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Editorial

The Italian National Health Service: Crucial Issues and Potential Remedies

Livio Garattini[1], Antonino Mazzone[2], Andrea Zovi[1,*]

[1]Department of Health Policy, Institute for Pharmacological Research Mario Negri IRCCS, 20156 Milan, Italy
[2]Department of Internal Medicine, Legnano and Magenta Hospitals, ASST Ovest Milanese, 20025 Legnano, Italy
*Correspondence: Zovi.Andrea@gmail.com (Andrea Zovi)

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1. Introduction

Starting from 1978, Italy has adopted a (Beveridge-type) public National Health Service (NHS) to govern health care, formally providing universal coverage funded by general taxation, with services free of charge at the point of delivery [1]. Since 1992, the Italian NHS (INHS) has been progressively decentralized, with many powers transferred from the central government to regions [2]. The Italian territory is divided into 20 regions, all governed by elected politicians, which vary considerably in terms of both size — ranging from 3261 km^2 (Aosta Valley) to 25,832 km^2 (Sicily) — and population — ranging from 130,000 (Aosta Valley) to 10,000,000 inhabitants (Lombardy) [3].

Here, we summarize the crucial issues affecting the INHS. Then, we outline the potential remedies to address them.

2. Crucial Issues

The main weaknesses currently affecting the INHS can be classified as institutional, organizational and financial issues.

• The first major issue is institutional. Health is by far the largest item in all regional budgets (accounting for over 80% of their total spending in many regions), making it an importantpolitical topic for local elections [4]. Owing to local autonomy, regions are allowed to develop very different health strategies without the need for national endorsement. This devolution has progressively transformed the INHS into many uneven regional health services within the same country. Actually, although involving much fewer geographical entities (four nations vs twenty regions), something relatively similar has happened in the British NHS [4,5].

To give an emblematic example of the present heterogeneity, here we summarize the institutional differences between Veneto (capital Venice) and Lombardy (capital Milan), two wealthy neighboring Northern regions not so different from a physical geography perspective and with quite similar political contexts in recent decades [4]. Although the territory of Lombardy is about 1/4 larger and its population is approximately 1/2 higher, mainly due to the metropolitan area of Milan, there are 38 health authorities and 97 acute hospitals (68 public and 29 private hospitals) in Lombardy, whereas Veneto has only 13 authorities and 36 hospitals (33 public and 3 private hospitals). This simple comparison confirms that the organization and management of healthcare services have been shaped very differently, even in geographically, economically and politically similar regions.

• The second issue is organizational. Community services have historically been penalized in all Western European countries for their lower impact on local economies compared to hospitals, and Italy is no exception. General practitioners (GPs) should be the 'pillars' of primary care in the INHS. GPs are formally self-employed professionals mainly paid on a capitation basis under national contracts [6]. Each GP has her/his own list of patients (up to 1500, with local exceptions) and must guarantee a minimum number of weekly opening hours (at least 15h per week according to the last national contract). In practice, the minimum number of weekly opening hours often corresponds to the actual average. Although many regions have encouraged group practices since the late 1990s, patients are registered with a single doctor, and this is a major barrier for working in groups [6]. Unlike their British colleagues, most Italian GPs still work in solo practices, and their actual gatekeeping role in accessing higher levels of care is very limited.

Besides GP practices, many other facilities traditionally provide community services within the local units of health authorities, the most important of which are population screenings, vaccinations, family planning counseling, and home-care services [6]. In general, the piecemeal delivery of primary care is difficult to manage for local health authorities and is still confusing for Italian citizens. Consequently, the recent efforts to co-locate these services together with GP practices in the so-called 'community houses' seemed logical [2]. However, as expected, the main general practice associations still oppose this move, thus GPs co-location in these multi-functional facilities is still problematic almost everywhere in the country. In general, their associations fiercely resist the proposal of making GPs employees of the INHS (like in the UK).

• The third issue is financial. Overall, Italy spends much less than other main Western European countries (e.g., France, Germany, the UK) both per capita and as a percentage of gross domestic product (GDP) [2]. At the same time, the number of Italians who have subscribed to private health insurance has almost tripled over the past two decades (reaching at least 15 million). This trend was strongly enhanced by two national laws in 2008 and 2009, which provided a tax benefit for insurance funds and mutual aid societies that offer substitutive health coverage [7].

Another issue is the so-called *intra moenia* activity in public hospitals. Introduced in 1996, it is a highly controversial form of dual practice (DP), as public healthcare employers provide private activity in their facilities [8]. Such an extreme form of DP can undermine institutions' ability to achieve their primary goals and has been associated with the ethical concept of institutional corruption in the literature [9]. In general, a likely negative consequence of any kind of DP is longer waiting times, since many health professionals are (obviously) interested in encouraging demand for their private care. According to a quite recent survey, the average waiting time per service was almost 11 times shorter for *intra moenia* than for public services [10]. In practice, Italian *intra moenia* has resulted in further unjust taxation for patients, low extra income for health professionals, and significant diversion of administrative and physical resources for public hospitals.

