Evolution and implementation of the Italian health service reform of 1978

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Abstract

The study seeks to answer two questions: Why and how was a national health service introduced in Italy in 1978? How, and how well, has the service worked?

First proposals were made to improve public hygiene and access to health care in Italy in 1945. However, only in the 1970s was there political support for full reform. The principles of the national health service - full population cover, public funding, comprehensive services, local control - were agreed by most political parties; but there were also differences between parties over important issues. Parliament approved the law during an exceptional period in 1978 when the Christian Democrat party depended on the Communist party to sustain their government.

The Servizio Sanitario Nazionale (SSN) has been implemented through the 19 regions and 2 autonomous provinces. 673 Unita Sanitarie Locale (local health units) provide the organisational structures for local management, with a wide range of services including general practice and hospital care, hygiene and prevention, occupational health and veterinary care. Terms of service are uniform across the country and negotiated nationally. About 15% of inpatient care, and about 30% of ambulatory care, is contracted to non-SSN salaried physicians.

Public services in Italy are usually believed to be inferior to private services, to be excessively bureaucratic and of poor quality. Some evidence supports these perceptions, more commonly in the south than in cental or northern regions. Several features of the SSN, such

as national planning, prevention and occupational health, and public participation, have not developed as intended in the reform. Neverthless, the SSN has also achieved several major objectives - a public health service available to all, an acceptable mix of public and private-contractual provision, public representation through regions and communes, and national financial control. On balance, the Italian health reform of 1978 has been a success.

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The Italian Health Reform

INTRODUCTION

This study of the Italian health reform addresses two questions:

- Why and how was a national health service introduced in Italy in 1978?
- How, and how well, has the service worked?

The study seeks to describe the history, structure and functioning of the Italian national health service - the Servizio Sanitario Nazionale - over the years of its establishment as the 1978 reform law. Historical, financial, administrative and epidemiological information contribute to an evaluation based on criteria of effectiveness, efficiency, equity, acceptability and the fulfillment of expectations within the law itself.

The study is focused primarily on Italy, although drawing some comparisons with Britain to illuminate the Italian position. The health systems of Italy and Britain are similar in many ways. Both are national services, financed by funds voted by Parliament. Both separate medical practice in primary care (general practitioners) from secondary care (hospital specialists). Both have chosen a structure with indicative regional planning and local managerial control. But the systems of the two countries also differ in details. Britain has strong central political control from the Department of Health, whereas the Italian Ministry is weak. On the other hand, Britain has sought to depoliticise the regional and local tiers, whereas these are dominated by local politicians in Italy. Britain has regulated the number and practice of doctors, whereas Italy has an excess and little

distributional control.

The British National Health Service (NHS) was an important part of the welfare reforms of the postwar period in Britain. It has continued to receive strong public support, although successive governments have made alterations to the original structure. The proposals for reform by the present government (Department of Health 1989) are as profound as any over the last 40 years. Yet the National Health Service remains an exemplar of 'socialised' health care system, sometimes contrasted with the 'free enterprise' system of the United States.

Because of the historic importance of the NHS, its public support, and perhaps also through insular attitudes, health policy makers in Britain have not often looked beyond the national level. When they have, it has tended to be towards countries where English is spoken as the first language, especially the United States, Canada and Australia, or readily spoken as a second language, especially northern Europe (McLachlan & Maynard 1982, Saltman 1988, Doan 1988, Ham 1989). Little attention has been given to the health systems of southern European countries.

While some lessons can be drawn from highly contrasting systems, an alternative approach is to compare countries with similar systems. A 'similar systems' comparison reduces variability, and allows a small number of factors to be isolated and more readily investigated (Przeworski & Teune 1970). There has been increasing interest in the United States in comparing their system with Canada, especially the decentralised system in Ontario (Relman 1989, Inglehart 1989). In the

same way, study of the Italian health system can be relevant to Britain, since the countries have similar systems.

Methods

The study combines historical, economic and managerial information from a range of sources. For many years scholars from both Britain and abroad have published research on the British NHS, based on information from historical documents, public and private reports, and statistical material from the Registrar General, Office of Population Censuses and Surveys and the Department of Health. Information in Italy is not so readily available. To meet the needs of central government some national and regional statistics are recorded by the Istituto Centrale di Statistica (ISTAT); the Ministry of Health provides limited information from its library and data systems, such as the hospital Sistema Informatico Sanitario (SIS); but these sources needed to be supplemented by books and periodicals, and 'grey literature' gained from discussions and interviews at regional and local levels. I have supplemented this material from sources in Britain, using libraries at University College London, Kings Fund Centre, University of London (Senate House), London School of Hygiene and Tropical Medicine, London School of Economics and Political Science, and Institute of Education. I also searched the periodical literature using Social Science Citation Index.

I used public libraries in Italy especially for historical material. It proved difficult to study the reports of the parliamentary debates during the period of the reform, from 1968 through to 1978 for technical and organisational reasons. While some of the reports of the debates

had been collected together usefully in a Ministry of Health publication (Ministero della Sanita 1977), copies of the full debates are stored only in certain libraries and by no means all the relevant debates are reported. Organisationally, it proved impossible, even in Rome, to get hold of a copy of the debates to read. They are not in the libraries of the Istituto Sanitario di Sanita nor the Institute for Study of the Regions. Copies for earlier years in the century are to be found in the National Library in Rome, but the series stopped before the years relevant to the reform.

Two appropriate sources would have been the libraries of the two Houses of Parliament - the Senate and the Chamber of Deputies. The Senate library is closed to members of the public. The Chamber would have been possible, except that it was transferring all its material onto microfilm and was thus also closed. A final hope in Rome was the State Archives, one of the main buildings of the EUR (Esposizione Universale Roma), administrative satellite city built by Mussolini in the hope of staging a World Fair in 1942. The room in which the documents were stored, however, was closed to house an exhibition about the planning and architecture of the EUR (Mariani 1987). I was finally able to track down the documents at the National Library in Florence, a library that is older and larger than the National Library in Rome, and which proved to have not only the relevant parliamentary publications but also other useful books.

Acknowledgements

A minority of informants spoke English, so that gaining the information I needed, if it existed at all, had to be mediated through both cultural and language differences. I am grateful to the informants listed below, and others unnamed, who have guided this research on the Italian health service.

Early in this work I met Dr Hugh Faulkner, formerly GP of the Caversham practice in Kentish Town, London, who moved to Greve, near Florence, in 1977. With Marion his wife, Hugh's house was always a welcoming place to visit, a forum for discussion, and a source of information.

My primary contact in Rome was Dr Piero Morosini, Director of the Unit for Evaluation in the Department of Epidemiology and Biostatistics in the Istituto Superiore di Sanita, who I first met at the Kings Fund College when he came to Britain in 1981 to study our NHS information system. This academic Institute is the main Public Health School in Italy and is sited close to Rome University (La Sapienza). It is funded by the Ministry of Health and is mainly concerned with biomedical aspects of public health rather than epidemiological or social aspects. I was also helped by Dr Francesco Tarroni, Dr Bepe Traversa, Dr Francesco Cecere and Ms Antonella Lattanza, also in the Unit for Evaluation at the Istituto Superiore di Sanita. Other doctors in Rome who gave advice include Dr Franco Taggi; Dr Carlo Vetere and Dr Paolo Piergentile at the Ministry of Health; and Dr Carlo Perucci, director of the Osservatorio Epidemiologico Regionale.

To balance this medical perspective I have been much helped by Mr George France at the National Research Council's Institute for Regional Studies in Rome. This small group, founded to monitor the development of the Italian Regions in the 1970s, has a leaning towards economic and political analysis; health services are but one of many of its fields of interest. Mr France has been generous with his time in talking about economic aspects, and I have also drawn from his published work. I have also benefited from discussions wich Dr Aldo Piperno, Professor of Sociology at the University of Naples; and Dr Carla Collicelli, a social scientist at the private survey organisation CENSIS.

I made visits to the several of the Italian regional capitals, meeting doctors and administrators working within the SSN and some in academic settings. Among these, I would like to note:

Turin. Professor Benedetto Terracini, Dr Franco Merletti and Dr Paolo Vineis in the Medical Faculty of the University; Dr Nereo Segnan and Giuseppe Costa at the Turin City Epidemiological Unit; and Dr Mario Rey and Dr Renato Balma at the Centro di Ricerca per l'Economia, l'Organizzazione e l'Amministrazione della Sanita - Cresa.

Milan. Ms Francesca Ripetto, director of information and planning in Lombardy Region, Milan; Professor Pagano and Dr Cristofallo in the Department of Public Health, University of Milan; Dr Borgonovi of Bocconi University; Dr Franco Bertazzi at Seveso; Dr Franco Berrino and Dr Milena Sant at the Instituto Nazionale di Tumori; Drs Alessandro Liberati, Carlo la Vecchia, Benedetto Saraceno, Paula Bollini at

Istituto Mario Negri; and Dr Danielle Cohen at Rho hospital.

Bologna. Dr Raffaella Stiassi and other staff at the Osservatorio Epidemiologico, Regione Emilia Romagna; Mr Rino Fasol, sociologist at the University of Trento and also working at Ferrara; Dr Claudio Paulo at the Public Health Department.

Mestre. Dr D Braga, planning administrator in the Veneto region.

Trieste. Mr S Mertiach, planning administrator in Friuli Venezia region.

Florence. Dr Hugh Faulkner provided a valuable base at USL 10/H, and advice was given by Dr Giovanna Marsala and Dr Mario Postiglione. At the Tuscany Region I made use of the library and gained information about the policies for subregional financing of the SSN. I was also helped by Dr Alberto Renieri, a social scientist at SAGO, a private economic research foundation with health service contacts; by Dr Favilla, Medical Assessore for the Commune of Florence, and Dr Franco Franceschini, a surgeon at the Cancer Institute in Florence.

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Finally, I thank Dr June Rawlinson at the British Council in Rome, who arranged a scholarship from the Consiglio Nazionale di Recerche to assist one stay in Rome and Florence.

Translation notes:

In general I have used English translations of Italian terms. Occasionally it has been necessary to use the original Italian where no English equivalent exists (for example, the commune-supported general practitioner called a 'medico condotto'). I have reserved the term National Health Service for the health service in Britain, and called the Italian service the Servizio Sanitario Nazionale. The Ministry of Health is Italian, compared with the Department of Health in Britain. I have retained Italian for the references, for example, Ministero della Sanita; and the initials USL for the Unita Sanitaria Locale, whose direct translation would be Local Health Unit, and more roughly the Local Health Authority.

Exchange rates between the British pound and Italian lire have varied over the years, but a rough estimate would be 2000 lire = 1 pound.

CHAPTER ONE: ITALY

'It is the particularism of different cultures that continues to produce that variety and diversity of health systems that we see around the world' Field M (1989: 21).

The development and structure of a health service needs to be understood within its cultural framework. 'Cultural' covers a range of fields - history, sociology, anthropology, geography, economics. The description in this chapter, drawn from general writing and specialised studies in these various fields, seeks to present a context to understand the Italian health service reform.

North and South.

Italy is a long, narrow country, and much of the centre and south is mountainous, making travel difficult. It formally became a single state in 1870, not much more than a century ago. Not surprisingly, therefore, the country is not homogeneous. The most important difference in the country is between the north and the south. In his survey of anthropological studies of Mediterranean countries, Davis (1977: 163) found that 23 of 92 focused ethnographic studies available up till 1975 were set in Italy; and all but two were in central or south Italy. Davis himself had studied Pisticci, a town in Basilicata, on the 'instep' of the heel of Italy (Davis 1973). The studies in northern Italy were both of alpine villages.

The anthropological tradition has focused on local, often village life. There have been studies of economic issues, such as the relationship of peasants to landlords, cooperation between each other and labour migration; of stratification by wealth, honor, class or bureaucratic position; of politics, especially the working of patronage; and of family life and kinship. The analyses are mirrored in the literature of life in southern villages, including well known accounts such as Christ Stopped at Eboli (Levi 1947), and Silone's Fontamara (Silone 1949).

At the same time, sociological scholarship has looked at similar issues from the viewpoint of industrialised society (Pinto 1980). Migration has been considered through its impact in the north; social structure is predominantly an issue of economic class; housing, education income support are public as well as personal welfare issues; and 'the South' is seen as a problem of underdevelopment.

Figure 1.1 Regions of Italy.

North and south have more precise official definitions. There are eight northern and four central regions (which include Lazio, the region of Rome); there are six mainland regions and two islands in the south. The south is smaller than the north, but not by much: it has 35% of the population and 40% of the land area.

The history of two cultures

The cultural differences between north and south are the product of different histories (Procacci 1973). After the fall of the Roman state, the north came under the influence of Austro-Hungaria. Charlemagne, who was crowned Holy Roman Emperor in Rome in 800 AD, headed a state that stretched from Spain to Hungary and from the Rhine to the Tiber. Gradually, the northern and central Italian cities developed economic independence, and spread their influence outwards to form city-states. Their increasing wealth, from industry and trade, supported the ideas and art of the Renaissance. The power of these states continued until the seventeenth century, when industry in more northern European towns was prospering, and they once again became provincial colonies of more powerful Kingdoms - Austria, France and Spain - and of the Pope in Rome.

In contrast, the southern regions, which had links with Greece pre-dating Roman times, remained a part of Byzantine culture for several centuries. Subsequent invasions and colonisation, by the Arabs (7th to 10th century), Normans (11th to 12th century) and Spain (16th to 18th century) led to the land, which had once been the prodigal gardens of both Roman and Greek civilisations, falling into increasing poverty. Until well into the twentieth century, southern Italy retained a feudal

pattern of land tenure, social stratification and economy. The differences between north and south are economic - entrepreneurial versus dependency.

Constitutionally, modern Italy is one of the younger countries in Europe. Unification of various parts of the country came rather suddenly in the middle of the nineteenth century (Beales, 1981; Mack Smith 1985). The French revolution, and the Napoleonic wars transformed European countries from post-Medieval federations of territories ruled by autocratic monarchs and princes into constitutional states whose geographical boundaries were an expression of linguistic and cultural unity (Hobsbawm 1962). 1848 saw uprisings in Milan, Rome and Naples, where radicals sought to overthrow the weight of reactionary foreign domination - by the Austrians, the French and the Bourbons. The Piedmontese found an ally in Louis Napoleon of France to drive back the Austrians in Lombardy in 1855, and in 1859 persuaded Tuscany to join an alliance of 'Italy' under the constitutional monarchy of the King of Sardinia (Mack Smith 1985). In 1860, the miraculous victories of Garibaldi in Sicily and Naples provided the opportunity for Piedmontese forces to unite the north with the south. The Veneto seceeded from Austria in 1867 and, in 1870 when the Pope's French guards had returned home to fight against Germany, Italian troops breached the walls of Rome. The peninsular was united, and Rome was chosen as the seat of the central government.

These years of nineteenth century revolution set many of the social patterns that would affect Italy up to the second half of the twentieth

century. In a large country with poor communications, the relation between local people and the central state would always be difficult. The Piedmontese constitution defined a central rather than federal state, electoral rights strictly limited by property, strong powers for Parliament, and government-appointed Prefects in each province to see that the law was carried out.

On the other hand, Parliamentarians also had a common interest in limiting the power of the State. Rome was the titular capital, but the centres of learning and trade were further north. For many in the south, the change perceived was minimal. Feudal control by a foreign coloniser was changed for bureaucracy and rule from Rome. The local relationships remained the same - landless peasant and powerful landlord. The failure of the State to attain monopoly control of coercive power in the south has been recognised as a precondition for the development of camorra, 'ndranghetta and mafia power (Blok 1974, Duggan 1989). However, 'It is clearly not a question of backwardness; the present misery of the Italian south has extremely modern aspects, they are features not of underdevelopment but of a modern political system' (Sassoon 1986: 254).

Patronage remains a major form of power relationship in Italy, but it is mediated now through the political parties. It is described in local studies in Abruzzo (White 1980) and in Turin (Kertzer 1980). Clientelism has been a dominant form of control for the Christian Democrat party, which has held power in Rome for all 45 years of the Republic and has dispensed its spoils of office to the party faithful. 'The party loyalists who are placed in key positions in turn command

enormous amounts of patronage. They award contracts for the construction of buildings, highways, and factories; they grant bank loans, pensions, and promotions; they allocate franchises, financial subsidies and jobs. And they do it strictly on the basis of partisanry' (Spotts & Weiser 1986: 6).

The centralising state.

Italy entered the first world war against Austria in 1915. The fighting was mostly trench warfare, although Austrian troops reached the Po valley in 1917. The Italian counter-attack in 1918 overran German-speaking territory, and the alpine province of Bolzano was given to Italy in the peace settlement. Social unrest was widespread in Europe, leading to new social movements in many countries. The Italian government introduced universal male suffrage to reward the returning soldiers (Clark 1984: 212), and saw the rise of the first populist parties, especially the Communist Party and the Italian People's Party (predecessor of the Christian Democrats, founded in 1944). The new voting led to major shifts in party power, with the 'government' parties in a minority.

However, the impasse was peremptorily resolved in 1922. Mussolini, a journalist and former socialist and anarchist, was leader of the Fascist party that had gained fewer than ten per cent of votes in the general election (Mack Smith 1981). But the political stalemate emboldened Mussolini to bring his supporters and squadristi together in a 'March on Rome'. Faced with the possibility of overthrow, and to prevent

extension of populist power, the King colluded with Mussolini and appointed him Prime Minister.

Twenty years of fascism gave two enduring features to the Italian state. The first was a desire for greater participative democracy. The new constitution, drafted in 1946-47, promised a return to parliamentary rule. However, the lawyers who wrote it sought to limit the power of central government, choosing proportional rather than majority representation, and thus coalition rather than single party government. While Parliament has, constitutionally, to be elected only every five years, each Parliamentary term has had, on average, 6 governments. Each new government, formed without an election, represents the juggling for power within and between parties more than underlying political changes: year by year the votes cast for the main parties have shown only small changes. Governments are seen to be a 'stage army', as the same powerful politicians shuffle between different Ministries and portfolios. Parties, rather than Parliament, are where power mainly lies.

Decentralisation was also written into the 1948 constitution, which defined several tiers of elected local government - regions, provinces and communes - seeking to widen the distribution of power after the years of Fascist centralism. But in practice the government in the post-war years continued to operate through the provinces, the level that had been established in the nineteenth century in imitation of France. Decentralisation depended on central power being yielded; and it was not until 20 years later that the government passed legislation to create the regions written into the 1948 constitution, and then in

the face of widespread public agitation for reform. Moreover, the first laws provided such limited regional powers that new legislation was demanded in 1975, again only in response to further political pressure. However, by the 1980s regions were spending 40% of public expenditure, or 18% of the total national public and private spending. The largest single part of the regional budgets is for health services.

The second legacy of fascistm remains more widespread: it was the development of agencies (enti). Agencies are of various types (Serrani 1978). The 'enti ausiliari' are connected with the state apparatus, answerable to a Minister but not to Parliament, and have officers nominated by the Minister. There are three broad groups: agencies providing services (for example, hospitals before 1974); agencies that oversee and control economic sectors (for example, the National Electicity Board); and agencies that act as independent businesses but with partial state control. These last are an unusual hybrid of public and private funding. IRI, the Institute for Industrial Reconstruction, was founded in 1937, and became a major actor in the economic boom of the 1950s (Lewis 1984: 141).

Expansion of the social security system during the fascist period led to multiple agencies for single occupational groups. These, however, were then brought together into massive, self-financing corporations: the Istituto Nazionale della Prevedenza Sociale (INPS) is perhaps the largest of these, empowered to raise and distribute social benefits without formal parliamentary control - indeed, without formally entering the Government's budget. The agencies are thus the means of

sottogoverno and clientelism, the patronage of the political parties in power. They provide jobs for party workers while promoting their careers; they give opportunities for 'donations' (tangenti) to party funds; they enhance support for the party by helping individual cases (this has been especially the case with abuse of invalidity pensions) (Serrani 1978). And they mean that the Christian Democrats, who still dominate the patronage system, have had little incentive towards the policies of other centre-right European governments of privatisation or reducing public spending.

Postwar Transformations

In the second World War, north and south once again had different histories. The Allies invaded the south in the spring of 1943, and set up an interim government. In September of the same year the King secretly fled behind the allied lines. Mussolini was briefly captured, but daringly released by the Germans, who sustained a defence line south of Rome until 1945 (Mack Smith 1981). As in the nineteenth century, northern patriots once again fought for Italy's independence - this time in the Resistance behind the lines, organised mostly by the Socialist and Communist parties.

