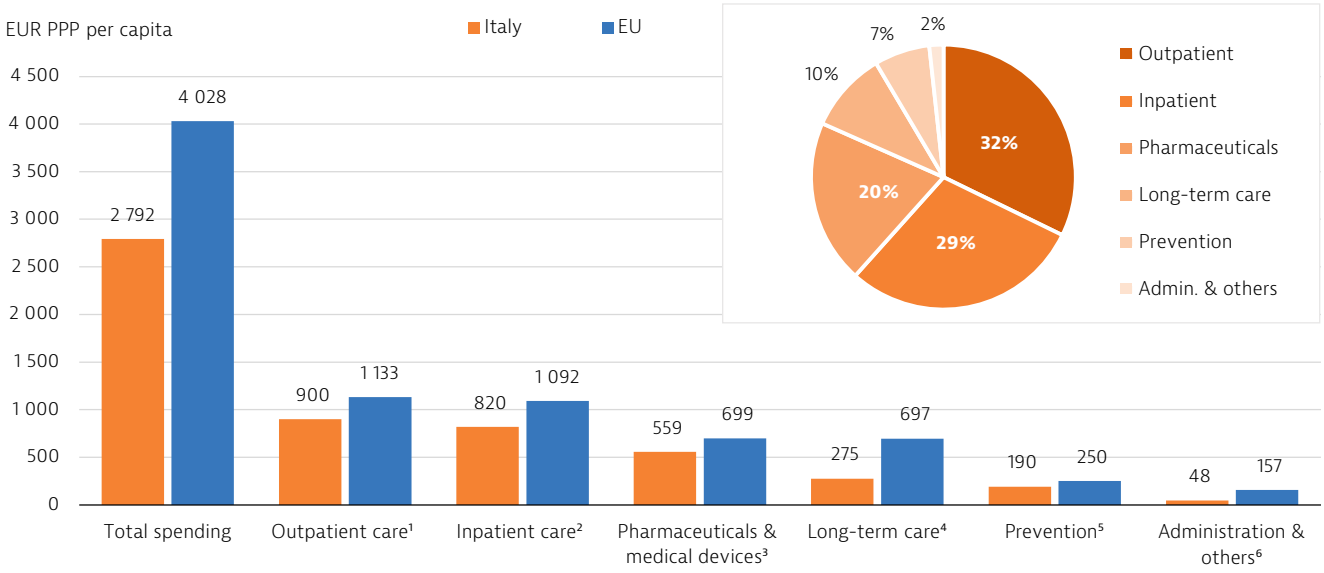
Outpatient and inpatient care collectively account for over 60 % of health spending

In 2021, outpatient care constituted nearly a third of Italy's health expenditure – a marginally higher proportion than both the EU average and inpatient care (29 %), which also absorbed a slightly above-average share of Italy's health budget. Expenditure on pharmaceuticals and

medical devices accounted for a fifth of Italy's total health spending – a larger proportion than the EU average, yet still 20 % below the EU average in per capita terms. Approximately two thirds of all pharmaceutical spending in 2021 was absorbed by consumption in hospital settings – one of the highest percentages among EU countries (AIFA, 2022).

Contrastingly, despite having one of Europe's most aged populations, Italy's relative budget allocation for long-term care (LTC) totalled less than 10 % in 2021 – a share notably over 6 percentage points below the EU average (Figure 10). To a large extent, Italy's small budget for LTC reflects the country's historical reliance on informal care arrangements as a means of provision. In 2021, Italy's expenditure on prevention reached an unprecedented 6.8 % of total health spending, as additional spending was driven by the procurement of COVID-19 vaccines and tests.

Figure 10. Long-term care absorbs less than one tenth of Italy's health expenditure



Notes: 1. Includes home care and ancillary services (e.g. patient transportation); 2. Includes curative-rehabilitative care in hospital and other settings; 3. Includes only the outpatient market; 4. Includes only the health component; 5. Includes only spending for organised prevention programmes; 6. Includes health system governance and administration and other spending. The EU average is weighted.
Source: OECD Health Statistics 2023 (data refer to 2021).

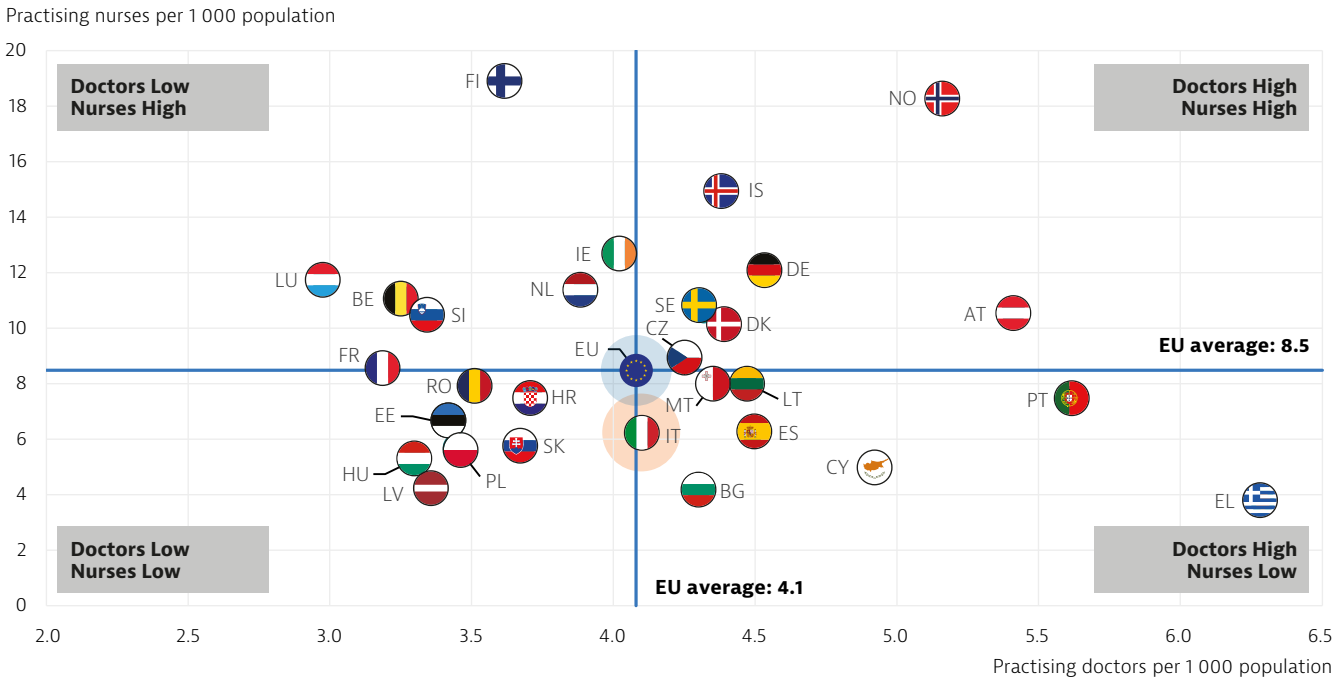
The number of doctors in Italy aligns with the EU average, but GPs are in short supply

In 2021, Italy had 4.1 practising doctors per 1 000 population – a density on a par with the EU average and an increase from 3.8 doctors per 1 000 population in 2010, and an estimated 6.2 nurses per 1 000 population – a density approximately one quarter below the EU average (Figure 11). Although the density of doctors in Italy aligns with the EU average, the increasing demand for care from an increasingly old and multimorbid population results in several regions facing shortages of physicians, which vary significantly in their severity across specialties.

At the national level, general practice stands out as one of the specialties with the most pressing shortages, which are further compounded by the uneven distribution of GPs across regions (Figure 12) and the age distribution of Italian GPs, that is highly concentrated in the older age groups. During the first two years of the pandemic, general practice saw significant attrition, as the number of practising GPs declined by 5.4 % between 2019 and 2021 (AGENAS, 2023).

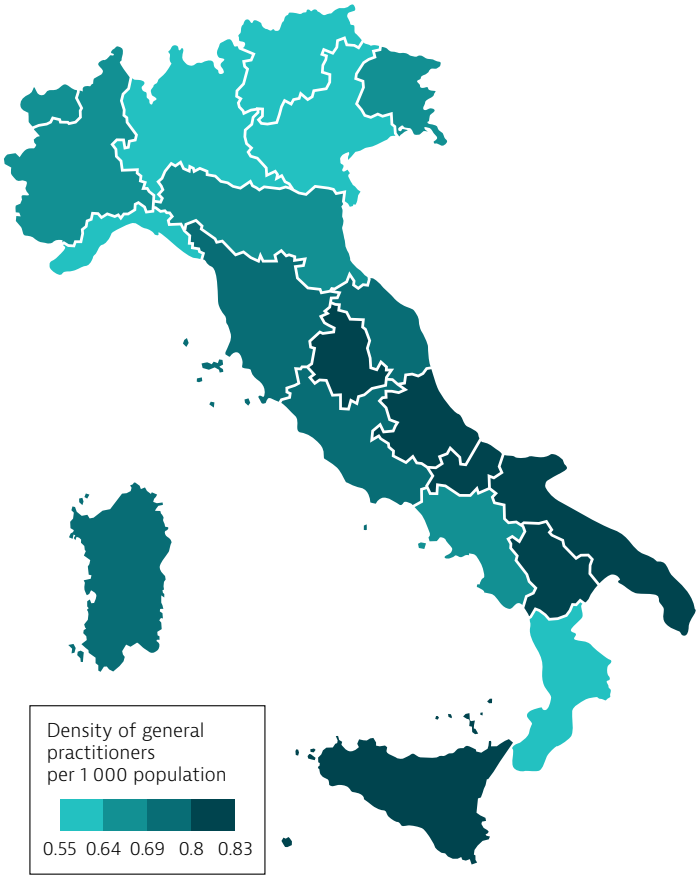
Concerns surrounding the availability of GPs and medical professionals are exacerbated by their ageing profile, which stands out as one of the most senior in Europe. With more than 55 % of doctors over the age of 55, over a quarter will reach retirement age by 2027. At the same time, the annual influx of newly trained specialists will struggle to compensate for retirement attrition and accommodate increased demand for medical personnel in the upcoming years. A significant portion of this issue stems from the fact that since 2013, Italy's medical workforce training pipeline has been constrained by a number of postgraduate residency training slots that were lower than the annual output of medical graduates from university. This scenario has arisen from the protracted implementation of reduced turnover of medical personnel in public hospitals as a means to moderate cost increases as well as from limited

Figure 11. While the density of doctors is on a par with the EU average, Italy has a lower density of nurses



Notes: In Portugal and Greece, data refer to all doctors licensed to practise, resulting in a large overestimation (of around 30 % in Portugal) of the number of practising doctors. In Greece, the number of nurses is underestimated as it only includes those working in hospitals.
Source: OECD Health Statistics 2023 (data refer to 2021 or the nearest available year).

