social sciences

MDPI

Review

A Comparison of the Italian and Chinese Health Care Systems: Policy, Convergence, and the Need for Reform

Filippo Gibelli [1], Giovanna Ricci [2], Giulio Nittari [3,*], Alberto Blandino [4], Jingyi Liu [2], Tommaso Spasari [5] and Paolo Bailo [2]

[1] Independent Researcher, 46100 Mantova, Italy; filippo.gibelli@unicam.it
[2] Section of Legal Medicine, School of Law, University of Camerino, 62032 Camerino, Italy; giovanna.ricci@unicam.it (G.R.); jingyi.liu@studenti.unicam.it (J.L.)
[3] Telemedicine and Telepharmacy Centre, School of Medicinal and Health Products Sciences, University of Camerino, 62032 Camerino, Italy
[4] Faculty of Medicine, University of Vita-Salute San Raffaele, via Olgettina 58, 20132 Milan, Italy; blandino.alberto@hsr.it
[5] Forensic Medicine and BioLaw, Niccolò Cusano University, 00166 Rome, Italy; tommaso.spasari@unicusano.it
* Correspondence: giulio.nittari@unicam.it

Abstract

Health systems are fundamental to ensuring the right to health and maintaining the stability of welfare states. In this broad framework, this narrative review takes a look at Italy and China—two countries with very different historical backgrounds and institutional paths—as they deal with challenges like demographic aging, increasing chronic illnesses, and ongoing disparities in access to care. This paper aims to examine the most relevant peer-reviewed studies, as well as current legal and policy documents, in order to outline a comparative overview of the approaches to financing, coverage, and service provision in Italy and China, two very different countries. The Italian National Health Service, financed through general taxation and designed to be universal, aims to ensure equitable access to healthcare while having to contend with significant regional differences and financial difficulties. On the other hand, China, which operates with a mixed model, has rapidly expanded its insurance coverage using a variety of schemes and embracing technological advances, which has enabled large-scale access to healthcare, although considerable differences remain between urban and rural areas and provinces. When compared, each system shows particular strengths: Italy's local care networks and focus on continuous services offer a model for inclusive welfare, while China's use of digital tools demonstrates how innovation might help overcome obstacles in settings with limited resources and maintain continuity of care. There is a noticeable overlap in how both countries handle chronic diseases and their shared concern for equity in health policy. Considering these points, mixed approaches that combine universal coverage, financial viability, and flexible use of technology could provide useful ideas for crafting more fair, effective, and resilient health policies in various settings. Rather than proposing direct policy transfer, the comparison identifies context-dependent strategies that may inform future healthcare reforms.

Keywords: universal health coverage (UHC); comparative health systems; healthcare financing; equity in access to care; digital health innovation

Check for updates

Academic Editor: Qingyun Peng

Received: 4 March 2026
Revised: 8 August 2026
Accepted: 12 August 2026
Published: 19 August 2026

Copyright: © 2026 by the authors. Licensee MDPI, Basel, Switzerland. This article is an open access article distributed under the terms and conditions of the Creative Commons Attribution (CC BY) license.

1. Introduction

Health systems represent a cornerstone of modern welfare states, shaping both the realization of the right to health and the broader socioeconomic equilibrium. Health systems are commonly classified into different organizational models, ranging from tax-funded systems inspired by the Beveridge tradition to insurance-based systems relying on social or private contributions. These models differ in terms of governance, financing mechanisms, and the balance between public and private provision, shaping how access to care is structured and delivered (Bevan et al. 2010; Esping-Andersen 1990).

While national models of healthcare provision have developed in response to specific historical, cultural, and economic trajectories, contemporary global challenges—such as demographic aging, the increasing burden of chronic diseases, and inequalities in access to care—require shared solutions (Maccheroni et al. 2025). Comparative research can offer both theoretical perspectives and practical suggestions for how healthcare policies might develop over time (Zhou et al. 2019).

This paper centers on Italy and China, two systems that, while both well-known, differ quite a bit in their structure. Italy's National Health Service (Servizio Sanitario Nazionale, SSN), created in 1978, operates within the framework of a Beveridge-style system, guaranteeing universal coverage by means of funding based mainly on taxation. In its long history, the system has witnessed numerous changes aimed primarily at the decentralization process with ever more power granted to regional authorities in managing healthcare. Although this has allowed flexibility in the functioning of the system, it has also caused the considerable differentiation of regions in regard to the accessibility and effectiveness of medical services (Mucelli and Spigarelli 2017; Fattore et al. 2023; Ricciardi and Tarricone 2021). On the contrary, the Chinese healthcare system can be characterized by a mixed model with various public institutions working in cooperation with numerous social health insurance organizations. Following the reforms of 2009, the population coverage rate in China has grown considerably thanks to such programs as Urban Employees, Urban Residents and Rural Population. However, certain shortcomings still exist in the current structure, namely fragmentation, imbalance between urban and rural territories and a rather heavy dependence on out-of-pocket payment sources (Naghavi et al. 2025; Yi 2021).

By looking closely at how these two systems differ and overlap in areas like service delivery, how resources are distributed, and policy execution, this study aims to pinpoint effective approaches, expose key weaknesses, and suggest ways in which each country might learn from the other.

Although several studies have examined the Italian or the Chinese healthcare system separately, comparative analyses have generally focused on specific dimensions, such as financing, service delivery, or individual reforms. In the authors' view, only few contributions have attempted to integrate these institutional, organizational, and policy dimensions within a single comparative framework while considering the common pressures generated by demographic aging, chronic diseases, and territorial inequalities. This review seeks to address this gap by providing an integrated comparison of the two healthcare systems, highlighting not only their structural differences but also the policy logics underlying recent reforms and the conditions under which selected experiences may offer useful insights for other contexts.

2. Materials and Methods

2.1. Study Design

This study adopts a documentary and comparative research design based on a narrative literature review. A systematic review or scoping review methodology was initially

considered; however, in the authors' view, it proved methodologically unsuitable for the purposes of this study. The available literature on the Italian and Chinese healthcare systems, in fact, is highly heterogeneous in terms of scope, methodology, language, and institutional focus, encompassing policy analyses, legal frameworks, epidemiological studies, and health economics reports.

Given this heterogeneity, the application of rigid systematic review protocols (e.g., PRISMA-based screening and strict inclusion criteria) would have led to the exclusion of key sources such as policy documents, institutional reports, and context-specific analyses, which are essential for understanding governance structures and reform trajectories. Therefore, a structured narrative review was deemed more appropriate to capture the complexity of the two systems and enable meaningful cross-national comparison. Compared with a systematic review, this approach offers greater flexibility in integrating heterogeneous forms of evidence and is particularly useful in comparative health policy research, where institutional arrangements cannot always be assessed through standardized outcomes. Its main limitation is the lower degree of reproducibility and the greater role of interpretative judgment in source selection and synthesis. For this reason, the narrative approach adopted here was combined with explicit selection criteria, thematic analysis, and triangulation of different types of evidence, as described below.

2.2. Search Strategy and Data Sources

The literature search was conducted across major international databases, including PubMed, Scopus, Web of Science, and ScienceDirect, as well as institutional sources such as OECD Health Data, the WHO Global Health Observatory, and the European Observatory on Health Systems and Policies (HiT series).

The search was performed between January 2024 and March 2025 and included publications in English and Italian. Additional relevant sources were identified through backward citation tracking and consultation of institutional repositories.

Search terms were combined using Boolean operators and included: "Italy National Health Service," "China healthcare reform," "urban rural healthcare disparity China," "comparative health systems Italy China," "aging and chronic disease health policy," "telemedicine China," "long-term care Italy," and "cross-national health policy comparison."

2.3. Inclusion and Exclusion Criteria

Although the review does not follow a fully systematic protocol, explicit inclusion and exclusion criteria were applied to enhance transparency and reduce selection bias.

Included sources met the following criteria:

(i) Relevance to healthcare system structure, financing, governance, or reform in Italy or China;
(ii) Focus on key thematic areas such as coverage, equity, regional disparities, chronic disease management, digital health, or long-term care;
(iii) Publication in peer-reviewed journals, institutional reports, or official statistical databases.

Exclusion criteria were as follows:

(i) Studies with a purely clinical focus not connected to system-level analysis;
(ii) Publications lacking methodological clarity or institutional credibility;
(iii) Duplicate or redundant analyses without additional substantive contribution.

Rather than applying rigid quantitative thresholds, the selection process was guided by conceptual relevance and the ability of sources to contribute to the comparative analytical framework.

2.4. Selection Process and Analytical Approach

The selection of sources followed a two-step process. First, titles and abstracts were screened to identify potentially relevant contributions. Second, full texts were assessed qualitatively based on their relevance to the study's analytical dimensions.

To address the risk of subjectivity inherent in narrative reviews, the authors adopted a thematic selection strategy, ensuring that each included source contributed to at least one of the predefined domains of comparison: financing models, service delivery organization, governance structures, and reform dynamics.

The analysis was conducted through qualitative synthesis, with findings organized according to these thematic domains. Quantitative indicators from WHO and OECD databases were used to support and contextualize the comparison, particularly with regard to expenditure, coverage, workforce, and resource distribution.

To further reduce the risk of selection bias, evidence was triangulated whenever possible by comparing peer-reviewed publications with reports issued by international organizations and national health institutions. Preference was given to recent sources, although seminal studies were retained where necessary to explain the historical evolution of the two healthcare systems. Divergent findings were interpreted in light of differences in study design, institutional context, and publication objectives rather than being excluded from the analysis.

2.5. Comparative Framework

To move beyond a purely descriptive approach, the study employs an explicit comparative framework based on three analytical dimensions:

(i) Institutional design (financing mechanisms, coverage models, and governance structures);
(ii) Implementation and regional variation (including disparities in access and service delivery);
(iii) Reform trajectories and system sustainability (with particular attention to demographic change, chronic disease burden, and digital health development).

