# REGIONS AT THE CROSSROADS BETWEEN PUBLIC AND PRIVATE HEALTHCARE

## *WHAT THE DATA SHOW (AND THEIR AVAILABILITY)*

### Introduction

Public opinion is usually interested in the public policies of its own Region, and only rarely in the functioning capacity of the regional administrative system, without which no public policy can be implemented. This is why the European Commission devotes many of its actions and recommendations to what it defines as "administrative capacity." Without an efficient administration, even the most significant policies risk failure, especially at the local level.

To strengthen the administrative system, it is first necessary to understand its overall state of health. This is precisely what we do at the Research Center on Public Entities (REP): each year, we map the overall performance of Public Administrations, including Regions, through the collection and analysis of data that these administrations are legally required to publish on their respective institutional websites[1]. This makes it possible to identify the strengths and weaknesses of each individual entity and to intervene in a targeted manner to support it.

[1] The analysis of Public Administration performance is based on the Administrative Capacity Index, a comparative evaluation model developed by Fondazione Etica for over fifteen years. It differs from other evaluation models because: it uses exclusively objective data as published by the entities themselves, rather than data derived from interviews or questionnaires; it is based not only on budget data but also on five other macro-areas that assess the ESG sustainability of each entity (governance, personnel, services, procurement, environment); and the assignment of a scoring system is carried out on a comparative basis.

A relevant area of regional performance concerns **the governance of the healthcare system**, particularly the role currently played by accredited private providers. The analysis focuses on indicators relating to the share of expenditure on accredited private providers and their prevalence within the total number of regional healthcare facilities.

## Healthcare Governance between the Public and Private sectors

The governance of regional healthcare systems represents one of the most complex and sensitive areas of public action, as it must reconcile constitutional principles, stringent financial constraints, and organizational arrangements that are highly heterogeneous across the national territory. The healthcare system, in fact, constitutes the primary domain for the exercise of regional autonomy, as well as the function that absorbs the largest share of decentralized public expenditure, making the link between policy choices, administrative capacity, and achieved outcomes particularly evident.

Within the National Health Service (NHS), the regionalization of healthcare has, over time, produced differentiated governance models, in which **the principle of universal access to care has progressively been confronted with diverse strategies for organizing service provision**. Within this framework, the integration between public facilities and accredited private providers is not considered an anomaly of the system, but rather one of the structural outcomes of the reform process initiated in the 1990s. The use of accredited private providers has thus emerged as one of the instruments through which Regions have sought to respond to the demand for healthcare services, compensating for structural limitations of public provision, organizational rigidities, and staffing constraints

The centrality of this issue becomes particularly evident when considering that accredited private providers contribute to the delivery of the Essential Levels of Care (LEA), thereby directly affecting the guarantee of healthcare-related citizenship rights. In this sense, the balance between public and private provision is not neutral with respect to territorial equity objectives, as **significant heterogeneity in the diffusion of accredited private providers may translate into substantial differences in access to care pathways**. Healthcare governance is therefore called upon not only to ensure the financial sustainability of the system, but also to safeguard the overall coherence of service provision with the founding principles of the NHS.

The issue of the role of **accredited private providers** repeatedly intersects with another highly topical concern: **waiting lists**, which currently represent one of the most critical and sensitive areas in the performance of regional healthcare systems. Indeed, waiting lists constitute an indirect measure of the public healthcare system's capacity to respond to the demand for services and have a significant impact on citizens' perceptions of their local healthcare authority. In this context as well, the use of accredited private providers is frequently employed by Regions as a tool to supplement service provision, with the aim of reducing waiting times and absorbing portions of demand that the public system is unable to meet in a timely manner.

Against this background, the following analysis aims to examine **the share of expenditure on accredited private providers and their diffusion within regional healthcare systems**, interpreting the results not as isolated values, but as potential signals of different governance models that affect the ability of Regions to ensure an efficient, sustainable, and equitable healthcare system.

It should be noted that, at the beginning of February 2026, when this report was drafted, the publicly available data for calculating both indicators were only **updated through 2023**. A few days later, the data for one of the indicators, the expenditure on accredited healthcare providers (source: MEF), were updated **to 2024**, but the data on the number of such facilities (source: Ministry of Health) were not. Nevertheless, it was decided to maintain **the analysis based on 2023 data** for consistency between the two indicators

In light of this, it is inevitable to reflect on the possible **consequences of such a delay in updating public data** that are so relevant and sensitive for citizens, especially today, in an era in which digitalization and artificial intelligence have become the flagship slogans of public communication. It is evident that, given these timelines for data publication, any intervention in healthcare policies risks being conducted, if not "in the dark," certainly with very little light to illuminate the path to be taken. An eventuality to be avoided.