Figure 12. The density of GPs across Italian regions varies significantly



Note: Data refer to 2021.
Sources: AGENAS (number of GPs by region) and ISTAT (regional population).

resources to finance a suitable number of specialist medical training contracts.

To address this problem, since 2018 Italy has significantly expanded the number of students admitted to medical faculties as well as postgraduate residency training positions for specialists. Notably, the number of medical residency slots for general practice more than doubled between 2018 and 2021 compared to previous four years – an achievement partly supported by Italy's Recovery and Resilience Plan (see Section 5.3). The outcomes of these substantial increases are projected to fully materialise towards the end of the decade, when the inflow of newly qualified medical specialists is projected to more than offset retirement attrition. However, shortages in specific specialties – such as emergency medicine, are likely to persist due to their limited attractiveness among medical students.

The density of nurses also has been gradually increasing over the last decade, but at 6.2 per 1 000 population it remains notably lower than the EU average of 8.5 per 1 000 in 2021. Following substantial strengthening in recent years, the current nursing training pipeline is projected to ensure a sufficient supply of newly trained nursing professionals in the coming years to compensate for retirement attrition and accommodate new recruitment needs to strengthen care in the community (AGENAS, 2023).

5 Performance of the health system

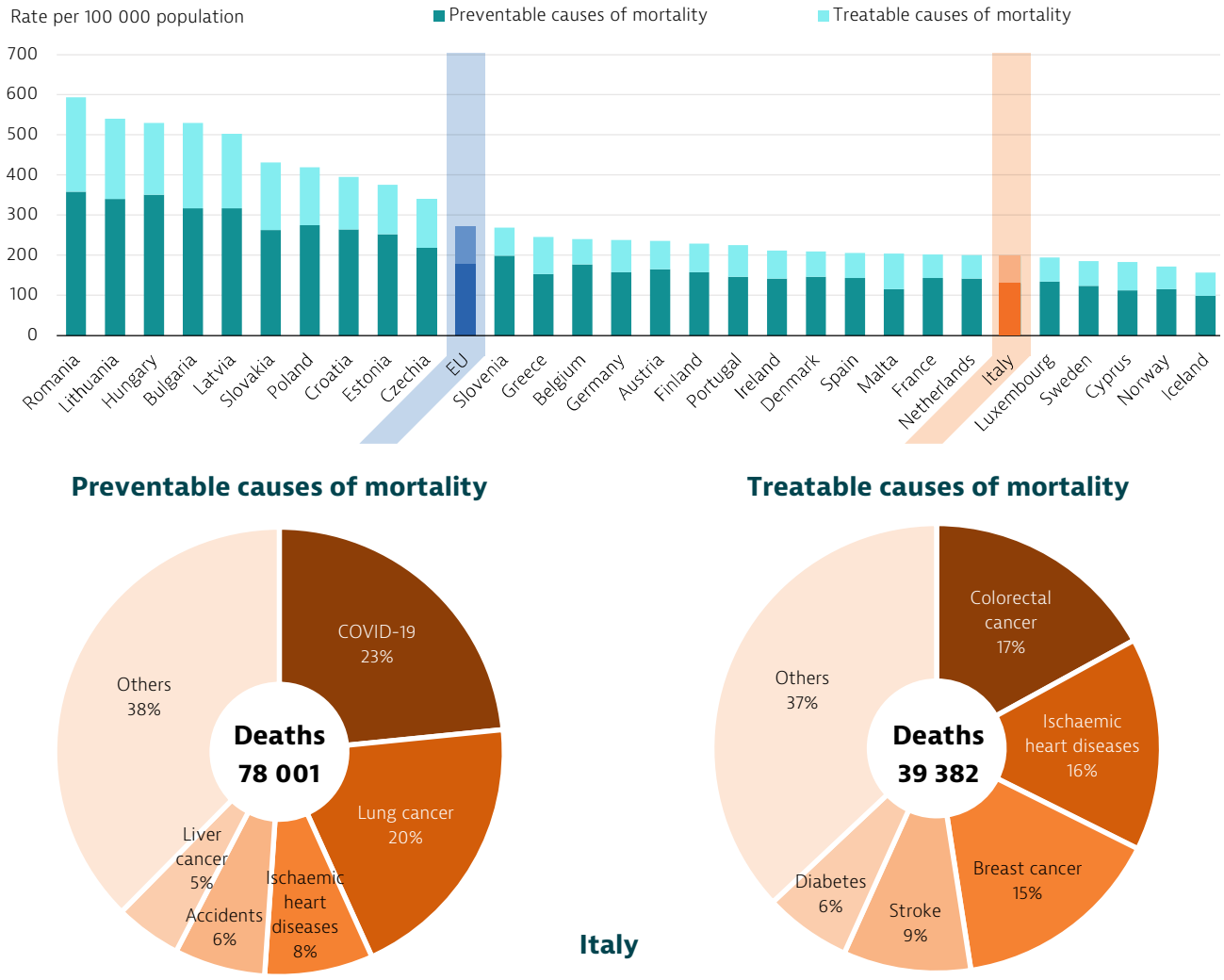
5.1 Effectiveness

Mortality rates from potentially preventable and treatable causes remain low

In 2020, the mortality rates from causes considered generally preventable and treatable in Italy were over 27 % lower than their respective EU averages (Figure 13). Against the backdrop of a nearly 17 % surge in the EU's preventable mortality rate in 2020, Italy experienced a 29 % increase, reflecting significantly higher COVID-19 mortality among its population under 75 years of age compared to most other EU countries. Despite this increase, Italy's significantly lower disease prevalence and mortality from ischaemic heart disease, stroke and colorectal cancer contributed to keeping the overall preventable mortality rate low. The main causes of Italy's preventable mortality were COVID-19 and lung cancer, collectively accounting for over 40 % of all potentially preventable deaths in 2020.

Over the past decade, Italy's treatable mortality declined at a rate in line with the EU average, reflecting improvements in mortality rates from ischaemic heart diseases, colorectal and breast cancer. These conditions remained nevertheless the leading causes of death that could be avoided through timely healthcare interventions, accounting for nearly half of all deaths from treatable conditions.

Figure 13. Italy had among the lowest rates of preventable and treatable mortality in the EU in 2020

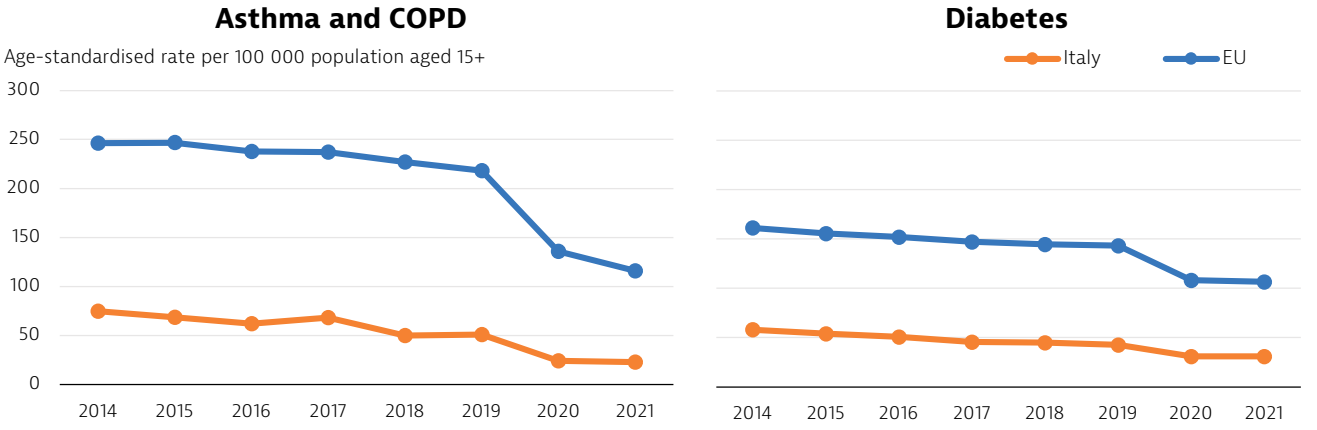


Notes: Preventable mortality is defined as death that can be mainly avoided through public health and primary prevention interventions. Treatable (or amenable) mortality is defined as death that can be mainly avoided through healthcare interventions, including screening and treatment. Both indicators refer to premature mortality (under age 75). The lists attribute half of all deaths from some diseases (e.g. ischaemic heart disease, stroke, diabetes and hypertension) to the preventable mortality list and the other half to treatable causes, so there is no double-counting of the same death.
Source: Eurostat Database (data refer to 2020).

