Focosi. Top Ital. sci. j. 2025;2(3)
https://www.doi.org/10.62684/YJKJ6217

Top Italian Scientists Journal

Open Access | Editorial | Social Sciences

ISSN 3033-5132

Gerontocracy and Cronyism in the Italian National Health System

Daniele Focosi

Pisa University Hospital, Pisa, Italy

Correspondence to: Daniele Focosi, daniele.focosi@gmail.com .

Published: 1 Jun 2025

Abstract

Gerontocracy, the centralization of political power in elderlies, is often a consequence of demographic crises. In particular gerontocracy paves to way to self-perpetuating cronyism, which represents a relevant hurdle against progress in societies. Unfortunately, gerontocratic societies are also prone to suffer from cronyistic health systems. In this manuscript, I dissect evidences supporting the cronyistic state of the Italian health system, their causes oand their dismal consequences on both immediate services to the citizenship and long-term sustainability of the system itself. I finally advocate an urgent reform of selective criteria that focus on objective meritocracy and the introduction of robust term limits.

Keywords: gerontocracy, cronyism, italian national health system

Editorial

Traditionally, age has been associated with positive behavioral traits, such as savory, experience, and competence, as opposed to instinctive behaviors of youth. In a fast-changing world, this is no longer the case, with age being associated with difficulties to adapt to rapidly-emerging novelties.

According to EuroStat 2023 report, Italians have the second longest life expectancy at birth (83.8 years), the second highest ratio between the share of population above 65 and the one 15-65 years (37.8%), as well as one of the lowest fertility rates (6.4 newborns per 1,000 inhabitants per year). With the highest median age across Europe (48.4 years, when it was 44 years in 2013), Italy is now facing a demographic short-circuit: under a publicly-funded social system, annuities to retired citizens have to be paid by young workers, but the number belonging to the latter category is no longer sufficient. Data from the 2024 Italian ISTAT survey demonstrated a fertility rate as low as 1.18 per female and 24.7% of the population above age 65 [1]. Demographic projections for 2050 show that 35% of Italians will be older than 65 years, and only 11.7% will be younger than 14 years[2]. Italy is serving as a nowcast model for most of the westernized countries, which will face Italy-like demographic settings in the coming decades. Despite immigratory fluxes can partially compensate population ageing, immigrants tend to reduce their fertility rates until they approach the one of their new country. The ever-growing public debt is making things even harder in Italy. The immediate solution repeatedly issued by governments has been delaying the age for retirement, which clearly delays the entry of young persons into the workforces, causing the second highest age at which youngs leave their homes among the Europeans (30 years), and emigration (approximatively 25,000 per year, of whom 70% is 18-50 years old). This is unlikely to change, given that politicians have to look for votes from elderlies, who use to think individually to their descendants, rather than at a social level. As a proof for that, in 2013 the youngest political party in Italy (5-Star Movement) was voted by half of citizens below age 25, but only 12% above age 65.

In a single word, all of this can be called "**gerontocracy**" [3]: by restricting powers to a few hundreds individuals in Italy [4], gerontocracy is stalling the growth of the entire country. Outside the political sphere, gerontocracy may be observed in other institutional hierarchies of various kinds. Historically, the demoscopic mark of a gerontocracy is the presence of a substantial number

of septuagenarian or octogenarian leaders, but under the current fast-changing epoch even people in their 60's can be too old to keep the pace of progressing knowledge. Gerontocracy paves the way to "**cronyism**", a specific form of in-group favoritism, the spoils system practice of partiality in awarding jobs and other advantages to friends or trusted colleagues. For example, cronyism occurs when appointing "cronies" to positions of authority regardless of their qualifications. This is in contrast to **meritocracy**, in which appointments are made based on merit. Many democratic governments are encouraged to practice administrative transparency in accounting and contracting, but there often is no clear delineation of when an appointment to government office is "cronyism". The economic and social costs of cronyism are paid by society. Those costs come in the form of inflated consumer goods prices, reduced motivation in affected organizations, and the diminution of economically productive activity. **Cronyism is self-perpetuating** and can only be dismantled by a comprehensive, effective, and enforced legal code, with empowered government agencies which can effect prosecutions in the courts.