Italy's rising postwar importance in Europe has not been founded on political leadership: Britain, France and Germany have all claimed a greater role in international affairs. Italy joined Europe's leaders because of the economic 'miracle' of the fifties and sixties. Economic production in 1966 was three times the level of 1951. There were 1.6 million cars in 1960 and 11.3 million by 1971. Electicity was rare in rural areas in 1950, almost universal by 1970. The industrialisation is

shown by the change of sectors of employment: between 1950 and 1980, the proportion of people working in agriculture fell from 41% to 11%; in industry rose from 32% to 45%; and in services rose from 27% to 44% (Slater 1984: 69).

This heady economic expansion has no single explanation. It was driven by industrialists in the north, with landless peasants migrating up from the south to find work. It depended on cheap energy from the natural gas fields discovered only forty kilometers outside Milan and oil along the shores of Sicily. It was helped by home markets protected by tariffs, and export markets extending in the European Community, which Italy joined at its inception. It was founded on large, internationally competitive, private manufacturing companies, household names such as Olivetti, Fiat and Pirelli. These in turn were supported by a state sector, including oil and tobacco monopolies, transport and, to some extent, banking.

Industrialisation continued from the fifties through to the early seventies, when the combined effects of rising oil prices and large pay rises for industrial workers left Italy vulnerable to price competition in foreign markets. From the mid seventies the economy was described as 'stagflation' - high levels of inflation matched by sluggish growth. But the smaller industries in central Italy remained competitive during the world recession; and the giant northern manufacturers shed staff, redesigned their products and production, and participated again in the boom of the 1980s (Ginsborg 1989).

Yet entrepreneurial industrialism remains a northern idea. In the south, few landowners were interested in developing manufacturing as an alternative use of capital. Economic development in the south was led through cash grants in a programme of regional redistribution larger than anywhere else in Europe (Lewis 1984). The Southern Fund (Cassa per il Mezzogiorno), set up after the war to pay for land reform, was transformed into an industrial development agency for the under-developed areas. However, its economic effect has been less than the 'take-off into sustained growth' expected by the orthodox economic theory of the time (Rostow 1971). Being capital intensive, the investments created little new local employment; they often needed expertise of northern business, and profits returned to the north; and they did not achieve a 'multiplier' effect on the regional economies. By the late 1970s, the policy was acknowledged to have been economically misconceived, and large capital investment was stopped. Some of the industrial sites are to be seen, abandoned and decaying, around the shores of southern Italy. The main beneficiaries of the Cassa appear to have been the Christian Democrats (for whom it was a major source of patronage) and the mafia (Arlacchi 1983).

Political parties.

Italy has seen three constitutional periods since the initial unification - liberal, fascist and republican (Hine 1979: 156). The state was established as a constitutional monarchy in 1870 with two houses of Parliament but substantial powers reserved to the King. As few as 2% of the population were entitled to vote. The main political parties were the Liberals and the Republicans, both dominated by

bourgeois and landowning interests. Male suffrage was extended to 25% of the population in 1911, and after the First World War to all males over 21.

Parliament's powers were eroded when the King appointed Mussolini as Prime Minister in 1922. One of Mussolini's most successful political moves was to reach an agreement with the Vatican in 1929 (the 'Lateran Pacts'), on the involvement of the Catholic Church in secular affairs. The issue had been outstanding since 1870, although after 1911 the Church had allowed faithful Catholics to be involved in politics, since it recognised the potential strength of populist and socialist movements and wished to influence them.

After the war, with universal suffrage, two major political groups developed: the Christian Democrats, broadly based on the secular organisations of the Catholic church in the north and rural communities in the south; and the Socialists and Communists, based on central strongholds (with their legacy in the Resistance) and, increasingly, the northern industrial centres. Although, in the first elections of 1946, votes were divided between these three parties, the Christian Democrats won a clear majority under the new constitution in 1948, reflecting the feelings of the Western Alliance at the height of the Cold War. The Christian Democrats stood for two fundamentals - for the Church, and against Communism.

Subsequently, as the opposition parties became more moderate, the Christian Democrats have remained in power through coalitions. Trying

to represent a kind of national unity, a party-state based on reciprocal ties and an ideology of neutrality, the Christian Democrats' policies have appeared to depend on 'non-initiative' and supporting interest groups that maintain stability.

The Communist party, although an heir to the Italian labour movement, was considered dangerous by the United States in the Cold War period because of its links with Russia. Italy joined NATO and the EEC, and the USA has supported the Christian Democrats in excluding the Communists from any possibility of coalition in central government. (Spotts & Wieser 1986: 281-2). Nevertheless, from the size of electorate regularly voting for the Communist party, it is clearly a mass party, with similar support to the Labour party in Britain, rather than a small, revolutionary party. This acceptance of Parliamentary democracy was made explicit in the 1970s by the then party leader, Enrico Berlinguer, by his proposals for an 'historic compromise'; and, for the period in 1977-78 which was crucial to establishing the Servizio Sanitario Nazionale, the Christian Democrat parliamentary majority depended on support from the Communists.

There is also a spectrum of smaller parties. On the far right is the neo-fascist Social Movement party, which has steady support in the middle-class quarters of the larger cities. The Liberals and Republicans did not regain their pre-war strength. A small but influential Radical party developed in the later half of the 1970s, campaigning for issues that have not fallen easily within the programmes of the other parties. Support for the Socialist Party (and subsequently the Social Democrats) weakened after their initial post-war strength,

but in the 1980s the Socialists have re-emerged in a new Centre-Left alliance with the Christian Democrats and three smaller parties, and the Socialist party leader, Bettino Craxi, has become the longest holder of the office of Prime Minister since the last War.

The geographical pattern of voting in Italy has been remarkably stable, despite the country's economic transformation. Traditionally, the northeast and the southern regions favour the Christian Democrats, and the northwest and central regions favour the Socialists and Communists. These are thus known as the 'white' and 'red' belts respectively. Both major parties depend on grass-roots local organisations to sustain their support. Christian Democrats are from Catholic middle and working class backgounds, and southern agricultural communities. Communists are usually industrial workers, central Italian farming communities, and intellectuals (Kertzer 1980). Support for the smaller parties comes particularly from professional and self-employed workers.

Politics are clearly perceived in everday life. An individual's party allegiance will usually be known to others, and appointments in public services are often arranged through party contacts. Indeed, the public services and national 'agencies' provide opportunities for patronage that are indispensible to maintaining party strength. Because the Christian Democrats have held much of the power for four decades, they have gained the most from clientelism, using it also for the internal struggles between groups within their party. Since the power sharing of the 1960s national centre-left governments, the Socialists have also built up clientelist relations; and they have been especially benefited

by the development of regional power, where they mediate between the Christian Democrats and Communist control. An analysis in 1980 showed that the proportion of posts in regional government was distributed Christian Democrats 44%; Socialists 24%; Communists 16%, whereas the percentage votes won in the elections the previous year had been Christian Democrats 35%; Socialists 13%; Cmmunists 30% (Sassoon 1986: 217-8).

Parliament

Constitutionally, parliament is the sovereign body of the Republic. It elects the President (so far, always from among its members), whose duties are predominantly formal. Parliaments are voted at a maximum of every 5 years, and do not depend on a formal 'government'. A government submits its resignation to the President when it is unable to assure a Parliamentary majority. But this is usually because of dissension between party and coalition factions. While a new coalition is being created, and discussions between the President and the invited new Prime Minister are under way, the old government maintains Ministerial control.

There are two Houses, the Camera dei Deputati (chamber of deputies, the lower house) and Senato della Repubblica (Senate, the upper house). There are 630 elected deputies, who must be age 25 or more, and 315 elected senators, who must be aged 40 or more. Further senators include ex-Presidents (by right) and 5 appointed by the President for distinction in social, scientific, artistic or literary fields. Legislation must pass both houses, but is usually initiated in the

Camera. Legislation is considered not only in full sitting of the house, but also by permanent or temporary Commissions, which are composed of representative members and can undertake work more expeditiously. An interparty committee, rather than the President of the House (who is elected from Members to control debates) decides on which path legislation takes (Sassoon 1986: 188).

Given the lack of majority of any single party (a result of proportional representation), the Prime Minister chooses a cabinet, either from just one party (depending on support or abstention of other parties) or as a coalition. Cabinet members are the 20-odd Ministers, plus a few extra places for members without portfolios. The Prime Minister's power is less than in Britain, because of the compromises of coalition politics and because of factionalism within parties. The Cabinet's power to ensure voting by its coalition members is lessened by secret voting in Parliamentary sittings.

These factors combine to make the Cabinet, and thus Parliament, a relatively weak and indecisive body. Beyond the formal power of Parliament, other negotiations between industrialists, trades unions, and individuals allow ministers substantial opportunities for individual action.

Public Administration

Despite a population of 57 million, Italy is still a country of small towns.

The traditional local government unit is the commune, and there are over 8000 of them. Six communes have populations of more than 500 000 people, but almost two-thirds of Italians live in communes of less than 100 000, some smaller than 1000 people.

The 95 provinces persisted as political entities after the introduction of regions in the 1970s, but their reponsibilities are limited to maintenance of roads and development planning.

There are 19 regions and 2 autonomous provinces. Six have special status: Sicily and Sardinia, each with independent traditions as islands, and the three regions with non-Italian cultural and language traditions - Val D'Aosta (French speaking), Trentino-Alto Adige (formally two provinces, of which the northern Tyrolean part, Bolzano, is German speaking) and Venezia-Friuli Giulia (partly Slav speaking). The regions vary in population from Val D'Aosta, of only 100 000, to Lombardia of 8 million. They also show a marked gradient in economic power. An ISTAT survey showed that average per capita income in 1979 was 30% higher than the national average in Lombardia (the region around Milan), and 35% below in Sicily and Campania (the region around Naples) (Spotts & Wieser 1986: 301).

However, along with such strong political forces in public life, the tradition for public administration is weak. The Republican and Liberal ideals were for little State intervention. During the Fascist period, the State entered into many areas of industry, commerce and public assistance, and, with jobs in public agencies being used to give favours

for political support, public services became widely mistrusted. This was compounded by poor recruitment into the civil service. Whilst at the beginning of the century the civil service in Rome was a small group of northerners, by the post-war period it had become a large bureaucracy dominated by southerners. A British political scientist, in the 1970s, described top Italian civil servants as 'illiberal, elitist ... fundamentally undemocratic' (Clark 1984: 338).

The decentralisation from Rome, needed when the regions were established in the 1970s, and reorganisation of the assistance organisations to form the new health departments from 1979, proved hard for these bureaucrats. It was not made easier by a tradition of promotion according to seniority rather than merit, rules designed to protect the positions of workers competing in periods of unemployment but not suitable for a modern, flexible administration (Hine 1979: 179). The Ministry of Health is no exception, and implementation of the Servizio Sanitario Nazionale has been hampered by this bureaucratic tradition. The service has depended more on initiatives by the regions than leadership from the Ministry.

Ministries are usually divided into functional sections, each headed by a Director General (Hine 1979: 165). The hierarchical structure of these directorates leads to blockages of work, as lower officials are unable or reluctant to take responsibility for action. There is no single top administrator; the Minister is kept informed by a cabinet of directors and outside advisers, who also provide the link between the Minister, other Ministries, Parliament, and the press. All ministries

also have an outposted section of the Treasury's central accounting office as well as their own accounts department and staff from the Court of Accounts.

Welfare

Italy was by no means slow among European countries in introducing social legislation: sickness, unemployment and pension insurance were all legally compulsory for at least some parts of the workforce by 1919 (Ferrera 1984: 33). But in the fascist period, social insurance was both centralised into government-controlled agencies, yet divided among 'corporatist' economic groupings; there was no agreement about essential needs nor uniform provision. As the economy grew during the 1950s and 60s, the proportion of public spending grew also. However, the large national insurance bodies, the 'Mutue', grew into independent agencies actively opposing government reform and seeking to maintain and enhance their own position. In the main, therefore, Italian social insurance is centralised, bureaucratic and provided through cash rather than direct services.

Ferrera (1984: 52) has analysed ISTAT data to show the relative proportion of social spending by broad groups from 1953 to 1980. Income support has been roughly steady at 50% of all spending; education was 20% at both ends of the period, although reaching 25% in the 'sixties; health expenditure rose from 9% in 1953 to 20% by 1975; social assistence fell from 19% at the beginning to 5% by the end; and housing fell from 6% to 1%.

The following brief descriptions of welfare services are from Ferrera (1984: 287-309).

Occupational pensions are compulsory for employed and self-employed workers, but with different schemes for different employment groups. There is a voluntary scheme for housewives. All people over 75 on low incomes are eligible to pensions.

Accident and sickness benefits are financed by compulsory insurance paid by employers, and vary according to employment sector.

Family benefits are paid monthly. They vary with family characteristics but not employment group. The contributions required of employers, on the other hand, do vary.

Unemployment benefits are for full, partial or temporary periods, usually with a maximum of 180 days in any one year. Contributions, made by employees, vary by employment sector, and benefits are a mixture of flat sum and extra payments.

Social assistance and services are provided for needs lying outside other social insurance, especially needs of minorities, elderly, families and children. A wide range of cash and service provision is financed from national taxes and distributed through regions. Legislation in 1977 abolished the many agencies delivering the benefits and services, and communes have full responsibility for provision.

Education is compulsory up to the age of 15. About 60% of pre-school aprovision is private, 6% primary school, 1% middle school and 30% middle school. Private schools receive state subsidies. Universities are open to all who have completed upper school, and charge low (subsidised) fees. Public schools are directly controlled by the Ministry of Public Instruction, and teachers are civil servants. Schools have local representative management boards.

Housing subsidies exist for both public and private sectors, using both tax relief and direct support. The Ministries of Finance and Public Works regulate these payments. Regions and communes also contribute to provision.

Health services are described in more detail in the following sections.

CHAPTER 2: A REVIEW OF LITERATURE

2.1. Comparing welfare systems

Health care is part of the welfare system of a country. Studies of comparative welfare have developed from various traditions of social administration research in different countries (Higgins 1981, Flora & Heidenheimer 1981). But comparative welfare research and comparative health systems research have studied rather different questions. Many welfare studies have sought to explain why systems, or policies, develop; most health studies have sought to make a judgement on whether a system, or policy, is successful.

To an extent, researchers in different countries have tended to value more positively the features of their own system, validating to their own readership the rightness of the internal political choices made. Thus, the concluding speaker at a conference on the British and US health systems said: 'There seems to be an optimism, however, on the part of all speakers that the problems which exist with regard to their own system ... are curable, and that substantial advances will be made. My guess is that few, if any, people at this meeting would trade their system for that of their colleagues on the other side of the Atlantic' (Mahon 1986: 316).

An important problem in comparative social research is that the main actor is the state - an organisation rather than an individual. No-one can fully explain action by the state, as the state does not have

individual views. Its views are corporate, although affected by officers, public representatives and outside pressure groups. There can be an 'official' view, and the chief actors can give their personal views: but the actual course of events is a mix of forces that cannot be separated. The researcher must build up a picture from different sources without being certain of any single 'right' answer.

There is also the issue of translation. The researcher needs to be able to compare like with like. Even within a similar language, different cultures apply different meanings to the same words or the same meaning to different words. For example, Kaim-Caudle (1973) has shown how the US and UK use widely different words for the same welfare services. The researcher needs to be capable linguistically and culturally to make comparisons, and also to have a theoretical basis for analysis (Higgins 1981). Heidenheimer, Heclo and Adams (1983:8) advise that 'pursuing comparative public policy studies demands individual judgement, as much as it does skills for measuring objective social conditions'.

On the other hand, few countries have developed their welfare systems in isolation. Most countries contemplating a major reform have taken note of experience elsewhere. The United States has been collecting reports on health care in other countries for over 50 years (Newsholme 1931), although there is little evidence of direct application of this knowledge. Britain periodically considers whether financing health care might be more effective through means other than a National Health Service, and reports have been collected on the financing and structure of health services in other countries (British Medical Association 1970,

McLachlan & Maynard 1981, Hurst 1985, Ham Robinson and Benezeval 1990). In Italy, in the early 1970s, the Ministry of Health also collected and published reports on health systems in other countries (Ministero della Sanita 1977).

Indeed, similar forces exist in many countries. These include the development of new technologies for intervention, changing demographic structures (especially falling birth rates and the growing numbers of elderly people in the population), rising standards of education, and the increasingly democratic structure of political systems.

Lastly, the researcher must be aware of national biases within traditions of research. Thus, Flora and Heidenheimer (1981) suggest that extensive analysis of Britain as a paradigm for the welfare state has limited the interest of academic researchers in making comparisons. From the viewpoint of a research group in Germany, 'The British case is not the optimal way of starting to grasp the general characteristics of welfare state development ... The British experience is unrepresentative of Western Europe as a whole'. Writing in the United States, Heidenheimer, Heclo and Adams (1983: 10) recall that 'The first great national program of social insurance was initiated by the German Emperor William I'.

Welfare systems research: explaining change

'To ask why governments pursue particular courses of action is obviously as difficult to answer as it is important to ask' (Heidenheimer, Heclo & Adams 1983: 2).

Welfare systems research in Britain has developed within the tradition of social administration. After the second world war, comprehensive welfare services were made available to the whole population 'from the cradle to the grave'. The new social provision was the product of academic thought and advice, from Cambridge (Marshall and Keynes) and the London School of Economics and Political Science (Tawney and Beveridge). Subsequent academic research tended to look inward at the problems of the new services, responding to critics on the political right. Foreign comparisons were mainly with the English-speaking countries, with a prewar British heritage, the Scandinavian countries, and with the United States, where individualism dominated as a social value over social provision. Nevertheless, some studies with a broader international perspective were undertaken, for example, Abel Smith (1972) and Kaim-Caudle (1973). More recent British comparative studies have researched areas of the welfare state in more depth (eg Mangen 1987) while remaining within the British social administration tradition of political choice and social justice.

In the United States, comparative welfare research has been led by Wilensky, who has studied the influence of political parties and power in creating welfare systems (Wilensky et al 1985, Higgins 1981). In the 1960s, the United States began to hold more positive images of a welfare state than previously, but with a strongly different ideological history compared with the British model. Wilensky proposed two models of welfare, the 'residual' and the 'institutional'. These were originally conceived to describe different ways that social work appeared to deal with tasks, but the models were developed to contrast more broadly the

British and American welfare systems.

Wilensky has suggested political explanations for the different development of welfare states (Wilensky et al 1985). In the post war period, he said, 'Catholic parties' created more social welfare than 'left parties'. Wilensky claimed that 'there is no relation between left power and actual social security spending' and suggested that 'left parties with a substantial mass base increase popular expectations, make promises beyond their capacity to deliver, and thereby increase backlash'.

Wilensky's thesis has been challenged by Castles (1978, 1982). Castles acknowledged that increases in welfare spending have mainly been associated with parties of the right - except for health care - as transfer payments have allowed ideology to be squared with political need. But he suggested that Wilensky's political analysis did not have a class basis, since his 'left' parties include the Democratic party in the United States, while Catholic parties are noted for their interclass voting.

Castles used a narrower definition of left than Wilensky. His left parties had to demonstrate majority support from the working class, have union affiliation and participate in the Socialist International, a definition which excluded communist parties. The extent of welfare provision, according to Castles (1982: 57) depended on who controls the right. He argued that high levels of welfare in Scandinavian countries was due to left dominance in the party system, that is a vote of at least 40%, and a divided right. (Britain, a mirror image of this

position in the 1980s, supported his prediction in reverse). He identified various ways of measuring the strength of political parties - including the percentage total vote, the percentage seats in parliament, the number of years in office and the number of cabinet seats held. Castles saw welfare as needing support from a majority of wage earners. Successful welfare programmes, he proposed, seek to 'maximise the minimum'.

A third school of comparative welfare research has developed in Germany - the QUAM (Quantitative Analysis of Modernisation) project. This major programme arose from a UNESCO workshop in Lausanne in 1971, and had two contributing streams: that of 'modernisation theory', taking various ideas of economic and social development, and efforts to create cross-national indicators. Flora (1983) noted that, at the start of the research, there was the underlying, 'perhaps obsolete', idea of general laws of the evolution of society.

The QUAM project set a grand historical stage. It saw the unity of European history since Christendom and assigned an important role to 'the Germanic Kingdoms with their traditions of legislative-judicial assemblies of free heads of families'. The Reformation separated southern and northern cultures, not only in moral principles but also in economic and social relations. The State took over much Church property, and individual freedom increased as feudalism declined. However, the decline of the Church, and of the manor, left responsibility for the poor with the local parish and the State - thus the Poor Law.