Effective primary care and a low disease burden contribute to low avoidable admissions, but variation across the country is wide

Hospital admissions volumes for conditions that are typically manageable outside of hospital settings provide insights into the availability and effectiveness of outpatient care services. In this aspect, Italy performs better than the vast majority of other EU countries. In 2019, Italy's collective hospitalisation rate for diabetes, congestive heart failure, asthma and chronic obstructive pulmonary disorder (COPD) was less than half the EU average, partly reflecting a below-average prevalence of these conditions among the Italian population. However, data from Italy's National Healthcare Outcomes Programme highlights significant differences across and within regions for admission rates for COPD and diabetes. These variations lack a distinct geographical pattern and likely arise from differences in local disease prevalence and variations in thresholds for admission (AGENAS & Ministry of Health, 2022). Between 2019 and 2021, hospital admission rates for asthma and COPD more than halved, while admissions for diabetes registered a more moderate decline of 27 % – in line with their respective EU averages (Figure 14). These declines must be interpreted in the context of the disruption caused by COVID-19, which severely impacted the capacity of hospitals to provide acute care and altered patients' healthcare-seeking behaviour (see Section 5.3). Therefore, these declines are not indicative of improved accessibility or quality of care for these chronic conditions in outpatient settings.

Figure 14. Avoidable hospital admissions for selected chronic conditions are well below the EU average



Note: Admission rates are not adjusted for differences in disease prevalence across countries.
Source: OECD Health Statistics 2023.

COVID-19 had a dampening effect on the uptake of cancer screening programmes

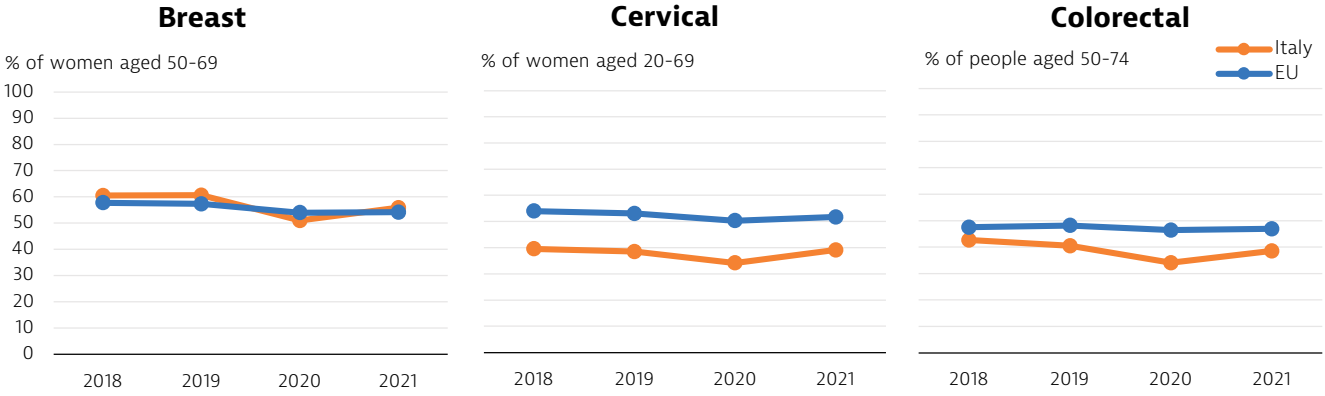
Prior to the onset of the pandemic, Italy's screening rates for cervical and colorectal cancer were consistently below the EU average, while the breast cancer screening rate was slightly above it (Figure 15). As in most other EU countries, the pandemic-induced reconfiguration of health services had a negative impact on cancer screening programmes in Italy. Screening activities were halted completely in March and April 2020, and although they gradually resumed over the course of May and June, there were notable variations in the extent of activity resumption both across regions and within them (National Institute for Health, 2022c).

The temporary suspension of screening programmes led to a significant decline in the breast cancer screening rate, which dropped by nearly 10 percentage points to 52 % in 2020 following a decline of nearly 38 % in the number of mammographies performed compared to 2019. (Osservatorio nazionale screening, 2023). Likewise, the cervical cancer screening rate decreased by 4.3 percentage points to 34 %, and the colorectal cancer screening rate fell by 6.4 percentage points to 34 %. The most substantial reductions in screening rates were observed in the Northern regions, where healthcare systems faced more severe disruptions due to the impact of the COVID-19 pandemic. The combined effects of disruptions in cancer screening activities, lower GP availability and reduced patient adherence resulted in an unprecedented decline in the identification of new malignancies in Italy in 2020. Estimates indicate that disruptions to routine cancer screening pathways in 2020 postponed the detection of at least 3 300 cases of breast cancer, 2 700 cases of cervical cancer, and 1300 cases

of colorectal cancer (Ministry of Health, 2023a). Diagnostic delays have also contributed to an increase in the number of cases diagnosed in later stages, albeit with notable geographical variations linked to the population's varying levels of engagement in secondary prevention programmes (AIOM, 2022).

As screening activity volumes rebounded in 2021, screening rates for breast and colorectal cancer partly recovered to levels 92 % and 95 % of their pre-pandemic levels respectively, while the screening rate for cervical cancer even slightly exceeded its 2019 rate.

Figure 15. Cancer screening rates, in particular for cervical cancer, remain below EU average



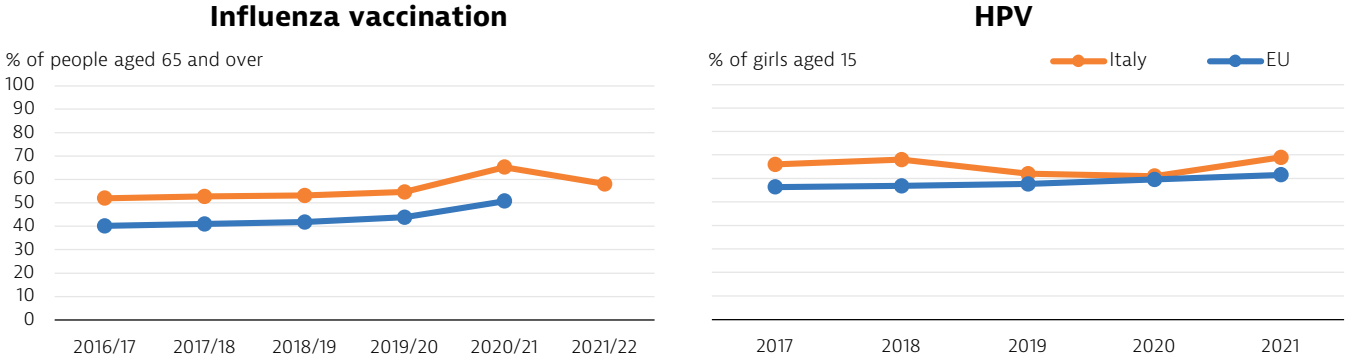
Note: Rates refer to the share of individuals within the target groups who have undergone screening in the last two years (or within the specific screening interval recommended in each country).
Source: OECD Health Statistics 2023 (based on national programme data).

A greater share of Italians aged 65 and over chose to get the flu vaccine during the pandemic

Similar to other EU countries, Italian health authorities have long recommended older people to get the influenza vaccine, which the Italian NHS provides free of charge to people in various at-risk groups, including people aged 65 and above. Throughout the last decade, Italy consistently maintained a higher flu vaccination coverage for this target group, surpassing the EU average by approximately a quarter. As in most other EU countries, the emergence of the COVID-19 pandemic contributed to an increased interest in receiving the flu vaccine among people at higher risk of complications and hospitalisation. As a result, in 2021 Italy's flu vaccination coverage rate among people aged 65 and above rose to 65 %, marking a substantial increase of over 12 percentage points from 2019. In 2021, the flu vaccination rate waned somewhat, declining to 58 % (Figure 16).

In recent years, Italy has also undertaken various initiatives to boost the uptake of the human papillomavirus (HPV) vaccine, which is offered free of charge to all children aged 11-15. In recent years, the HPV vaccine coverage rate among 15-year-old girls remained consistently above 60 % – a slightly better performance compared to the EU average. Nevertheless, this result falls short of meeting the WHO target for cervical cancer eradication, which foresees attaining a 90 % coverage rate. Vaccine coverage rates among boys have been historically lower, but increased significantly since the start of the pandemic, reaching a rate of over 50 % in 2021.

Figure 16. COVID-19 spurred increased uptake of the flu vaccine among people aged 65 and over



Sources: OECD Health Statistics 2023 and Eurostat Database (influenza) and WHO (HPV).

5.2 Accessibility

A lower share of Italians reports unmet healthcare needs compared to the EU average