The Italian Health System makes no exception to the logic of Italian gerontocracy, facilitated by population ageing. The median age of physicians rise from 48 years in 2010 to 51 years in 2019. As of December 2022, Eurostat shows that 53.9% of Italian physicians were aged 55 years and over, a share second only to Bulgaria (54%) within the EU. : in most of the remaining EU countries for which data are available, the relative proportion of this age group in the total number of physicians was between 23.0% and 34.3%[5].

Many Italian regional health systems are recruiting retired physicians as freelance contractors. Actually, it represents one of the clearest examples of gerontocracy, likely due to fact that the salaries of healthcare professionals are in general much higher than those of the general population, and are then highly attractive. In this essay, I will provide several practical examples following the top-bottom hierarchy cascade.

Sicne the foundation of the Italian National Health System in 1978 [6], the general directors of public hospitals were nominated (without any public competitive procedure) by political parties governing the regional health systems [7]. Such a huge ingerence of politicians without and training in biomedical sciences within the National Health System represents the leading cause of the corruption of the system itself. The creation of a national list of eligible general directors has

not improved the system so much, given that they continue to be selected just by political affinity, as opposed to objective meritocratic criteria. As a confirmation for this assumption, general directors are routinely replaced after each regional election round. The gross annual salary of general directors approaches 250,000 EUR each, and their main task is complying with the short-term budget targets postulated by the health councilor within the regional political body. A health councilor that doesn't have to fulfill any specific qualification, and who is often totally underqualified for the role. In 2023, a national law raised the maximum age for inclusion in the national list of eligible directors from 65 to 68 years.

The directors of units within the hospital (called "unita' operative" or "strutture complesse" in Italy) have been historically nominated by public procedures, with each position currently having a gross annual salary of about 150,000 EUR. Directors use to regularly survive replacements of general directors, making their willingness often predominant within hospitals. Public competitions tend to be won by complacent employees, who are preferred because they just do not pose any critic to the system. The latter happens because of multiple factors: anergy, ambition to a higher salary, and not rarely because of lack of competence (in an ever-lasting cycle). Among complacent employees, indigenous elderlies (whose full complacency has been demonstrated for decades) are generally favored, since the rules of public competitions allocate points based on the number of years covering the former position(s). To give an example, a top-ranked region is nowadays issuing competition announcements for full directors of units granting as little as 10 points out of 100 for objective studies and publications, plus 30 points for career appointments within the hospital, as opposed to 60 points for a subjective 10-minute job interview held by the medical director of the hospital. This generally leads to paradoxical situations where brilliant young candidates with full-grade PhD and master degrees and hundreds of publications are ranked inferior to elderly candidates without equivalent studies and with just a few publications (hironically often co-authored by their younger competitors). As a consequence, more than 90% of winners of public competitions for unit directors are locals and aged more than 60. Unit directors in their 40's make newspapers headlines in Italy [8].

In order to limit the ability of unit directors to boycott and veto the decisions of general directors of hospitals, the latter are nowadays favoring the creation of smaller units (called "sezioni dipartimentali" or "strutture semplici") whose directors have lower salaries (in the range of 80,000

EUR/year) and, importantly, whose nomination does not require a public competition. In the name of the presumed maximum subspecialization, this minimizes rebellions and at the same time reduces the institutional power of (not fireable) full directors. E.g., at a given hospital I know very well, I can now count 20 different directors from the mouth to the anus (7 full directors and 10 nominated directors), in spite of a single school of specialization in gastroenterology, clearly dismantling holistic competences and consequently hurdling across-unit personnel mobilization in the long-term.

Within each unit, directors have the capability to promote some of their employes to higher ranks, accounting for 5,000-20,000 EUR in addition to their baseline 60,000 EUR yearly salary. Until the economy was flourishing, such positions were easily assigned, although (until the retributive annuities system was left in place) they tended to be allocated at the oldest employees in order to increase their annuities after retirement. Nowadays, under severe budget constraints [9-12], such promotions are limited in number and steps, often making complacency rather than age their primary driver: clearly, this prevents critiques and discussion within each unit, which would instead be the driver of progress.