In the view of Flora and Heidenheimer (1981), 'It has become ususal to identify the beginning of the modern welfare state with the innovation of social insurance'. This developed beyond the provisions of the Poor Law in four ways.

1. It sought to prevent destitution through routine means rather than to help in emergencies;
2. It sought to sustain income at specific emergencies rather than permanently;
3. It was aimed at working men rather than their family dependnts;
4. The beneficiaries were usually forced to contribute along with their employer (and subsequently from taxes also). 'The break with liberalism lay above all in the principle of compulsory insurance as well as in the recognised amount of state (financial) responsibility.'

The QUAM project identified the dates when European countries introduced legislation for social programmes. Protection against industrial accidents, with factory inspections, was usually the first; then followed sickness insurance and pensions; then unemployment insurance. (This 'general' pattern is particularly true for Germany). Welfare as direct benefits, for example, housing and employment, were later developments - and only in the UK was more than preventive public health included.

In contrast to these historical studies, the British literature has cautioned against seeking single explanations for complex social processes (Carrier and Kendall 1973). Higgins (1978) has suggested

several possible forces creating social policies.

1. Compassion: a desire of the ruling classes to create change for the greater good. Higgins recalls the words of Lloyd George introducing social insurance in 1911: 'The individual demands it; the state needs it; humanity cries for it; religion insists on it'. But she comments that 'social conscience normally requires the support of powerful interests before it is translated into practice'.
2. Ad hocism: change 'actuated by a purely pragmatic spirit'. Higgins comments that this is an essentially conservative view which depoliticises the process and, by keeping conflict invisible, helps to maintain the status quo.
3. Ineluctable paths: a historical perspective suggesting that welfare is a consequence of the needs of industrial production and therefore inevitably led by the economically advanced countries. However, this approach does not easily explain the diffidence towards welfare of the United States.
4. Conspiracy: Higgins reviews the work of Piven and Cloward (1977) on 'poor peoples' movements', who proposed that 'relief arrangements are initiated or expanded during the occasional outbreaks of civil disorder produced by mass unemployment and are abolished or contracted when political stability is restored'. She comments that 'this theory attributes greater powers of foresight, planning and efficiency to policy makers than seems reasonable', and fails to explain how benefits are gained by the weak and non-threatening, for example benefits for the disabled, sick or blind.
5. Disjointed incrementalism: Higgins suggest that 'Policy

makers ..when evaluating these changes ... do so, not in terms of the total situation ... but by comparing them with existing policies'. She quotes Popper: 'The piecemeal technologist or engineer recognises that only a minority of institutions are consciously designed while the vast majority have just 'grown up' as the undesigned results of human actions'.

Some of these explanations were conceived during the era of welfare expansion of the 1970s, and have an inherent sense of progress and inevitability. But, Higgins (1978:14) quotes Piven: 'The mere fact that people are poor or that the poor need special services never led governments to respond'. The theory of change must be built on an understanding of conflict, sometimes mediated through parliamentary politics, sometimes by economic factors, sometimes by external pressure.

2.2. Comparing health systems: which is better?

'Comparative health policy research is a field characterised by the optimism of its researchers in the face of strong pessimism among its users' (Stone 1981).

'This literature focuses on too few countries. Just try and find a good description of medical care in Spain, Argentina or Italy ... Guides to aspiring physicians embarked on the grand tour' (Dumbaugh and Neuhauser 1979).

Stone (1981) has addressed the basic question of what can be learned from comparative health research. She says that we have barriers to learning from abroad. We believe that 'our country is unique'; we take learning to mean copying, rather than understanding; and we regard our own country as likely to be innately superior'. But Stone suggests four types of learning: new ideas for services design; understanding causal factors that reside in culture or environments; predicting the impact of policy options; and recognising the presence of political and strategic factors within systems.

Wilensky (1985) criticised the effects of separating comparative health research from other comparative welfare research. 'Because researchers have relied on intensive case studies and assumed that each health system is unique, there have been few attempts to examine health policy in relation to other priorities or to social policy as a whole' (Wilensky et al 1985: 49). He is also critical of the methods used. 'No significant progress has been made in the systematic evaluation of

how various institutional structures shape the degree of government involvement in health care provision ... studies ... either display a lack of skill in the use of quantitative data or a lack of conceptual rigor, or both.' He suggests that researchers have not been impartial in selecting studies for examination. In the comparative health care literature 'there is a general acceptance of the view that health systems are the products of historically unique circumstances. However, by selecting only a few countries that differ greatly in the provisions they make for health care, analysts are biased towards these conclusions.'

Lastly, Wilensky suggests that the emphasis on economic factors in health care analyses is misplaced. 'There appears to be a widespread consensus among health policy analysts that public expenditures for health are soaring relative to both inflation rates and other social expenditure'; but this view, he says, is not supported by data. He also argues that 'in so far as theory guides health research, it tends to be mainstream economics'. But deficiencies of market place analysis are well known in other areas of welfare. 'Health policy analysts have shown an over-riding concern with cost-control'.

Wilensky points out that much more attention has been given to rising medical costs than, for example, rising housing expenditures or social security payments. It is, indeed, hard to explain. Perhaps it is related to the privileged status of doctors, whose ability to claim high salaries and be independent of bureaucratic control conflicts with aspirations to public regulation and controlling public expenditure.

Direct social insurance cash benefits, and other welfare such as housing, education and social work, do not have practitioners that can bargain so effectively to sustain their independent practice at public expense.

While health care studies have not, usually, been placed within the broader context of comparative welfare research, it is also true that welfare research has not always included health care. Thus Kaim Caudle (1973: 313), describing social policy in ten countries, relegates health care to an appendix with the disclaimer: 'A description of the health services of the ten countries in any detail and a discussion of the problems to which they give rise would require another book'. Similarly, the development of health care systems did not originally form part of the QUAM project.

Typologies of health systems

The literature on comparative helath services is large. Rodwin (1984) has divided the published literature into descriptive and analytic studies of whole systems, and single theme studies (where financial studies predominate). Among the multi-country descriptive studies are those by Babson (1972), Fry and Farndale (1972), Douglas-Wilson and McLachlan (1973), Roemer (1977), Raffel (1984), Saltman (1988) and Field (1989). Duplessis (1989) describes specifically the public health services of 14 countries. Analytic studies were differentiated by Rodwin (1984) into data-based, including the WHO-ICS-MCU study (Kohn and White 1976); single country, eg Eckstein (1958) on Britain, Stone (1981) on the FDR, Field (1967) on the USSR; and evaluative - a much smaller

field, including Anderson (1972) comparing the US, UK and Sweden, conceptual reviews by Roemer (1977) and Field (1989), and Ellings' (1980) overview with particular reference to developing countries. Of single themes, the commonest include health policy: Rodwin (1984); health planning: Bates (1983), Leichter (1979); and finance: Langendonk (1975), Abel Smith (1976), and McLachlan and Maynard (1981).

Roemer (1977) suggests a typology of health systems in five countries based on the patterns of economic development of countries: free enterprise (eg the USA); welfare (eg Norway); under-developed (eg Peru); transitional (eg Ghana); and socialist (eg USSR), for which he gives descriptions of each of the countries named based on his own observations. However, these are evidently not homogenous groups. The typology fails to recognise the different histories within European countries; fails to take into account different colonial patterns; and suggests that all socialist systems are similar. The typology fails most where there is greater similarity of countries between, rather than within, groups: for example, is Lebanon more like the US or Ghana in its system? Is Mozambique like the USSR or Peru?

Field (1989) proposes a rather different typology, mainly of use for developed countries. There are five types of health care, including: emergent - health care as individual consumption (some developing countries); pluralistic - health care as broad consumer service (eg USA); insurance - health care as guaranteed consumer good (eg Japan); national health service - state supported health care (eg UK); and socialised - full public provision (eg USSR). This approach has the

attraction of suggesting a spectrum of systems, but it also appears to have a determinist, evolutionary aspect - there is a suggestion that it would be beneficial for countries to move down the list. A typology could be more useful if it were neutral in values.

Studying health systems.

Method of comparing health systems may be polarised as 'contrasting health systems' (Elling and Kerr 1975) and 'similar systems' (Alber et al 1987). Widely dissimilar systems can be compared to identify the aspects of the services held in common. The opportunity of two contrasting health systems in Eastern and Western Germany has been used by Light and Schuller (1986) to investigate the effect of different political strategies for health care on underlying cultural values held in common. On the other hand, similar system comparisons can indicate important differences. Thus, Britain and Sweden have broadly similar patterns of hospital ownership and medical payments; but different levels of political control of state finance for health care have led to different budget patterns (Anderson 1972).

Przeworski (1987: 32), writing about comparative policy research in general, has suggested that 'We should consider as cross national any and all theoretically guided studies in a single country, even if they contain no references to other countries identified by name ... a study of a single country is cross-national as long as it takes a system-level variable to be a cause of some intra-systemic patterns of behaviour'.

Alber et al (1987) comment: 'Just like the participant observer in field

research, the social policy analyst must find out the narrow path between the two evils of 'going native' and 'going naive'. Case studies tend to run the first risk. Although the researcher may become more sensitive to the meaning of the data, he or she will easily confound nationally specific and general aspects of welfare - state development and may fail to achieve the social science goal of general explanation. Sweeping comparisons, on the other hand, easily fall prey to the second risk. As noted, they encounter equivalence problems in the operationalisation of variables, and given the large masses of data, they may fail to detect statistical artifacts.'

An overview of health systems studies is given by Reich (1989), which suggests conceptual issues for comparison. These include models of systems; ideologies (including efficiency, effectiveness and equity); structures (including planning, primary health care and the public/private mix); finance; and indicators of efficiency. Rather more abstractly, Liechter (1979) also suggested an 'accounting scheme' for comparing public policy in the health sector. He suggests that four groups of factors need to be assessed: situational, which are specific to local events; structural, relating to demography, language, institutions; cultural, the political, religious, ethical values of groups; and environmental, the events values and influence from outside. Leichter commented that the few studies that have included several or many countries in an analytic framework have tended to focus on economic issues.

Frenk and Donabedian (1987) suggest that state intervention in medical care can be characterised by two parameters - the form of state control and the basis of eligibility. Their description of state control includes ownership (concentrated or dispersed) and financing (concentrated or dispersed), although these categories are not mutually exclusive. The paper identifies both convergent and divergent historical trends in these parameters. The role of physicians is also noted, although the proposal is circular - physicians that are well organised are believed to be powerful, but power is often assessed in terms of the physicians' abilities to organise about issues such as health care structures.

Abel Smith (1976: 28) suggests that most methods of classifying health care systems 'give prominence to one feature rather than another ... What is more helpful is to list some key questions which need to be asked to describe a system organising and financing health services'. Widman and Light (1986) suggest six areas for comparison, derived from the literature. These include: how policies are legitimised, regulated and validated; financing; eligibility for services; organisation allowing implementation of specific health policies; the scope and limits of benefits; and outcomes of the system.

Finally, under the heading 'An agenda for the future', Lisle (1987: 494-5) has proposed 'an axiom and five principles'. The axiom is that cross-country comparisons in the social sciences are needed to enhance the advancement of knowledge and understanding of mankind and society. The principles require of those that pursue them:

1. Scholarship in one's own discipline - including scientific methods of experimental design and statistical analysis; history of ideas in the discipline; and how these constructs translate into other languages and cultures.

2. Expertise in the problem under investigation - the administrative context, history, data available, the population, policies and accompanying controversies.

3. Experience in collaborating with experts from other disciplines between the social and natural sciences ... Universities should provide both opportunities and greater rewards for interdisciplinary research.

4. Knowledge of other countries, their language, history and civilisation. ('Fluency in one, and preferably two, foreign languages should be required of all social science graduates.')

5. Opportunities to meet and collaborate with colleagues from other countries.

The literature reveals no preferred method for cross-national welfare or health research. Methods based on various disciplines have sought to answer different questions. Thus, historical studies, for example, the studies of the UK by Eckstein (1958), Lindsey (1962), Stevens (1966) and Hollingsworth (1986), have described how particular health services developed. Quantitative approaches that include several countries, for example, by the OECD (1985, 1987) provide narrower information than qualitative approaches, since data do not readily describe cultural patterns. The comparative historical, political and cultural analysis (Payer 1988) of health systems is underdeveloped, and may be the point at which welfare systems research has most to offer health systems

research. The current functioning of a single health service is best investigated by a combination of description and analysis (Abel Smith 1976, Stone 1981, Widman and Light 1986).

2.3 Evaluating health care

There are many ways that health care can be evaluated. These depend on the level of analysis (national, local, individual), method of investigation (sociological, medical, administrative, economic), and focus of concern (effectiveness, efficiency, equity). In practice, most health care evaluation studies, although giving precedence to one viewpoint, usually draw from more than one paradigm.

Evaluation implies an outcome - that something has happened. The outcome is often intermediate, but sometimes may be final. For example, the World Health Organisation's global programme against smallpox achieved its final outcome - worldwide eradication of the disease - through a long and insistent programme, country by country. But few interventions in health care are so precise: most are only seeking improvements towards what will forever be a distant target - the WHO concept of physical, mental and social well-being. For useful evaluation, it is necessary to identify a range of criteria that match the objectives of the service. Although intermediate objectives of health care may include policies and planning, availablity of facilities and staff, service quality and levels of activity, broad outcome criteria may be grouped under four heading: effectiveness, efficiency, equity, and acceptability.

In closely controlled scientific experiments it is possible to repeat an intervention enough times to demonstrate its effect in comparison with non-intervention controls. At the level of clinical practice, such studies (randomised controlled trials) give reliable information on

which to make clinical management decisions. Evaluation undr such controlled conditions is often termed efficacy, distinguishing it from broader evaluation of clinical outcomes in ordinary practice - usually termed effectiveness. However, national health systems are rarely subjected to scientific analysis, probably more from political constraints than from cost implications: the RAND Health Insurance Experiment in the United States (Williams and Brook 1990) is a rare example of a pre-formulated test of national health policy.

An alternative is to seek comparisons in another country over the same period. Italy was not alone in making welfare reforms duing the 1960s and 1970s, as the QUAM project has shown. However, as yet detailed descriptions are not available of health and social policy changes in other European countries during this period. In broad terms, the United Kingdom and the Scandinavian countries consolidated their post-war welfare states based mainly on state provision, whereas France, West Germany and the Benelux countries continued to develop social insurance models. It was the Mediterranean countries that slowly made changes in the welfare systems, with Italy leading. A comparison of health systems in these other European countries is beyond the scope of the present work.

Lastly, and most commonly, it is possible to draw some policy conclusions from observation of a service over time. However, this approach has limitations. Most notably, it impossible to be sure that no similar events would have happened in the absence of the intervention being evaluated. It is useful to review historical trends together, so

as to be able to draw inferences with suitable supporting data. For example, changes in housing, sanitation, nutrition and eduational levels in post war Italy are more likely to account for the falling perinatal and infant mortality rate than specific health care interventions - a view argued in detail for the United Kingdom by McKeown (1979). Another problem of data series is to be sure of their validity - that, for example, expenditures recorded in national accounts under specific heads actually were spent on those services in the field. An example in Italy might be the allocation of funds to the Cassa per il Mezzogiorno which failed to yield substantial economic development.

Effectiveness

The final outcome of health care must be to improve or sustain health. From a negative viewpoint, this can be measured either by deaths (or years of life lost through death) or as loss of health status (morbidity). There is a difficulty in morbidity data if they are derived from health service contacts - the more extensive the service, the greater the possiblity of recording disease. A repeating population-based survey could yield useful trends, but it is of note that, in reports from the United Kingdom General Household Survey, The purpose of a health service is to meet the health needs of a population, although medical practice cannot necessarily cure them. Trends in mortality and morbidity in Italy are described in Chapters 6 and 7, but many factors other than health care will have contributed to these changes.

Efficiency

Efficiency or economic evaluation is described by Drummond, Stoddart and Torrance (1987: 6) as determining whether resources used for health care could be better used in another way. The authors distinguish this form of evaluation from measurement of efficacy (intervention under controlled conditions), effectiveness (intervention in ordinary settings) and availability (reaching those who need it). In a more limited way, efficiency is an assessment of how resources are used, either providing more health care for the same cost or providing the same care for less cost. Among the difficulties of measuring efficiency are that full cost data are not readily available (for example, costs borne by patients instead of health services or costs allocated between health and other welfare services); that costs are usually average rather than marginal, and so do not reflect potential for redistribution; and that data in public services are often not available down to the level of individual patients.

Efficiency can be assessed to some extent through the availability and utilisation of health services. Resource use such as levels of staff, facilities available for a defined population, or patient throughput, all indicate a measure of efficiency. However, when compared in international settings (OECD 1987) or even within the country itself care must be taken not to draw conclusions beyond the level of accuracy of the data.

Equity

Equity is a relative concept, in distinction to equality which suggests that everything should be the same. Equity implies social justice, but

there are different conceptions of justice within a society, One method of increasing justice is the political process: the Health Reform was a part of this process in Italy.

Nevertheless, equity is a judgement. Since no health system has yet succeeded in meeting all health demands, let alone needs, what is the fairest way of distributing available health resources? Is it appropriate that all parts of the country should have the same expenditure per capita or should there be more available in richer parts where more of the national wealth is produced? Such conflicting questions can only be resolved through political processes.
Equity of health care may be divided into equity of inputs, services and outcomes. Geographical variations in provision are seen in all countries, often relating to towns and centres of economic development. But more may not mean better: intensity of provision may be balanced by the quality of care. Another aspect of equity of increasing concern is socio-economic differences. Little is known about socio-economic use of services across Europe because of difficulties in recording data (Fox 1989). Equity of outcome can be measured indirectly through socio-economic differences in mortality, but, as has already been discussed, these are probably more affected by factors outside health services than directly by health care itself.

Acceptability

In paternalistic health systems there has been a tendency for the views of service providers to be heard more than those of the patients. Only in recent years has a formal approach developed to gaining information from health care consumers. Some surveys are becoming available in

Italy. But unless market mechanisms are brought into play, consumer views are likely to remain under-recorded in comparison with other health care data.

Conclusion

Evaluation of the Italian health reform - the question 'How well has the service worked?' - requires a range of information which is set out in the following chapters. Effectiveness is considered in relation to health indices in Chapters 6 and 7. Efficiency is considered in relation to service provision in Chapter 4 and to financing in Chapter 5. Equity is considered in relation to service provision in Chapter 4, to financing and planning in Chapter 5, and to health indicators in Chapter 6.3. These three, - effectiveness, efficiency and equity - are reconsidered in Chapter 8 and followed acceptability (Chapter 8.4). Chapter 9 provides a retrospect and prospect for the SSN.

2.4. Health services in Italy

A description of the financial and administrative arrangements of health services in Italy in the early 1970s was made by Maynard (1975) in a review of health systems in the (then) nine countries of the European Community. At that time, the service was still organised through multiple public insurance funds while the reform law was being debated. Maynard (1975: 183-4) concluded: 'Many of the problems involved in the more efficient use of health care resources in Italy stand out in stark relief against the background of political machinations. Whether these machinations are capable of producing and effectively implementing reform is uncertain'. A PhD thesis at the same period (Miguel 1976) described Italian health services as part of a study of health system change in four Mediterranean countries (Portugal, Spain, Italy and Yugoslavia). Kohn (1977) also gave a brief description of arrangements in Lombardy during this period.

Law 833/78 initiating the Health Reform was translated into English by the Italian Ministry of Health (Ministero della Sanita 1979). Abel Smith (1984) descrives financial changes of the new system and issues of const containment. Robb (1986) has given a short description and analysis of the service in English. Political analyses of the reform were made by Brown (1984) in English and Fragniere (1980) in French. Other descriptions in English include Berlinguer and Fiorella (1983), Meneguzzo (1988), and Hanau (1989).

In the Italian literature, a handbook of the stuctures and administration of the SSN after the reform was written by Bernabei et al

(1980). La Rosa (1982, 1984) has edited collections of reports on organisational aspects, and Cavazzuti et al (1981), Merusi et al (1982), Freddi (1984) and Ferrera and Zincone (1986) have edited commentaries. More recent contributions include Muraro (1987), Clerico and Rey (1987), Bianchi and Fasol (1988) and France (1989).

CHAPTER THREE: THE DEVELOPMENT OF HEALTH SERVICES IN ITALY

'Causality and significance reside cumulatively in the concatenation and phasing of actions and conditions' (Abrams 1982: 314).