This framework enables the identification of both convergences and divergences between the two systems and supports a more interpretative and critical comparative analysis rather than a simple descriptive juxtaposition.

2.6. Methodological Limitations

This study has important methodological limitations. The narrative review design does not allow for full replicability or statistical generalization, and the selection of sources inevitably involves a degree of interpretative judgment. However, given the structural and institutional differences between the Italian and Chinese healthcare systems, a fully standardized systematic review would not have captured the contextual complexity required for meaningful comparison.

The approach adopted here prioritizes analytical coherence and contextual depth over procedural rigidity, while maintaining transparency in the selection process and clearly defined analytical criteria.

Additional limitations should also be acknowledged. The narrative approach does not permit formal assessment of study quality or quantitative synthesis of findings, and publication bias cannot be completely excluded. Furthermore, the inclusion of policy documents and institutional reports, while essential for understanding healthcare governance, may reflect the perspectives of the issuing organizations. These limitations should therefore be considered when interpreting the conclusions, which are intended to provide an analytical overview rather than definitive causal inferences.

3. Health Coverage in Italy and China: Universality vs. Selectivity

Italy's healthcare system is founded on the principle of universalism, guaranteeing equal access to services for all residents through the SSN (Ying et al. 2020; de Belvis et al. 2022). Financed by general taxation, it provides coverage irrespective of income, employment status, or geographic location, and periodic updates to the essential levels of care (Livelli Essenziali di Assistenza—LEA) enable adaptation to evolving public-health needs, balancing distributive equity with standardized service provision (OECD and European Commission 2022). The LEA guarantee basic services, such as primary care, hospital care, emergency response, and chronic disease management (Ministero della Salute 2023a). In 2021, 98% of the population were registered with a general practitioner, and the rate of hospitalization (148 per 1000) was in line with the average rates in the EU (Ying et al. 2020; de Belvis et al. 2022). The emergency departments handled over 23 million visits, with 70% of cases addressed on the same day thanks to optimized protocols and specialized staff (AGENAS 2021). Chronic diseases are also incorporated into the LEA structure: 92% of patients were treated by family doctors, and virtually the entire population had access to basic services, with coverage of 99.5% in primary care and 99.7% in emergency care (de Belvis et al. 2022; OECD and European Commission 2022). Updates to the LEA structure between 2017 and 2021 incorporated new therapeutic achievements: immunotherapy for oncology, rare diseases, and early Alzheimer's diagnosis (OECD and European Commission 2022). During the 2021 COVID-19 campaign, over 85% of the population had free access to vaccination (Ministero della Salute and ISS 2022). Supportive policies for vulnerable populations include specific exemptions from user charges: in 2021, approximately one quarter of the population benefited from exemptions, and about 43% of total health spending was covered by public services for vulnerable populations and chronic/rare diseases (de Belvis et al. 2022; OECD and European Commission 2022). Free influenza vaccination reached 87% of older adults, surpassing the EU average (OECD and European Commission 2022). Universal access reduces administrative complexity, mitigates social inequalities, and strengthens prevention and health promotion, while public financing alleviates individual financial burdens and favors long-run cost containment via investment in primary care and prevention (Fattore et al. 2023; Ying et al. 2020).

In contrast, the Chinese model is based on a selective strategy around a core biomedical insurance system that balances near-universal coverage with a pyramidal service delivery system that aims to maximize resource allocation (Li and Fu 2017; Wang et al. 2020a). As of 2023, the basic medical insurance (BMI) scheme has covered more than 95% of the population (Wang et al. 2020a). There are three main schemes in place: the Urban Employee Basic Medical Insurance (UEBMI) scheme for employed city dwellers, offering the highest level of protection (≈75–85% co-payment); the Urban and Rural Residents Basic Medical Insurance (URBMI/URRMI) scheme for non-employed individuals, offering lower levels of protection (≈50–60% co-payment); and Catastrophic Illness Insurance, which helps fund expensive care with 50–70% co-payment (Ministero della Salute and ISS 2022; Wang et al. 2020a). Despite broad coverage (≈1.34 billion people), disparities remain (Maccheroni et al. 2025; Li and Fu 2017). UEBMI beneficiaries typically enjoy higher reimbursement ceilings (e.g., CNY 500,000 in Beijing) than URBMI beneficiaries (≈CNY 200,000) (Ministero della Salute and ISS 2022; Wang et al. 2020a). Out-of-pocket payments still represent roughly 27–28% of total health expenditure (Wang et al. 2020b). The tiered design reflects China's demographic scale and regional heterogeneity, but it also generates unequal benefit distribution.

Policy emphasizes efficient allocation via multilevel insurance, with a focus on primary care and public health, reduced subsidies for high-level care, and private insurance for individualized needs (Ministero della Salute and ISS 2022; Li and Fu 2017). Differen-

tial payments and cost-sharing mechanisms are employed to minimize waste and optimize system efficiency (Ministero della Salute and ISS 2022; Bevan et al. 2010). There has been significant progress made, with public subsidies for URBMI increasing from CNY 10 to CNY 640 (2003–2023), and the list of drugs expanding from 300 to 3088, including 74 anticancer and 80 rare disease drugs; the annual cost of imatinib has reportedly decreased from CNY 300,000 to CNY 6000 through national negotiations (Wang et al. 2020b; Luo et al. 2024; Macabeo et al. 2023; Yuan et al. 2021). Private insurance has expanded dramatically, with premiums reaching approximately CNY 850 billion in 2022 and covering over 100 million people, complementing public benefits with access to premium services, imported drugs, and innovative therapies not included in the basic package (Wang et al. 2020b). In conclusion, the Chinese healthcare system has shown flexibility in its operation and resource optimization through selective coverage, but equity remains a concern; the Italian universal healthcare system ensures equal access to essential services but requires improved resource allocation to address territorial inequalities (Ying et al. 2020; de Belvis et al. 2022; Ministero della Salute and ISS 2022).

4. The Territorial Impact of Health Policies

Italy established its SSN in 1978, ensuring universal, tax-funded healthcare coverage for all residents (Coppola et al. 2008). Recognized globally by the WHO (Mladovsky et al. 2009), this model has substantially reduced the financial burden of healthcare, particularly for disadvantaged groups. However, its reliance on public funding has exposed vulnerabilities during economic recessions (WHO 2020; Cylus et al. 2016).

Post-2010 austerity measures undermined operational capacity in several regions, resulting in increased waiting times for specialized healthcare services (OECD and European Observatory on Health Systems and Policies 2021). The 2001 constitutional reform transferred responsibility for healthcare governance to regional authorities, with the goal of improving flexibility and responsiveness (Siciliani et al. 2013). At first, this decentralization allowed wealthier northern regions to strengthen and better manage service delivery (France et al. 2005). Over time, however, it widened regional disparities: regions such as Lombardy now offer high-quality, well-funded services, while southern regions like Calabria continue to face underfunding and administrative inefficiencies. The lack of consistent national standards has further deepened differences in access to specialized care across the country (Borgonovi and Compagni 2013).

In recent years, financial constraints have created a significant gap in healthcare investment (WHO 2020; Cylus et al. 2016; Masseria and Giannoni 2010). Since 2010, the growth of Italy's healthcare spending has remained below the OECD average, leading to structural pressures on the system (WHO 2020). Persistent underfunding has accelerated the deterioration of infrastructure, reduced access to services, and weakened overall quality of care (Cylus et al. 2016). Between 2010 and 2018, healthcare personnel decreased by 8% (Corte dei conti 2025), intensifying workload pressure and necessitating rationing measures such as reduced outpatient hours, postponed surgeries, and a general deterioration of patient experience.

Since 2003, China has steadily moved toward near-universal health coverage for both urban and rural populations through the introduction of the New Rural Cooperative Medical Scheme and the Urban Resident Basic Medical Insurance (Eurostat 2018; Zhang et al. 2017). These reforms have markedly improved access to healthcare in rural areas, offering essential protection to low-income groups and helping reduce medical impoverishment. In 2016, the integration of urban and rural insurance systems further narrowed health disparities (Zhang et al. 2017; Yip et al. 2019). By 2020, basic medical insurance coverage had surpassed 95%, making China's program one of the largest in the world (Zhao et al. 2014).

Despite this progress, regional differences in funding and reimbursement remain, particularly in economically disadvantaged areas (Zhang et al. 2017). While essential services are generally covered, advanced and high-cost treatments are still reimbursed at relatively low levels. Market-oriented reforms introduced in the early 2000s expanded the role of the private sector, contributing to greater efficiency (WHO 2022). The growth of private institutions has reduced pressure on public hospitals and encouraged innovation, but it has also created challenges, including defensive medical practices and strained doctor–patient relationships (Liu et al. 2017).

In leading urban hospitals, profit-driven practices have sometimes encouraged the overuse of expensive drugs and technologies, raising overall costs. The commercialization of healthcare has further widened the urban–rural divide, concentrating high-quality resources in major cities while rural regions continue to face shortages in infrastructure and healthcare personnel (Liang and Langenbrunner 2013).

The "Healthy China 2030" strategy reflects a shift from a treatment-centered model to one focused on prevention, overall well-being, and stronger public health integration (Blumenthal and Hsiao 2015). Priorities include chronic disease management, health education, and community-based prevention initiatives. Strengthening primary care institutions and general practitioners has enhanced local service capacity and improved control of non-communicable diseases (Tan et al. 2019).

At the same time, the strategy promotes the development of broader health-related sectors—such as fitness, nutrition, and mental health—thereby diversifying the healthcare system (Blumenthal and Hsiao 2015; Tan et al. 2019). Nevertheless, regional gaps in public health infrastructure, workforce training, and health education limit implementation. Public commitment to preventive care remains suboptimal, necessitating sustained government investment and promotion efforts (Zhang et al. 2017; WHO 2022).