What are the dismal consequences of such a gerontocratic health system? I will give you a few examples.

- In the rush for the declining number of high salaries, nepotism is rampant. The average gross salary of a physician is about EUR 75,000 per year (approximately EUR 3,400 net per month), 119% higher than the average monthly salary in Italy. Annual salary significantly increases according to seniority (from EUR 24,000 during the training period to over EUR 100,000 for chief physicians) [13]. Hospitals increasingly look like family-owned businesses. At the same hospital I mentioned above, among the 500 medical executives appointed, I can count up to 80 first-degree relatives (i.e. 160 executives, or 32%): while spouses are expected based on relationships built during the work shifts, siblings and prole appointed within the same hospital should instead represent extraordinary findings. The Global Corruption Barometer published by Transparency International in July 2013 highlights how Italian citizens consider corruption a very serious

problem for public administration, especially due to the expansion of clientelism and nepotism[14].

- general directors are almost invariably locals from the same region they administer.
- without meritocracy, the governors miss competence. This invariably translates into:
    - frauds perpetrated by unsatiable, smart employees, which pass totally undetected by governors[12]. E.g., extra budgets that have been allocated for specific targets (e.g. reducing the waiting times on the transplant list) are instead routinely used by directors to bypass public tenders and buy whatever instrument they want, eventually looming corruptive logics solicited by organized crime groups [15]. in 2012 Italy earned penultimate place in Europe in the CPI ranking, the index for the perception of corruption in the public and political sector. In the World Bank Worldwide Governance Index, under the entry "control of corruption" Italy went down from a best of 77.1/100 in 2000, to 57.3 in 2011 [14].
    - public tenders, the way of procuring diagnostics and drugs under the national health system, are increasingly led by corrupted healthcare professionals demanding for useless instruments or diagnostics [16,17], which further worsened during the COVID pandemic[18]. In order to limit their claims, in the "best case" scenario, underqualified administrative personnel have to apply linear cuts. Headlines of international journals and TVs regularly report that mafia corruption is putting the Italian health system in state of emergency[12,19-21], but current strategies[22] often overlook high-level sub-national corruption risks. [23].

Both such consequences further worsen the budget constraints, perpetuating a vicious circle.

- Between 2000 and 2022, approximatively 180,000 Italian healthcare professionals (131,000 medical doctors and 48,000 nurses) have emigrated to more remunerative and attractive countries. In 2020-2022, more than 40,000 freshly graduated healthcare professionals have left Italy. Considering how much their training costed to the National Health System, they correspond to 3.5 billion euros fled away [24].

- Citizens are no longer the focus of assistance: budget constraints cause shortage of personnel (expecially nurses) which invariably cause disservices. E.g., in many hospitals at 6:00 a.m. every citizens who have not booked their blood sampling queue, and only the first 15 will be actually sampled. Wait list management invariably reveals corruptive logics [25].
- As recently highlighted in an Editorial by the *Lancet Regional Health*, the Italian health data system, guided by informatics-naïve administrators, is broken: *"Many hospitals and facilities continue to rely on outdated, incompatible systems, making the transfer of patient records and diagnostic images manual and labour-intensive, even within the same region or city. The absence of standardisation prevents the creation of national registries, hampering effective care, and crisis management"*, but also hurdling interregional healthcare mobility and investigator-initiated multicenter clinical trials[26].

What are the solutions for such a crisis?

1) Changing the selective criteria is what is needed. Criteria that will encourage earlier retirements and favor meritocracy in personnel recruitment and promotions. Gerontocracy generally occurs as a phase in the development of an entity, rather than being part of it throughout its existence. Opposition to gerontocracy may cause weakening or elimination of this characteristic by instituting things like term limits or mandatory retirement ages. Wikipedia provides several examples:
   - Judges of the United States courts, for example, serve for life, but a system of incentives to retire at full pay after a given age and disqualification from leadership has been instituted.
   - The International Olympic Committee instituted a mandatory retirement age in 1965
   - Pope Paul VI removed the right of cardinals to vote for a new pope once they reached the age of 80, which was to limit the number of cardinals that would vote for the new Pope, due to the proliferation of cardinals that was occurring at the time and is continuing to occur.
2) Objective bibliometric indexes have been established. The *h*-index reflects academic age [27], but new indexes should guide recruitment of academic personnel at University hospitals. The recently launched Stanford University-Elsevier press initiative named "Top 2% Scientists"

embeds more transparent criteria [28]. On the contrary, the count of medical or surgical procedures should guide recruitment of non-academic personnel (hospitalists). Non-academic doctors with bibliometric indexes above their academic colleagues should be proactively recruited by local Universities in sight of their attitudes. Top Italian scientists should have a key role at soliciting the introduction of such meritocratic criteria.