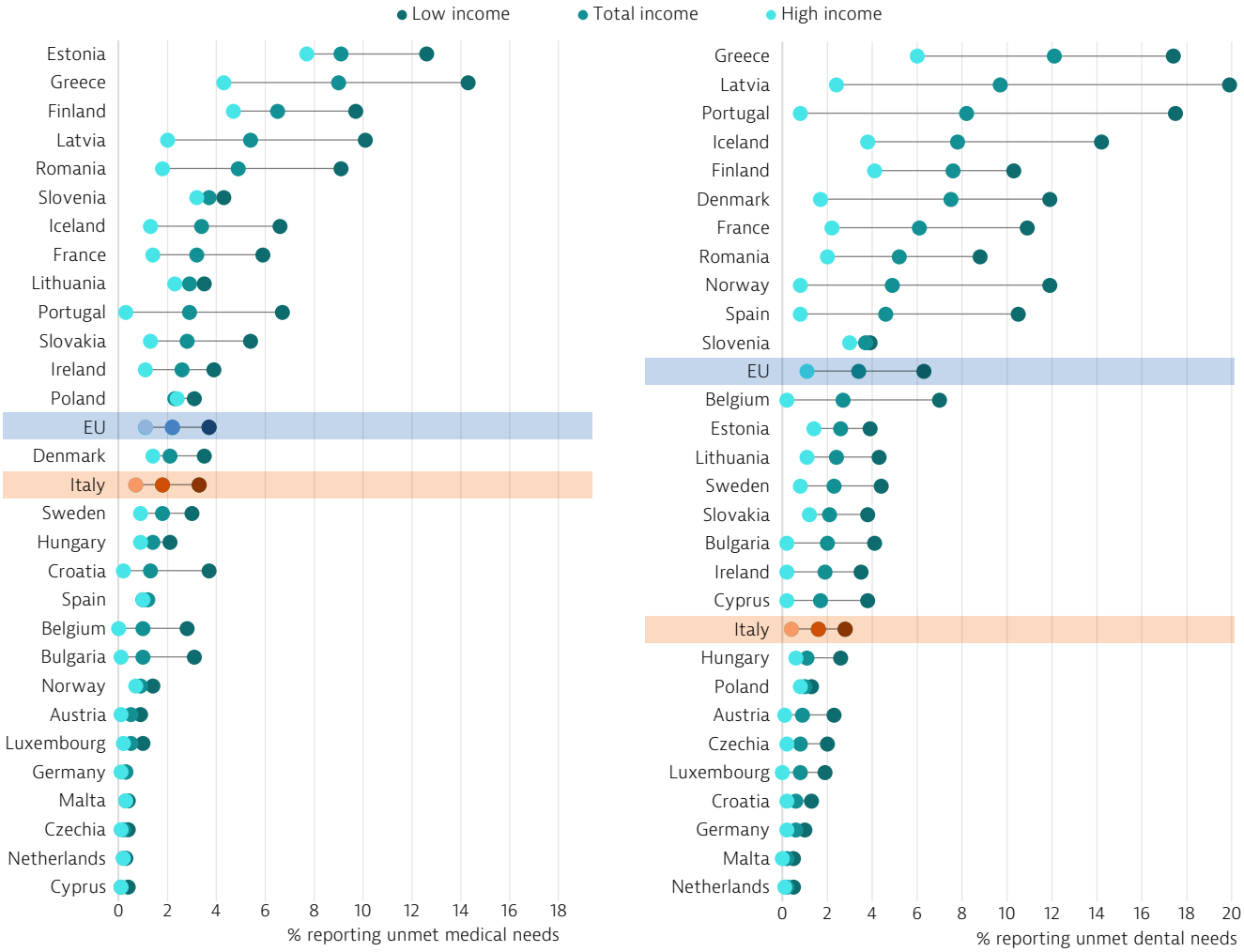
In 2022, 1.8 % of the Italian population reported experiencing unmet needs for medical care due to either excessive costs, travel distance or waiting times. This proportion was slightly lower than the EU average of 2.2 %, and equal to Italy's pre-pandemic rate from 2019. A greater proportion of women reported unmet medical care needs, with cost being the primary reason for both genders. Among individuals in the lowest income quintile, 3.3 % reported unmet medical care needs compared to only 0.7 % among those in the highest income group (Figure 17). While this gap was slightly wider than the EU average, it had decreased by over 50 % compared to 2019, driven by a reduction in individuals in the lowest income quintile reporting unmet needs due to cost.

Similarly, only 1.6 % of Italians reported experiencing unmet needs for dental care – a proportion that was less than half the EU average and lower than the 2.7 % reported in 2019. As with medical care, the main determinant of unmet dental care needs was their cost, reflecting Italy's limited public coverage for dental care services. The NHS provides these services free of charge exclusively to children under the age of 14 and selected vulnerable groups.

A monitoring system is in place to ensure compliance with the basic benefits package across regions

As noted in Section 4, the Italian NHS operates on a regional basis and provides automatic, universal coverage for all residents. The healthcare system is structured into three levels – national, regional and local. The national level is responsible for setting the overall objectives and core principles of the

Figure 17. Unmet needs for healthcare are low, and income-based differences are consistent with the EU average.



Notes: Data refer to unmet needs for a medical examination or treatment due to costs, distance to travel or waiting times. Caution is required in comparing the data across countries as there are some variations in the survey instrument used.
Source: Eurostat Database, based on EU-SILC (data refer to 2022, except Norway (2020) and Iceland (2018)).

national healthcare system. Regional governments, through their health departments, are tasked with ensuring the provision of the ample, standard guaranteed benefits package (known as Essential Levels of Assistance). This package is defined at the national level, and is implemented through a network of population-based health management organisations (known as Local Health Units), public and accredited private hospitals.

Since 2020, a revised compliance monitoring framework – the New Guarantee System (NGS) – has been implemented at the national level to ensure health services provided by regions align with the Essential Levels of Assistance and adhere to standards of effectiveness, appropriateness and uniformity of service delivery across the country. The NGS uses a selection of performance indicators organised into three macro-areas – prevention and public health, outpatient and hospital care to identify regions that fail to guarantee appropriate access to the Essential Levels of Assistance for their populations (Ministry of Health, 2023b). In 2021, the NGS identified seven regions with insufficient scores in at least one macro-area – a decrease from 10 regions in 2020, but still higher than the six identified in 2019 before the onset of the COVID-19 pandemic (Figure 18). Insufficient scores were mostly concentrated in the southern regions of the country.

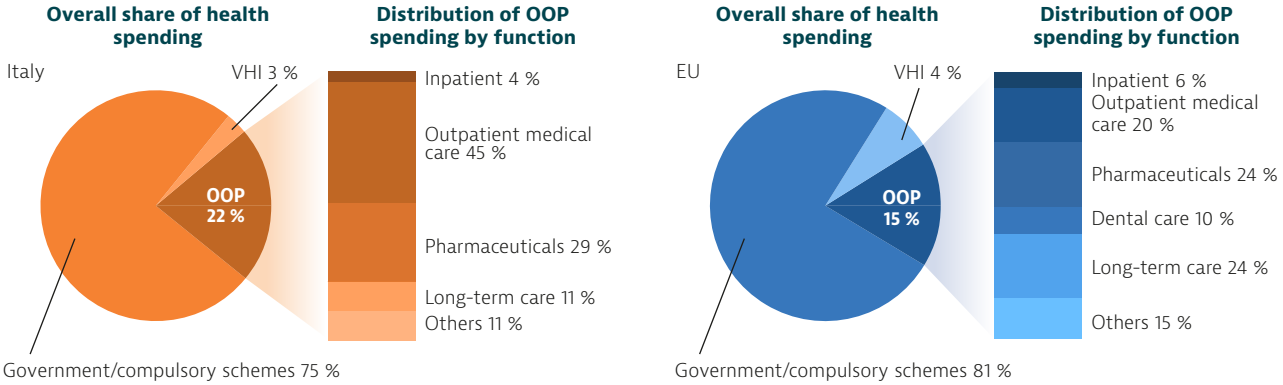
Figure 18. Seven Regions fell short of guaranteeing full coverage of Essential Levels of Assistance in 2021

Notes: The composite scores for "Prevention", "Outpatient care" and "Hospital care" summarise the capacity of regional health systems to guarantee Essential Levels of Assistance based on a suite of 22 core indicators. A score of 100 indicates optimal performance, while values falling below 60 points (i.e. within the grey shaded area) are assessed as insufficient.
Source: Ministry of Health (2023b)

Out-of-pocket health spending is high and primarily driven by direct payments for services

The financing structure of the Italian healthcare system is characterised by a comparatively large share of expenditure sourced OOP (21.9 %) and a slightly smaller share (2.6 %) sourced from voluntary health insurance (VHI). Collectively, health spending financed through OOP and VHI accounted for 24.5 % of Italy's total health expenditure in 2021 – a share 30 % higher than the EU average of 18.9 % (Figure 19).

Figure 19. Out-of-pocket payments are high, driven by outpatient specialist care and pharmaceuticals



Notes: VHI also includes other voluntary prepayment schemes. The EU average is weighted.
Sources: OECD Health Statistics 2023; Eurostat Database (data refer to 2021).

The composition of Italy's OOP expenditure by specific function also diverges significantly from the EU average. Notably, 45 % of total OOP spending in Italy is directed to outpatient medical care. While this figure encompasses spending on dental care as well, it nevertheless remains considerably higher than the combined average proportion of outpatient medical care (20 %) and dental care spending (10 %) in the EU. Outpatient pharmaceuticals also absorb an above-average share of total OOP spending at 29 %. Conversely, LTC and inpatient care and absorb comparatively low proportions of OOP expenditure.

While in all regions selected vulnerable groups are exempted from cost-sharing arrangements, individuals' OOP spending is not subject to an annual cap. However, only a small portion of total OOP expenditure results from the moderate copayments that are levied on outpatient specialist visits with a GP referral, prescribed pharmaceuticals and diagnostic services. Over 90 % of Italy's OOP expenditure on health reflects direct payments for over-the-counter pharmaceuticals and (non-referred) outpatient consultations, which patients purchase to gain faster access to medical specialists.

5.3 Resilience

The COVID-19 pandemic has proved to be the most significant disruption to health systems in recent decades. It has shed light on the vulnerabilities and challenges within countries' emergency preparedness strategies and on their ability to provide healthcare services to their populations. In response to the enduring effects of the pandemic – as well as other recent crises, such as cost-of-living pressures and the impact of conflicts like the war against Ukraine – countries are implementing policies to mitigate the ongoing impacts on service delivery, invest in health system recovery and resilience,[3] improve critical areas of the health sector, and fortify their preparedness for future shocks.

Following a drop of over 18 % in 2020, hospital admission rates partly rebounded in 2021

Partly owing to its effective outpatient care, emphasis on day surgery and strict gatekeeping at the primary care level, Italy's hospital capacity is considerably smaller than in most other EU countries.