5. Accessibility and Quality of Services

The Italian healthcare system delivers widespread and high-quality services through a network of general practitioners and uniform national standards. Primary care physicians manage both acute and chronic conditions, preventive care, and patient education. During the COVID-19 pandemic, remote consultations and local monitoring helped reduce hospital burden and support epidemic control (Li et al. 2020; Guarducci et al. 2025). For example, consistent diabetes management has been associated with a 15% reduction in complications and related hospitalizations (Conferenza Stato–Regioni 2020).

Emergency services have also performed strongly: in 2021, emergency departments recorded 23 million visits, 70% of which were resolved within 24 h thanks to standardized protocols and specialized training (OECD and European Commission 2022). Despite these positive outcomes, marked regional disparities remain. Lombardy has 4.2 physicians per 1000 inhabitants, compared with 2.9 in Calabria, and hospital bed availability ranges from 4.6 to 3.0 per 1000 residents (Ying et al. 2020). Access to advanced technology differs as well: Da Vinci surgical robots are widely available in northern regions, while MRI scanners are still limited in parts of the South.

Operational gaps are also evident in waiting times—around 15 days for specialist visits in the North compared with 35 days in the South—with non-urgent surgeries in some southern regions postponed for more than six months (Ministero della Salute 2023a). These disparities contribute to patient mobility: in 2021, 12% of complex cases from southern regions were treated in the North, particularly in oncology and cardiac surgery (Ministero della Salute 2023b; AGENAS 2019). Bed occupancy rates are also higher in the South (78% versus 62%), suggesting greater systemic strain despite efforts to standardize services through the LEA. To address these imbalances, the government allocates targeted

resources through the National Health Fund (Fondo Sanitario Nazionale, FSN), with particular attention to strengthening infrastructure and service quality in southern regions (AGENAS 2024; Conferenza Stato–Regioni 2021). Interregional cooperation has also increased: in 2021, San Raffaele Hospital in Milan sent 120 healthcare professionals to Sicily to support and train local staff (Fondazione GIMBE 2024). Telemedicine has further enabled real-time specialist consultations across all regions, overcoming geographic barriers and improving care in underserved areas.

Within China's healthcare system, resource allocation is being steadily refined through a multi-tiered service model, stronger integration between urban and rural networks, and the expansion of telemedicine. Although territorial disparities persist, ongoing policy initiatives and technological innovations are gradually narrowing equity gaps.

At the center of the system is a hierarchical structure: primary care clinics manage common illnesses and preventive services, accounting for 60% of first diagnoses in 2023, while secondary and tertiary hospitals focus on more complex and critical conditions (Gazzetta Ufficiale della Repubblica Italiana 2023). Rural community health centers place particular emphasis on maternal and child health, helping guarantee access to essential services.

To reinforce primary care, the government has promoted family physician-based services. In 2022, six national agencies jointly issued guidelines aimed at improving service quality and broadening coverage, with targets of reaching 75% of the general population and 85% of priority groups by 2035 (NHC 2024a). Differentiated reimbursement policies further encourage patients to seek treatment at lower-level facilities. Nonetheless, urban–rural disparities remain significant. In 2019, urban areas had 3.82 physicians per 1000 inhabitants, compared with 1.79 in rural areas (NHC 2022). Advanced hospitals in cities such as Beijing and Shanghai draw patients from across the country, while many village clinics continue to face infrastructure shortages. To help close this gap, China has invested in integrated healthcare networks and digital health solutions. Through teleconsultation platforms, leading tertiary institutions such as Peking Union Medical College Hospital provide remote clinical support to underserved provinces including Guizhou and Qinghai (NHC 2022). By 2022, remote analysis of imaging and ECGs improved diagnostic efficiency in underserved regions (NHC 2022).

Innovation in e-health has also restructured access to medications. Regulated by the 2022 Regulation on Online Drug Sales, electronic prescriptions and home delivery have enhanced continuity of care in remote areas (General Office of the NHC et al. 2023). Electronic health records now interconnect institutions, reducing redundant testing and improving care coordination.

In addition, the 2023 Notice on High-Quality Primary Healthcare and the Three-Year Development Plan for Community Hospitals aim to upgrade more than 30% of community health service centers into community hospitals by 2025, with the creation of over 500 new facilities each year (NHC 2022).

Public health programs are designed to reach the entire population and include chronic disease management, maternal and child health monitoring, vaccination campaigns, and preventive health education. Data from 2023 indicate a rise in public investment, particularly in chronic disease care and epidemiological surveillance (SAMR 2022). A national healthcare quality monitoring system has also improved service outcomes: in 2022, tertiary public hospitals reported reductions in complication rates and surgical infections (NHC 2024a).

6. Health Expenditure Financing

The SSN, primarily funded through taxation, ensures universal access to high-quality care via a publicly managed system, complemented by modest direct payments ("ticket") to maintain equity and sustainability (Ying et al. 2020). In 2021, health expenditure reached 8.7% of GDP, below the EU average of 9.9% (de Belvis et al. 2022). Public spending accounted for 75% of total health expenditure through the FSN, while the remaining 25% was covered by private payments and insurance for services beyond the essential LEA (OECD and European Commission 2022; OECD and European Observatory on Health Systems and Policies 2023).

Resource allocation closely mirrors policy priorities. Hospital care represents the largest share of spending (28–30%), covering acute admissions, surgical procedures, and intensive care. In 2021, there were more than 9 million hospitalizations, driven largely by population aging and the concentration of specialized public centers in fields such as oncology, cardiology, and neurosurgery (OECD and European Commission 2022).

Ambulatory care accounts for 22.4% of total expenditure and includes diagnostic services, specialist consultations, and rehabilitation. Italy records over 2.5 billion outpatient visits each year, with around 30% taking place in the more economically developed northern regions. Growing demand for specialist services—particularly cancer screening and advanced imaging—has contributed to rising costs in this area (de Belvis et al. 2022).

Pharmaceuticals and medical devices make up 17.8% of overall health spending. In 2021, this sector reached €24 billion, with 65% financed by public funds (Ministero della Salute 2024). The expanding use of targeted and biotechnological therapies, especially in oncology, has led to annual growth rates of 8–10% in pharmaceutical expenditure.

Long-term care represents 10.1% of total expenditure, primarily for the elderly, chronically ill, and disabled, delivered through home and residential services. More than 3 million elderly individuals required such care in 2021. However, regional disparities persist, especially in the South, where infrastructure and workforce shortages compromise service quality (Conferenza Stato–Regioni 2020; NHC 2024b; Guarducci et al. 2023; Guarducci et al. 2022; Nante et al. 2021).

Primary care and prevention constitute 10–15% of expenditure. Approximately €18 billion in 2021 was allocated to programs such as vaccination campaigns, chronic disease screening, and health education initiatives. During the COVID-19 pandemic, more than 85% of the population received vaccinations free of charge (AIFA 2021). The nationwide network of general practitioners and pediatricians—serving 98% of residents—plays a central role in chronic disease management and ongoing health monitoring (Ying et al. 2020; Conferenza Stato–Regioni 2020). Additional services, accounting for 5–10% of total expenditure, include public health administration, digital infrastructure such as electronic health records, telemedicine, emergency response systems, and epidemic preparedness and control (de Belvis et al. 2022).

China's healthcare system operates under a government-led framework supported by a diversified financing structure, with the goal of ensuring basic coverage for the entire population (ISS 2021). Health financing rests on three main pillars: public funding, social health insurance, and private expenditure. Public funds are directed toward essential services, including vaccination programs, chronic disease management, and maternal and child healthcare. Social insurance schemes—primarily UEBMI and URBMI—serve as the core safety net, complemented by a critical illness insurance fund that helps cover high-cost treatments. Out-of-pocket payments are mainly used for medications not included in reimbursement lists, premium services, and private healthcare.

According to the 2023 Statistical Report, total health expenditure reached 9.06 trillion yuan (6425.3 yuan per capita), representing 7.2% of GDP. This underscores the growing

economic importance of the health sector and the government's continued efforts to improve both quality and accessibility (SAMR 2022; ISS 2021).

Public expenditure accounted for 2.41 trillion yuan (26.7%), primarily financing public hospitals and essential services—from inpatient and emergency care to national immunization campaigns and chronic disease prevention programs. Targeted investments in central and western regions aim to narrow infrastructure gaps. Social health insurance contributed 46% of total spending (4.17 trillion yuan), mainly through UEBMI, URBMI, and critical illness coverage. Employers and institutions further enhance protection through supplementary insurance and subsidies, while private investment in healthcare infrastructure and innovation helps diversify services and strengthen system resilience.

Private spending made up 27.3% of total expenditure (2.48 trillion yuan), largely directed toward non-reimbursed medications, advanced diagnostic services, personalized health check-ups, and rehabilitation in private facilities—reflecting a rising demand for individualized and preventive healthcare (SAMR 2022).

Table 1 below summarizes the core differences between the two healthcare systems.

Table 1. Core differences between Italy and China health systems.