3) More conflict-of-interest policies should be implemented in Italy: the US Physician Payments Sunshine Act that works in private health systems should be further reinforced in publicly funded health systems. Actually, this has not happened yet, with transparency acts at individual hospitals and at national level being regularly disattended because of the lack of a sanctioning mechanism. Such illicit behavior grants continuing participation to tender procedures which would otherwise remain forbidden to executives. Company regulations are in place to encourage rotation of workplaces, but they are regularly disattended on the ground of professional specificities. While changing workplace and city can be dramatic for elderly workers, moving to units sharing similar specificities within the same hospital should be mandatory for unit directors and executives. In addition, general directors should mandatorily come from foreign regions and be nominated randomly.

Do I hope such simple solutions will be soon applied in Italy? IMHO, not before the total default of the public health system. Alternatively, the demographic crisis itself could leave more apical positions in search of candidates.

Caveat: this essay will likely be charged of stereotyping, prejudice and ageism. As Alessandro Manzoni wrote *"Ai posteri l'ardua sentenza"*. I declare I have no conflict of interest related to this manuscript.

Declarations

Conflict of Interest

The Author declares that there is no conflict of interest.

References

1. INDICATORI DEMOGRAFICI | ANNO 2024 - Istituto Nazionale di Statisrtica. Accessed at https://www.quotidianosanita.it/allegati/allegato1743409398.pdf on April 1, 2025.
2. Statista. Forecasted population in Italy from 2025 to 2050. Accessed online at https://www.statista.com/statistics/573324/population-projection-italy/ on January 9, 2025.
3. Eisele, F.R. Origins of "gerontocracy". *The Gerontologist* **1979**, *19*, 403-407, doi:10.1093/geront/19.4.403.
4. Catani, S. Gerontocrazia. Il sistema economico che paralizza l'Italia. Edizioni Garzanti. **2014**.
5. European Council . Healthcare personnel statistics - physicians on December 2024. Accessed at https://ec.europa.eu/eurostat/statistics-explained/SEPDF/cache/37382.pdf on April 16, 2025.
6. Giorgi, C. A history of Italy's health policy from the Republic to the new century. *Modern Italy* **2023**, *28*, 1-17.
7. Fragnito, M. The Medicalisation of Politics or the Politicisation of Medicine: The Case of Italian Struggles to Design Public Healthcare Institutions. *DAT Journal* **2021**, *6*, 75-94.
8. Guarner, J.; Hale, G.L. Four human diseases with significant public health impact caused by mosquito-borne flaviviruses: West Nile, Zika, dengue and yellow fever. *Semin Diagn Pathol* **2019**, *36*, 170-176, doi:10.1053/j.semdp.2019.04.009.
9. Boffardi, R. How efficient is the Italian health system? Evidence on the role of political-institutional dynamics. *Socio-Economic Planning Sciences* **2022**, *84*, 101388, doi:https://doi.org/10.1016/j.seps.2022.101388.
10. Cicchetti, A.; Giorgio, L.; Di Paolo, M.; Daugbjerg, S.; Laurita, R.; Morandi, F.; Tattoli, A.; Villani, L. Sustainability and Resilience in the Italian Health System. *The London School of Economics and Political Science* **2021**.
11. Taroni, F. Health care policy and politics in Italy in hard times. *Journal of Health Services Research & Policy* **2015**, *20*, 199-200, doi:10.1177/1355819615585894.
12. BBC. Italy's Calabria has two pandemics: Covid and the mafia. 30 November 2020. Accessed at https://www.bbc.com/news/world-europe-55098415 on April 16 2025.
13. de Belvis, A.; Meregaglia, M.; Morsella, A.; Adduci, A.; Perilli, A.; Cascini, F.; Solipaca, A.; Fattore, G.; Ricciardi, W.; Maresso, A.; et al. Italy: Health system review. *Health Systems in Transition* **2022**, *24*, i-203.
14. "Unhealthy Health System" project report co-funded by the European Commission. Accessed at https://www.againstcorruption.eu/wp-content/uploads/2014/10/Corruption-and-waste-in-the-Healthcare-system.pdf on April 16, 2025.