## Accredited private providers: how many are there and what do they cost the Regions

The two indicators examined capture two distinct but complementary dimensions of the role of accredited private healthcare providers within regional healthcare systems.

**The first indicator** measures **the share of expenditure on accredited private providers within total healthcare service spending**, providing only a partially financial perspective. Indeed, it allows us to observe the relative weight of accredited private providers within regional healthcare budgets, while at the same time highlighting choices regarding resource allocation and the modalities of healthcare service delivery.

**The second indicator**, relating to **the number of accredited private healthcare providers per 10,000 inhabitants**, instead captures the structural and territorial dimension of the phenomenon. It therefore allows for an assessment of the spread of accredited private providers in relation to the resident population, providing a measure of the coverage of contracted private healthcare services. Even in this case, the indicator alone does not reflect the volume of activity carried out by individual facilities nor their economic weight, but provides useful information on the organizational structure of regional healthcare systems and on decisions regarding service planning.

**It is the joint reading of the two indicators** that allows us to understand the extent **to which a Region relies more on the private sector than on the public sector in healthcare.** Theoretically, a Region could accredit a high number of private facilities; however, if these are assigned low-value activities (blood tests rather than prosthetic surgery), in this case, one could think of an administration that prefers to focus on public healthcare. Conversely, a Region might allocate significant financial resources to a limited number of private facilities. The data analysis provides an interpretative compass in this regard.

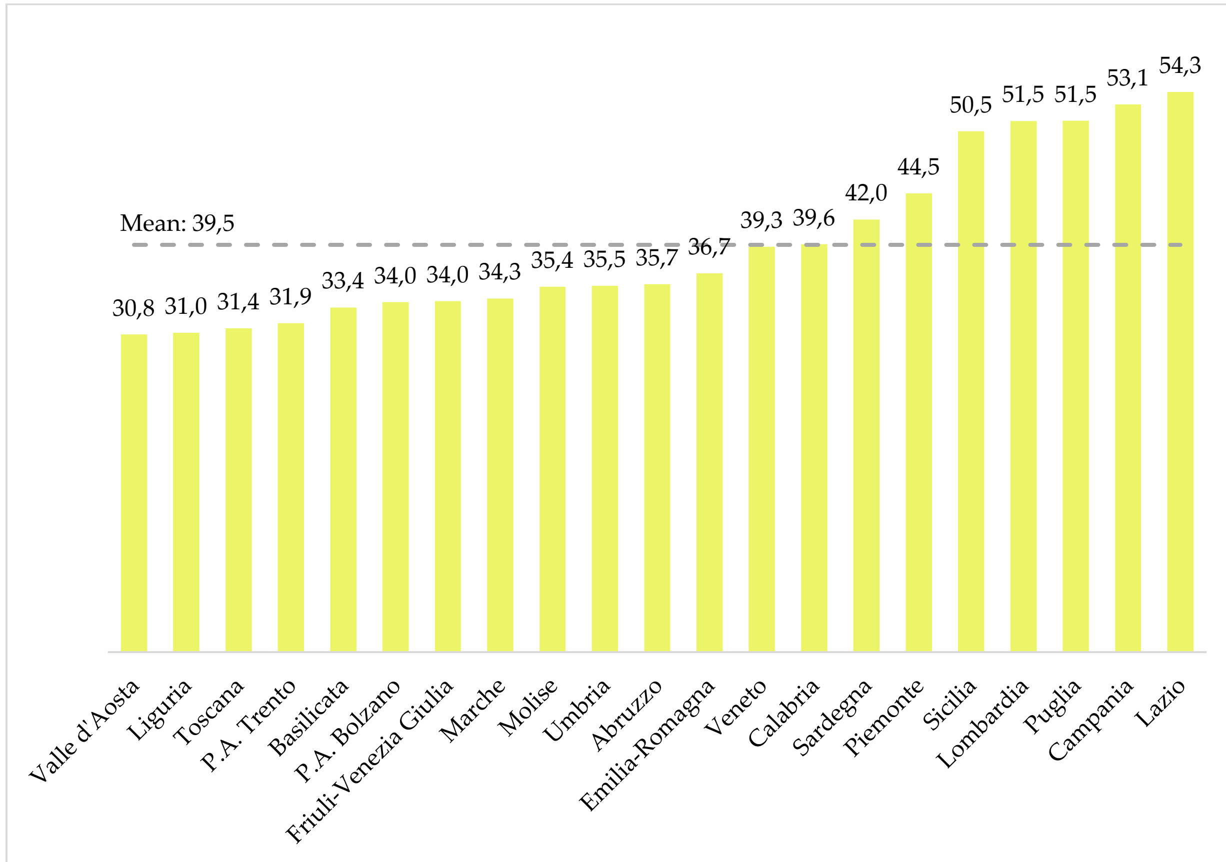
The first chart (Figure 1) concerns the share of expenditure on accredited private providers within total healthcare service spending, highlighting significant differences between the Regions. Indeed, they fall within a fairly wide range compared to the national average of 39.5%.