3.1. From the nineteenth century to 1945: a summary

The Italian State's interest in health care started during the middle decades of the last century. Some communes had appointed a 'medico condotto' as a general physician for the poor. Legislation in 1886 and 1890 established a directorate-general for health within the Ministry of the Interior, with a hierarchy of central and provincial health committees acting through the provincial prefect and the commune sub-prefect and mayor. The medico condotto, while maintaining rights for private practice, was also made responsible to the commune for public health advice. A closed register for doctors (the Ordine dei Medici) was agreed in 1910.

A national census of Church welfare services (Opere Pie) was undertaken in 1880 (Terranova 1975: 56). This revealed a total of 17 897 organisations of all types (schools, institutions, home care &c), of which there were 1187 hospitals and 14 institutions for the mentally ill. State influence in hospitals, initiated in 1862, was strengthened by legislation in 1890. The new law reduced the Church's control of hospitals by introducing boards of administration controlled by the prefect. The majority of hospitals became autonomous, sustained by private subscriptions, gifts and state subsidies, although much of the

nursing continued to be provided by religious orders.
The laws required that the costs of needy patients admitted to hospital should be reimbursed by the communes. This led to some communes trying to limit these costs by questioning the appropriateness of admissions, and to the hospitals seeking increases in the payments made. Hospital beds increased from 1.8 per 1000 population in 1887 to 2.5 per 1000 in 1907, and total hospital admissions almost doubled (from 372 965 to 607 804 over the period 1891 to 1907 (Piperno 1986: 32).

By the end of the nineteenth century Italy was also responding to the development of social insurance in other countries, especially Germany (Ferrera 1984: 22). A General Association for Friendly Societies was established in 1860. They developed rapidly, from 445 societies in 1862 to 6535 in 1904 when they were formally recognised in law (Piperno 1986: 27). A national fund for work accidents was set up, with contributions changing from voluntary (1883) to compulsory (1898). In 1886, legislation was introduced to control employment of minors, and in 1898 voluntary arrangements for pensions and sickness benefit were established in response to the growing numbers and political organisation of the working classes. Compulsory health insurance was also proposed by the increasing number of socialist members in Parliament, but it was not taken up by the government.

The Giolitti government had brought in universal male sufferage in 1912, and the period after the First World War was one of intense discussion and expectancy. Two major social insurance law were introduced in 1919, for compulsory pensions and voluntary unemployment benefit. A Parliamentary Commission was set up to review social insurance in full.

Against a background of the influenza epidemic, that killed as many Italians as the Great War had done (Clark 1984: 201), the report's 'maximum' proposals suggested unification of the insurance funds for pensions, sickness benefits, work accidents, unemployment benefit and medical care, as well as proposals for major restructuring of the hospitals, placing them under state control.

These farsighted ideas - "from workers' insurance, through social insurance to the threshold of social security" (Ferrera 1984: 32) - were stopped by the arrival of fascism. Indeed, the developments were reversed: the proposed unified sickness insurance scheme was abandoned and agricultural workers were excluded from security benefits. In 1927 the fascist state introduced the concept of 'corporations', a means of state control of business and workers in the various sectors of the economy. This was proudly described as demonstrating 'the collaboration of capital and labour', but the costs were entirely laid on the workers - there were no contributions from employers or the state. The self-help sickness societies were replaced by insurance funds, grouped according to manufacturing sectors. Labour contracts were required to include some form of health insurance. To support the pro-natalist policies of the government, a special fund for maternity and child welfare was created (ONMI).

Administration of the various funds was collected together in 1933 in three large groups: INAIL (for occupational accidents and illnesses); INPS (for pensions, sickness benefits, unemployment benefits, family benefits and tuberculosis care for the employed); and INAM, for medical

insurance and maternity. Yet the amalgamation was for administration of the funds only: the contributions and benefits of the funds remained diverse. The coverage of the insurance schemes was also limited. In 1927, there had been more than a thousand different funds covering only 650 000 people. By 1937 2.2 million workers were insured, covering 46% of industrial employers, 24% of agricultural workers and 17% of commercial workers. Overall, by 1939 24% of the population were covered, and - with the advent of war - 35% by 1940 (Piperno 1986: 54). In 1943 a single scheme for medical insurance was introduced, but only for private employers, and a number of small funds remained for special categories - state and local authority employees, certain professionals, broadcasting, theatre, and self-employed workers (Ferrera 1984: 35).

The fascist period saw two contrasting tendencies. On the one hand fascists wished to increase state control; on the other they wanted to limit the powers of the traditional local government bodies. The directorate for health in the Ministry of the Interior was abolished in 1934, and new agencies were established, such as the public health laboratories and services for tuberculosis control (paid for by a special levy on workers). These were parallel to, but independent of, the local structures, and usually directed from Rome. Some services were redistributed to other ministries: for example, malaria control became the responsibility of the Ministry of Agriculture, and occupational health passed to the Ministry of Industry.

Lack of resources held the modernisation of hospitals back. A law in 1926 returned the Church's influence in the administration of hospitals, helping the fascist government along the path to the 1929 Lateran Pact

with the Vatican (Piperno 1986: 48). Some prestigious new hospitals were built in the large cities, where they had a high profile - for example the University Polyclinic in Rome. There was also some charitable and private hospital development. But, in contrast to Britain at this period, no municipal hospitals were built. Instead, the state set up polyclinics in provincial towns to provide consultations by private specialists: insured patients were reimbursed by their insurance funds.

3.2 1945-68: the post war period.

After the end of the war, a meeting at Venice on 12 September 1946 brought Regional Commissioners for Health together with an expert group of public health doctors and practitioners from the Veneto, and was led by two leading scientists, Egidio Meneghetto and Augusto Giovanardi (Ministero della Sanita 1977: 121-146). The group's report criticised the existing system of health services for their inequalities and poor quality:

(1) While the cities provided reasonable preventive (hygiene) services, the rural areas were 'a dessert'. Many towns still had no proper refuse disposal, the provincial laboratories mainly did work for the provincial capital, and most people in rural areas were still cared for at home rather than in hospital.

(2) The services were overlapping and confusing. For example, maternal and child health was provided by the government's fund ONMI, treatment and preventive sevices for tuberculosis by INPS, and other medical care through the various sickness funds;

(3) administrative control and distant bureaucracy prevented rapid and effective local response. The report commented that 'many communes and bodies have waited not just for months but for years for the return of a project for a waterpipe or a hospital sent to Rome for the blessing of the central authorities'.

The group recommended a three tier system to unify preventive and care

services, with strong local services independent of political and administrative control. The local Health Office was taken from models already existing in some provincial capitals. It would be run either by a commune or, in the rural areas, by a consortium of communes. It would coordinate prevention and care, under a medical head, and would have a laboratory and a polyclinic. Consortia of Health Offices could cooperate to provide a large modern hospital, with specialities and isolation wards, and the Health Office would be represented on the hospital's administrative board. There could still be small hospitals run by individual Offices. Local hospitals would be subject to the Region, which would also directly run the mental hospitals, sanitoria and other large specialist hospitals, and have strong powers for coordination and planning. A central Ministry of Health would be responsible for all medical services, although with no direct control for providing them. The group considered that general funds, rather than a special health fund, would be preferable, both for efficiency of collecting and because typically other commune services also were provided from general funds.

The caretaker government, led by a Christian Democrat government, De Gasperi, from June 1946, finally formed an advisory group to advise on welfare provision, headed by Ludivico D'Aragona, between July 1947 and Feb 1948. Gross inflation during the war years had diminished the insurance benefits of many citizens. The Commission's 88 proposals anticipated many of the ideas that were to emerge in the '60s. They recommended that cover for sickness, pensions, medical care and work accidents should be extended to all employed people, including the self-

employed and their families, and proposed unification and simplification of the social insurance system (Ferrera 1984: 36-37). For health care, the Commission proposed extensions of insurance, both in range of people and character of service. Nevertheless, the Commission chose to work from the viewpoint of the Mutue, rather than from underlying needs. In retrospect, the Study Centre of the Ministry of Health commented: 'The term 'reform' became synonymous with a cautious advance along the traditional path. Institutional and political questions of health care were not mentioned: everything could be resolved at a technical level' (Ministero della Sanita 1977).

There was little development in social welfare during the 1950s. The rules laid down by the Aragon Commission in 1948 were accepted. There was an extension of Mutue cover, but by creating new Mutue rather than integrating them into the existing structures. There were actuarial incentives to the workers and employers to do this, since the rates of interest that could be gained for new members were more favourable than from joining an already established fund (with the costs of existing retired members).

Health care began to surface as a political issue in the later 1950s. A conference on 'problems of health care' was held at the Palazzo Torlonia in Rome in 1957 as a response to the law setting up the Ministry of Health (Istituto di Studi Parlamentari 1957). Issues discussed included the existing fragmentation of provision, variations in benefits, need for hospital provision in the south and need to improve medical education. But there was little discussion of the role of the new Ministry.

In 1954, the Communist party had proposed free health care for people below a fixed income, and in 1956 for all workers (Ferrera 1984: 227). In 1957 the Communist-led trade union confederation CGIL first proposed a national health system, and this was taken up in 1959 at the national conference of the Communist party in Rome that year (Longo 1973). The government's planning committee also proposed extending hospital care to all citizens (Ferrera 1984: 227).

A book by two Communist party members, Berlinguer and Delogu (1958) provides a useful representation of the issues at the start of the health reform debate. The authors' critique of medicine was divided into 7 chapters, and was followed by proposals for a national health service:

Chapter 1 describes the multiplicity and overlap of systems. As the Council of Venice had argued in 1946, there was confusion over who pays for what. For example, who should pay for a TB patient in hospital? If TB is active, then INPS may. If TB is non-active, INAM may. For those not covered by INPS or INAM perhaps the Consorzi Provinciale Antituberculare might pay. Or if in extreme poverty the commune might pay. However, if you fall into more than one of these groups, each wanted the other to pay.

Chapter 2. Large variations in health indicators existed between regions: hospital provision, from 8 beds per 1000 in Liguria to 0.7 per 1000 in Basilicata; stillbirths, from 22/1000 in Val d'Aosta to 51 per 1000 in Basilicata; children born in hospital, from 63% in Val d'Aosta to 4% in Basilicata.

Chapter 3. The medical faculty was described as 'the great sickness of Italian universities'. Poor instruction was indicated by failure rates of up to 50%. There was a lack of preclinical equipment, of clinical teaching, and of research.

Chapter 4. There were large numbers, misuse and poor understanding of pharmaceuticals.

Chapter 5. There was a need for doctors to yield their autonomy and to change from individual to team work.

Chapter 6. The Mutue system for financing health care was regressive and there was unnecessary workload of clinical examinations by doctors for sickness certification.

Chapter 7. Criticism of contemporary medical practice. Continuing infections, such as 4452 new cases of polio in 1957; the hazards of poor diets; and the need to change the mental health laws. The authors' concerns are described in a joke: "Bertoldo is reported to have told King Alboino that there are only three uncurable diseases - madness, cancer and debts." The authors distinguished public health, a function of government which acts upon the community, from preventive medicine, which helps single individuals and should be undertaken by single practitioners.

Chapter 8. Citing the British NHS as an example of better organisation, the chapter set a series of proposals for reform -

extension of insurance cover to all citizens; unification of the Mutue; a hospital development plan for the South; tax-based finance; and control by the Ministry of Health.

Much of the health sector was outside the direct control of the Ministry of Health when it was established in 1958 (Colombo 1977). The Mutue were controlled by the Ministry of Employment and Social Security: yet, in 1973, INAM, the largest of the Mutue, directly ran more than 900 ambulatory care units for generalist and specialist care. The hospitals, up to the 1968 law, were responsible to the Ministry of the Interior through commune Prefects; and there was similar control of the rural doctors (mediche condotti) and the school medical services.

The first indication of political intent was the introduction into Parliament 1961 of a hospital law: this was first approved in the Senate, but failed to complete its course through the Chamber of Deputies because of the end of the legislature (Longo 1973). Also indicative was the first Communist party conference specifically on health, "Riforma sanitaria e sicurrezza sociale" held in Rome 28 February - 2 March 1963, which set a platform for social reform to be pursued by the unions during the sixties with increasing concern (Berlinguer 1982 and Longo 1973)

The period of the Third legislature, from 1958-63 saw a slow move of two political parties towards the central ground of politics. The Socialist party, which had run joint candidates with the Communist party for the 1948 election, was becoming a modern social democrat party, separable from the Communist party in recognising the option of reform through

supporting the Christian Democrats. Equally, some of the factions within the Christian Democrats, always a broad coalition of interests, wished to draw away from the right wing parties that had supported the Christian Democrats in the second legislature. This trend was led by Fanfani, whose first centre left government in 1962, a three party (DC-PSDI-PRI) coalition, received Socialist party parliamentary support.

The centre-left coalition programme promised a number of major reforms, including nationalisation of electricity, support for agriculture, reform of schools, establishment of the Regions (as foreseen in the 1948 Constitution) and setting up a planning commission to consider better integration of the private and public sectors (Mammarella 1978: 369). In the 1963 elections, the Christian Democrat vote fell from 42% to 38% (since 1958), confirming the trend away from the Christian Democrats in local elections.

After the party conferences had agreed the new alignments, Aldo Moro was able to lead a true centre-left government, a four party coalition (DC-PSI-PSDI-PRI). Moro sustained this coalition from December 1963 to June 1968, although the government needed to be reconstituted twice in this period because of inter-party dissension. As time went on, a deteriorating economic position led to decreasing support for the reforms. Thus the third government, from March 1966, included hospital reform within its legislative programme, although the original intentions of this law were much reduced in cabinet. The government did eventually see through two symbolic pieces of legislation: the economic plan for 1965-69 finally became law on 27 July 1967; and a law to hold

regional elections was passed in February 1968.

Constitutional and administrative laws provide constraints on the executive through various courts and committees (Hine 1979: 194 seq). One such committee is the National Council for the Economy and Labour (CNEL), which includes 60 representatives of areas of the economy and 20 experts from other committees and government bodies. It has 'enjoyed considerable prestige over the years as a forum for debate on a wide range of affairs' (Hine 1979: 199).

In October 1963, a short report by CNEL discussed social insurance and services (Ministero della Sanita 1977). While the Committee foresaw the eventual nationalisation of these funds, their short term proposals were to coordinate three groups of social security funds - for sickness and retirement, for accidents and occupational diseases, and for health care - and to widen insurance to the whole population according to ability to pay and without constraining economic development. For health services they proposed extension of hospital care and greater uniformity of benefits for the insured groups. Noting that 'direct provision' of hospital care was preferable, they accepted that patients could opt for 'reimbursed' (ie private) services. They also suggested reviewing the work of the 'mediche condotti' whose position was felt to be anomalous. No mention was made of a formal Health Service, nor of the Ministry of Health (which had been established 5 years previously), nor of the role of decentralised levels of government.

However, the Centre-Left government constituted a new Commissione Nazionale per la Programmazione Economica (CNPE). This had a

subcommittee for health which did not sit ('for political reasons', according to Berlinguer (1964)), but CNPE commissioned a background paper (Longo 1973) which was written by Berlinguer. Thus, there is marked similarity between the eventual proposals in the Plan 1965-69 and Berlinguer's own thoughts at this time, expressed in his second book (1964): full coverage; prevention, especially of accidents; a move to income-related funding; control by the Ministry of Health through a hierarchy; and control of finances in a single organisation.

In its Chapter VII, the Plan was far more definite about the reform of health care than previously. It proposed a Servizio Sanitario Nazionale, to operate at commune, province and regional level, using public and private sectors coordinated by the Ministry of Health, and for the gradual fusion of the enti and the hospitals. The Commission proposed the need for a framework law (legge quadro) for the organisation and financing of health care. It suggested that prevention should be organised through Unita Sanitarie Locale, for populations of 15 000 to 50 000: the text defines 2113 USLs to be necessary, (the same number that Berlinguer proposed in his book of 1964) which, given Health Offices already existing, meant constructing 1400 new offices. (No further details were given in the Plan of where these should be, or how they would be organised in practice.) 82 000 new hospital beds would be needed within the 5 planning years (and 200 000 by 1978), of which 70% would be for the south. The plan did not discuss the organisation of hospitals, and their relationship with the state structures. Broad capital and revenue costs were stated, and the funds were seen to be derived from 'gradual fiscalization of the contributions'.

This Commission report was influential in two ways. First, with the working documents it generated, the report provided a touchstone for ideas and proposals. For example, the words 'Unita Sanitaria Locale' remained up to the 1978 Law, while the concept of the USL expanded from an organisation primarily aimed at population preventive services to one controlling all health services within a given territory. Secondly, the orientation of the report was towards abolition of the Mutue system, and transferring health care financing to the state - a path eventually leading to the SSN. This was crucial: if there had been greater belief in reform of the mutue at this stage, it might have been possible to avoid the increasing debts and financial crises of the late sixties and early seventies.

The Camera dei Deputati reviewed the budget of the Ministry of Health each year since its foundation in 1958. The Ministry sought funds to help the deficits of hospitals. In 1964, 'awaiting a full hospital reform', the Camera noted 'grave tensions' existing between the hospitals and the Mutue. The system, in simple terms, was that the hospitals put their claims to the Mutue, who paid them. However, as Berlinguer showed, this was not a simple system. The Mutue argued about their responsibility for payment, and the resulting deficits for the hospitals mounted up: in 1965 they totaled 100 million lire, in 1966 they were 130 million lire. By 1967 the hospital doctors were angry because the 1966 state subsidy had been used by the Mutue to pay off the general practitioners rather than the hospitals. Moreover, rising hospital costs were now also hitting the provinces.

In 1967, as part of the negotiations on the hospital law, a special payment of 476 million lire (over 3 years) was made to the Mutue, and a Commission was set up to consider, inter alia, the cause of the rises in hospital bed-day rate and to consider hospital-mutue cooperation. The Commission concluded that polyclinic-hospital cooperation could improve out-of-hospital investigation of patients, and that provinces should set up local committees to look at the care of long-stay patients. The underlying trend was too strong, however, and the Mutue debts continued to rise.

Planning was not a style that the government was accustomed to. For 20 years the Christian Democrats had practised slow incremental change, sometimes rudely termed 'non-government'. Instead, they preferred extending state involvement with central control, to build up their system of 'sottogoverno'. Their way forward, rather than the broad idealism of the Plan, was to reform specific areas. Two pieces of legislation did reach Parliament in 1968 through the efforts of Mariotti, the (socialist) minister of health from 1965-68: the first was a law on general hospitals, the second a reform of the 1905 mental health law.

Mariotti first put a proposal for hospital legislation to the Cabinet in 1965, but was 'continually frustrated' (Delogu 1978) until the conservative majority were satisfied that it protected the independent status of the hospitals, religious and private interests, and the position of the senior hospital doctors. Aldo Moro, leader of the main left wing stream within the Christian Democrats, said: 'So that this

delicate operation does not become the Trojan horse of state medicine, and of nationalisation and salaried doctors...then the law must confirm the continuation of private contracting ('convenzioni')' (Bruni et al 1977: 226). The law was eventually passed in February 1968, shortly before the dissolution of the third legislature.

The Hospital law 132/68 promised a substantial renewal and restructuring of the national hospital network (Censis 1969). Public hospitals were to be available to everyone, without restrictions of insurance group. There would be a defined administrative structure and accountability of acute hospitals, ensuring more representation for the provinces and communes, and for the Mutue. Hospitals were to be classified into local, provincial or regional according to the facilities provided. It proposed to plan hospital building through national and regional committees (although the national planning mechanism was not implemented), and established a national hospital fund to improve hospital equipment. It defined the organisation of hospital staff, encouraged development of paramedical training, and required a post-qualification hospital year for all medical graduates before independent practice (Parlamento Italiano 1968: 2364-75.)

While the Hospital law was certainly an advance, improving the regulatory framework for the Ministry of Health, it fell far short of the ideas floated by the Comissione Nazionale per la Programmazione Economica in 1963. It did not touch on the other health sectors or how they might better articulate with the hospitals. It continued the system of hospital reimbursement by the Mutue according to bed-days used. And it promoted the existing trend to build more hospitals rather

than improve the quality of services within existing stock. These factors tended to increase rather than to limit hospitalisation, and placed greater pressure on the total health budget (Di Carlo 1983)

Later in the same year Parliament also passed the mental health law 431/68. This law sought to ease the practice of psychiatry in mental hospitals. Voluntary admissions were legalised, and the names of people admitted to psychiatric hospitals were no longer legally notifiable to the police. The law also made suggestions for the development of psychiatric services, recommending psychiatric 'sectors' in general hospitals and a contraction of the psychiatric hospitals to no larger than 500 beds.