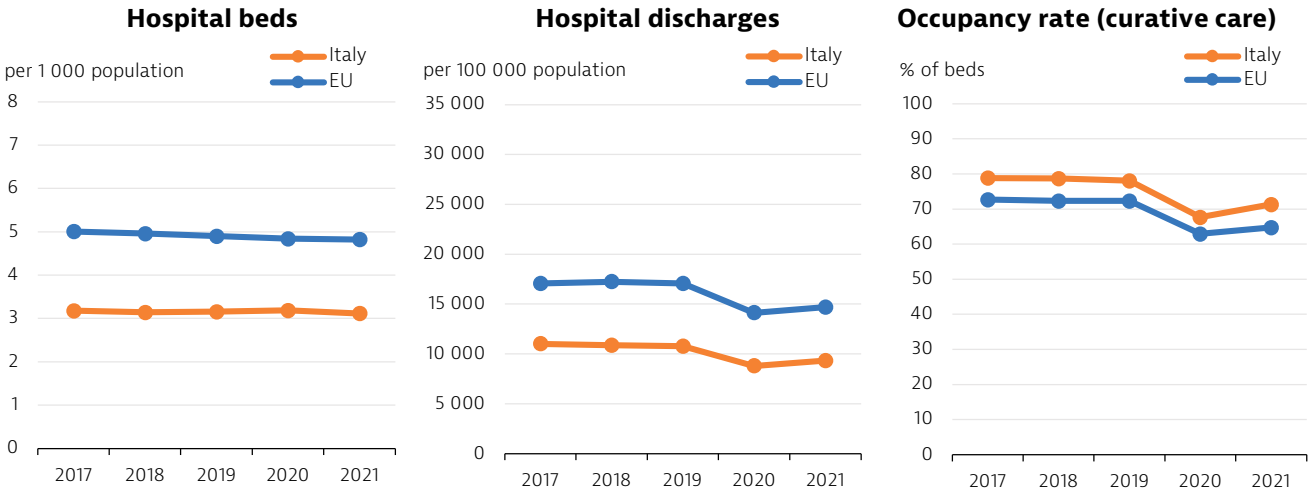
In 2019, Italy's hospital bed density stood at 3.2 beds per 1 000 population – a level approximately two thirds of the EU average that had been stable since 2014. Throughout the five years before the start of the pandemic, hospital admission rates

3 *In this context, health system resilience has been defined as the ability to prepare for, manage (absorb, adapt and transform) and learn from shocks (EU Expert Group on Health Systems Performance Assessment, 2020).*

were about around two thirds of the EU average and the occupancy rate of acute beds remained consistently below under 80 % (Figure 20).

In response to the increased demand for acute care caused by the virus in 2020, Italy took various measures to expand its intensive care unit (ICU) capacity. The number of ICU beds per 100 000 population rose to 11.8 per 100 000, representing an increase of over 35 % compared to 2019. To minimise the risk of hospital outbreaks and establish a resource buffer of beds, personnel and equipment, large volumes of non-urgent planned hospital services were postponed. The effects of these contingency measures are partly reflected in the large decreases between 2019 and 2020 in hospital discharges (-18.2 %) and curative bed occupancy rates (-13.3 %).

Figure 20. Hospital discharges and occupancy rates increased in 2021 following a significant drop at the onset of the pandemic



Sources: OECD Health Statistics 2023 and Eurostat Database.

The extent of the decline in hospitalisations in 2020 varied markedly across different regions and by medical condition. Regions in the north-west and south of the country experienced more severe reductions in hospitalisations compared to their pre-pandemic baseline. At a national level, hospitalisations for pregnancy/childbirth (-11.7 %), cancer (-14.5 %) and injuries (-17.3 %) registered relatively smaller declines, while hospitalisations for diseases of the musculoskeletal (-29.5 %), digestive (-34 %) and genitourinary (-25.2 %) systems saw the largest declines (ISTAT, 2022). By 2021, Italy's hospital admission rate had partially recovered to approximately 86 % of its 2019 level.

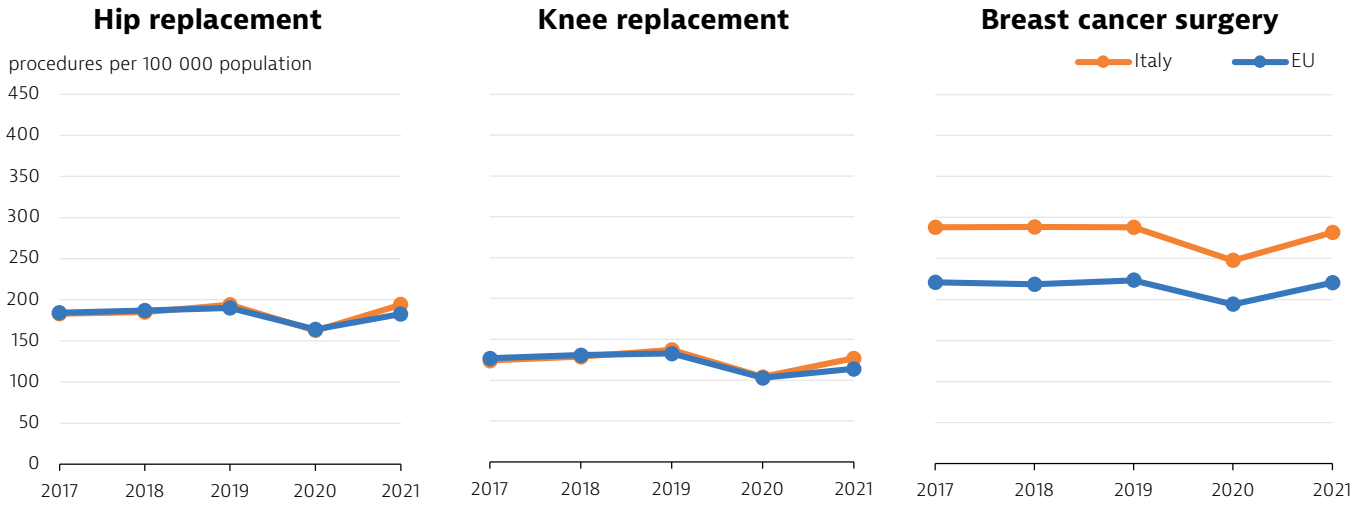
Volumes of elective surgical procedures rebounded strongly in 2021

As in other EU countries, the intermittent suspension of elective surgical procedures throughout the peaks of the pandemic in 2020 resulted in notable reductions in the volume of non-urgent, planned surgical procedures in Italy. Hip and knee replacement rates fell by more than 16 % and 24 % respectively, whereas breast cancer surgery rates saw a relatively more moderate reduction of 14 % These declines were marginally more severe than the average declines observed across the EU. As the Italian healthcare system resumed significant volumes of non-COVID-19-related hospital activities in 2021, knee replacement and breast surgery rates rebounded strongly, returning to over 92 % and 97 % of their pre-pandemic levels respectively (Figure 21). Moreover, the hip replacement rate marginally exceeded its 2019 rate, indicating some, albeit modest, progress towards reducing the surgical backlog that had formed during 2020.

COVID-19 vaccination rates waned somewhat with the second booster dose

Throughout most of the pandemic, Italy consistently outperformed most other EU countries in all COVID-19 vaccination uptake metrics, achieving coverage rates above the EU average for both the primary course of vaccination and the first booster dose. By the end of 2022, nearly 90 % of the adult population in Italy had completed the primary COVID-19 vaccination course, compared to 82.4 % in the EU, and 86 % had received a first booster dose compared to less than two thirds in the EU. However, with the commencement of the programme for administering the second booster

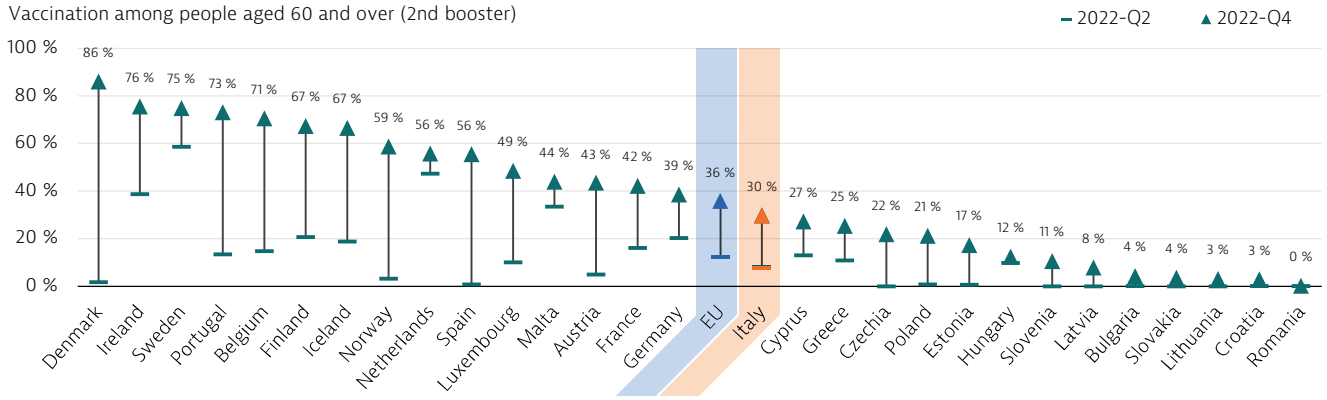
Figure 21. Breast cancer surgery volumes rebounded to nearly pre-pandemic levels in 2021



Note: The EU average is unweighted.
Sources: OECD Health Statistics 2023 and Eurostat Database.

dose to individuals aged 60 and over in mid-2022, uptake rates saw a significant decline. As of December 2022, less than 30 % of Italians aged 60 and above had received a second COVID-19 booster dose – a lower share than the EU average of 36 % (Figure 22).