15. European Union Agency for Criminal Justice Cooperation. Fraud against Italian national health system halted with Eurojust support. Accessed at https://www.eurojust.europa.eu/news/fraud-against-italian-national-health-system-halted-eurojust-support on April 16, 2025.
16. Financial Times. How the Mafia infiltrated Italy's hospitals and laundered the profits globally. Accessed online at https://www.ft.com/content/8850581c-176e-4c5c-8b38-debb26b35c14 on April 16, 2025.
17. Previtali, P.; Cerchiello, P. The Prevention of Corruption as an Unavoidable Way to Ensure Healthcare System Sustainability. *Sustainability* **2018**, *10*, 3071.
18. Antonelli, M. Corruption in healthcare system during Covid-19. The italian case. 4th General Conference on Organised Crime, Pisa and Online, 4 – 6 July 2022. **2022**.
19. Mail Online. Mafia corruption puts Italian healthcare system in 'state of emergency'. 12 December 2007. Accessed online at https://www.dailymail.co.uk/news/article-501529/Mafia-corruption-puts-Italian-healthcare-state-emergency.html on April 16, 2025.
20. Lagravinese, R.; Paradiso, M. Corruption and health expenditure in Italian regions. *Economic Bulletin* **2014**, *34*, 1498-1511.
21. Gandolfi, A. A story of the mafia and an inefficient health service. Accessed at https://www.alessandrogandolfi.com/stories/a-story-of-the-mafia-and-an-inefficient-health-service-84 on April 16, 2025.
22. De Fiore, L.; De Micheli, V.; Brunetti, M.; Ferrante, L.; Rivoiro, C.; Solfrini, V.; Corti, G.; Dirindin, N. An Italian initiative to prevent corruption in health and social care. *BMJ : British Medical Journal* **2014**, *349*, g4595, doi:10.1136/bmj.g4595.
23. Del Sarto, S.; Gnaldi, M.; Salvini, N. Sustainability and high-level corruption in healthcare procurement: Profiles of Italian contracting authorities. *Socio-Economic Planning Sciences* **2024**, *95*, 101988, doi:https://doi.org/10.1016/j.seps.2024.101988.
24. Hoenen, T.; Groseth, A.; Feldmann, H. Therapeutic strategies to target the Ebola virus life cycle. *Nature reviews. Microbiology* **2019**, *17*, 593-606, doi:10.1038/s41579-019-0233-2.
25. La Stampa. Wait list mismanagement reveals corruption in Italy's public health care system. January 19, 2018. Accessed online at https://www.lastampa.it/esteri/la-stampa-in-english/2018/01/19/news/wait-list-mismanagement-reveals-corruption-in-italy-s-public-health-care-system-1.33969346/ on April 16, 2025.
26. The Lancet Regional Health –, E. The Italian health data system is broken. *The Lancet Regional Health – Europe* **2025**, *48*, doi:10.1016/j.lanepe.2024.101206.
27. Fassin, Y. The ha-index: The average citation h-index. *Quantitative Science Studies* **2023**, *4*, 756-777, doi:10.1162/qss_a_00259.
28. Bermingham, A.; Chand, M.A.; Brown, C.S.; Aarons, E.; Tong, C.; Langrish, C.; Hoschler, K.; Brown, K.; Galiano, M.; Myers, R.; et al. Severe respiratory illness caused by a novel coronavirus, in a patient transferred to the United Kingdom from the Middle East, September 2012. *Euro surveillance : bulletin Europeen sur les maladies transmissibles = European communicable disease bulletin* **2012**, *17*, 20290.