In the meantime, Mariotti had established on 2 May 1966 a 'Commissione consultiva generale per la riforma sanitaria di base'. Two submissions to the Commission indicate the position of some doctors at this time (Ministero della Sanita 1977). Serpelli, professor of public health at Perugia, was critical of the tendency of the Mutue to individualize medicine and to reward treatment rather than prevention. He emphasised the USL as the fundamental structure for local care, with a strong service from salaried doctors fully supported by paramedical assistants.

A larger group of doctors, representing a multiplicity of organisations described three fundamental liberties:.lsl

- of the citizen to choose any doctor
- of the doctor to choose salaried or independent practice
- of private practice to be integrated in the public sector.

They foresaw as short term goals only (1) unification and rationalisation of the Mutue and (2) USLs to coordinate prevention. Only in the long term would there be (3) tax based funding and (4) unification of prevention, cure and rehabilitation under the USL, but their report is quite detailed about the structure at this final state.

Political will at this point is recorded in a speech by Moro at the inauguration of the new Ospedale S. Carlo in Milan, 14 October 1967:

'We have put forward a programme, which is now a law, for comprehensive health care as part of social security. Health care that protects the fundamental needs of human liberty, covers the entire Italian population and draws on the tax system as well as insurance contributions from employees and employers' (Longo 1973). Nevertheless, the centre left coalition fell at the end of the legislature with little evidence of the wider reforms promised in 1963.

3.3 1968-74: the years of delay

The health services in 1968 were organised within structures created in several previous periods of central government control. Public health services, school health and medical care for the poor were organised by the provinces and communes, and were ultimately responsible, following the Napoleonic system introduced by the Savoy King in 1860, to the Ministry of the Interior through the Prefects.

In 1968 there were 9090 mediche condotti and 7382 ostetriche condotti employed by the communes, who also ran 354 pharmacies. Just under 2 million people were registered to receive free care, including 400 000 children in institutions. The communes paid 57 billion lire for 608 000 hospital admissions and spent in total 126 billion lire. The provinces spent more, 181 billion lire on services for 178 697 mentally ill, 40 007 mentally handicapped, 136 330 orphans and 61 133 other patients. In comparison, the state subsidy to the mutue that year was 189 billion lire (Parlamento Italiano 1975).

The hospitals were also responsible to the Ministry of the Interior, but the 1968 law, changing them into 'autonomie istituzioni di assistenza e beneficenza' gave them more independence. The Mutue were also 'enti', quasi-public bodies, answerable for their financial affairs only to the Minister of Employment and Social Security, not directly to Parliament. This offered opportunities for political patronage, especially for the Christian Democrats. The largest insurance fund, INAM, with about 70% of the population enrolled, directly ran a network of 900 local polyclinics. Doctors, although increasingly working full time

(salaried) in hospitals, clung to their traditional position as 'liberal professionals' "which enriches and perfects the abilities and knowledge of medicine" (Censis 1986:139).

Political activism and development of the regions were the key influences keeping pressure for health service reform in this period. Increasing strength of popular protest was seen in all European countries. Union organisation had re-emerged in Italy during the 1960s in the recently industrialised north. In 1969, the year of the 'autunno caldo', over 300 million working hours were lost in strikes (Sassoon: 51). Yet although the unions did achieve substantial wage increases in 1969 and 1970, militancy was also directed towards the conditions of work. With dating plant, management had sought to overcome falling profit margins by increasing the speed of production lines. Unions responded with a coherent critique of manufacturing processes, calling for workers to be able to determine the rhythm of production and calling for changes in monotonous work on health grounds.

Some of the political tension for greater participation was relieved by the elections for Regional Councils, which Parliament had agreed in February 1968 and were finally held in March 1970. As with many government laws, the 1968 law had been primarily a framework law. The actual responsibilities of the regions were subject to further legislation. In January 1972 the government passed a Decreto Delegato to implement the regional powers, but used a strict interpretation of section 118 of the constitution. They chose to transfer from the centre limited powers for planning and monitoring and some direct services were

taken from the provinces. However, on the grounds of 'national interest', most of the public bodies, such as the hospitals, which were part of the sottogoverno system, remained in the control of the central Ministries. These decisions were backed up by the Constitutional Court, which usually interpreted the powers of regions in a narrow and limiting fashion (Presidenza del Consiglio dei Ministri 1978).

Assessori for health in the new regions met in Trento only three months after the elections (Delogu, 1978), and the role of the regions reawakened discussions in the parties. Most of the parties agreed on three broad principles: that health care for prevention, treatment and rehabilitation should be organised in a National Health Service and administered through the regions; that the services should be available to, and equal for, all citizens; and that there should be the (eventual) dissolution of the Mutue and funding through a National Health Fund. Nevertheless, these broad guidelines left substantial room for disagreement, and - because of coalition politics - disagreement meant lack of action.

The views of the main parties around 1970 are set out in documents reprinted by the Ministry of Health (Ministero della Sanita 1977) in Rome. (The positions of the Italian Social Movement party MSI, the 4th largest party, and the smaller PLI, which had a brief spell in government coalition in 1972-73, were not reprinted, suggesting that that the government at the time of the 'historic compromise' did not wish to be identified with neo-fascist or conservative views in the health debates). The documents presented can be characterised as Christian Democrats: vague; Communists: idealistic; Socialists and

Republicans: technical.

The Christian Democrats proposed considerable autonomy for the regions to define their local arrangements, but within the constitutional control of the courts. For example, regions would be allowed to create 'agencies' for the administration of the health services. They preferred local services to be 'coordinated' rather than directly managed (giving reasons of being against hierarchy and bureaucracy). Thus the USLs and the hospitals would be separate enti under the region. One surprising feature was the Christian Democrat proposal that a part of the pharmaceutical industry should be nationalised - although the Christian Democrats had already nationalised the electicity industry as part of the centre-left agreement, and had interest in sustaining nationalised industries such as IRI because of the patronage afforded.

The Communists brought forward issues that were not much on the other parties' agendas, yet were already slogans for the political debate on the left - greater emphasis on prevention and on public participation. The push to prevention came through the union movement, and at the head of Communist demands was an improvement in preventive care and control in the workplace. Participation was proposed through strong local presence in the USL by the communes (or groups of communes) and formal involvement of committees of health staff, medical and non-medical. The Communists saw all health facilities controlled by the USL, including the mental hospitals which, at this time, they regarded as better placed than the general hospitals because they are already under state control. All staff should have a single, centrally negotiatied contract, and

eventually be salaried without rights to any private practice. The whole of the pharmaceutical industry would be nationalised. There would be a National Health Committee under the presidency of the Minister of Health, with expert and regional representatives.

The Socialists and Republicans were more structural. The Socialists, recognising the disparity between 8000 communes, 2000 USLs and around 1300 hospitals indicated the regions as the fulcrum of the system. But the USLs were expected to provide a wide range of services:

hygiene and infectious disease control
medical care, at home and ambulatory
hospital care
preventive medicine, rehabilitation and recovery
legal medicine
health education.

(at this point there was no mention of veterinary, dental or occupational services). The USL would have an elected management committee; above this would be provincial, regional and national committees with planning and control functions. The Republicans suggested a structure very similar to the British NHS, separating regions and districts, with all hospitals joined to a district structure of preventive and community services, but with the GPs independent.

Other views expressed during the period of consultation included those of the regions, unions, the doctors and the Consiglio Superiore di Sanita.

Accepting the concepts of a national health fund, and USLs, the regions were concerned to maximise their own place in the system - that is, to get as much power as possible transferred from central government and to see the abolition of the provinces. Given that regions represented various political parties, the concern was not so much what was to happen but that it would happen at all. In December 1973 they had a meeting with the Minister of Health, and presented their own proposals, setting out the transfer of all enti and personnel to the regions. Their main worry, at this point, was that the government might also transfer the Mutue system to them, debts and all, without the resources to balance the budgets.

Like the regions, the unions, represented by the CGIL-CISL-UIL coalition, also cut across party politics, although to a lesser extent. They were concerned with extension of all citizens and equal services; like the Communist party, they wanted participation (especially by staff) in the structure of the new service; and they made extensive representations for the importance of the prevention in the workplace. But they were not against a mixture of public and private medicine, and guarded the rights of professionals to choose full time, part time or fully private work.

In contrast, the doctors appeared to have less power in the debates. Represented by a loose federation of their Ordini dei Medici (FNOOMM), they were divided within themselves. Some doctors were afraid of any

changes and wanted to retain the status quo. Others were seeking to practice a new form of medicine - these especially in the small but influential left wing groups who had a following in the post-1969 students studying medicine (see Nuova Medicina, 1972; Arbosti, Bertazzi, Carreri et al, 1972). On the many central issues - such as prevention, participation, structure of the USLs, central-local powers, even methods of funding - the doctors' organisations appear to have had relatively little direct influence. Fragniere (1980), drawing on Berlinguer's writings, notes that, while the President of FNOOMM wrote in the December 1978 issue of the doctor's journal, 'the reform will fail because it has elements that simply will not function', the following month its editorial, headed 'The health reform: an event of great political and social importance' claimed 'a major opportunity to realise a deep and substantial renewal'.

Nevertheless, doctors had other paths for influence. For example, the Consiglio Superiore di Sanita commented on the draft SSN law in April 1974 and made 2 particular comments: first, that USLs should serve populations of about 50 000, and never more than 100 000. This showed the concept of the GP and the polyclinic as the geographical concept, rather than the hospital. As for hospitals, they accepted that zone hospitals and some provincial hospitals could be managed by USLs, but stated that other provincial hospitals, and also regional, specialist and university hospitals, should remain as autonomous 'enti' outside the USL structure.

1969-70 was a period of many, confused social movements. The strikes organised by the Unions, trying to regain control of the grass roots

movements, used social conditions as part of their bargaining. Ripamonti was Minister of Health in the first and second Rumor governments, December 1968 - July 1969, and August 1969 - Feb 1970. In the 'autunno caldo' of October 1969, the Ministries of Health and Employment & Social Security set up a joint working party, with two subcommissions to look at the cause of the rising costs and ways of enabling the health reform (Ministero della Sanita, 1977). The economic groups identified four areas contributing to the rising costs of health care: the expanding population; the aging population; rising use of services per person; and rising costs per episode of use, especially in the hospital and specialist sectors. No evidence was discussed about the appropriateness of care. The sub-commission endorsed the concept of a national health fund. The structure group indicated two principles for the development of the SSN: that health should be articulated through democratic channels; and that care should be integrated rather than fragmented. Their solution, following from the recent law for hospital development, was to propose regional committees for coordination of hospital planning.

In April 1970 trade unions produced a joint document on the SSN. It called for the immediate creation of USLs providing a full range of health services; creation of a national health fund and regional funds; creating unformity of eligibility; and extension of care to groups at present unprovided for. The document also made two new proposals that were to become more evident in the debate. These were (1) participation at various levels and (2) a strong emphasis on prevention, especially for risks at work and in the environment. To support these proposals,

new issues were introduced in the prevention debate (Censis 1971).

These included:

- Italy had fallen from 13th to 18th place in the nations of Europe for perinatal and infant mortality over the previous 20 years;
- high morbidity of genetic, environmental and social factors for the health of school children;
- high rates of accidents at work;
- increasing pollution as a result of the 'economic miracle'.

The third Rumor Government, March - July 1970, saw the return of the socialist Mariotti as Minister of Health, and he remained there under Colombo until Jan 1972. In October 1970 the government and unions signed an accord which committed the government to present a proposal for the SSN to Parliament by 15 March 1971. 'There opened a long period which could be described as a 'hoax' in which the unions were nailed down in prolonged discussions to produce and refine papers and accords that were then systematically disregarded' (Terranova 1980). By 1971, Censis (1972) noted that 'the likelihood of success in the reform is notably slowed because of the sectoral interests ' - the Mutue, the Ordini dei Medici and 'sottogoverno'. New issues of debate were visible: centre versus periphery; democratic representation; representation of unions on the elected bodies; and rivalry between the Ministry of Health and the Ministry of Labour.

Mariotti, as Minister of Health, put forward a design law first on 16 December 1970. (It would be almost 4 years before a design law would

actually reach Parliament, and over 8 years before it was fully approved.) This law proposed that hospital and ambulatory care should be entirely free, based on a National Health Fund by amalgamating the Mutue. Structurally it saw USLs as the decentralised bases of the SSN, but the provincial and regional hospitals remaining independent of the USL. Nevertheless, these proposals by the Socialist minister were attacked by the PCI, who wanted: USLs based fully within communes; abolition of the independet hospital boards and full integration of the hospitals; abolition of the private sector.

Mariotti played down the expected costs of the new service, maintaining that the rich not currently covered would not be users of a new public system and the poor are already paid for by the communes. In March 1971 Mariotti and the Consiglio Superiore di Sanita proposed a timescale: to extend coverage to all citizens from January 1972; to provide free hospital care from July 1972; free drugs from April 1973; free specialists from October 1973; and a fully free service from January 1974. Mariotti said on TV: 'I don't know the costs: but this extension must be accepted by the government in the interests of the country' (Petroni & Marini 1977).

The proposal was put to the Cabinet on 28 March 1971, but was delayed there. An interministerial group, set up to look at the costs of the reform, met in October 1971. Mariotti argued that costs could be cut by rationalisation, concentrating the service within INAM, and that this would allow the extension of the service to the full population. INAM, on the other hand, published a report suggesting that there would be an average 9% increase in costs by extension to the unprotected.

Eventually the Consiglio dei Ministri turned the proposal down on 7 December 1971 on grounds of costs. The crisis of the government in Jan 1972 overtook Mariotti, and general elections were held. After a caretaker government, Gaspari was appointed minister of health within the new centre-right government of Andreotti, in July 1972.

Mariotti, now in opposition for the PSI, introduced his own proposal law, no 352 on 28 June 1972. With increasing party frustration, this was followed by Longo (Communist) on 13 June 1973 and de Maria (Christian Democrat) on 20 December 1973. But two issues were now running side by side - the eventual creation of the SSN, and the current escalating costs. INAM proposed a new classification of their pharmacopoea. In 1974 this contained 16 039 drugs, of which only 4639 were considered to have a single active principle. (This compares with a total of 3300 drugs available in Britain and 2500 in Sweden in 1972 - Ghiandai & Innocenti 1977). INAM proposed reducing the total 16 039 by a mere 564, yet Gaspari rejected this. Instead, withstanding criticisms of delay in the Commission on Hygiene and Public Health (October 19 and 14 December) Gaspari circulated a revised bill to the Christian Democrat council by December 1972, and on 18 April 1973 the government started consultations on the new draft.

Andreotti's coalition fell in June 1973 without the bill reaching Parliament. The new Christian Democrat coalition government was led by Rumor, with Gui as Minister of Health. The government proposed that the health reform question should be examined by an interministerial commission, chaired by Valiante. They reported their proposals in

January 1974, and had discussions with the regions and unions. The draft was approved by Cabinet on 3 July 1974 and was put to the Camera dei Deputati on 12 August 1974 - but not before the government's interim decree law on hospital financing had been approved.

1974 was the key year in the development of the SSN because the financial crisis of the hospitals finally pressured the Government to change the financing system. The 1968 hospital law had been intended, among other issues, to solve the hospital deficits. But the one-off payment included in the legislation had not resolved the costs of the underlying expansion. The hospital deficit of 300 billion lire in 1968 had risen to 1280 billion in April 1972, and it continued to rise dramatically - 1900 billion in October 1972, 2300 billion in March 1973 and 3000 billion by December 1973 (Sereni 1975).

By 1971 the hospitals had broken their contracts for paying staff and debts to contractors, increasing the pressure for reform. In 1974 the debts were estimated to be distributed 40% to the banks, 5% to the Mutue and 55% to suppliers. The national federation of hospitals, FIARO, proposed that the government should pay off these debts, create a national health fund, abolish bed-day reimbursment and institute a distribution formula. These proposals would be economical, they believed, by saving bank interest, reducing administrative costs and even argued that paying off the debts would lead to an improvement of the country's trading position (Sereni 1975).

In April 1974 Vittorio Colombo became Minister for health. (It was Emilio Colombo, as Prime Minister, who had made the agreement with the

Unions in 1970 to implement the health reform.; His autobiography (Colombo 1977) gives only a brief account of this time. He explains the 'growing demand' for hospital care as due to (1) increased demand by citizens (2) more prudent medical practice (3) also imprudent medical practice (4) rising care for the elderly. But he makes no mention of supply factors. While the hospitals were running up huge debts, Colombo considered the option of raising the Mutue charges:

'In that general situation of economic and energy crisis, while prices were constantly rising and the country at a difficult moment of monetary devaluation and recession, that solution appeared unthinkable: it wasn't possible to ask more sacrifices of the workers.' (Colombo 1977).

He doesn't mention that some, at least, of the mutue debts were from evasion by self-employed workers, so that raising the charges would fall unduly on salaried workers.

The government introduced a decree law dealing with the hospitals independently of the full SSN reform. It came to Parliament (no 264) on 8 July 1974 and was ratified (no 386) on 17 August 1974. The law was passed at a politically stormy time. There was rapid inflation and political confusion. The 1973 oil crisis had hit the already unstable Italian economy badly. The International Monetary Fund demanded fiscal balance: the Republican Party wanted to cut social programmes, while the Socialist party defended them; and the Christian Democrats were tied by the political patronage flowing from their distribution of public funds.

The Communist party, under its new leader Enrico Berlinguer, was rising to its historic highest point in votes, enhanced by its evident success in responsible regional coalition governments in the central 'red belt' of Emilia, Tuscany and Umbria. The Christian Democrats, on the other hand, were isolated from their coalition partners by their opposition to the recent divorce law, and further weakened by internal differences in economic policy.

In February 1974, the Republican Party withdrew from the coalition. The Christian Democrat Prime Minister, Rumor, formed a new government in April with only the Socialist and Social Democrat parties alone. The Christian Democrats accepted the International Monetary Fund proposals, but the Socialists refused to implement them. The Socialists withdrew, and Rumor submitted the whole government's resignation on June 11. But there was no visible alternative, and President Leone rejected the resignation. Rumor's government thus continued limping along until, in November, Moro succeeded in bringing the Republican party back into another coalition.

It was also the time of the rise of the terrorist groups. On Sunday 4 August 1974 neofascists exploded a bomb on the railway between Florence and Bologna, killing 13 people and injuring 100: the next day Rome was blocked with protests organised by the left parties and the unions. In the USA the Watergate scandal was at its peak and on 8 August Nixon resigned from being President. The vote in the Camera dei Deputati was held on a Saturday evening. It passed with 266 votes of the government for (DC, PSI, PSDI, PRI) and 221 against (PCI, PLI, MSI) (Il Messaggero 1974).

3.4. After 1974: slow completion

Although not the full health reform law, Law 386/74 contained many new developments:

1. It transferred ownership of the hospitals to the regions.

2. It paid off the current hospital debts (of the Mutue, 2700 billion lire, to the provinces and communes).

3. It transferred the Mutue payments for hospitals into a Fondo Nazionale per L'Assistenza Ospedaliera (FNAO) - but left other health care payments, for specialist consultations and general practitioners, still with the mutue.

4. It changed hospital payment from bed-day reimbursment to a fixed prospective budget.

5. It defined a future date for the dissolution of the Mutue - 2 years from June 1975.

This last requirement was, for the SSN as a whole, the most important, since it ensured that the role of the Mutue would continue to be reviewed by Parliament. The amendment was only introduced during the Commission on Hygiene and Public Health's debate on the decree law (interposed as section 12 bis in law 74/386). These debates are not publicly recorded, and even a recorded debate would not reveal what compromises were traded by the left for this advance.

However, the new system remained an imperfect vehicle for controlling costs. Hospital bed numbers were rising; the Mutue could transfer their costs by encouraging admission of patients; and the new service was to

be available without restriction of length of time, in contrast to the 180 day limit of many Mutue. The health reform thus continued in an unstable position: more legislation would be needed. As part of the politics of getting law 386 through, the government at last presented their first full proposal for a servizio sanitario nazionale to Parliament on 12 August 1974.

The summer of 1974 was a crucial period in the history of the final health reform, but it also released the immediate pressure for reform. Law 386/74 temporarily solved the financial problems and gave the regions major new responsibilities which had to be met. Regions that had been foremost in pressing for the reform now had to set up administrative structures, financial systems, planning bodies. At the same time, Parliament was debating the complete reform bill, albeit at a snails' pace, within the Commission on Hygiene and Public Health.

A joint document between the Communist and Socialist parties indicates the contemporary political agreement between these two parties in the reform debate (Ministero della Sanita 1977). They suggested three areas for controlling spending:

(1) Rationalisation of provision of general practitioners: continuing eduation; full capitation payment; limitation of list sizes to 1500 patients; and incentives to practice in under-doctored areas.
(2) Control of use of pharmaceuticals: reducing the number of pharmacists; reducing the number of drugs available on the approved list; revising the pricing structure; and improving medical knowledge of drugs.