Finally, the adoption in 1995 of fixed tariffs based on diagnosis for funding hospital admissions, derived from the American experience of diagnosis-related groups (DRGs), has led to significant distortions in the allocation of financial resources within the INHS over the long run [11]. Notably, activity-based funding has rewarded over-treatments in for-profit private hospitals contracted with the INHS, which are (obviously) likely to concentrate on the most profitable services [3].

3. Potential Remedies

Below we raise the main institutional, organizational and financial proposals to restore the INHS.

• The institutional role of regions within the INHS should be reconsidered. A logical solution would be to exclude regions from the INHS management at both the financial and organizational levels, replacing them with a merely administrative second tier fully managed by the central one [4]. This would also allow the geographic borders of the second tier to be rationally redesigned without necessarily coinciding with those of regional jurisdictions, thereby reducing cross-boundary flow of patients among neighboring regions.

At the national level, because democracy implies that governments can affect health through public regulation, which is often shaped by current ideologies, central governments should not be allowed to easily modify the baseline institutional framework of the INHS. Therefore, major national laws regarding health policy should always be subject to safeguard clauses (e.g., approval by at least a two-thirds majority in the Italian Parliament) so as to restrict political influence [4].

• An organizational re-balancing of services between community and hospital care is needed within the INHS in this era characterized by an aging and multi-morbid population. Assuming that all health professionals working for the INHS should become employees for better managing their activity, GPs should be full-time employees, like their colleagues in hospitals, and should be located in community houses throughout the day [3]. Broadly, all health, social and administrative professionals working in community care should be brought together in these large-scale facilities. Notably, an ample staff of health professionals should help extend daily access to healthcare services, improve the management of out-of-hours services, and increase the provision of home care for patients unable to move. Moreover, these large organizations could provide urgent daily care for low-complexity cases, thereby filtering unnecessary access to hospital accident and emergency services [6]. In general, INHS managers should promote collaboration among health professionals rather than adopting a rigid hierarchical approach [3]. For instance, senior medical staff could be placed on an equal footing, and patients could be subdivided among them in their health care facilities, as in the UK NHS. Moreover, outpatient care could be delivered exclusively in community settings, with hospital consultants rotating weekly into these facilities.

• Once assumed that the State is the best 'insurer' to cover the illness risks of its citizens and thus that the most rational criterion for financing the INHS is universal coverage through general taxation, employers and citizens who opt for subscribing to additional health insurance schemes should not receive any tax discount, so as to avoid financial distortions in health care [8]. Moreover, the INHS total budget should be increased and linked to GDP in order to ensure its financial consistency over time.

The ban of any form of DP for providing health care is strongly supported by business administration [12]. It would be highly unusual for an employer to allow employees to conduct private business with its clients in their free time. Therefore, even *intra moenia* activity should be prohibited in the INHS. Consistently, the current wages of the main types of INHS health professionals should be increased to ensure them a decent standard of living in a civilized society, and the INHS should become formally accountable for legal expenses in case of lawsuits for non-gross medical negligence [13]. Finally, once competition and pricing have been ruled out as ways to manage the INHS, since healthcare is a typical example of 'market failure' in economic theory [8], any kind of DRGs-like tariffs should be abolished and replaced by budgeting and planning to enhance local efficiency within the INHS.

4. Conclusion

In light of the current institutional, organizational, and financial issues facing the INHS, we believe it is time to adopt the recommended remedies urgently. Otherwise, we are afraid that the INHS will hardly survive in the long run and will inevitably function as a mixed public and private health system, unable to provide universal coverage for the Italian population.

Key Points

• The first major issue of the INHS is institutional, since the twenty Italian regions are allowed to develop substantially different health strategies at the local level thanks to local autonomy.

• The second issue is organizational in community care, mainly due to the weakness of GPs who still work mainly in solo practices and thus play a very limited gatekeeping role to higher levels of care.

• The third issue is financial, since Italy spends much less than other main Western European countries, the number of Italians who have a private health insurance has grown dramatically, and dual practice in public hospitals has increased progressively.

• The institutional role of regions within the INHS should be radically reconsidered, and a very logical solution would be to replace them with a merely administrative second tier fully managed by the central one.

• GPs should become full-time employees as their colleagues in hospitals, and should be located in community houses together with all the health, social and administrative professionals working in primary care.

• Health insurance schemes should not benefit from any tax discount, the INHS total budget should be anchored to the GDP, any form of dual practice should be banned, and any kind of tariffs should be abolished and substituted by budgeting and planning.

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Not applicable.

Author Contributions

LG, AM and AZ designed the editorial. LG drafted the manuscript. All authors contributed to the important editorial changes in the manuscript. All authors read and approved the final manuscript. All authors have participated sufficiently in the work and agreed to be accountable for all aspects of the work.

Ethics Approval and Consent to Participate

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Conflicts of Interest

Livio Garattini is serving as one of the Editorial Board Members of this journal. We declare that Livio Garattini had no involvement in the review of this article and has no access to information regarding its review. Full responsibility for the editorial process for this article was delegated to John Alcolado. Antonino Mazzone and Andrea Zovi declared no conflicts of interest.

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