Dimension	Italy	China
Governance and organization	National health service with strong regional autonomy and nationally defined essential levels of care; mixed hospital-community delivery	Central and provincial stewardship of multiple basic medical insurance schemes; hierarchical delivery (primary–secondary–tertiary)
Financing mix	Predominantly tax-financed with modest co-payments	Mixed model combining government budget transfers, social health insurance contributions, and household out-of-pocket payments
Coverage design	Universal entitlement to essential levels of care regardless of employment status	Near-universal enrolment via employee and resident schemes with differing benefit packages; supplementary catastrophic coverage as a top-up
Cost-sharing profile	Broad exemptions for vulnerable groups; comparatively low out-of-pocket burden	Higher and more variable cost-sharing with local deductibles and ceilings; household payments remain salient
Primary care model	General-practitioner-centered continuity of care and chronic-care pathways	Expanding family-doctor contract services and incentivized gatekeeping, but strong patient preference for tertiary hospitals
Territorial equity	Marked North–South disparities in capacity, waiting times, and technology	Pronounced urban–rural and inter-provincial gaps in personnel, infrastructure, and benefits
Provider landscape	Predominantly public providers with selective private involvement.	Large public sector alongside rapid growth of private hospitals and commercial insurers
Digital health	Telemedicine scaled during the pandemic; progressive integration of electronic health records	Rapid expansion of telehealth, electronic prescriptions, online pharmacies, and interoperable records
Pharmaceutical policy	Rising expenditure on innovative therapies managed within the public benefits package	National price negotiations and formulary expansion, notably for oncology and rare-disease medicines
Selected quantitative indicators	Health expenditure: 8.7% of GDP (2021); physicians: 4.2/1000 in Lombardy vs. 2.9/1000 in Calabria	Health expenditure: 7.2% of GDP (2023); physicians: 3.82/1000 urban vs. 1.79/1000 rural

Overall, the comparison suggests that the main difference between the two systems lies not only in their financing mechanisms but also in the institutional logic through which resources are allocated. Italy prioritizes equal entitlement to essential services and accepts higher fiscal responsibility in exchange for universal coverage. China, in contrast, emphasizes progressive expansion of coverage through differentiated insurance schemes and targeted resource allocation. These alternative approaches reflect different policy priorities rather than different commitments to improving population health, illustrating how institutional context influences the balance between equity, efficiency, and financial sustainability.

7. Health and Social Challenges in Italy and China

7.1. Chronic Diseases

Non-communicable chronic diseases (NCDs) are characterized by gradual onset, prolonged progression, and complex recovery. They are multifactorial in origin, often only partially understood, and not attributable to infectious agents. These conditions include cardiovascular diseases (e.g., hypertension and stroke), cancers, diabetes, and chronic respiratory diseases. Non-communicable diseases (NCDs) are an increasingly pressing global health concern. According to the World Health Organization (2025), they are the leading cause of death worldwide, responsible for 41 million deaths each year—around 71% of all global deaths (NHC 2023; PAHO 2023). Their growing prevalence, closely linked to socioeconomic development and lifestyle changes, places heavy pressure on health systems and calls for urgent, integrated strategies focused on prevention and long-term management. In Italy, data from 2011 to 2014 show a stable trend in NCD-related mortality among people over 65 years of age (WHO 2024). This relative stability can be partly attributed to Italy's early demographic transition and its long-standing investment in a well-structured, mature healthcare system (Ying et al. 2020). A strong primary care model, centered on general practitioners, supports continuous and personalized management of chronic conditions. This approach has helped reduce hospital admissions and improve overall system efficiency (Ying et al. 2020; France et al. 2005). Preventive measures—including smoking bans, public health campaigns, and lifestyle interventions—have also generated tangible benefits, such as declines in smoking-related diseases (ISTAT 2017; Cesaroni et al. 2008). Nonetheless, population aging and rising healthcare costs driven by technological innovation continue to test the long-term sustainability of the Italian system, making further innovation and strategic resource allocation essential (Ying et al. 2020).

In China, data from 2011 to 2014 indicate a steady rise in deaths from cancer, cardiovascular diseases, and diabetes among individuals over 60, with cardiovascular diseases being the most common cause (Maccheroni et al. 2025). Chronic respiratory diseases remained relatively stable and represent a comparatively smaller public health burden. These trends reflect the rapid growth of the elderly population living with chronic conditions, increasing demands on the national health security system. Reimbursement rates in China currently vary, averaging around 60% for urban–rural resident insurance and 70% for employee insurance, with exact levels determined by local policies (Barone-Adesi et al. 2011; Yip et al. 2012). At the same time, population aging is shrinking the working-age population while raising the prevalence of chronic illness among older adults, further intensifying pressure on social welfare and healthcare systems. In response, China has introduced resource-optimization policies targeting vulnerable populations. A key measure is the implementation of annual expenditure thresholds for access to centralized health funds (deductibles), enabling local authorities to tailor eligibility criteria. Out-of-pocket costs below the threshold are not reimbursable, thereby prioritizing support for high-cost cases (Yip et al. 2023; ILO 2025).

7.2. Demographic Aging

Population aging, characterized by declining birth rates and increasing life expectancy, is progressively reshaping societal structures. According to international benchmarks, a population is considered "aged" when individuals over 60 years constitute more than 10%, or those over 65 years exceed 7% of the total population (The Commonwealth Fund 2023; IEG 2019).

Italy provides a compelling example of this demographic paradox. Despite possessing one of the most advanced health systems in the world, ranked first globally for the management of respiratory diseases, it faces growing challenges associated with population aging. In 2023, individuals aged 65 years or older accounted for 24.46% of the total population, an increase of four percentage points over a decade (GBD 2017 Italy Collaborators 2019; ISTAT 2024). Simultaneously, the 0–14-year age cohort declined to 12.2%, narrowing the contributor base and intensifying pressure on social care systems (ISTAT 2024).

China, following a different demographic trajectory, is experiencing a similar acceleration. Since the 1950s, three distinct baby boom cycles have produced demographic waves that now manifest in 217 million individuals over 65 years, growing at an annual rate of 4.5% since 2014 (ISTAT 2025; NBS 2024). Since officially entering an aging phase in 1999, China has experienced a steadily rising demand for geriatric care and long-term support services.

Both China and Italy now face similar challenges: optimizing resource allocation in the context of a shrinking workforce, expanding services tailored to age-related conditions, and maintaining a balance between financial sustainability and high-quality care. Population aging has therefore become a crucial test of how effectively health systems can adapt to changing social and demographic realities (Yip et al. 2019; UNDP 2024).

7.3. Health Inequalities: Regional and Economic Dimensions

In Italy, the decentralization established by Article 5 of the Constitution has resulted in significant regional disparities (Ying et al. 2020; NHC 2023). The northern regions, benefiting from stronger economies, provide higher-quality care, advanced technologies, and shorter waiting times (NHC 2024b). By contrast, southern regions such as Calabria and Sicily suffer from chronic underfunding, outdated infrastructure, and shortages of medical personnel, which drive substantial internal patient migration (AGENAS 2024; Toth 2014).

Similarly, in China, the long-standing urban–rural divide continues despite recent reforms (Naghavi et al. 2025; AGENAS 2023; Yip et al. 2012). Urban centers such as Beijing and Shanghai are equipped with advanced hospitals and highly specialized staff, while rural areas remain dependent on underfunded and less capable facilities (Eurostat 2018; AGENAS 2023). Patients from these regions often travel long distances to access advanced care, incurring prohibitive costs in the process (AGENAS 2023; Yip et al. 2012).

Both countries exemplify a broader pattern: territorial inequalities in healthcare mirror socioeconomic disparities and risk consolidating existing social divisions (Ying et al. 2020; AGENAS 2023).

In Italy, although essential healthcare services are publicly guaranteed, access to expensive treatments and private care options remains limited for lower-income groups (NHC 2024b; Zhao et al. 2021). Regional disparities further hinder equitable access, with "health tourism" driving substantial patient migration from less-resourced regions to better-equipped ones (AGENAS 2024; Fondazione GIMBE 2024).

In China, near-universal insurance coverage can mask ongoing inequalities (AGENAS 2023; European Commission and ESPN 2018). Urban residents generally enjoy more comprehensive benefits, while rural populations face lower reimbursement rates and higher

out-of-pocket costs—especially for chronic and serious illnesses—contributing to persistent risks of medical impoverishment (Naghavi et al. 2025; Wang et al. 2020b).

Despite their universal frameworks, both systems struggle to protect vulnerable populations, highlighting the urgent need for more equitable and targeted health strategies, especially in disadvantaged areas (Ying et al. 2020; NHC 2024b; AGENAS 2023).

7.4. Access to Healthcare for Vulnerable Populations

In both Italy and China, vulnerable groups encounter systemic barriers to healthcare. In Italy, migrants and undocumented workers face linguistic, legal, and bureaucratic obstacles that limit access to non-emergency services and continuity of care. Although urgent treatment is legally guaranteed, irregular legal status often restricts engagement in long-term healthcare pathways, with particularly severe consequences for mental health—the so-called invisible diseases of migrants (Yao et al. 2022; World Health Organization and Regional Office for Europe 2018).

In China, the Hukou system continues to restrict internal migrants' access to healthcare outside their registered residence (European Commission and ESPN 2018; Wang et al. 2020a). Although reimbursement reforms have been implemented, complex procedures and limited coverage still represent significant obstacles (Müller 2016; Zhou et al. 2024).

While Italy has emphasized community-based inclusion policies, such as multilingual services, and China has expanded interregional reimbursement and poverty-reduction health initiatives, both systems continue to face challenges in implementation (European Commission and ESPN 2018; Wang et al. 2020a; Yao et al. 2022). The central issue remains ensuring substantive rather than merely formal access to care for disadvantaged populations (NHC 2024b; AGENAS 2023).

7.5. Overburdened Centers of Excellence

Healthcare in both countries also demonstrates a tendency toward centralization. In Italy, northern hospitals—particularly those in Lombardy—serve as hubs for advanced diagnostics and highly specialized care, drawing patients from across the country (Ying et al. 2020; AGENAS 2019). This concentration creates heavy workloads and long waiting times in major centers, while local facilities elsewhere remain underused. As a result, peripheral healthcare services are weakened, and opportunities for professional development and training become more limited (NHC 2023; Toth 2014).

A comparable pattern can be observed in China. Tertiary hospitals in large cities such as Beijing and Shanghai often face persistent overcrowding, whereas rural hospitals struggle with limited resources and lower levels of public trust (Eurostat 2018; AGENAS 2023; Yip et al. 2019). Centralization thus reinforces inefficiencies, exacerbates inequalities, and deepens regional health divides (Naghavi et al. 2025; AGENAS 2023).

7.6. Deficits in Health Literacy and Education

Health education plays a crucial role in prevention and in the sustainability of healthcare systems, yet disparities remain marked. In Italy, southern regions and marginalized communities—such as migrants and low-income families—exhibit lower health awareness, limited access to preventive programs, and delayed care-seeking behaviors (Bevan et al. 2010; Esping-Andersen 1990). Language barriers and lower levels of education further limit people's ability to navigate the healthcare system effectively, particularly among migrant populations (Yao et al. 2022).