(3) Hospitals: reduce admissions by 'filtering' through an admissions department; reduce lengths of inpatient stay; review the hours worked by doctors to give maximum efficiency.

But 1975-8 was the period of highest political tension in Italy since the immediate postwar years. Because of proportional representation, and compulsory voting, local elections are a close reflection of political support. The second regional elections in June 1975 showed substantial gains for the Communist party, from 27.9% in 1970 to 33.4%, a rise of 5.5% at the expense of centre-right parties. The Milan stock exchange fell 8% in one day. After the complex negotiations necessary for forming coalitions, 5 regions (Piedmont, Liguria, Emilia, Tuscany and Umbria), and several of the large cities (including Milan), had Communist or Communist-Socialist coalition governments. The central government was rent by the anomaly of Socialist support in the central coalition while in opposition in regional and local governments. At the beginning of 1976 the Socialists formally withdrew from the central government, forcing the dissolution of Parliament.

The political turmoil was not resolved by the national elections, held in June 1976. The Communists showed a further advance, reaching their historic highest proportion of votes at 34.4% (compared with 27.1% in the national elections of 1972). The Christian Democrats also recovered the losses suffered a year before at the regional elections. The combined votes of Socialist and Communist parties did not give an overall majority, but the Socialists saw themselves squeezed between the two major parties, rather than holding their traditional position of

'broker' for the Christian Democrats: Craxi was elected to the party leadership to strengthen their reorganisation.

Without clear coalition partners, the Christian Democrats only found agreement to govern through abstention of the other major parties. But the Communists also gained the position of Speaker for the Chamber of Deputies, and the Chairs of three committees in both the Chamber and the Senate (Kogan 1983).

New bills for the health reform were tabled by the parties shortly into the new legislature:

PCI 22 December 1976

DP (Democrazia Proletaria) 3 February 1977

PSI 11 February 1977

PLI 18 March 1977

The health reform was low on the new government's list of priorities, and the government's bill was only reintroduced by the Minister of Health, Dal Falco, in April 1977. The 26 articles agreed in the previous legislature to 1976 were incorporated, but two thirds of the articles were still to be debated.

In the meantime, the 3 year period of grace for the abolition of the Mutue, set in the law of June 1974, was at an end. The Regions had strong reasons for pressing for the end of the Mutue. Not only was the NHS a major future function as yet untransferred from central control, but regions had pressing difficulties in being responsible for running

the hospitals without control of their finance. Although law 386/74 required that Mutue funds be transferred into the National Hospital Fund, the financial position of the Mutue was still not sound. As a result of investment in hospital building, especially in the South, rising numbers of doctors practising, and the broader coverage of insured people, hospital expenditures continued to grow. The Mutue had no system of direct regulation of hospital costs or use, and their accounting systems were kept separate from the regions' control. Bank debts persisted, and some were not finally paid off by central government until March 1981. Not least, persistent evasion of Mutue contributions led to chronic underfunding.

In May 1977, Dal Falco introduced crisis legislation through the Commission on Hygiene and Public Health. This extended the life of the Mutue by placing them in the hands of Commissioners who would oversee the funds until their dissolution by 1979. The law, 349/77, required that the Mutue be integrated, that patients could be insured with any one, and that there would be only a single contract with each GP. Voting on 22 June 1977, the Commission passed the law by 41 votes to 1 (the neo-fascist Socialist Movement-National Right coalition representative voted against) (Parlamento Italiana, 1979). A further law, passed on 4 August 1978 (461/87), required a survey of expenditure for 1976 and 1977 by all agencies, setting at last a firm foundation for the coming health service fund.

The Andreotti Christian Democrat government lasted for 18 months. The Communists were becoming increasingly resentful of waiting on the

sidelines, and sought greater influence through an 'historic compromise' of sharing power in a social democrat state. Many Christian Democrats, vocally supported by the United States, continued to reject the possibility of Communist participation in the central government. But Aldo Moro mediated a second Christian Democrat government, lasting less than a year from March 1978 to January 1979, which proved to be the springboard for achievement of the three most important pieces of health legislation of the decade. This government agreed to a radical step: that, while the Communist party would not be formally within the government, they would be consulted on all important issues and become part of the parliamentary majority. This formula, of being partly within government, had been used before for other smaller parties in coalition with the Christian Democrats, but never before with the Communists in central government.

It was a gamble for the Communist party that did not succeed. The picture was profoundly changed by the abduction, and subsequent assassination, of Aldo Moro by members of the Red Brigade shortly after the negotiations of the new government had been completed. While the political crisis brought some accorde between the two major parties as they faced the common enemy of state terrorism, the electoral impact was profound. Elections for communes covering 10% of the population in May 1978 saw the Christian Democrats recover their lost votes, while the Communist vote fell back severely. The coalition continued through till the beginning of 1979, but collapsed with the Christian Democrats' increasing confidence that a general election would see a return of their traditional support and a turn away from radicalism. Yet these short months saw the completion of all three pieces of health

legislation - psychiatric reform, abortion reform and the Servizio Sanitario Nationale - that the left had been pressing for ten years.

The health law took its slow course in various parliamentary committees during these crises. With a very different national political perspective than a decade earlier, when the original proposals for a Servizio Sanitario Nazionale were made, the debate focused on technical issues (Bernabei, Cirinei & Zolo 1980). There was concern to ensure spending control through identifiable budgets; to encourage planning through recommended norms of provision and standards of service; 'a policy for personnel to restore efficiency'; redeployment of personnel between state agencies; and measures to control demand for services - for example, reducing long stay psychiatric care, limiting specialist referrals, controlling drug use and stopping the expansion of hospital beds.

The Commission for Health debated the bill during 1977, and finally approved it in December. It was then put to the full Camera dei Deputati, who approved it in July 1978. The Senate then debated it, making alterations on the structure of the USLs, the definition of districts within USLs, representation on the Consiglio Nazionale di Sanita, and redefining the work of the Istituto Superiore di Sanita. Finally, on Saturday 12 December 1978, the Senate voted their assent, and returned it to the Camera, which was deeply in debate about reform of the Universities. On 21 December, the Camera voted on the Law, with a substantial majority of 381 for, 77 against (parties from the extreme right and the Liberals) and 7 abstentions (Il Messaggero 1978). With

the approval of the Senate, and the President, the Law was finally passed on 23 December 1978.

CHAPTER FOUR: THE SERVIZIO SANITARIO NAZIONALE

4.1. Structure and functions

The 1978 Servizio Sanitzario Nazionale law (833/78) sets out the responsibilities and structures of the three tiers of the new health service. The Law defines the Servizio Sanitario Nazionale as

"the totality of functions, structures, services and activities aimed at promotion, maintenance and recovery of physical and mental health of the whole population, without distinction between individuals and ensuring equality of citizens before the service." (article 1)

The health functions are divided between three levels of public authority established by the constitution: the state, the regions and the communes. (The provinces, while continuing to exist constitutionally, were excluded from the SSN, although supracommunal and infraregional associations, such as the Assemblee Generali, were recognised.)

Central

The State retained to itself responsibilities for:

a) planning national objectives

b) deciding overall levels of provision of health services

c) regulations to ensure the maximum levels of health for the population.

Central administrative functions include:

a) international relations;

b) control of dangerous substances (pharmaceuticals, drugs, foods and energy);

c) regulations for national issues - for example, organ transplants, work contracts, health of the military and state police;

Central State power for the SSN is divided in three:

1. The Cabinet (of the ruling parties) - or delegated to the Comitato Interministeriale per la Programmazione Economica - oversees the work of the Ministries. Regions, however, are constitutionally independent, and their laws can only be revoked by the Constitutional Court.

2. The Consiglio Sanitario Nazionale (National Health Council) is established to advise the Cabinet and the Ministry of Health in three areas: determining national health policies; developing the triennial national health plan; and implementation of the plan. The CSN gives guidance on norms and levels of services, and should provide annually for Parliament a Report on the Nation's Health. The CSN is appointed for 5 years. Its 45 members include representives of all the regions and autonomous provinces, many other Ministries, and the main scientific health advisory bodies.

3. The Ministry of Health. The Minister acts on the decisions of Parliament. The Ministry, with about 500 civil servants supporting the Minister, is not regarded as very strong. It lacks direct control over

the Regions, and the SSN budget is controlled independently by the Treasury. The Minister of Health is advised by several technical consultative boards and institutes, including

* the Consiglio Sanitario Nazionale,
* the Istituto Superiore di Sanita (the large Institute of Public Health in Rome, with responsibilities for biomedical and technical advice, monitoring, research and public health education),
* the Istituto Superiore per la Prevenzione e Sicurezza del Lavoro (Institute of Occupational Health, undertaking research and education, and providing advice to local occupational health services),
* the Consiglio Superiore di Sanita (Scientific Advisory Council - appointed every three years by the Minister of Health).

Regions

The Regions and Autonomous Provinces are the main administrative level of the SSN, responsible for implementing decisions taken by Parliament. Each has an elected Council and ruling group (giunta), and a large administrative department for health services (Assessorato Regionale alla Sanita). The health budget is the single biggest item of the regional budget, and the health Assessore has, therefore, relatively more power locally then the Minister of Health has nationally.

Regions are formally responsible for much of the SSN provision, but regional actions must be covered by regional laws which have to be approved by Parliament. The regional laws cover the whole range of SSN provision, but are independent of every other region. Particular laws for the SSN include:

1. constitutions, geographical areas, organisation, structure and functions of the USLs;

2. regulations for financial accountability of the USLs;

3. the triennial regional health plan.

Using their power to implement USLs with a variety of ways, some Regions have joined health and social services together, creating Unita Socio-Sanitarie Locale ('USSLs'). Central powers for infectious disease prophylaxis, and control of dangerous substances and veterinary products are also delegated to regions.

Communes

Communes are the natural local political unit. There are more than 8000 of them and they vary enormously in size, from a few thousand people in rural areas to over a million people in the bigger towns. The intended size of a health service unit in the SSN proposals was about 50-200 000 people. The solution was to create USLs which were either parts, or multiples, of communes, thus achieving roughly balanced populations.

Within the larger cities, the USLs have usually been created according to existing submunicipal boundaries - but again with considerable variations in size. Some cities, Turin for example, were divided on paper into many small units, the electoral wards, but in practice keeping power within one city-wide USL. Other cities, Bologna for example, spent years in consultation about the USL boundaries within the city.

Communes have independent legal status within the State. Traditional local government functions with a public health interest include the police, monitoring of consumed products, refuse collection and agricultural pest control.

The original 1978 SSN law required communes to meet together through a new body, the Assemblea Generale. These assemblies met rarely, however, perhaps six-monthly. Their formal function was to elect the USL management committee of between 7 and 15 members. Being composed of commune politicians, the assemblies tended to try to intervene in the affairs of the USLs or to take financial decisions with a political intent.

Partly as a response to criticisms of inefficient management of the USLs, the Assemblee Generale were abolished in 1986. Each USL president and management committee became directly appointed by the commune council (or an inter-commune assembly appointed by the region where several communes contribute to one USL). This regulation, however, still does not apply in the special mountain communes in the alps, where the USL and communes are coterminous and the president and ruling group of the commune directly become the committee of the USL. Elsewhere, the management committee was reduced to 5-7 people, a president and 4-6 members, who are elected (in the words of the law) from 'citizens with experience in management and administration, demonstrated in a curriculum'. The members chosen can include people who are not elected politicians.

The USLs

The USL president is a paid, full-time appointment. The other members have been elected in a proportion that closely reflects the balance of power within the communes rather than a straight apportionment according to electoral votes. Thus, in Communist Party strongholds of Tuscany and Emilia Romagna, USLs have a majority of communist members; but a national study in the early 1980s, of 530 presidents and members of USLs, showed that the three main parties took the large majority of places, and the Christian Democrats and the Socialists held a higher proportion of posts than expected by their votes in commune elections - Table 4.1 (see also Ferrera and Zincone 1986: 227-40)

Table 4.1 Party representation on management committees (Freddi 1984: 229)

Party	President	Vice president	Member	1980 comune elections
	%	%	%	%
DC	54.0	25.6	39.2	35.7
PSI	20.0	37.0	19.0	14.1
PCI	20.3	20.5	19.0	30.0

Each USL also has a Collegio dei Revisori (auditors) of three members, appointed by the Treasury, the Region and the Commune respectively, who oversee the financial activity of the USL. They provide three monthly reports to the regions, and to the Treasury and the Ministry of Health (France & Prisco 1986). (More details about political and administrative arrangements are given in Caselli 1983.)

The Unita Sanitarie Locale (USLs) are responsible for the actual running

of health services. While in principle they serve populations of between 50 000 and 200 000, the range is wider in practice, see Table 4.2.

Table 4.2 Distributions of USLs by resident population (Collicelli 1986: 67)

Population	No. USLs	% total
up to 40 000	119	(17%)
up to 80 000	301	(43%)
up to 120 000	144	(21%)
up to 160 000	76	(11%)
up to 200 000	39	(6%)
more than 200 000	16	(2%)

Regions themselves vary substantially. For example, the region of Veneto, averaging 121 000 per USL, has 35 USLs with populations that vary from 21 000 to 380 000, whereas Molise has smaller USLs with an average of 48 000 per USL (ISIS 1986 (5)).

The USL is the natural unit for coordination of hospitals, but smaller divisions, distretti sanitari di base (districts), are described in the SSN law for the more effective organisation of primary care. Districts were expected to be an important level for participation between the health services and the local population. However, few USLs have been active in making districts work, for political and financial reasons.

The functions of districts would include

* monitoring the environment of daily life, work and food;
* emergency primary care;

* GP and pediatric care at home and in clinics (this latter by nursing care);
* specialist consultations;
* preventive medicine - immunisation and school medicine;* nursing care of elderly, chronically sick, mentally ill and people with drug dependence;
* family advice, planning and infant welfare.

Each USL has a central office, for administrative and political functions. The staff include two managers, one a doctor and one an administrator. The doctor is usually a hospital clinician, working extra time in this managerial role. The administrator has usually been transferred from a previous position within the health administration, for example in INAM. Both managers are appointed on fixed term contracts of not less than three years which are renewable.

Health services are provided either in hospitals, or in community-based clinics. But USLs also have several responsibilities beyond patient care. These include health education, occupational and environmental health, pharmacy, family planning and child health care, information services and veterinary care (including supervision of abattoirs). These functions are usually divided into separate administrative sectors.

Services

Because of the different traditions of clinical practice in Italy compared with British practice, the following descriptions indicate the

use of the words -

* hospital: provides inpatient care for one or several specialities, with investigation facilities and possibly also outpatient care. Hospitals may be public (fully owned by the SSN, a public university or a public Institute) or private (contracted regularly or for certain services to the SSN, or independent of the SSN). Mental hospitals have only psychiatric patients, but general hospitals often have an acute psychiatric ward.

* polyclinic: a community-based public facility where salaried or contracted specialists provide outpatient care; polyclinic consultations within the SSN depend on referral by the GP.

* clinic: where a specialist sees patients for personal, usually ambulatory, consultation; includes consultations for diagnostic tests (laboratory or imaging). Private specialists provide consultations either fully privately, or (more often) contractually through SSN if referred by GP and agreed by USL. Most larger hospitals have 'clinics' where staff undertake both public and private practice.

A picture of an 'average' USL in 1984 has been drawn from national data: (ISIS 1986 (6) 66-68).

The USL extends over 18 000 hectares, across 12 communes, and has a population of 85 000 people (0-12: 16%, 13-59: 65%, 60+: 19%). Primary medical care is provided by 92 contracted doctors and the equivalent of 5 out-of-hours doctors (covered in practice by 28 doctors). Primary

care creates 575 000 prescriptions from 21 pharmacies, and 610 000 requests for specialist examinations and investigations per year.

Specialist consultations are provided by 51 doctors at the hospital, at 6 clinics (3 polyclinics) directly provided by the USL and 27 private contractual clinics - 7 chemistry and microbiology laboratories, 2 immunology assay labs, 6 radiology, 4 physiotherapy and 8 other specialties. Together they provide 332 000 laboratory tests, 123 000 physiotherapy treatments, 38 700 Xrays, and 116 000 other specialist services - including 11 900 orthopaedic, 16 400 obstetric and gynaecological, 14 900 dental, 10 500 oculist. The USL has a public hospital of 565 beds and a private nursing home of 86 beds. These together provide for 14 300 admissions with 166 000 bed days. Of these, 8000 people are admitted to surgical wards, and 3000 operated on.

Public health, veterinary and occupational health are provided by 53 staff, including 11 doctors (only 1 in occupational health), and 6 vets. There are 4 maternal and child health clinics, with 10 doctors and 20 assistants. Overall, 900 people are employed by the USL (see Table 4.3), and another 300 contracted. Thus 5 to 6% of the people living within the USL also work for it.

The annual budget in 1984 was 56 billion lire, equivalent to 656 500 lire per inhabitant per year. Of this, 60% is for hospital care, 15% for drugs, 7% for GP and paediatric primary medical care, 5.7% for ambulatory specialist care, and 4.3% for public health.

Table 4.3 Staff in an average USL directly employed by SSN (ISIS 1986: (6) 67)

		no.	per 1000 pop
Medical			
	doctors	115	6.4
	nurses	348	1.4
	other	77	0.9
Professional		1	
Technical		289	3.4
Administrative		70	0.8

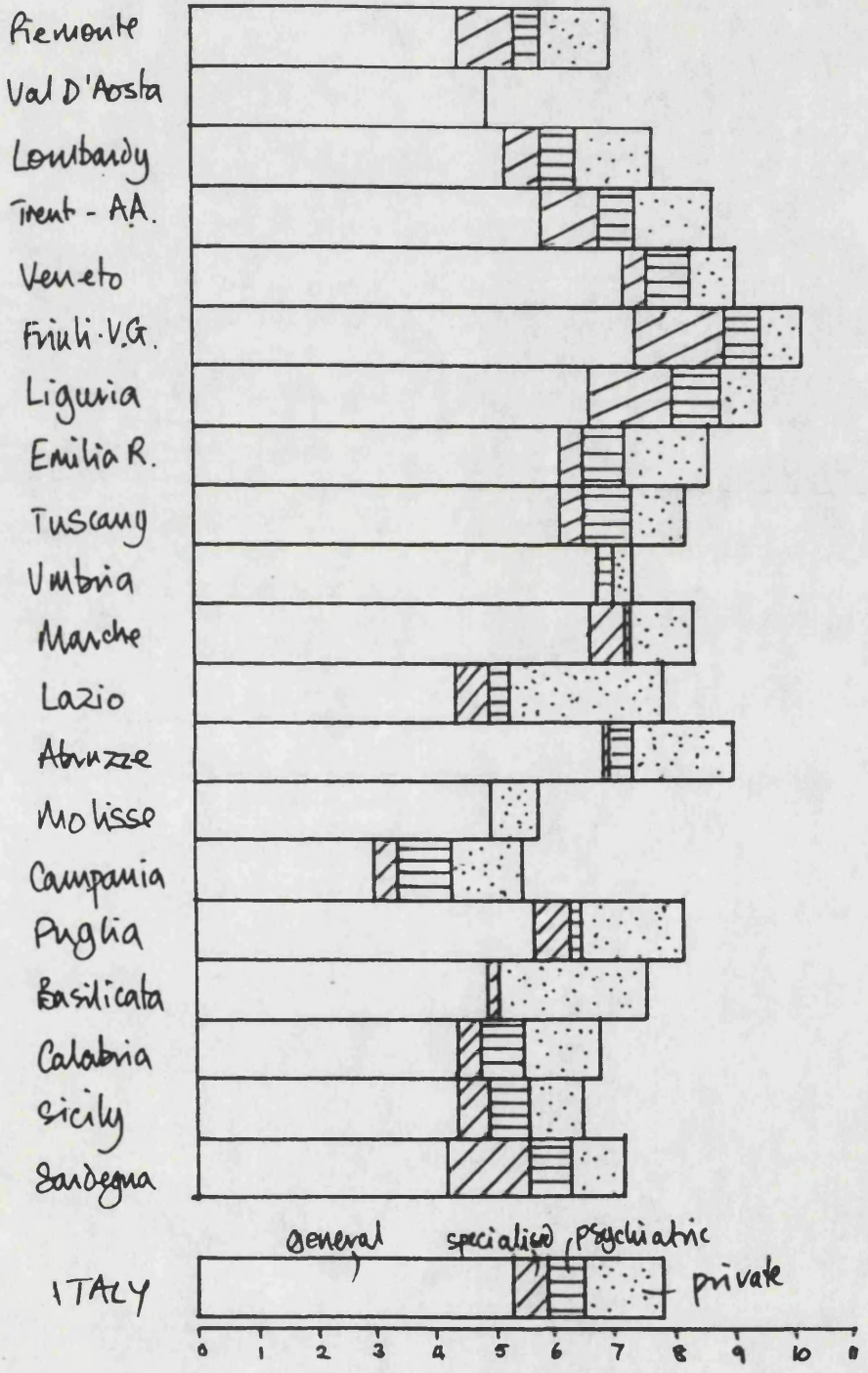
4.2. Hospitals

More than half of an average USL's budget is spent on hospitals. The majority of hospitals are public. They are mostly directly managed by the USL, but some have 'public contractual' arrangements. Among the latter are University hospitals, scientific institute hospitals, 'classified' religious hospitals, and other hospitals identified in particular regions. (Legal details of these contracts are discussed by Pizzi, 1982.) These hospitals have different financing to the main USL hospitals: they are reimbursed by the SSN by a fixed sum per patient treated (not differentiated by diagnosis or severity). Overall, in 1987 there were 1061 public hospitals (334 000 beds) directly run by the USLs, 84 'public contractual' hospitals (28 000 beds), and 611 private hospitals (68 000 beds) (CSN 1988: 473-80; France 1988: 14). The Ministry of Health expects a general hospital to include at least four 'basic' services - general medicine, surgery, obstetrics and gynaecology and paediatrics. In 1981 about one in seven USLs lacked one or more of these services (CSN 1983: 264).