**Several Regions show values below the national average,** such as Valle d'Aosta (30.8%), Liguria (31%), Tuscany (31.4%), and the Autonomous Province of Trento (31.9%), and therefore a relatively low share of expenditure on accredited private providers within total healthcare spending.

**At the opposite end of the distribution** is Lazio, the Region with the highest share (54.3%), followed closely by Campania (53.1%), Apulia (51.5%), Lombardy (51.5%), and Sicily (50.5%), all with expenditure

on accredited private providers absorbing more than half of the total regional healthcare service spending. Therefore, a choice in financial resource allocation directs the budgets of certain Regions, distributed across the South, Center, and North, as also confirmed by above-average values in Piedmont (44.5%) and Sardinia (42%).

*Figure 1. Share of Regional Expenditure on Accredited Private Providers in Relation to Total Healthcare Service Spending (%)*




*Source: REP Administrative Capacity Index – Elaborated from MEF data (2023)*

The second chart (Figure 2), which concerns the number of accredited private healthcare providers per 10,000 inhabitants, shows a partially different configuration.

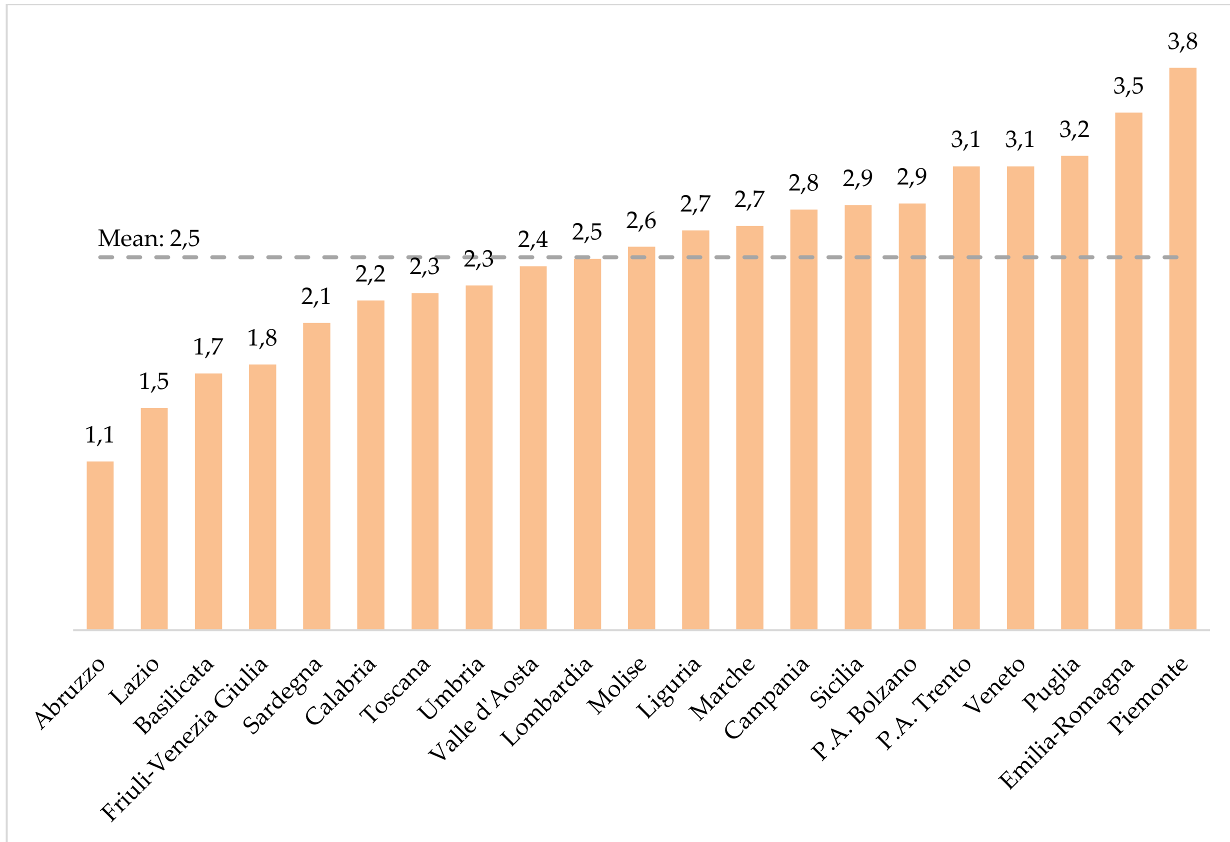
**The Region in the South with the fewest private providers** per 10,000 inhabitants is Abruzzo (1.1). It is followed by Lazio (1.5) and, not far behind, Basilicata (1.7), with a provision of accredited private facilities significantly below the national average of 2.5 facilities.