In China, although urban residents generally have higher health literacy and better access to digital health tools, rural communities continue to experience significant informational gaps (Bevan et al. 2010; Esping-Andersen 1990). Lower literacy levels, inadequate

infrastructure, and the need to prioritize basic economic survival often reduce participation in preventive healthcare initiatives (AGENAS 2023; Yip et al. 2019).

The outcome in both countries is a heavier burden of avoidable disease and greater strain on health systems. To mitigate these effects, tailored, equity-oriented health education strategies are essential. By enhancing communication, accessibility, and community awareness, both Italy and China can reduce health disparities and promote more proactive engagement with care (NHC 2024a).

Table 2 below summarizes the main challenges facing the two healthcare systems.

Table 2. Principal challenges (shared and system-specific).

Challenge Area	Italy	China
Population aging and long-term care	Rapid aging strains long-term care; stronger integration between health and social care is needed.	Fast-growing older population; scale-up of community and primary geriatric services required.
Chronic diseases	Mature general-practitioner networks, but cost growth (innovative drugs and technologies) pressures public budgets.	Rising burden among older adults; benefit ceilings and thresholds can limit financial protection.
Territorial inequalities	Persistent regional differentials; patient outflow from Southern regions.	Urban–rural divide in workforce, beds, and advanced services; migration toward metropolitan centers.
Workforce distribution	Shortages and uneven skill mix after years of fiscal restraint; waiting-time differentials.	Lower physician density in rural areas; overcrowding of tertiary hospitals.
Financial sustainability	Health spending as a share of gross domestic product remains below the European Union average; need to rebalance hospital and community spending.	Significant household out-of-pocket burden; regulation of private sector growth and transparent procurement are ongoing priorities.
System centralization	Centers of excellence overloaded; peripheral capacity underused.	Referral pathways not yet fully effective; congestion at top-tier hospitals.
Access for vulnerable groups	Administrative and language barriers for migrants; uneven uptake of preventive services.	Household registration system constrains portability; complex cross-region reimbursement.
Health literacy and prevention	Regional gradients in health literacy and screening adherence.	Persistent deficits in rural health education and digital access.
Technology governance	Need to scale telehealth and artificial intelligence with equity, safety, and interoperability standards.	Rapid digitalization requires stronger regulation, safety oversight, and equitable access mechanisms.

8. Discussion

The comparative analysis of the Italian and Chinese healthcare systems highlights distinct institutional trajectories but also strikingly convergent structural challenges. Both countries grapple with the tension between universality, financial sustainability, and equity in healthcare delivery (Zhang et al. 2017; WHO 2022; Liang and Langenbrunner 2013). From a theoretical perspective, the comparison can also be interpreted through the lens of welfare state theory and institutional path dependence. Although Italy broadly reflects the Beveridge model, characterized by universal tax-funded coverage, China has developed a state-led insurance model that combines public regulation with differentiated insurance arrangements. These institutional configurations shape not only financing mechanisms but also the distribution of responsibilities between central and local governments, the

degree of territorial variation, and the policy instruments available to address emerging demographic and epidemiological challenges. From this perspective, the comparison suggests that similar pressures do not necessarily produce institutional convergence. Rather, common challenges such as population aging, chronic disease, and territorial inequality are mediated by pre-existing financing and governance arrangements. This extends the existing literature by bringing institutional design, territorial implementation, and reform trajectories within the same comparative framework, rather than examining individual policy dimensions in isolation.

Italy's tax-funded universal model places strong emphasis on primary care integration and chronic disease management, making general practitioners pivotal in an aging society (Ying et al. 2020; NHC 2024a). However, the constitutional framework of regional autonomy, rooted in Article 5, has generated enduring territorial inequalities, particularly in the allocation of resources and infrastructural development (Siciliani et al. 2013; Bevan et al. 2010).

These disparities, most visible between northern and southern regions, have been further exposed during fiscal crises, when reliance on public financing has underscored systemic vulnerability (Ying et al. 2020; NHC 2024b).

This calls for diversified funding mechanisms capable of sustaining universal coverage without undermining its foundational ethos (France et al. 2005).

China, by contrast, demonstrates how emerging economies can expand healthcare coverage through segmented insurance schemes for urban and rural populations, complemented by rapid technological integration (Zhang et al. 2017; WHO 2022). The deployment of artificial intelligence and big data has significantly improved diagnostics and resource management. Yet, rural–urban inequalities persist, and market-driven incentives have at times encouraged unnecessary medicalization, underscoring the importance of stronger regulatory oversight (Naghavi et al. 2025; Corte dei conti 2025; Eurostat 2018; Zhang et al. 2017).

Despite following different development paths, both healthcare systems face comparable challenges. Future reforms must strike a careful balance between efficiency and equity, supported by adaptive governance that aligns local realities with international best practices (NHC 2024a). For Italy, strengthening territorial cohesion remains a central priority. More targeted fiscal transfers and better harmonization of national standards could help narrow the persistent divide between the North and the South. At the same time, expanding telemedicine and digital health platforms presents valuable opportunities to improve access to care for underserved and remote populations (Ying et al. 2020; NHC 2024a; Bevan et al. 2010).

China's reform priorities differ but are equally pressing. The polarization of healthcare provision demands substantial investment in rural infrastructures, the reinforcement of primary medical training, and the raising of reimbursement ceilings for chronic and severe illnesses (Naghavi et al. 2025; Zhang et al. 2017; Bevan et al. 2010).

Addressing postcode-based inequities requires sustained investment in rural health centers (Naghavi et al. 2025).

Financial sustainability represents another shared challenge. Italy could expand Diagnosis-Related Group (DRG)-based reimbursement systems to curb rising expenditures and reduce inefficiencies (Zhao et al. 2018). China, on the other hand, must focus on improving transparency in pharmaceutical procurement and regulating private-sector involvement to reduce household financial burdens while preserving public equity (Macabeo et al. 2023; Yuan et al. 2021).

Demographic transitions add a further layer of complexity. The rapid aging of both populations makes long-term care (LTC) reform unavoidable. In Italy, existing long-term

care (LTC) services need to be expanded and more effectively integrated with mental health and social support systems (Siciliani et al. 2013; Cavalieri et al. 2013). China faces comparable demographic pressures and must ensure that expanding elderly care services does not deepen the gap between urban and rural areas. Technological innovation represents both a shared opportunity and a point of divergence between the two systems. For Italy, this means strengthening investment in artificial intelligence, robotics, and digital health, supported by cross-border collaboration and public–private partnerships. Smart technologies for elderly care could significantly enhance both efficiency and quality of service (Liang and Langenbrunner 2013). China, while already advancing rapidly in medical innovation, requires stronger regulatory mechanisms to ensure ethical and safe deployment (WHO 2022).

Cross-national learning is therefore possible at the level of policy mechanisms rather than through direct institutional replication. Italy may draw lessons from China's rapid deployment of digital health tools and their use in connecting highly specialized centers with underserved areas. China, conversely, may draw on the Italian experience of universal entitlement, primary-care continuity, and nationally defined essential levels of care. In both cases, these lessons require adaptation to existing financing and governance arrangements. Taken together, these insights suggest that Italy and China, despite their distinct institutional legacies, share the imperative of building more equitable, efficient, and resilient healthcare systems. Their experiences demonstrate the need for context-sensitive reforms that address territorial and social inequalities while leveraging innovation for the benefit of vulnerable populations. At the same time, they highlight the potential of cross-national learning to support the global advancement of inclusive and sustainable healthcare.

The authors would like to point out that the comparison should not be interpreted as suggesting a direct transfer of policies from one country to the other, since the institutional arrangements are deeply embedded within different political, administrative, demographic, and economic contexts. Consequently, successful reforms cannot simply be replicated but must be adapted to local governance structures, financing capacities, and population needs. Rather than identifying universally transferable policies, the comparison points to selected mechanisms that may be adapted across institutional settings. These include nationally defined minimum standards combined with targeted territorial funding, stronger primary-care coordination, interoperable digital platforms linking peripheral and specialized services, and reimbursement mechanisms designed to improve financial protection for vulnerable populations. Their transferability depends on adaptation to each country's governance structure, financing capacity, and existing organization of service delivery.

9. Conclusions

Despite the notable differences in the institutional setting, the level of decentralization, and historical context of the two nations, some converging structural factors have been identified, which exert significant influence upon both healthcare systems. These include aging demographics, the rise in prevalence of chronic diseases, and persistent territorial inequalities. While these phenomena create common grounds for policy reform, the strategies to address them are quite distinctive—Italy relies on its decentralized, tax-funded universal healthcare system whereas China opts for its unique insurance-based model led by the state. Perhaps one of the most crucial issues of transformation is the increase in the role of preventative measures, including vaccination policies. Indeed, both countries have implemented extensive immunization programs; however, there is considerable variation in terms of effectiveness, reliability of vaccines provided, and the ability to reach the older population. Thus, in order to enhance system sustainability and reduce the burden on the healthcare system, the priority would be to improve the rates of vaccine uptake.

Furthermore, digital health becomes a prominent feature of contemporary transformations in healthcare. Indeed, in China, significant strides have been made in the sphere of developing digital platforms and using advanced technologies in delivering healthcare services to the patients. Italy also shows some progress in using e-health technologies, although the lack of coherence in implementing reforms at the regional level remains an issue. Thus, not only the introduction of new tools should be considered: it is also important to align institutions and ensure the interoperability of digital health systems.

The third major issue of reform relates to public–private partnerships (PPPs). In fact, both countries are characterized by the presence of private health facilities providing medical services to patients. However, the extent of PPPs is different in the two cases. For instance, China promotes the development of partnerships with the private sector in order to increase its capabilities. In Italy, private providers complement the universal system, which implies some additional opportunities for addressing healthcare capacity issues.