Hospital resources

A national standard of 6.5 hospital beds per thousand population was set in the draft national plan, a level lower than the national average, which was around 7.5 public and 1.5 private in the early 1980s. Only two regions were below the national standard in 1983 (Val D'Aosta 5.54 and Molise 6.21) when both public and private beds are included, but several southern regions were below for public sector beds alone, and some northern regions above (see Figure 4.1).

Figure 4.1. Hospital bed provision per 1000 population, regions, 1987



About 600 000 people are employed by the SSN, and 500 000 of these within the hospitals (ISIS 1986: (7-8) 60). There are about 70 000 doctors (full and part time) and just under 200 000 nurses. The regions show variations in staffing levels per capita, reflecting differences in hospital bed provision (Table 4.4).

Hospital use

In 1987 there were 150 discharges per thousand population in public sector hospitals (including psychiatric hospitals), and 172 per thousand including mental hospitals (ISTAT 1989: 96). The hospital throughput stabilised in the 1980s: while there were 149 discharges per thousand for both public and private hospital beds in 1976, discharges in 1983 were similar to the level of 1987.

The mean length of stay in public (non-psychiatric) hospitals in 1987 was 11 days, but longer in private hospitals 17 days, giving a combined national average length of stay of 12 days. However, there has been a historic trend of falling lengths of stay in public hospitals. For example, in 1960-62 the mean length of stay in public hospitals was 26 days (private 23 days), falling to 19 days (private 18 days) in 1970-72 and 14 days (private 18 days) in 1978 (ISTAT 1981: 68). The longer private sector stays were not mainly in general hospitals (which had an average of 13 days), but in 'specialised' private hospitals, about a quarter of all private beds, which have an average stay of 30 days. A high proportion of these patients are classified by specialty of 'longstay' and 'other', and the hospitals are evidently providing a 'nursing home' function (ISTAT 1989: 96).

Table 4.4 Staff per 1000 population in regions, 1984 (ISIS 1986 (7-8): 61)

	Returns (%)	doctors	nurses	all staff
Piemonte	100	1.30	3.59	9.52
Valle D'Aosta	100	1.54	4.77	11.77
Lombardia	83	0.90	2.81	7.64
Bolzano	100	1.06	3.46	9.41
Trento	100	1.21	5.76	14.38
Veneto	94	1.26	4.67	11.48
Friuli VG	100	1.81	6.24	15.89
Liguria	100	1.54	4.79	13.93
Emilia R.	100	1.46	4.59	12.16
Toscana	93	1.47	5.30	12.52
Umbria	100	1.80	4.73	11.91
Marche	100	1.64	4.64	12.24
Lazio	78	1.96	2.60	10.38
Abruzzi	93	1.54	4.41	11.49
Molise	100	1.86	3.68	9.70
Campania	84	1.18	1.91	7.42
Puglia	96	1.24	3.36	8.88
Basilicata	86	1.19	3.16	8.43
Calabria	84	1.67	3.47	10.81
Sicilia	69	1.39	3.22	8.82
Sardegna	100	1.54	4.11	11.40
Italia	89	1.37	3.68	10.20

Hospital bed supply and use are indicators of efficiency, but require interpretation. In the 1960s and early 1970s there was a rising provision of beds with rising admissions but a falling trend in bed stays. In the later 1970s bed supply was sharply reversed, and began to fall; admissions plateaued in the 1980s, while length of stay continued to fall. Occupancy in public general hospitals in 1987 was 67%, lower than optimal. In particular, paediatrics, which doubled in beds between 1961 and 1978 had an average occupancy under 40% in 1987.

It would appear that, with the health reform, regions were able to respond to control the expansion of hospital beds and benefit from falling lengths of stay due to changes in clinical practice (in part derived from improvements in the technology and practice of medicine). It is also of note that Italy has controlled inpatient admission rates during the 1980s in contrast to France and Germany (bearing in mind caution in reliability of these OECD data): Table 4.5. (There is, of course, no 'correct rate', since the variables - population need, benefit from care, alternative sites of care - are unknown.)

Table 4.5. Inpatient admission rates by country (% of population) (OECD 1990: 149)

	1966	1976	1987
France	6.7	17.2	21.2
Germany	14.0	17.3	21.1
Netherlands	9.2	11.3	11.0
United Kingdom	10.2	12.3	15.8
Italy	11.0	15.9	15.0

Table 4.6. Inter-regional flows of hospital patients in public and private contractual hospitals, 1987 (CSN 1988: 474, 484)

	total	inflow	outflow	net
Piemonte	668378	5.4	7.1	-10540
Valle D'Aosta	17302	7.6	21.4	-2712
Lombardia	1659001	5.9	4.1	26964
Bolzano	80553	6.7	6.4	422
Trento	91635	12.0	11.8	-341
Veneto	825641	6.7	4.2	20355
Friuli VG	290254	8.3	4.0	11900
Liguria	376794	13.6	6.0	28163
Emilia R.	815330	9.1	4.0	40060
Toscana	609967	7.0	4.8	12137
Umbria	124290	9.5	6.4	4583
Marche	282926	6.9	6.1	2588
Lazio	719481	8.2	5.6	16758
Abruzzi	241904	6.2	8.3	-5063
Molise	54815	14.7	17.7	1747
Campania	816534	1.9	5.9	-31172
Puglia	716454	3.0	5.6	-12579
Basilicata	83811	6.0	21.4	-18990
Calabria	326646	2.5	12.1	-33480
Sicilia	679378	0.9	7.4	-40886
Sardegna	236366	1.0	5.5	-7192
Italia	9049082			

Flows

Nine out of ten USLs have at least one general hospital, but within the SSN patients can go to any hospital: patterns of flow to larger neighbouring hospitals, existing before the boundaries of the USL were drawn, continue. There are also inter-regional flows: about half a million episodes (524,632 in 1987) of hospital care are outside the region of residence (Table 4.6).

Emilia Romagna is the most notable net receiver of patients. 66.4% of patients treated in hospital in 1981 were treated within their own USL, and 88.5% of all hospital patients were from within the region - a regional inflow of 12.5%. The Rizzoli orthopaedic Institute in Bologna provides a specialist national service, but general medicine and surgery are, in numerical terms also important specialties for inflows, see Table 4.7.

Table 4.7. Residence of discharged patients treated in Emilia Romagna: sample survey 1981 (Assessorato alla Sanita 1984: table 4.2A)

	ER	north	central	south/isles	total
	%	%	%	%	
paediatrics	82.7	8.3	2.1	4.6	6 335
general surg	92.6	2.8	0.9	1.8	36 788
general med	93.0	2.6	0.9	2.1	50 958
orthopaedics	79.7	5.6	2.8	8.7	27 153
total	88.7	3.8	1.8	3.7	213 820

(Total percentages less than 100 because of patients from abroad and some residences not recorded.)

Table 4.8. Distribution of public and private beds per 1000 population by region, 1987 (ISTAT 1989: 92-3).

	Public			Private	Total
	General	Specialised	Psychiatric		
Piemonte	4.5	1.0	0.4	1.2	7.1
Valle D'Aosta	5.0	--	--	--	5.0
Lombardia	5.3	0.6	0.6	1.3	7.8
Bolzano	5.4	0.5	0.2	1.5	7.4
Trento	6.3	1.5	1.0	1.1	9.9
Veneto	7.3	0.4	0.7	0.8	9.2
Friuli VG	7.5	1.5	0.6	0.7	10.3
Liguria	6.7	1.4	0.8	0.7	9.6
Emilia R.	6.2	0.4	0.7	1.5	8.8
Toscana	6.2	0.4	0.8	0.9	8.3
Umbria	6.8	--	0.3	0.3	7.4
Marche	6.7	0.6	0.1	0.9	8.3
Lazio	4.4	0.6	0.3	2.6	7.9
Abruzzi	6.9	0.1	0.4	1.7	9.1
Molise	5.0	--	--	0.8	5.8
Campania	3.0	0.4	0.8	1.2	5.4
Puglia	5.7	0.6	0.2	1.7	8.3
Basilicata	4.9	0.2	--	2.5	7.6
Calabria	4.4	0.3	0.6	1.3	6.6
Sicilia	4.3	0.6	0.7	0.7	6.3
Sardegna	4.2	1.4	0.7	0.9	7.2
Italia	5.3	0.6	0.6	1.3	7.8

Private hospitals.

There are some problems in defining private hospitals. The nationally published data from ISTAT includes 'public contractual' within all public hospitals (about 32 hospitals, 9110 beds, Mapelli 1987: 174). Other private hospitals are inscribed in two organisations - the Association for Religious Hospitals (ARIS), with about 89 hospitals and 11 000 beds, and the Association of Independent Hospitals (AIOP) with about 548 hospitals, 51 000 beds (Mapelli 1987: 174 - these data are not in complete accord with the CENSIS survey below).

There are substantial regional variations in provision of private hospital beds, see Table 4.8. Lombardy and Lazio stand out with large numbers of private hospitals - 69 in Lombardy and 124 in Lazio - and beds - 11 160 in Lombardy and 13 469 in Lazio (ISTAT 1989: 93). Only 1.6% of all patients admitted to hospital are purely private, and they are almost entirely covered by private insurance. Table 4.9 summarises the differences between public and private hospitals.

Table 4.9. Selected indices of public and private hospitals 1987 (ISTAT 1989: 95-96)

	public	private
beds	367 601	72 586
admissions	8.6 mill	1.2 mill
occupancy	69%	79%
average stay (days)	11	17

These summary data show that, while private hospitals have longer lengths of stay and lower throughput, they also have higher occupancy and therefore lower (average) costs per day. Private hospitals are reimbursed per bed day, whereas public hospitals are financed in lump sums - systems that have different incentives for occupancy. Private hospitals also have lower staffing levels compared with public hospitals: 2.6 staff per bed compared with 4.6 per bed (1980) (3.4 compared with 6.7 if occupied beds only are taken as the denominator) (Rossi nd: 99).

The case-mix of public and private hospitals is dissimilar. There are more private hospital admissions for general surgery and more neuropsychiatric patients (a group with particularly long lengths of stay), while intensive care, neurosurgery, and paediatric patients are under-represented in private hospitals (Table 4.10). A substantial proportion of admissions to private hospitals are for elective surgery - 46.6% of contractual and 63.0% of pure private admissions (France 1988: 14).

There have been significant shifts in the casemix of the private hospitals since the 1970s. Between 1970 and 1984 general medicine admissions rose from 8% to 15%; general surgery from 17% to 24%; and orthopaedics from 6% to 9%. Opposite shifts were seen in the public hospitals: general medicine from 22% to 19%; and general surgery from 23% to 17% (Rossi nd: 87).

Table 4.10 Admissions and lengths of stay in public and private hospitals by specialty, 1984 (ISTAT 1986: 104)

	Public hospitals			Private hospitals		
Specialty	Admissions (000s)	%	Length of stay (days)	Admissions (000s)	%	Length of stay (days)
Gen medicine	1724	19	12	183	15	16
Gen Surgery	1495	17	11	293	24	10
Obs & Gynae	1230	14	6	178	14	7
Paediatrics	732	8	6	9	1	8
Trauma & Ortho	1060	12	8	114	9	12
Other medical	540	6	15	38	3	23
Ophthalmology	213	2	10	26	2	10
ENT	227	2	7	40	3	4
Urology	241	2	12	19	1	13
Neurology	215	2	13	43	3	31
Psychiatry	127	1	98	38	3	122
Ger/rehab	270	2	22	28	2	76
Other/n.s.	640	7	9	207	17	13
Total	8855	100	11	1223	100	17

4.3. Ambulatory care

There are three forms of ambulatory specialist care (ISIS 1986 (6): 62-4):

1. Hospital outpatient care (for either public or contractual hospitals). It is provided by 50 000 doctors in about 800 hospitals. The doctors are remunerated by extra payments (a fixed number of patients per session) at an average monthly cost of 660 000 lire per doctor per month (in 1984).

2. Specialist care is also available in 4900 free-standing public clinics and policlinics. Most of these were originally set up by the communes, or INAM, which did not directly run hospitals, and provided for the majority of the working population. Some have been reported to be both poorly furnished and poorly equipped (Freddi 1984). These SSN clinics employ about 24 000 doctors part-time on sessional fees, with an average monthly cost (in 1984) per doctor of 1 224 000 lire. The public sector also provides almost 3000 maternal and child health clinics.

3. There are also 7500 private contracted clinics for consultations, 280 thermal spas (CSN 1990: 52) and 9000 clinics for laboratory services and radiology. Numbers of medical staff employed by these clinics are unrecorded. Doctors working in private clinics are employed on sessional rates if they do not own the clinic. They are paid per attendance from the USL, or directly from the patient, if they own the clinic. Visits to patients at home are remunerated per visit.

Outpatient care was estimated to cost 410 million lire in 1984, that is 7.2 million lire per inhabitant and 5 523 lire per service. Payments were distributed:

hospital outpatients: 183m lire (44.6%)

polyclinics: 73m lire (17.8%)

contracted clinics: 154m lire (37.6%)

The services provided, at 1984 costs, are shown in Table 4.11.

Table 4.11. Contracted expenditure for ambulatory care, 1984 (ISIS 1986 (6): 63)

	hospital	polyclinic	private	total
	(billion lire)			
laboratory tests:	122	27	74	223 (54.4%)
physiotherapy:	19	6	58	83 (20.2%)
radiology:	13	4	9	26 (6.3%)
orthopaedic:	5	2	1	8
obstetric/gynae	2	9	-	11
dental	1	5	4	10
oculist	2	4	1	7
other	19	16	7	42

Patients are referred for specialist investigations by their GP or attend directly if fee-paying. Referrals through the SSN can only be made by the patient' registered GP: specialists cannot refer patients to each other. (GPs and specialists, of course, may have coexisting public and private practices.) To see a specialist, the patient must present a

GP's prescription to an office of the USL to book an appointment. This may be a rather bureaucratic procedure for the patient when, as is sometimes the case, the booking has to be made in person and cannot be done by telephone.

Table 4.12. Ambulatory specialist clinics in public and private ownership, 1987 (CSN 1988: 464 - data reported as 97% complete)

	Public	Private
Piemonte	481	141
Valle D'Aosta	3	1
Lombardia	454	628
Bolzano	32	26
Trento	120	13
Veneto	515	357
Friuli VG	123	118
Liguria	160	850
Emilia R.	196	369
Toscana	390	470
Umbria	113	129
Marche	67	166
Lazio	284	935
Abruzzi	66	144
Molise	13	20
Campania	167	1055
Puglia	736	998
Basilicata	69	37
Calabria	172	125
Sicilia	144	8918
Sardegna	226	120
Italia	4531	7593

The patient may be booked either at the polyclinic or at an outpatient clinic within the hospital, or at the private office of a SSN-contracted specialist. There is some discretion for this choice with the patient, and some with the USL. The SSN law states that, if an appointment is not available in the public system within three days, the patient may use a private contracted specialist. (There are more flexible arrangements for some investigations, for example body scanning.) However, since the specialists at the hospital and polyclinic may be the same doctors (or their close colleagues) as the specialists in private practice, these arrangements are open to abuse.

There are marked regional differences in the ownership of ambulatory specialist clinics (Table 4.12)

In 1980 the total hours available weekly per thousand population ranged from 69 in Basilicata to 308 in Liguria. Table 4.13 contrasts various specialties in 13 regions providing information:

Table 4.13. Range of hours of specialty consultation by region, Italy, 1980 (CSN 1983: 263)

cardiology: Val D'Aosta 5.9 - Basilicata 29.0

physio-kinesiatherapy: Various regions 0.0 - Liguria 17.5

neurology: Abruzzo 1.6 - Umbria 13.3

ophthalmology: Bolzano province 3.2 - Umbria 19.6

dentistry: Abruzzo 7.3 - Umbria 44.2

orthopaedics: Basilicata 0.4 - Liguria 21.8

obstetrics: Basilicata 1.3 - Liguria 25.8

radiology: Abruzzo 2.4 - Liguria 39.7

For all specialties together, provision is greatest in the north east, followed by the north west, then the south and least in the central regions. While the total number of ambulatory clinics increased by 25% during the 1970s (from 1366 clinics in 1970 to 1712 in 1979), the proportions in the regions remained roughly similar. (Rossi nd: 91)

In southern regions the majority of specialist services are provided either by contracted specialists working within polyclinics or in private facilities. Services in northern regions are more frequently provided by full-time hospital staff. The new SSN saw a rapid rise in specialist services: for example, in Emilia Romagna, there was an increase of 75% in services provided, mainly through external contractual payments (Regione Emilia Romagna 1983: 49).

Referral rates are high: in Emilia Romagna there were, on average, eleven visits annually for each person in the region in 1982. Almost half the services were laboratory tests, and just over a quarter of all specialist services are private - Table 4.14:

The mix of use between public and private sectors for ambulatory care derived from a survey of health use (ISTAT 1983), using data from people who went to a doctor within the previous four weeks, showed that more than 90% of general practitioner consultations were within the SSN alone, and over 80% of diagnostic tests. However, results from other (smaller) surveys in the early 1980s indicated that between 40% (Collicelli 1986: 66) and 45% (Piperno 1986: 12) specialist

consultations were with private doctors.

Table 4.14. Specialist visits per 1000 population, Emilia Romagna, 1982 (Regione Emilia Romagna 1983: table 60)

	public	private	total
Cardiology	202	38	240
Surgery	119	73	127
Dermatology	95	21	116
Laboratory	4588	1410	5999
Nuclear Medicine	44	41	85
Neurology	34	8	40
Ophthalmology	162	20	182
Dentistry	129	72	201
Orthopaedics	183	268	211
Obstetrics & Gynaecology	105	23	128
ENT	155	23	178
Paediatrics	68	--	68
Chest medicine	80	1	81
Radiology	449	93	542
Rehabilitation	974	1256	2230
Other	919	53	972
Total	8304	3076	11383

Other ambulatory care

The national law to develop drug dependence services in 1975, and the law establishing family advice centres in 1978, gave an impetus to the long-established tradition of voluntary associations in Italian health and social care. There are more than 3000 maternal and child health clinics (almost entirely publicly provided (CSN 1988: 463), employing 6400 doctors (contracted at 12 hours per week) and 12 500 other staff (ISIS 1986 (6): 66). Voluntary organisations now use finance from the regions and communes for a wide range of activities: these include organ and blood donation and transfusion, home care, social assistance and rehabilitation for drug users, and patient-led organisations for specific conditions, such as haemodialysis, haemophilia and thalassaemia. There were estimated to be 1140 of these bodies in 1984 (ISIS 1986 (6): 66).

4.4. Primary care

The excess of doctors and relative lack of nurses and social care workers in the community makes primary care in Italy dominated by general practitioners. There were just over 62 000 primary care doctors in 1987 (CSN 1989: 438), of whom 57 700 (93%) were GPs and 4400 (7%) paediatricians. They are augmented by a further 18 000 doctors working the guardia medica, who provide cover out of hours and for non-registered patients (such as tourists). GPs are allowed in their contract to do other medical work, including polyclinic specialist clinics and hospital work (where they can be paid as a part-time doctor but not as full time).