Figure 22. Uptake of the second COVID-19 booster shot among Italians aged 60 and over was still low at the end of 2022



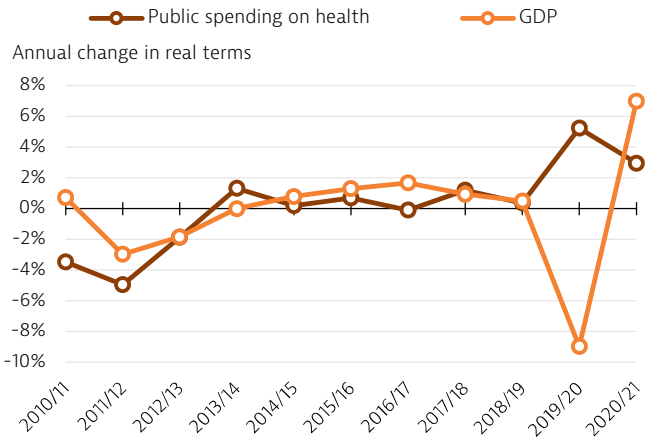
Source: ECDC.

The pandemic response brought massive but transitory changes to the composition of Italy's health expenditure financing

Following sizeable reductions during the years of the sovereign debt crisis, Italy's government expenditure on health returned to growth in 2014, increasing at an average annual rate of 0.5 % until 2019 – a rate below Italy's average annual GDP growth rate of 1 % during the same period. The COVID-19 pandemic disrupted this trend, as spending on health from public sources soared by over 5.2 % in 2020 alongside a massive 9 % decline in the country's GDP. As GDP rebounded by 7 % in 2021, publicly financed health spending growth decelerated to 2.9 % (Figure 23). In 2021, public health spending increases were mostly driven by sustained rises in COVID-19-related expenditure, including vaccines, COVID-19 tests and greater staff expenses – as well as a significant recovery of non-COVID-19 care activity within NHS hospitals.

The significant impact of the pandemic on Italy's healthcare system in 2020 was also reflected in the substantial, yet temporary changes in its financing structure. As total health expenditure grew by 2.2 % in 2020, private health expenditure experienced a 6.3 % decline, reflecting a large reduction in in volumes of outpatient specialist visits, pharmaceuticals and diagnostics which typically would have been paid out of pocket. This marked the first decline in private health

Figure 23. The COVID-19 shock decoupled public health spending and GDP trajectories in 2020



Source: OECD Health Statistics 2023.

spending since 2013, a period during which private health expenditure consistently outpaced overall health spending growth. With the rebound of non-COVID-19 medical care services in 2021, private health expenditure increased by over 5.5 %, approaching but still falling short of its 2019 level in real terms.

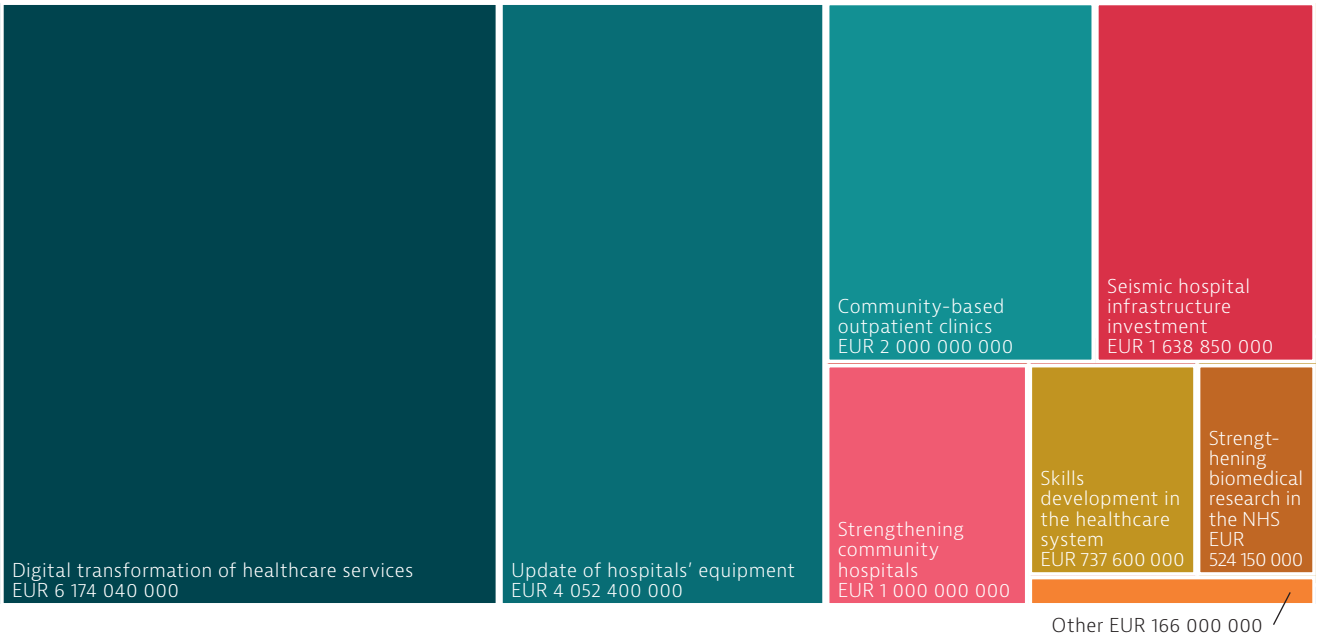
Italy's Recovery and Resilience Plan and EU Cohesion Policy are expected to boost health sector investment in the coming years

Italy's plans to strengthen local healthcare services for better management of chronic conditions will be massively supported in the coming years through the implementation of its Recovery and Resilience Plan (RRP), a key pillar of the EU's response to the COVID-19 crisis. Italy's RRP has defined a budget envelope of EUR 16.1 billion to deploy a set of investments and reforms to improve the accessibility, efficiency and sustainability of the Italian NHS by the end of 2026.

More than a third of Italy's RRP budget dedicated to health will be directed to support the digital transformation of healthcare services, including the establishment of a fully integrated and interoperable electronic patient record system, while about a fourth will be used to finance various hospital equipment upgrades (Figure 24). More than 18 % of the health budget will be used to strengthen community-based outpatient clinics and community hospitals. To boost the future supply of medical professionals and resolve the "training bottleneck" that characterises Italy's medical workforce training pipeline (see Section 4), about 4 % of the budget will be used to finance postgraduate residency programmes to train 2 700 GPs and 4 200 medical specialists.

These investments will be complemented by the rollout of the EU Cohesion Policy 2021-27 programming, which will see Italy invest a total of EUR 3.46 billion in its healthcare system. Approximately 57 % of this amount will be co-financed by the EU. Specifically, EUR 2.25 billion from the European Social Fund Plus (ESF+) will fund a range of measures aimed at enhancing the accessibility, quality and resilience of

Figure 24. Italy's Recovery and Resilience Plan prioritises investments in digital health



Notes: These figures refer to the original Recovery and Resilience Plan. The ongoing revision of the Plan might affect its size and composition. Some elements have been grouped together to improve the chart's readability.
Source: European Commission – Recovery and Resilience Scoreboard.

healthcare services in the less developed regions of the country, focusing on health workforce development and the elimination of barriers to access for vulnerable populations. Furthermore, EUR 1.2 billion from the European Regional Development Fund (ERDF) will be used for the acquisition of medical equipment and the modernisation of healthcare facilities within the Italian NHS.[4]

Despite policies to promote greater use of generics, spending on brand-name drugs is high

Italy has long implemented sound policies to promote a greater use of retail generic drugs among the population. Since 2001, whenever a generic version of a prescribed medicine is available, its price sets a limit to reimbursement, with patients having to pay any excess out of pocket if they wish to buy the brand-name drug (Law n. 405, 16 November 2001). Although the market share (in terms of volume) absorbed by generic drugs in Italy has nearly doubled over the past decade, reaching more than 27 % in 2021, this percentage remains significantly lower than in other EU countries with health expenditure sizes and compositions similar to Italy, such as Spain and Portugal.

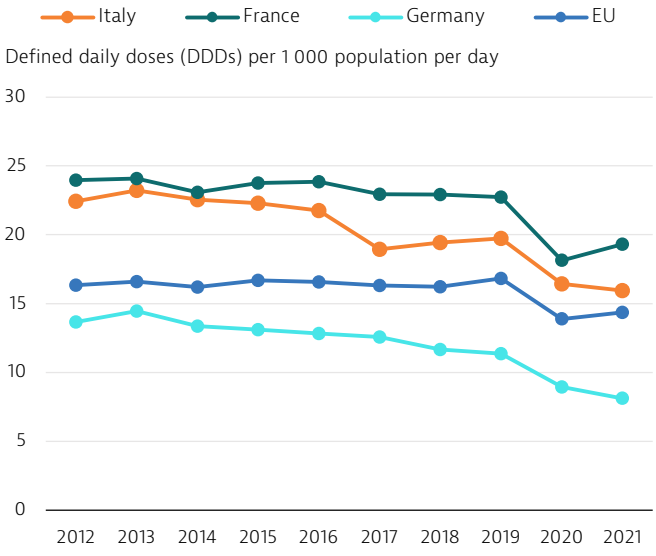
In 2021, total copayments for retail pharmaceuticals amounted to EUR 1.48 billion in 2021, a figure arising from the sum of small, fixed prescription fees and copayments paid by patients opting for brand-name drugs. Of this total, over 73 % consisted of (unnecessary) copayments from patients who chose to pay a premium for branded drugs. This amount accounted for approximately 10 % of total OOP expenditure on all retail pharmaceuticals in 2021 (Italian Court of Auditors , 2022). Paradoxically, avoidable OOP spending on brand-name pharmaceuticals was concentrated in the southern regions of Campania, Calabria, Sicilia and Basilicata, where average disposable income per capita is lower compared to regions such as Tuscany, Lombardy, Veneto and Emilia Romagna, which exhibited the lowest monthly expenditure per capita on brand-name drugs.