Last but not least, it is expected that healthcare financing will become an important determinant of future transformations in healthcare systems. Specifically, the Italian tax-funded approach is faced with rising difficulties related to the demographic trend and limited fiscal capacity. Thus, it is important to consider the possibility of modifying resource allocation approaches in order to achieve better balance. As for China, there is a need to reduce reliance on the out-of-pocket payments in financing healthcare. In general, the findings obtained during this comparison prove that cross-national learning can lead to important insights despite significant differences in the institutional settings. More specifically, Italy may draw lessons from the scale and speed of China's digital-health implementation, while China may draw on the Italian experience of universal entitlement and primary-care continuity. These mechanisms cannot be transferred unchanged, but they illustrate how cross-national learning can inform context-sensitive reform.

In conclusion, it can be stated that focusing on primary care, implementing prevention and digital innovations, optimizing cooperation between public and private sectors, and ensuring financing will be key steps towards achieving resilience and promoting equity in healthcare.

Author Contributions: Conceptualization, F.G. and G.R.; methodology, F.G. and G.R.; software not applicable; validation, F.G., G.R. and G.N.; formal analysis, F.G. and G.R.; investigation, G.R., G.N. and A.B.; resources, G.N., A.B. and J.L.; data curation, G.R., G.N. and A.B.; writing—original draft preparation, F.G. and G.R.; writing—review and editing, F.G., G.R., G.N., A.B., J.L., T.S. and P.B.; visualization, G.N. and A.B.; supervision, F.G. and P.B.; project administration, F.G., G.R. and P.B. All authors have read and agreed to the published version of the manuscript.

Funding: This research received no external funding.

Institutional Review Board Statement: Not applicable.

Informed Consent Statement: Not applicable.

Data Availability Statement: No new data were created or analyzed in this study. Data sharing is not applicable to this article.

Acknowledgments: During the preparation of this manuscript/study, the authors used DeepL and ChatGPT 5 for the purposes of text editing to improve fluency, syntax, and grammar. The authors have reviewed and edited the output and take full responsibility for the content of this publication. No data or content was generated by AI, and all information was manually written and discussed by the authors. The meaning of each sentence was double-checked by all authors, and in cases of discrepancies, the original version was restored.

Conflicts of Interest: The authors declare no conflicts of interest.

Abbreviations

The following abbreviations are used in this manuscript:

BMI	Basic Medical Insurance (China)
CNY	Chinese Yuan (Renminbi)
DRG	Diagnosis-Related Group
EU	European Union
FSN	Fondo Sanitario Nazionale (Italy's National Health Fund)
GDP	Gross Domestic Product
LEA	Livelli Essenziali di Assistenza (Essential Levels of Care)
LTC	Long-Term Care
MRI	Magnetic Resonance Imaging
NCD	Non-Communicable Disease
OECD	Organisation for Economic Co-operation and Development
SSN	Servizio Sanitario Nazionale (Italian National Health Service)
UEBMI	Urban Employee Basic Medical Insurance
UHC	Universal Health Coverage
URBMI	Urban Resident Basic Medical Insurance
URRMI	Urban–Rural Resident Basic Medical Insurance
WHO	World Health Organization

References

Agenzia Italiana del Farmaco (AIFA). 2021. *L'uso dei Farmaci in Italia—Rapporto OsMed 2021*; Roma: Agenzia Italiana del Farmaco. Available online: https://www.aifa.gov.it/-/L-uso-dei-farmaci-in-italia-rapporto-osmed-2021 (accessed on 15 February 2026).

Agenzia Nazionale per i Servizi Sanitari Regionali (AGENAS). 2019. *Linee Guida per il Monitoraggio Nazionale sui Tempi di Attesa (PNGLA)*. Roma: Agenzia Nazionale per i Servizi Sanitari Regionali. Available online: https://alpi.agenas.it/Doc/PNGLA2019.pdf (accessed on 15 March 2026).

Agenzia Nazionale per i Servizi Sanitari Regionali (AGENAS). 2021. *Reti Tempo-Dipendenti: Seconda Indagine Nazionale 2021*; Roma: Agenzia Nazionale per i Servizi Sanitari Regionali. Available online: https://www.agenas.gov.it/images/agenas/In%20primo%20piano/2021/reti/Report_Reti_Tempo_dipendenti.pdf (accessed on 15 March 2026).

Agenzia Nazionale per i Servizi Sanitari Regionali (AGENAS). 2023. *La Mobilità Sanitaria Interregionale—Dati 2022*; Roma: Agenzia Nazionale per i Servizi Sanitari Regionali. Available online: https://www.agenas.gov.it/images/2023/mobilita_sanitaria/Comunicato_stampa_Mobilit%C3%A0_sanitaria_interregionale.pdf (accessed on 12 February 2026).

Agenzia Nazionale per i Servizi Sanitari Regionali (AGENAS). 2024. *La Mobilità Sanitaria in ITALIA—Edizione 2023*; Roma: Agenzia Nazionale per i Servizi Sanitari Regionali. Available online: https://www.agenas.gov.it/images/agenas/monitor/quaderno/mobilita-sanitaria/Mobilita-sanitaria-nazionale.pdf (accessed on 12 February 2026).

Barone-Adesi, Francesco, Antonio Gasparrini, Laura Vizzini, Franco Merletti, and Lorenzo Richiardi. 2011. Effects of Italian Smoking Regulation on Rates of Hospital Admission for Acute Coronary Events: A Country-Wide Study. *PLoS ONE* 6: e17419. [CrossRef] [PubMed]

Bevan, Gwyn, Hans K. Helderman, and David Wilsford. 2010. Changing Choices in Health Care: Implications for Equity, Efficiency and Cost. *Health Economics, Policy and Law* 5: 251–67. [CrossRef] [PubMed]

Blumenthal, David, and William C. Hsiao. 2015. Lessons from the East—China's Rapidly Evolving Health Care System. *New England Journal of Medicine* 372: 1281–85. [CrossRef] [PubMed]

Borgonovi, Elio, and Amelia Compagni. 2013. Sustaining Universal Health Coverage: The Interaction of Social, Political, and Economic Sustainability. *Value in Health* 16: S34–S38. [CrossRef] [PubMed]

Cavalieri, Marina, Lorenzo Gitto, and Calogero Guccio. 2013. Reimbursement Systems and Quality of Hospital Care: An Empirical Analysis for Italy. *Health Policy* 111: 273–89. [CrossRef] [PubMed]

Cesaroni, Giulia, Francesco Forastiere, Nadia Agabiti, Pasquale Valente, Piergiorgio Zuccaro, and Carlo A. Perucci. 2008. Effect of the Italian Smoking Ban on Population Rates of Acute Coronary Events. *Circulation* 117: 1183–88. [CrossRef] [PubMed]

Conferenza Stato–Regioni. 2020. *Indicazioni Nazionali per L'erogazione di Prestazioni in Telemedicina (Rep. Atti n. 215/CSR, 17 Dicembre 2020)*; Roma: Conferenza Stato–Regioni.

Conferenza Stato–Regioni. 2021. *Repertorio Atto n. 152/CSR—Riparto FSN 2021*; Roma: Conferenza Stato–Regioni.

Coppola, Francesco S., Stefano Capasso, and Luca Russo. 2008. Profili evolutivi del SSN Italiano: Analisi e sintesi della produzione normativa dal 1978 ad oggi. Paper presented at XX Conferenza della Società Italiana di Economia Pubblica, Pavia, Italy, September 24–26.

Corte dei conti, Sezioni Riunite in sede di controllo. 2025. *I Quaderni del Rapporto sul Coordinamento della Finanza Pubblica. Quaderno n. 4: La Sanità in Cammino per il Cambiamento*; Roma: Corte dei conti.

Cylus, Jonathan, Irene Papanicolas, and Peter C. Smith, eds. 2016. *Health System Efficiency: How to Make Measurement Matter for Policy and Management*. Health Policy Series, no. 46. Copenhagen: European Observatory on Health Systems and Policies. ISBN 978-92-890-5041-8.

de Belvis, Antonio Giulio, Michela Meregaglia, Alisha Morsella, Andrea Adduci, Alessio Perilli, Fidelia Cascini, Alessandro Solipaca, Giovanni Fattore, Walter Ricciardi, Anna Maresso, and et al. 2022. Italy: Health System Review. *Health Systems in Transition* 24: 1–236. [CrossRef] [PubMed]

Esping-Andersen, Gøsta. 1990. *The Three Worlds of Welfare Capitalism*. Princeton: Princeton University Press.

European Commission, and European Social Policy Network (ESPN). 2018. *Inequalities in Access to Healthcare: Italy (ESPN Thematic Report)*. Luxembourg: European Commission. Available online: https://ec.europa.eu/social/BlobServlet?docId=20359&langId=en (accessed on 15 March 2026).

Eurostat. 2018. *Healthcare Personnel Statistics—Physicians*. Luxembourg: European Commission. Available online: https://ec.europa.eu/eurostat/statistics-explained/index.php?title=Healthcare_personnel_statistics_-_physicians (accessed on 15 March 2026).

Fattore, Giovanni, Dino Numerato, and Domenico Salvatore. 2023. Do Policies Affect Management? Evidence from a Survey of Clinicians of the Italian National Health Service. *Health Services Management Research* 36: 25–33. [CrossRef] [PubMed]

Fondazione GIMBE. 2024. *Mobilità Sanitaria Interregionale 2021*. Bologna: Fondazione GIMBE. Available online: https://www.gimbe.org/osservatorio/Report_Osservatorio_GIMBE_2024.01_Mobilita_sanitaria_2021.pdf (accessed on 12 February 2026).