Also below this average are two Regions with Special Statute: Friuli-Venezia Giulia (1.8) and Sardinia (2.1).

At the opposite end of the ranking, **the Region with the highest density of accredited private providers** in relation to the population is Piemonte (3.8), followed by another Northern Region, Emilia-Romagna (3.5), and a Southern Region, Puglia (3.2).

More than three private facilities are also present in Veneto and the Autonomous Province of Trento, both with 3.1, followed, just below 3, by the other Autonomous Province (Bolzano) and Sicilia, both with 2.9.

*Figure 2. Number of Accredited Private Healthcare Providers per 10,000 Inhabitants by Region (value/10,000 inhabitants)*




Source: REP Administrative Capacity Index – Elaborated from Ministry of Health data (2023)

## Comparative analysis of the results

Beyond the results of each of the two indicators, as mentioned**, it is the comparative analysis of the two that allows us to understand a Region's orientation,** which is called upon to allocate limited financial resources and to decide how much to invest in public healthcare and how much in private healthcare. Without demonizing any type of choice, let us see what the comparison between the two indicators reveals.

The results highlight a first case of Regions characterized by a combination of higher-than-average expenditure, but, at the same time, a very limited territorial spread of accredited private providers. This is the case, for example, of Lazio, which, as noted, is the Region that spends the most (54.3%) and is the second with the fewest private facilities (1.5). Therefore, these are facilities that absorb a large share of

public financial resources, presumably due to the high level of healthcare services and specialization, as well as the considerable number of patients coming from outside the Region[2].

The results also show a second type of case: that of Regions in which the number of accredited private facilities is high, but the financial weight, conversely, is limited. This is the case of *Emilia-Romagna*, which has the second-highest presence of accredited private providers in relation to the population (3.5), but expenditure below the regional average (36.7% versus 39.5%).

A different case is *Piemonte*, which shows a greater alignment between the two indicators, with the highest presence of accredited private healthcare providers (3.8) accompanied by expenditure on private facilities (44.5%) above the average.

The results for *Toscana* also appear consistent, but on the lower end of the distribution: it is among the three Regions with the fewest accredited private providers (2.3), corresponding to a low cost, percentage-wise below the average (31.4%).

The results for *Puglia* appear even more consistent, with the third-highest number of private facilities (3.2) and also the third-highest share of related expenditure (51.5%).

Finally, it is worth noting the case of Lombardia: usually considered, in public opinion, the "queen" of private healthcare, it is indeed among the four Regions, along with Apulia, with the highest share of expenditure on accredited private facilities (51.5%), but with a presence of private providers at the regional average level (2.5).

In conclusion, the data show that the **presence of a high number of private healthcare facilities within a regional territory does not necessarily imply a high share of related expenditure** within total healthcare service spending: indeed, the facilities may be small in size or focused on low-cost services. Conversely, **high expenditure may be associated with a smaller number of facilities** operating in high-complexity or high-cost areas.

In this sense, the use of regional examples is not intended to distinguish between "virtuous" or "critical" models, but rather to make territorial variability more understandable, while clarifying how the observed differences reflect non-homogeneous governance structures and service planning choices, expressed both financially and organizationally.

[2] It should be noted that this indicator is calculated based on the resident population, without taking into account interregional healthcare mobility. Hospitals in Lazio, particularly those located in Rome, indeed provide care to many patients coming from other Regions.