Italy's antibiotic consumption has declined, but overreliance on broad-spectrum products heightens concerns about antimicrobial resistance

Antimicrobial resistance (AMR) is a major public health concern in the EU, with estimates of about 35 000 deaths due to antibiotic-resistant infections and healthcare-associated costs of around EUR 1.1 billion per year (OECD/ECDC, 2019). Because antibiotic overprescription and overuse in humans are major contributors to the development of antibiotic-resistant bacteria, antibiotic consumption data are a useful tool to evaluate the risk of AMR and the efficacy of programmes to promote their appropriate use.

In this context, although Italy's performance has improved in recent years, it still lags behind the EU average. Over the past five years, total antibiotic consumption decreased at an average annual rate of 6.1 %, outpacing the EU average decline of 4.7 % and resulting in a total consumption rate 6.7 % above the EU average in 2021. This decline was in large part driven by decreased consumption in community settings, which remains marginally above the EU average and accounts for about 90 % of Italy's total antibiotic consumption. The COVID-19 pandemic played a significant role in reducing antibiotic consumption in the community, with Italy experiencing a comparatively large decline of over 19 % between 2019 and 2021 (Figure 25). This decline is partly attributed to pandemic containment measures, which led to fewer infections. Despite this significant decrease in the overall use of antibiotics, the composition of Italy's antibiotic consumption remains a cause for concern due to its above-average consumption of second-line broad-spectrum antibiotics classified under WHO's "Watch" category, which have a higher potential to expedite the development of AMR.

Figure 25. COVID-19 caused a significant reduction in antibiotic consumption in the community



Notes: The EU average is unweighted. The data only cover consumption in the community (outpatient).
Source: ECDC ESAC-Net.

4 *These figures for EU cohesion policy funds reflect the status as of September 2023.*

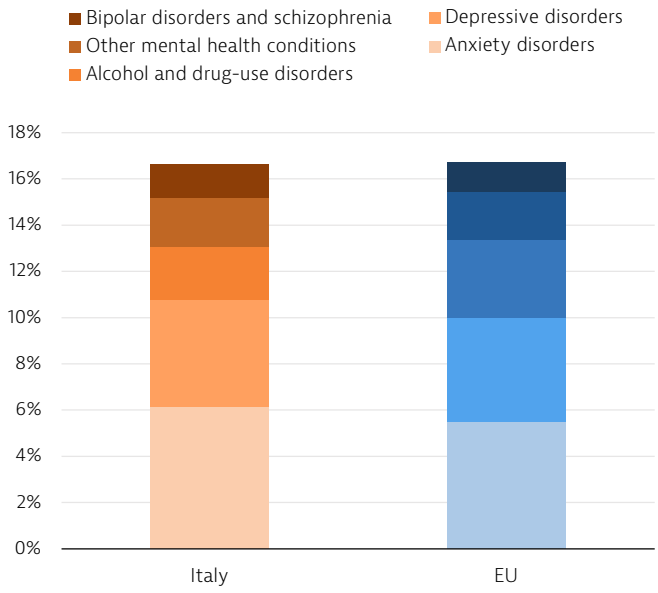
6 Spotlight on mental health

The prevalence of mental ill health in Italy is comparable to the EU average

As in other countries, determining the exact proportion of the Italian population affected by mental health disorders at any given time is challenging due to peculiar methodological limitations, which often lead to undercounting the actual burden of mental disorders. According to prevalence estimates from the Institute for Health Metrics and Evaluation (IHME), over 9.85 million individuals in Italy had a mental health disorder in 2019, representing 16.6 % of the population – a share in line with the EU average. Anxiety disorders were the most prevalent, affecting approximately 6 % of the population, followed by depressive disorders at 5 % and alcohol and drug-use disorders at 2 % (Figure 26).

The prevalence of mental health disorders in Italy significantly impacts the welfare of its citizens and has significant implications for the economy. In 2015, the total annual costs associated with mental health issues in Italy were estimated to amount to 3.3 % of GDP, with over a third of these costs attributed to reduced participation and productivity in the labour market (OECD/EU, 2018).

Figure 26. One in six Italians suffered from a mental health disorder before the pandemic



Source: IHME (data refer 2019).

Mental health services are being restructured to enhance community-based care

The organisation of mental health services in Italy aligns with the decentralised structure of its NHS, which provides universal healthcare coverage for all residents (see Section 4). At the local level, a network of 140 mental health departments is responsible for the planning and delivery of mental healthcare services within their respective catchment areas.

In the wake of a 2022 reform aimed at bolstering local provision of health services and seamlessly integrating the infrastructural investments financed through Italy's RRP into the healthcare sector (see Section 5.3), the services provided by each mental health department are being restructured along four tiers (Ministry of Health, 2022). At the primary care level, GPs are the initial point of contact for most individuals seeking mental healthcare. In partnership with community homes – multidisciplinary clinics staffed by both clinical and non-clinical personnel (e.g. social workers) – GPs play a pivotal role in the diagnosis and management of non-complex cases. Mental health centres, together with child and adolescent clinics and addiction clinics, provide outpatient specialist mental health services. Inpatient specialist mental healthcare is provided by hospitals, while services for specific conditions, such as eating disorders and severe mental health conditions, are arranged through specialised networks operating at the regional or interregional level of inpatient and outpatient services.

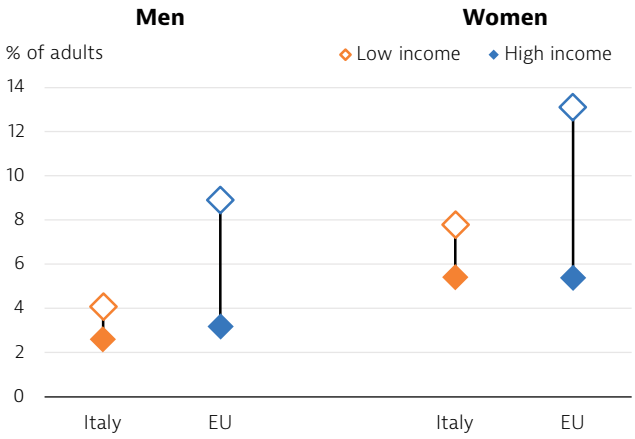
Italy's gender gap in the prevalence of depression is wider than the EU average

Based on self-reported survey data, 5.3 % of Italians suffered from depression in 2019 – a rate about 2 percentage points below the EU average and in line with Italy's rate reported in 2014. As with trends observed across other EU countries, men in Italy reported lower rates of depression (3.5 %) than women (6.9 %). This gender disparity in the prevalence of depression was higher than in most other EU countries, with nearly two women reporting suffering from depression for every man, compared to an EU average ratio of 1.6 women per every man. This notable gender skew – which is even more pronounced in other southern European countries – is likely to originate from a combination of factors, including internalised stigma among

men, which inhibits their recognition of the condition and subsequent help-seeking.

As in most other EU countries, in Italy higher income levels were associated with a lower reported prevalence of depression, although the differences were relatively modest. Among individuals in the lowest income quintile, 6.1 % reported experiencing depression, while this figure decreased to 4 % among those in the highest quintile. This gap was the smallest in the EU, and approximately 40 % smaller than the EU average (Figure 27).

Figure 27. Income-related disparities in the prevalence of depression are the smallest in the EU



Note: High income refers to people in the top income quintile (20 % of the population with the highest income), whereas low income refers to people in the bottom income quintile (20 % of the population with the lowest income).
Source: Eurostat Database (based on EHIS 2019).

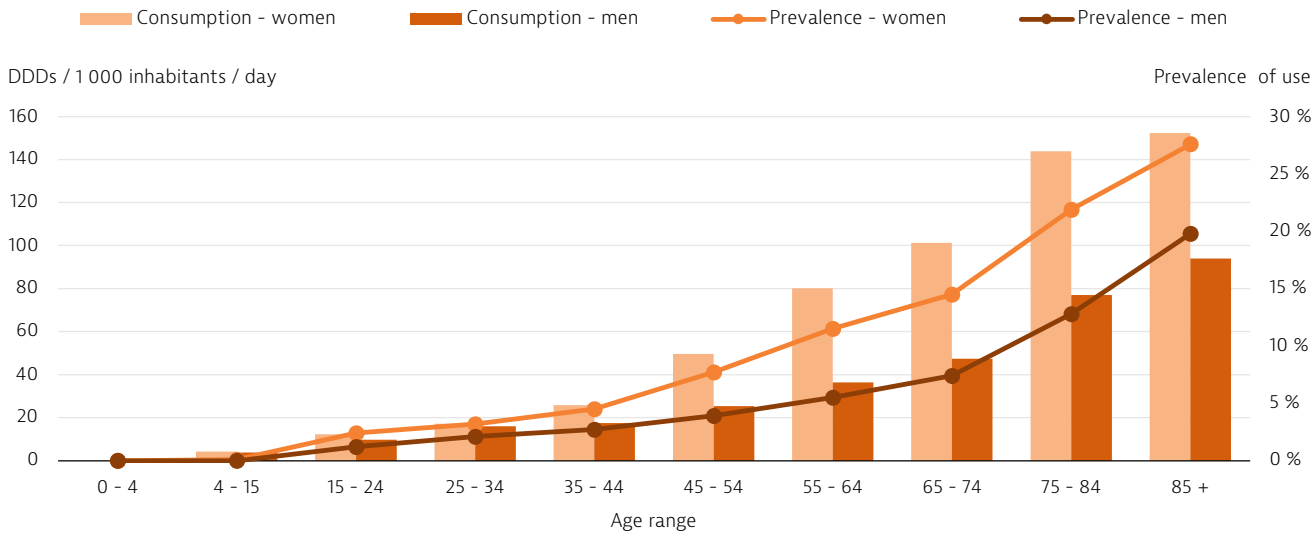
Italy's antidepressant consumption is lower than in most other EU countries

Like in other EU countries, antidepressants are the most commonly prescribed psychoactive medication in Italy, making up 3.5 % of all pharmaceuticals used in 2022. Their daily consumption level stood at 45.8 daily defined doses (DDDs) per 1 000 inhabitants, one of the lowest levels in the EU. From 2017 to 2022, antidepressant consumption of in Italy increased by 2.4 % per year – a modest rise compared to the EU average and peer countries such as Spain and Portugal, where consumption levels were more than double that of Italy.