France, George, Francesco Taroni, and Andrea Donatini. 2005. The Italian Health-Care System. *Health Economics* 14: S187–S202. [CrossRef] [PubMed]

Gazzetta Ufficiale della Repubblica Italiana. 2023. *Fondo Sanitario Nazionale 2021: Rettifica della Delibera CIPESS n. 70 del 2021 "FSN 2021—Riparto delle Disponibilità Finanziarie per il Servizio Sanitario Nazionale"*. *Gazzetta Ufficiale della Repubblica Italiana*; Serie Generale, no. 36, 13 febbraio 2023. Roma: Istituto Poligrafico e Zecca dello Stato. Available online: https://ricerca-delibere.programmazioneeconomica.gov.it/media/docs/2022/E220050.pdf (accessed on 8 January 2026).

GBD 2017 Italy Collaborators. 2019. Italy's Health Performance, 1990–2017: Findings from the Global Burden of Disease Study 2017. *The Lancet Public Health* 4: e645–57. [CrossRef] [PubMed]

General Office of the National Health Commission of the People's Republic of China, Comprehensive Department of the National Administration of Traditional Chinese Medicine, and General Office of the National Disease Control Administration. 2023. *Notice on the "High-Quality Primary Healthcare" Campaign and Three-Year Action for Community Hospitals*; Beijing: National Health Commission of the People's Republic of China. Available online: https://www.nhc.gov.cn/wjw/c100175/202401/d5a6227e6f3f48bc9d6333a7c6c8eb20.shtml (accessed on 12 February 2026).

Guarducci, Giovanni, Davide Golinelli, Luca Spadea, Giuliana Fabbri, and Nicola Nante. 2025. Is Cooperation Better than Competition? Evidence from Patient Mobility before and after the COVID-19 Pandemic in Tuscany, Italy. *Frontiers in Public Health* 13: 1551574. [CrossRef] [PubMed]

Guarducci, Giovanni, Gabriele Messina, Simona Carbone, and Nicola Nante. 2023. Identifying the Drivers of Inter-Regional Patients' Mobility: An Analysis on Hospital Beds Endowment. *Healthcare* 11: 2045. [CrossRef] [PubMed]

Guarducci, Giovanni, Gabriele Messina, Simona Carbone, Andrea Urbani, and Nicola Nante. 2022. Inter-Regional Patients' Migration for Hospital Orthopedic Intensive Rehabilitation: The Italian Experience. *International Journal of Environmental Research and Public Health* 19: 13726. [CrossRef] [PubMed]

Independent Evaluation Group, World Bank. 2019. *World Bank Support to Aging Countries: Approach Paper*. Washington, DC: World Bank. Available online: https://documents1.worldbank.org/curated/en/870611561130594816/pdf/World-Bank-Support-to-Aging-Countries-Approach-Paper.pdf (accessed on 15 March 2026).

International Labour Organization (ILO). 2025. *China's Experience in Pursuing Universal Health Coverage*. Geneva: International Labour Office. Available online: https://www.ilo.org/publications/china%E2%80%99s-experience-pursuing-universal-health-coverage (accessed on 12 February 2026).

Istituto Nazionale di Statistica (ISTAT). 2017. *L'evoluzione della Mortalità per Causa: Le Prime 25 Cause di Morte (Anni 2003–2014)*. Roma: Istituto Nazionale di Statistica. Available online: https://www.istat.it/it/files/2017/05/Report-cause-di-morte-2003-14.pdf (accessed on 8 January 2026).

Istituto Nazionale di Statistica (ISTAT). 2024. *Annuario Statistico Italiano 2024. Capitolo: Popolazione e Famiglie*. Roma: Istituto Nazionale di Statistica. Available online: https://www.istat.it/storage/ASI/2024/capitoli/C03.pdf (accessed on 8 January 2026).

Istituto Nazionale di Statistica (ISTAT). 2025. *Indicatori Demografici—Anno 2024 (Aggiornamento)*. Roma: Istituto Nazionale di Statistica. Available online: https://www.istat.it/wp-content/uploads/2025/03/Indicatori_demografici_2024.pdf (accessed on 15 March 2026).

Istituto Superiore di Sanità (ISS). 2021. *Vaccinazioni—Coperture e Documenti 2021 (Sezioni e Bollettini di Sorveglianza 2021)*. Roma: Istituto Superiore di Sanità. Available online: https://www.epicentro.iss.it/vaccini/2021 (accessed on 8 January 2026).

Li, Ling, and Hua Fu. 2017. China's Health Care System Reform: Progress and Prospects. *The International Journal of Health Planning and Management* 32: 240–53. [CrossRef] [PubMed]

Li, Xiaoyun, Harlan M. Krumholz, Winnie Yip, Ke Xu, Hong Wang, Qingyue Meng, and Chen Zhu. 2020. Quality of Primary Health Care in China: Challenges and Recommendations. *The Lancet* 395: 1802–12. [CrossRef] [PubMed]

Liang, Lilin, and Jack C. Langenbrunner. 2013. The Long March to Universal Health Coverage: Outside Looking in. *Chinese Journal of Health Policy* 6: 1–3.

Liu, Gordon G., Samantha A. Vortherms, and Xiaohong Hong. 2017. China's Health Reform Update. *Annual Review of Public Health* 38: 431–48. [CrossRef] [PubMed]

Luo, Da, Xumin Zhu, Xinyu Qiu, Jing Zhao, Xiangfei Li, and Yue Du. 2024. Healthcare Preferences of Chronic Disease Patients under China's Hierarchical Medical System: An Empirical Study of Tianjin's Reform Practice. *Scientific Reports* 14: 11631. [CrossRef] [PubMed]

Macabeo, Bérengère, Liam Wilson, Jianwei Xuan, Ruichen Guo, Petar Atanasov, Linda Zheng, Clement François, and Philippe Laramée. 2023. Access to Innovative Drugs and the National Reimbursement Drug List in China: Changing Dynamics and Future Trends in Pricing and Reimbursement. *Journal of Market Access & Health Policy* 11: 2218633. [CrossRef] [PubMed]

Maccheroni, Carlo, Nadia Mignolli, Roberta Pace, and Giuseppe Venere. 2025. Older Adult Surge and Social Welfare Inequalities in Italy: The Impact of Population Ageing on Pensions and the Welfare System. *Populations* 1: 9. [CrossRef]

Masseria, Cristina, and Massimo Giannoni. 2010. Equity in Access to Health Care in Italy: A Disease-Based Approach. *European Journal of Public Health* 20: 504–10. [CrossRef] [PubMed]

Ministero della Salute. 2023a. *Disposizioni per la Prevenzione e la cura del Diabete Mellito. Relazione 2023: Stato delle Conoscenze e delle Nuove Acquisizioni in Tema di Diabete Mellito*; Roma: Ministero della Salute. Available online: https://www.salute.gov.it/new/sites/default/files/imported/C_17_pubblicazioni_3480_allegato.pdf (accessed on 18 February 2026).

Ministero della Salute. 2023b. *Monitoraggio dei LEA attraverso il Nuovo Sistema di Garanzia: Metodologia e Risultati dell'Anno 2021*; Roma: Ministero della Salute. Available online: https://www.salute.gov.it/new/it/pubblicazione/monitoraggio-dei-lea-attraverso-il-nuovo-sistema-di-garanzia-relazione-2023/ (accessed on 24 February 2026).

Ministero della Salute, and Istituto Superiore di Sanità. 2022. *Infezioni da SARS-CoV-2, Ricoveri e Decessi Associati a COVID-19 Direttamente Evitati Dalla Vaccinazione (27/12/2020–31/01/2022)*. Roma: Ministero della Salute and Istituto Superiore di Sanità. Available online: https://asvis.it/public/asvis2/files/Doc_gruppi_di_lavoro/ISS_Min_Sal_morti_e_contagi_evitati_2020-2022__4_22.pdf (accessed on 13 March 2026).

Ministero della Salute, Direzione Generale della Programmazione Sanitaria. 2024. *Rapporto Annuale Sull'attività di Ricovero Ospedaliero: Dati SDO 2021*; Roma: Ministero della Salute.

Mladovsky, Philipa, Sara Allin, Cristina Masseria, Cristina Hernández-Quevedo, David McDaid, and Elias Mossialos. 2009. *Health in the European Union: Trends and Analysis*. Copenhagen: World Health Organization on Behalf of the European Observatory on Health Systems and Policies.

Mucelli, Attilio, and Francesca Spigarelli, eds. 2017. *Healthcare Policies and Systems in Europe and China: Comparisons and Synergies*. Singapore: World Scientific. [CrossRef]

Müller, Antonia. 2016. Hukou and Health Insurance Coverage for Migrant Workers in China. *Journal of Current Chinese Affairs* 45: 53–82. [CrossRef]

Naghavi, Mohsen, Giulia Zamagni, Cristiana Abbafati, Benedetta Armocida, Antonella Agodi, Giovanni Alicandro, Caterina Andrei, Francesco Azzolini, Marina Bellini, Silvio Brusaferro, and et al. 2025. State of Health and Inequalities among Italian Regions from 2000 to 2021: A Systematic Analysis Based on the Global Burden of Disease Study 2021. *The Lancet Public Health* 10: e309–20. [CrossRef] [PubMed]

Nante, Nicola, Giulia Guarducci, Chiara Lorenzini, Giulia Messina, Francesco Carle, Silvia Carbone, and Andrea Urbani. 2021. Inter-Regional Hospital Patients' Mobility in Italy. *Healthcare* 9: 1182. [CrossRef] [PubMed]

National Bureau of Statistics of China. 2024. *Statistical Communiqué of the People's Republic of China on the 2023 National Economic and Social Development*; Beijing: National Bureau of Statistics of China. Available online: https://www.stats.gov.cn/english/PressRelease/202402/t20240228_1947918.html (accessed on 18 January 2026).

National Health Commission of the People's Republic of China. 2022. *Guiding Opinions on Promoting the High-Quality Development of Family Doctor Contracted Services*; Beijing: National Health Commission of the People's Republic of China. Available online: https://www.nhc.gov.cn/jws/c100073/202203/ae7fd08b2d4545a9a2032a4cb8de5951.shtml (accessed on 14 February 2026).