In 2022, approximately 6.7 % of the Italian population was prescribed antidepressants at least once, with the median age of patients of 67 years. Their use was more concentrated among women, with 9 % receiving antidepressant treatment compared to 4.4 % of men, and rose consistently with age, reaching nearly 28 % among women over the age of 85 (Figure 28). Across all age groups, there was a stark gender divide in consumption levels, with women's consumption more than doubling men's in groups over the age of 45.

Data from electronic health records reveals that half of users received antidepressant treatment for less than six months, and that nearly 12 % of patients received a single prescription. This consumption pattern reflects the increased off-label use of antidepressants for a variety of therapeutic purposes, as well as potential limitations in accessing non-pharmacological therapeutic approaches.

Figure 28. Antidepressant use rises with age and is significantly higher among women



Source: AIFA (2023)

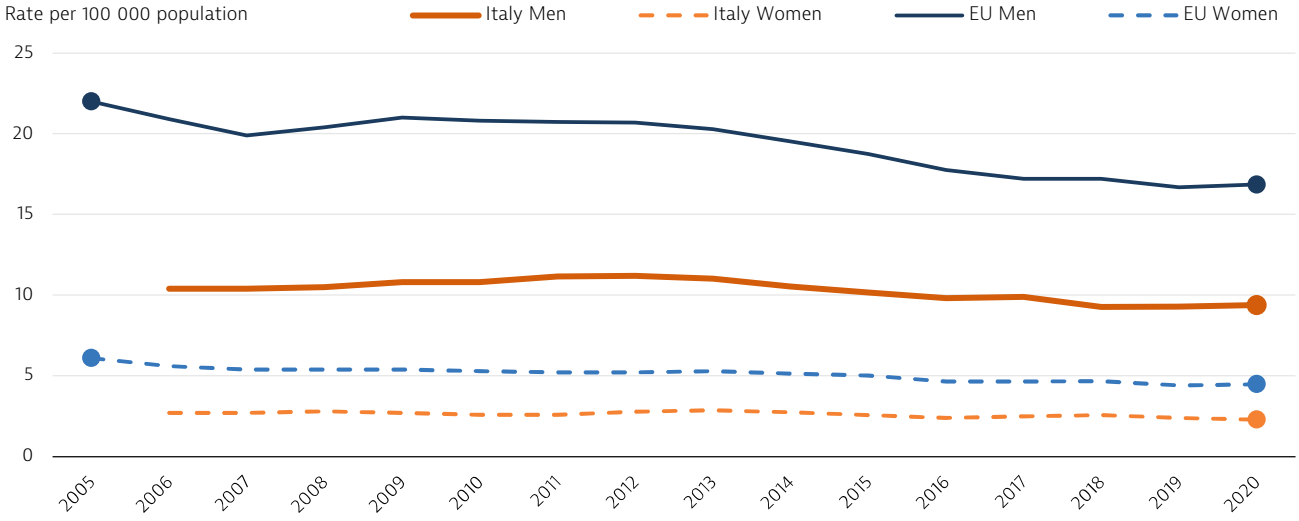
Suicide among Italians is significantly less common than in most other EU countries

Suicide is a significant public health problem in the EU, where it accounted for about 1 % of all deaths that occurred between 2015 and 2020. The factors contributing to suicide are complex, but extensive research and clinical practice have established that mental health problems play a substantial role as risk factors for suicide.

Although suicide in Italy claims more than 3 500 lives each year, the country's suicide rate for both men and women is approximately half that of the EU average (Figure 29). Despite having one of the lowest suicide rates in the EU already in 2010, Italy's suicide rate has fallen at an only slightly slower rate than the EU average over the last decade. Contrary to concerns that suicide rates might surge during the pandemic, the data for 2020 indicates that neither Italy nor the EU experienced a significant increase.

As in other EU countries, the prevalence of suicide in Italy is characterised by a marked gender split, with much higher incidence among men. In the last decade, in Italy men were about four times more likely to commit suicide than women.

Figure 29. Suicide rates in Italy have remained consistently low over the past 15 years

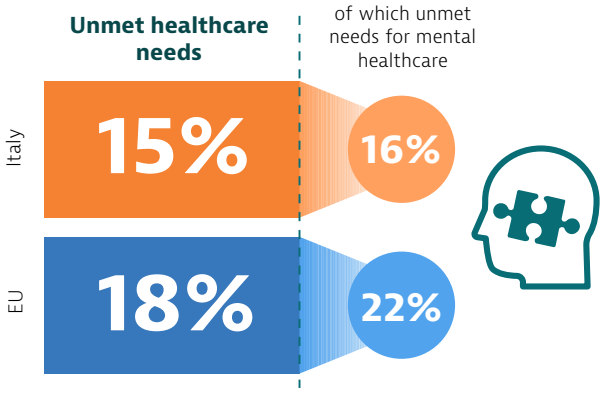


Source: Eurostat Database.

A significant number of people reported unmet needs for mental healthcare during the pandemic

As in most other EU countries, a significant number of individuals in Italy experienced unmet healthcare needs during the COVID-19 pandemic, including needs specific to mental healthcare. Findings from a European-wide survey conducted during the second and third years of the pandemic revealed that, of the 15 % of Italians who reported unmet healthcare needs, 16 % specifically indicated unmet needs pertaining to mental healthcare services – a sizeable proportion, which was nevertheless lower than the average across EU countries (Figure 30).

Figure 30. Nearly one in six individuals who reported unmet healthcare needs in spring 2021 had mental health specific unmet needs



Note: Survey respondents were asked whether they had any current unmet healthcare needs and, if so, for what type of care, including mental healthcare.
Source: Eurofound (2021; 2022).

7 Key findings

- In 2022, Italy's life expectancy at birth was the third highest in the EU, at 83.0 years. This figure marked a partial recovery from a significant decline in 2020, although it remained over 6 months below its pre-pandemic level. While COVID-19 accounted for more than 10 % of all deaths in Italy in 2020, circulatory diseases and cancer remained the primary causes of death, and were responsible for more than half of total fatalities. After peaking in 2020, excess mortality remained stable at approximately 10 % above its pre-pandemic baseline, with a slight increase in 2022, despite a sizeable decline in the number of confirmed COVID-19 deaths.
- Approximately one third of all deaths in Italy can be attributed to behavioural risk factors. While the adult smoking rate saw a gradual but steady decline in the decade leading up to the pandemic, between 2019 and 2022 it rose by over 1 percentage point. While obesity rates remain comparatively low, the high prevalence of physical inactivity among both adults and children compounds risks of increasing its prevalence in the future. On a positive note, alcohol consumption and regular heavy drinking rates among Italians are significantly less prevalent than in most other EU countries.
- Italy's health expenditure, both as a share of GDP and per capita, is lower than the EU average – primarily due to comparatively low government spending. Between 2019 and 2021, health expenditure per capita increased by nearly 7 %, driven entirely by increased public spending to tackle the COVID-19 emergency. Despite this rise in publicly financed expenditure, Italy's share of health spending financed out of pocket, which is largely driven by direct payments for outpatient specialist care and pharmaceuticals, remains significantly above the EU average.
- Despite the severe mortality impact from the pandemic, in 2020 Italy reported one the lowest mortality rates from preventable causes in the EU. Additionally, Italy boasts relatively low rates of avoidable hospital admissions, indicating successful management of chronic conditions in outpatient settings, although noteworthy variations exist among regions. As in most other countries, COVID-19 restrictions in 2020 led to a severe decline in cancer screening rates and a subsequent accumulation of a backlog of diagnostic procedures.
- In 2021, Italy had an average density of doctors and a below-average density of nurses compared to the EU averages. Although Italy's doctor-to-population ratio has increased in recent years, several regions experience shortages – particularly of general practitioners. Italy's doctor population is among the oldest in the EU, and there are concerns that the current health workforce training pipeline may struggle to compensate for the expected retirement-related attrition. In response, the government has taken decisive action to address past shortcomings in workforce development – including through its Recovery and Resilience Plan.
- In 2021, reported unmet needs for healthcare in Italy were low, and in line with the pre-pandemic period, with cost their main determinant. Citizens are entitled to a comprehensive array of services, but public coverage for outpatient specialist care – including dental care – is comparatively low. While modest copayments are applied to a wide range of healthcare goods and services, the vast majority of out-of-pocket expenditure consists of direct payments for over-the-counter drugs and outpatient specialist consultations.
- The burden of mental ill health in Italy is comparable to the EU average, with approximately one in every six people estimated to have had a mental health disorder in 2019. While a significantly larger proportion of Italian women reported suffering from depression, income-related disparities in depression prevalence among Italians are the smallest across the EU. Mental healthcare is organised locally by mental health departments, which coordinate delivery of services across a tiered structure comprising primary care, outpatient and inpatient mental healthcare. As in other countries, suicide is more prevalent among men, but Italy's suicide rate remains consistently among the lowest in the EU.

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Country abbreviations

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

European Commission

State of Health in the EU
Country Health Profile 2023

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

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

The 2023 edition of the Country Health Profiles provides a synthesis of various critical aspects, including:

- the current state of health within the country;
- health determinants, with a specific focus on behavioural risk factors;
- the structure and organisation of the health system;
- the effectiveness, accessibility and resilience of the health system;
- For the first time in the series, an account of the state of mental health and related services within the country.

Complementing the key findings of the Country Health Profiles is the Synthesis Report by the European Commission.

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

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