National Health Commission of the People's Republic of China. 2023. *China Health Statistical Yearbook 2023*; Beijing: National Health Commission of the People's Republic of China and Peking Union Medical College Press. Available online: https://www.nhc.gov.cn/mohws-bwstjxxzx/tjtjnj/202501/8193a8edda0f49df80eb5a8ef5e2547c.shtml (accessed on 9 March 2026).

National Health Commission of the People's Republic of China. 2024a. *Interpretation of the 2023 Statistical Bulletin on the Development of Health Undertakings* (2023年我国卫生健康事业发展统计公报解读); Beijing: National Health Commission of the People's Republic of China. Available online: https://www.nhc.gov.cn/wjw/c100178/202408/90e39fe93f0b48019d3ac34036f64b81.shtml (accessed on 23 March 2026).

National Health Commission of the People's Republic of China. 2024b. *Reply to NPC Proposal No. 6951 (Share of Visits at Primary Level, 2023 = 52%)*; Beijing: National Health Commission of the People's Republic of China. Available online: https://www.nhc.gov.cn/wjw/jiany/202408/d4799843fa2f435d85df745ce988cf79.shtm (accessed on 14 April 2026).

Organisation for Economic Co-Operation and Development, and European Commission. 2022. *Health at a Glance: Europe 2022*. Paris: OECD Publishing. [CrossRef]

Organisation for Economic Co-Operation and Development, and European Observatory on Health Systems and Policies. 2021. *Italy: Country Health Profile 2021*. State of Health in the EU. Paris: OECD Publishing. Brussels: European Observatory on Health Systems and Policies. [CrossRef]

Organisation for Economic Co-Operation and Development, and European Observatory on Health Systems and Policies. 2023. *Italy: Country Health Profile 2023*. State of Health in the EU. Paris: OECD Publishing. Brussels: European Observatory on Health Systems and Policies.

Pan American Health Organization (PAHO). 2023. *Noncommunicable Diseases*. Washington, DC: Pan American Health Organization. Available online: https://www.paho.org/en/topics/noncommunicable-diseases (accessed on 18 February 2026).

Ricciardi, Walter, and Rosanna Tarricone. 2021. The Evolution of the Italian National Health Service. *The Lancet* 398: 2193–206. [CrossRef] [PubMed]

Siciliani, Luigi, Michael Borowitz, and Valerie Moran, eds. 2013. *Waiting Time Policies in the Health Sector: What Works?* OECD Health Policy Studies. Paris: OECD Publishing.

State Administration for Market Regulation. 2022. *Provisions for the Supervision and Administration of Online Drug Sales (Decree No. 58; Promulgated 3 August 2022; Effective 1 December 2022)* (药品网络销售监督管理办法); Beijing: State Administration for Market Regulation. Available online: https://www.gov.cn/gongbao/content/2022/content_5717002.htm (accessed on 19 January 2026).

Tan, Xiaohui, Yi Zhang, and Hong Shao. 2019. Healthy China 2030, a Breakthrough for Improving Health. *Global Health Promotion* 26: 96–99. [CrossRef] [PubMed]

The Commonwealth Fund. 2023. China. *International Health Care System Profiles*. Available online: https://www.commonwealthfund.org/international-health-policy-center/countries/china (accessed on 12 April 2026).

Toth, Federico. 2014. How Health Care Regionalisation in Italy Is Widening the North–South Gap. *Health Economics, Policy and Law* 9: 231–49. [CrossRef] [PubMed]

United Nations Development Programme (UNDP). 2024. *China in Numbers 2023*. Beijing: United Nations Development Programme. Available online: https://www.undp.org/china/publications/china-numbers-2023 (accessed on 8 May 2026).

Wang, Jie, Hui Zhu, Hui Liu, Ke Wu, Xin Zhang, Miaomiao Zhao, Hang Yin, Xinye Qi, Yanhua Hao, Ye Li, and et al. 2020a. Can the Reform of Integrating Health Insurance Reduce Inequity in Catastrophic Health Expenditure? Evidence from China. *International Journal for Equity in Health* 19: 49. [CrossRef] [PubMed]

Wang, Yuxi, Adriana Castelli, Qi Cao, and Dan Liu. 2020b. Assessing the Design of China's Complex Health System—Concerns on Equity and Efficiency. *Health Policy Open* 1: 100021. [CrossRef] [PubMed]

World Health Organization. 2020. *World Health Statistics 2020: Monitoring Health for the SDGs, Sustainable Development Goals*. Geneva: World Health Organization. Available online: https://www.who.int/publications/i/item/9789240005105 (accessed on 8 May 2026).

World Health Organization. 2022. *Tracking Universal Health Coverage: 2021 Global Monitoring Report*. Geneva: World Health Organization. Available online: https://www.who.int/publications/i/item/9789240040618 (accessed on 8 May 2026).

World Health Organization. 2024. *Noncommunicable Diseases: Mortality—Global Health Observatory*. Geneva: World Health Organization. Available online: https://www.who.int/data/gho/data/themes/topics/topic-details/GHO/ncd-mortality (accessed on 8 May 2026).

World Health Organization. 2025. *Noncommunicable Diseases*. Geneva: World Health Organization. Available online: https://www.who.int/news-room/fact-sheets/detail/noncommunicable-diseases (accessed on 3 March 2026).

World Health Organization and Regional Office for Europe. 2018. *Report on the Health of Refugees and Migrants in the WHO European Region: No Public Health without Refugee and Migrant Health*. Copenhagen: WHO Regional Office for Europe. Available online: https://www.who.int/publications/i/item/health-of-refugees-and-migrants---who-european-region-%282018%29 (accessed on 8 May 2026).

Yao, Qian, Hongyan Li, and Chengxiang Liu. 2022. Use of Social Health Insurance for Hospital Care by Internal Migrants in China—Evidence from the 2018 China Migrants Dynamic Survey. *Frontiers in Public Health* 10: 1008720. [CrossRef] [PubMed]

Yi, Baokang. 2021. An Overview of the Chinese Healthcare System. *HepatoBiliary Surgery and Nutrition* 10: 93–95. [CrossRef] [PubMed]

Ying, Meiling, Sijiu Wang, Chen Bai, and Yue Li. 2020. Rural-Urban Differences in Health Outcomes, Healthcare Use, and Expenditures among Older Adults under Universal Health Insurance in China. *PLoS ONE* 15: e0240194. [CrossRef] [PubMed]

Yip, Winnie, Hua Fu, Angela T. Chen, Stephen Z. Zhai, Weijie Jian, Matthew Xu, Kumanan Rasanathan, and William C. Hsiao. 2019. 10 Years of Health-Care Reform in China: Progress and Gaps in Universal Health Coverage. *The Lancet* 394: 1192–204. [CrossRef] [PubMed]

Yip, Winnie, Hua Fu, Weili Jian, Jue Liu, Jay Pan, Duo Xu, Hanmo Yang, and Tiemin Zhai. 2023. Universal Health Coverage in China Part 2: Addressing Challenges and Recommendations. *The Lancet Public Health* 8: e1035–42. [CrossRef] [PubMed]

Yip, Winnie C., William C. Hsiao, Wen Chen, Shanlian Hu, Jin Ma, and Alan Maynard. 2012. Early Appraisal of China's Huge and Complex Health-Care Reforms. *The Lancet* 379: 833–42. [CrossRef] [PubMed]

Yuan, Jing, Z. Kevin Lu, Xiaomo Xiong, and Bin Jiang. 2021. Lowering Drug Prices and Enhancing Pharmaceutical Affordability: An Analysis of the National Volume-Based Procurement (NVBP) Effect in China. *BMJ Global Health* 6: e005519. [CrossRef] [PubMed]

Zhang, Xue, Matthew E. Dupre, Lijuan Qiu, Zhou Yang, and Xiangyu Zhou. 2017. Urban–Rural Differences in the Association between Access to Healthcare and Health Outcomes among Older Adults in China. *BMC Geriatrics* 17: 151. [CrossRef] [PubMed]

Zhao, Chunlin, Cheng Wang, Cheng Shen, and Qian Wang. 2018. China's Achievements and Challenges in Improving Health Insurance Coverage. *Drug Discoveries & Therapeutics* 12: 1–6. [CrossRef] [PubMed]

Zhao, Dan, Zhiyong Zhou, Cheng Shen, Rashed Nawaz, Dan Li, Yangling Ren, Yaxin Zhao, Dan Cao, and Xiaohui Zhai. 2021. Rural and Urban Differences in Patient Experience in China: A Coarsened Exact Matching Study from the Perspective of Residents. *BMC Health Services Research* 21: 330. [CrossRef] [PubMed]

Zhao, Yaohui, Yisong Hu, James P. Smith, John Strauss, and Gonghuan Yang. 2014. Cohort Profile: The China Health and Retirement Longitudinal Study (CHARLS). *International Journal of Epidemiology* 43: 61–68. [CrossRef] [PubMed]

Zhou, Maigeng, Haidong Wang, Xinyue Zeng, Peng Yin, Jun Zhu, Wanqing Chen, Haidong Yang, Yichong Li, Xing Zhao, Yanfang Wang, and et al. 2019. Mortality, Morbidity, and Risk Factors in China and Its Provinces, 1990–2017: A Systematic Analysis for the Global Burden of Disease Study 2017. *The Lancet* 394: 1145–58. [CrossRef] [PubMed]

Zhou, Meng, Lei Zhang, Ying Liang, and Yuxiao Chen. 2024. The Effect of Trans-Provincial Immediate Reimbursement for Healthcare Expenses on Inequity in the Utilization of Healthcare Services for Migrants. *International Journal for Equity in Health* 23: 49. [CrossRef] [PubMed]

Disclaimer/Publisher's Note: The statements, opinions and data contained in all publications are solely those of the individual author(s) and contributor(s) and not of MDPI and/or the editor(s). MDPI and/or the editor(s) disclaim responsibility for any injury to people or property resulting from any ideas, methods, instructions or products referred to in the content.