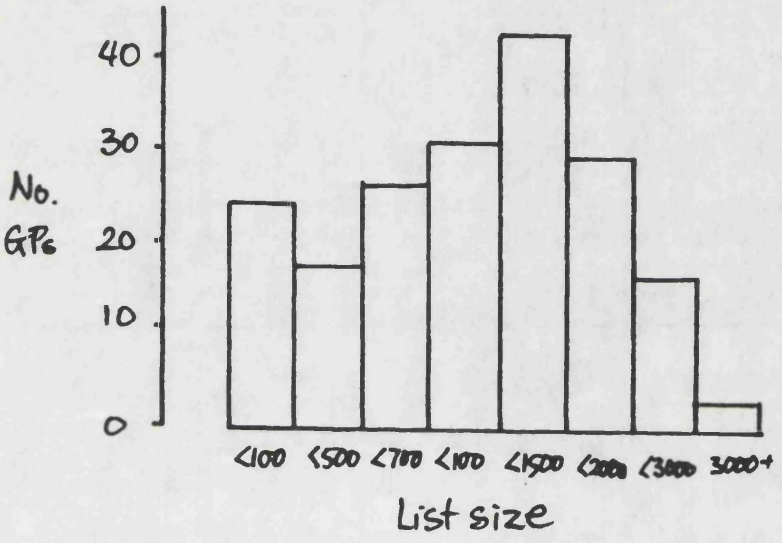
GPs usually work single-handed: a study in Emilia Romagna showed that only 10% of general practitioners were in partnerships (Stiassi 1986). They may share clinic premises with one or more colleagues for financial reasons, but they are in direct financial competition with each other. Patients are registered with one doctor alone, not with the doctors working in partnership.

Each general practitioner contracts with the appropriate USL to provide services for a given number of patients. The legal maximum list size for a single handed doctor is 1500, and 1800 for doctors in partnership, although higher lists continue where they existed before the 1978 agreement with the medical unions. The average list size over the country as a whole in 1987 was 818 patients (CSN 1988: 451). The cost was estimated at about 40 000 lire per patient per year, and 36 million lire per GP per year in 1985 (ISIS 1986: (6) 62).

Figure 4.2. Average list size (children and adults) of GPs and paediatricians combined by region, 1986 (CSN 1988: table 20.3).

Figure 4.3. Average list size of paediatricians, by region, 1986 (CSN 1988: table 20.3)

Figure 4.4. List sizes of GPs in a local study, Puglia, 1979 (Piperno 1982: 68)



There are regional variations in GP list sizes, see Figure 4.2. Contrary to the trend of hospital and specialist services in Italy, there are more GPs in the south than the north of the country. General practitioners are more evenly distributed within regions than hospitals and specialists, but it has been estimated that, even for GPs, two thirds work in the 95 provincial capitals, which include only one third of the population.

The variations are more marked for paediatricians considered separately (Figure 4.3). No region has a full complement of paediatricians: Liguria (which, as a retirement area, has a low proportion of children) is nearest to the recommended average of 500 children per paediatrician.

Within regions the differences are greater still. A study of general practitioners in Puglia in 1978 showed list sizes varying from 15 to 5000 (Piperno 1982) - see Figure 4.4. About half the GPs in Puglia were contracted to the SSN full-time. Just under a third of the GPs had a hospital appointment. Half the doctors had a postgraduate specialist qualification, one in five had two or more qualifications. Reflecting this mix of general practice with other work, the Puglia study showed that the doctors spent, on average, 23 hours per week on their practice work. Consultations in the doctor's own clinic lasted, on average 9.8 minutes, compared with 22.4 minutes spent on domiciliary consultations. There were more clinic consultations than domiciliary visits. The ratio was higher for part-time doctors (3.9 to 1) than for full-time doctors (2.9 to 1). On average, for the whole sample of GPs (although with widely varying list sizes) each doctor was estimated to receive 126 clinic visits by patients and make 38 domiciliary visits each week.

But, because domiciliary consultations take longer, they were estimated to take up 40% of the GPs' time. This finding spells out the lack of support staff, such as community nurses, for primary care in Italy, especially in rural settings.

Some information on the clinical work of general practitioners is available from a small study by a group of cooperating general practitioners in Milan (Tognoni 1982). Their report shows a higher proportion of consultations by women than men, and by older people (Table 4.15). Heart problems and infections are the commonest complaints and, on average, 15% of patients are under care jointly with a specialist (Table 4.16).

Table 4.15. Consultations in general practice: proportions by age and sex for 13 practices over 4 weeks, averaged together (Tognoni et al 1982)

	age group						
	0-4	5-14	15-44	45-64	65-74	75+	all
males	0.6	3.1	13.6	13.9	7.0	2.8	40.9
females	0.6	2.6	18.4	20.0	11.1	6.4	59.1
total	1.2	5.7	32.0	33.9	18.1	9.2	100.0

The Puglia study (Piperno 1982) estimated that each patient came to the doctor between 8 and 12 times a year, a higher rate than similar studies in northern European countries have found. Prior to the SSN, most of the insurance agencies reimbursed the doctor according to a scale of fixed charges per visit or service performed.

Table 4.16. Services provided by GPs according to disease group (data as for 4.15)

	GP care	investigation/ specialist	Hospital admission	(N=)
Circulatory	86.2	13.7	0.1	1574
Respiratory	93.8	6.1	0.1	731
Gastro-intestinal	73.5	25.3	0.1	889
Infectious	85.9	13.8	0.3	1422
Psychological	88.8	10.8	0.4	499
Cancer	84.5	13.2	2.3	129
Other	82.6	16.9	0.5	1713

Rather fewer insurance agencies used the capitation system, that is, a fixed sum agreed in advance each year per patient whatever the care provided. Item-of-service payment has a strong incentive for the doctor to sustain a high level of attendances, but a further reason has been that GPs have to validate all further care given by the polyclinics, by signing referrals for consultations and for investigations. This is laborious, but there is one possible advantage: it ensures that the GP is closely in contact with the patient thoughout a course of medical care, both as an advisor and in giving an explanation of what is happening.

Capitation was chosen as the main method of payment in the SSN: there are few item-of-service payments, and no fixed sum ('basic practice allowance') which in Britain is paid to all GPs. In principle, capitation should encourage preventive rather than curative

care, but in practice it also encourages the doctor to refer difficult patients more readily for specialist care. The lower list sizes in Italy, compared with other countries, may make this less of a problem. Higher levels of payment were negotiatied by GPs through hard political bargaining (including strikes) in 1982, and the average income is now comparable with senior hospital specialists - although the latter have greater opportunities for extra income from private practice. The level of capitation payment increases with the seniority of the GP (taken as years since graduation), and there is a weighting for elderly people in the list. Extra payments are also available for working in unattractive or sparsely populated areas.

Reinhardt (1987) has presented data indicating that GPs in Italy earn less than in other advanced industrialised countries (Table 4.17).These data are averages, and need to take account of a substantial number of Italian GPs working part-time, and gaining further income from specialist clinics, both public and private.

Table 4.17. Net practice income of GPs for selected countries (Reinhardt 1987: 153-76).

Country	Ratio to average employee earnings
FDR	4.7
US	3.9
France	2.8
UK	2.1
Italy	1.8

(The reliability of Reinhardt's data are unclear, however, since Sandier (in OECD 1990: 49) gives very different ratios for these countries, although no data for Italy.)

New arrangements for out-of-hours care were negotiated with the SSN. Each USL organises a 'guardia medica' for out-of-hours care. In 1987 there were 2800 guardia medica places for USLs, covered by 18 000 doctors. There are relatively more guardia medica doctors in the south than the north: for example, in 1987 in Piemonte there were 4179 patients per doctor, and 4638 in Lombardy, compared with 2482 in Tuscany, 1866 in Campania and 1500 in Sardinia (Rome proves an exception with a high ratio of 5302 patients per guardia medica doctor) (CSN 1988: 460). The doctors working for the guardia medica are usually young. This is partly because of the unsocial hours of the work, and partly because the selection rules for applicants give an extra weighting to young or recent graduates unable to find a practice themselves and needing to gain experience. Doctors working in the guardia medica are not allowed other contractual full or part-time employment, including general practice, but many provide GP locums.

A GP must make a home visit the same day if a patient makes a request before 10am; otherwise the visit can be done on the following day. In a national sample survey of GPs in 1988 (Censis 1989) 17% of consultations were at home (twice as frequently, 40%, for people over 75), and 4% by telephone (usually younger adults). The guardia medica is provided for urgent calls from 2pm on Saturday to 8am on Monday (and similar arrangements for other holidays) and from 8pm to 8 am on weekdays. A

study of the work of a sample of guardia medica doctors in the early 1980s (Coen 1984) showed that more than half of requests from patients came on Saturdays and Sundays (which include only 28 hours out of a total 102 hours weekly), while the rest were equally distributed among weekday nights. There were slightly more requests from men than women, in contrast to the experience in daytime where there are higher consultation rates from women. Only five per cent of consultations were concluded by telephone alone. Most visits were made quickly - over 80% within half an hour. Eight per cent of patients were sent to hospital, 30% were dispensed one or more drugs during the doctor's visit, and, in total, 57% of patients received short or medium term medication.

In a national study of the perception of 1500 GPs about their patients (Censis 1989: 285) 80% of patients were thought to be seeking a consultation, 48% a prescription or referral for tests, 4% immunisation or injections, 8% certification and 2% counselling (patients could be counted for more than one reason). The outcomes of consultations were distributed: 21% further investigation, 18% referral to a specialist, 72% prescription, included 32% advice, 7% no action (Censis 1989: 309).

Only a minority of visits in the national study of the guardia medica were considered to be for 'real' emergencies, but the lack of experience of the doctors recruited to the guardia medica suggest that they are not the best doctors to be giving emergency care. Sometimes guardia medica doctors are called for life-threatening emergencies. The authors of the study commented that 'their intervention seems to be at best useless since they are not equiped, nor often feel prepared to manage, such situations'.

The SSN law expects children under twelve to be looked after by general practitioners with special qualification in child health. These GP paediatricians contract with the USL in the same way as GPs, but have maximum list sizes of 1000; the national average list size is 500. The average capitation cost for paediatricians is slightly lower than for GPs, about 32 million lire a year, but the per capita payment is higher, and, thus, so is the cost per child - an average of 67 000 lire per child per year.

There are, however, still too few doctors trained in community child health: paediatricians form a much smaller proportion of primary care doctors than the proportion of children in the population. Many GPs continue to look after children, especially outside the large towns. This is a potential area of expansion for doctors in the SSN.

GPs wrote 387 million prescriptions in 1984, (ISIS 1986: (6) 64). The average cost per prescription was 16 800 lire, of which the patient paid on average 2000 lire (copayments were either flat rate or proportional, depending on the cost of the prescription). About one in six patients (13.4%) were exempted from these charges, representing 35% of their value. Prescriptions were provided through a network of pharmacists, including 1169 employed by communes, 11244 privately contracted, and 4532 rural pharmacists.

CHAPTER FIVE: RESOURCES

5.1. Funding the service.

The Servizio Sanitario Nazionale was introduced in part because of financial pressures. The Mutue experienced increasing deficits from the end of the 1960s, due to a combination of inadequate insurance contributions, increasing technical sophistication of medical practice, expanding provision, and therefore use, of hospital care, and an aging population. The immediate solution was government support. In the longer term, rather than reforming the Mutue the government moved towards public control. As shown in Chapter 3, the change happened slowly, not as part of an agreed plan but step by step, each part being fought out in Parliament.

Responsibility for the management of public hospitals was transferred to the regions in 1972, but the Mutue remained the agencies for collecting insurance contributions and for the reimbursement of hospitals. In 1974 Parliament transferred the control of resources for public hospitals to the regions, and decreed that the Mutue would be abolished as independent agencies within three years. Also, in this law, from 1975 hospitals were paid from a single Hospital Fund and reimbursed through budgets based on historical expenditure rather than by patient stay.

In 1977 a further law completed the framework for transferring the financing of specialist and primary care to the regions, and defined that the management of health services would be passed to the communes

by 1st January 1979, regardless of whether a full SSN had been established. In the last week of 1978, the SSN law brought all the public health expenditures into a single national budget, the national health fund (Fondo Sanitario Nazionale, FSN).

Health insurance had grown piecemeal. By the 1970s there were over 200 independent insurance schemes available, although 90% were covered within a small group of schemes (Abel Smith & Maynard 1979). The state scheme, INAM, insured 55% of the population, three other health insurance schemes for state employees covered 15%, and three schemes for the self-employed covered another 20% (Table 5.1). (Full coverage, and unification of benefits, was decreed by law 33/1980.) However, there were striking differences between the north and south (Table 5.2).

Table 5.1. Coverage for health insurance by nine main schemes, 1972 (Parlamento Italiano 1975: 9)

INAM	28 628 000
ENPAS	5 249 000
ENPDEDP	979 000
INADEL	2 113 000
Casse Mutue Trento e Bolzano	410 000
ENPALS	123 000
Coltivatori Diretti	4 739 000
Artigiani	3 785 000
Commercianti	2 752 000
Total	48 778 000

Table 5.2. Population covered by Mutue health insurance at 1980 (Mapelli (n/d): 132)

	Insured	not insured	%
North west	15 411 000	46 000	0.3
North east	10 246 000	195 000	1.9
Central	10 451 000	423 000	3.9
South	18 314 000	2 663 000	9.8

INAM became the foundation for the new system at national and regional levels. All the insurance schemes were amalgamated into the national health fund, which remains a separately identifiable budget within government revenue: there has been no legislation to absorb health financing into the general taxation of the country, despite the original intention to do so. The current account funds are distributed by the Ministry of the Treasury. Capital is distributed by the Ministry of the Budget (Ministero del Bilancio) in consultation with the Ministry of Public Works and the Ministry of Health. (For the South, until 1985, this was distributed through a separate agency, the Cassa per il Mezzogiorno.)

However, the various insurance funds had different actuarial risks, covered different types of services and therefore had different levels of contribution (CSN 1983; Sarpellon 1982) In 1980 the total contribution by an employed worker in industry was calculated as 11.73% of total earnings. This was built up from 0.30% direct contribution, 10.08% by the employer and 1.65% by the state. For commerce the total was 10.73% (a lower contribution by the employer). Payments by

independent transport workers were as high as 13.62%, whereas the total contributions of state employees ranged from 8.25% to 9.65% Self-employed workers and independent professionals payed much less than employees, estimated as only a third of the contributions of industrial workers (CIPE 1985). Formerly, these differences in contribution were balanced (in principle) by different levels of health service provision available under the different insurance schemes. But the SSN removed these inequalities of access, and the varied contributions became an anomaly.

At the start of the SSN, the contributions were standardised in three goups - employed, self-employed and uninsured. Contributions from employed people ranged from a minimum of 3.5% to a maximum of 13% of their earned income (CSN 1988: 49), self employed ranged from 4% to 35% and uninsured paid a fixed 5.5%. A reform of the contributions in 1986 reduced the maximum rate for employed workers from 13% to 11%, with a fall to 4% for income above 30 million lire (increased to 40 million lire in 1987), increased the contributions from self-employed workers from 4% to 7% (or 6% to 7% for employers) and included unearned income for the first time. The new rates recognised that many Italians gained income from more than one source.

The new contributions were less progressive, since contributions decreased with higher income, and still showed disparities between income from different sources. The contributions were much higher for employed people in comparison with unearned income (Table 5.3), a continued source of contention with the unions and the Communist party. (It was estimated that self-employed workers form one third of the work

force but contribute only 17% of the funds (CSN 1988: 43).)

Nevertheless, the combination of changes proved attractive enough to gain a majority of votes in Parliament while achieving a net increase in revenue for the government.

Table 5.3 Health insurance contributions, 1986. Examples of payments from two gross incomes: 30 million lire and 60 million lire (La Repubblica 1986)

	employed	self-employed	unearned	Total
Gross income				
30 Million lire	(11%)	(7.5%)	(7.5%)	
employed 30m	3.3m			3.3m
self-employed 25m + unearned 5m		1.875m	0.075m	1.95m
unearned 30m		1.95m	1.95m	1.95m
pension 10m + unearned 20m		1.2m	1.2m	1.2m
Gross income				
60 million lire	(11% + 4%)	(7.5% + 4%)	(7.5% + 4%)	
employed 60m	5.2m			5.2m
self-employed 50m + unearned 10m		3.4m	0.24m	3.64m
unearned 60m			3.64m	3.64m
pension 10m + unearned 50m			3.4m	3.4m

The SSN has never been fully funded out of insurance payments. A government contribution from taxes is included in each year's budget,

but expenditure every year has been higher than budget, leaving the deficit to be borne by the state.

Table 5.4. Financing of the national health fund 1981-87 (CSN 1988: 48)

	1981	1982	1983	1984	1985	1986	1987
	%	%	%	%	%	%	%
Insurance	36.5	53.8	47.8	52.5	52.0	65.9	59.8
Charges	2.8	2.7	0.6	2.4	1.6	1.8	1.2
Taxes	25.6	26.7	23.3	25.7	21.1	16.6	15.1
Deficit	35.1	16.8	28.4	19.4	25.4	15.7	23.9

Table 5.4 shows the composition of the national health fund since the start of the SSN. The contribution from state income fell from over 60% in 1981 to 44% in 1987, while contributions from insurance rose from 36% to 60%. Thus, the expectation that the Servizio Sanitario Nazionale would change from mainly insurance funding to funding out of general taxation has not been fulfilled.

Also, despite the intention of the SSN Law to ensure services free at the point of use, small direct charges have been introduced for some non-hospital services. These have varied over time, see Table 5.5.They have had marginal effect in reducing demand and are only a small source of extra income for the health budget; but they have helped to blur the boundary between public (free) and private care.

Table 5.5. Cost containment legislation 1978-1986 (Ferrera & Zincone 1986: 188, Mapelli 1987: 191).)

1978 - flat rate charge on all drugs not in the Approved Formulary (very few at this time) (introduced in law 484/78 before the reform)

1981 - an increase in the charge, with exemptions for low income

1982 - a flat rate charge on investigations ordered by GP (xray and laboratory); limit on drugs prescribable on one prescription; surveillance of drug prescribing.

1984 - exemptions for major diseases and pregnancy

1985 - Approved Formulary reduced and divided into drugs of decreasing 'worth', with percentage charges for some of these categories; survey of patients who self-declared low income; standardised prescription form.

1986 - raising of flat rate charges, and of the percentage on some drugs to 25%; new flat rate charge on specialist visits; change in exempted.

Paying the doctor

Salaries for all SSN staff are negotiatied nationally, and are uniform throughout the country. The separation of payment between hospital doctors (specialists) and general practitioners is fairly clear, because of their different contracts, although the same doctor may work part-time in both fields. Hospital doctors are paid by salary, which, for part-time doctors (and unofficially also for full-time doctors) can be enhanced by private practice. To encourage full-time practice, the government also introduced extra payments for outpatient sessional care.

A general practitioner (medico di base) is paid through capitation, with a scale of remuneration that takes into account the different consulting patterns of children, adults and elderly people. GPs can also do private practice, sessional work as a specialist in polyclinics, and, in some instances, can work part-time in hospital. There is no minimum list size for GPs, but remuneration is officially limited to 1500 people on a list (1800 for doctors in partnership).

5.2 Distribution of health care resources

National allocation.

Comparisons of health care costs between countries should be viewed with caution, because of the variety of accounting systems and the different definitions in public accounts statistics (OECD 1987). The proportion of the Italian economy spent on health care appears to have risen rather more rapidly in the early 1970s than in other developed countries. But Italy still remains among the lower spending countries in the developed world (Schieber and Poullier 1988).

Regional

In 1975 the Ministry of Health published a review of the distribution of health spending based on data from the Mutue (Ministero della Sanita 1975). This study brought out the disparities in per capita expenditure between regions, with broadly higher spending in the north than in the south (Figure 5.1). The report also provided some data on personal incomes, showing higher spending to be related to higher per capita incomes. For example, health spending was about 85% higher in Liguria than in Basilicata, but these two regions differed in per capita income by 140%. Thus, expenditure was already to some extent redistributing against income differentials. A clear explanatory variable for spending levels was the provision of hospitals. Figure 5.2 shows a close fit between hospital costs (making up about 58% of all expenditure) and beds available. Thus, a strategy to redistribute expenditure needed to focus on a better equilibrium of hospitals.

Figure 5.1. Per capita spending by mutue related to per capita income by regions, 1970

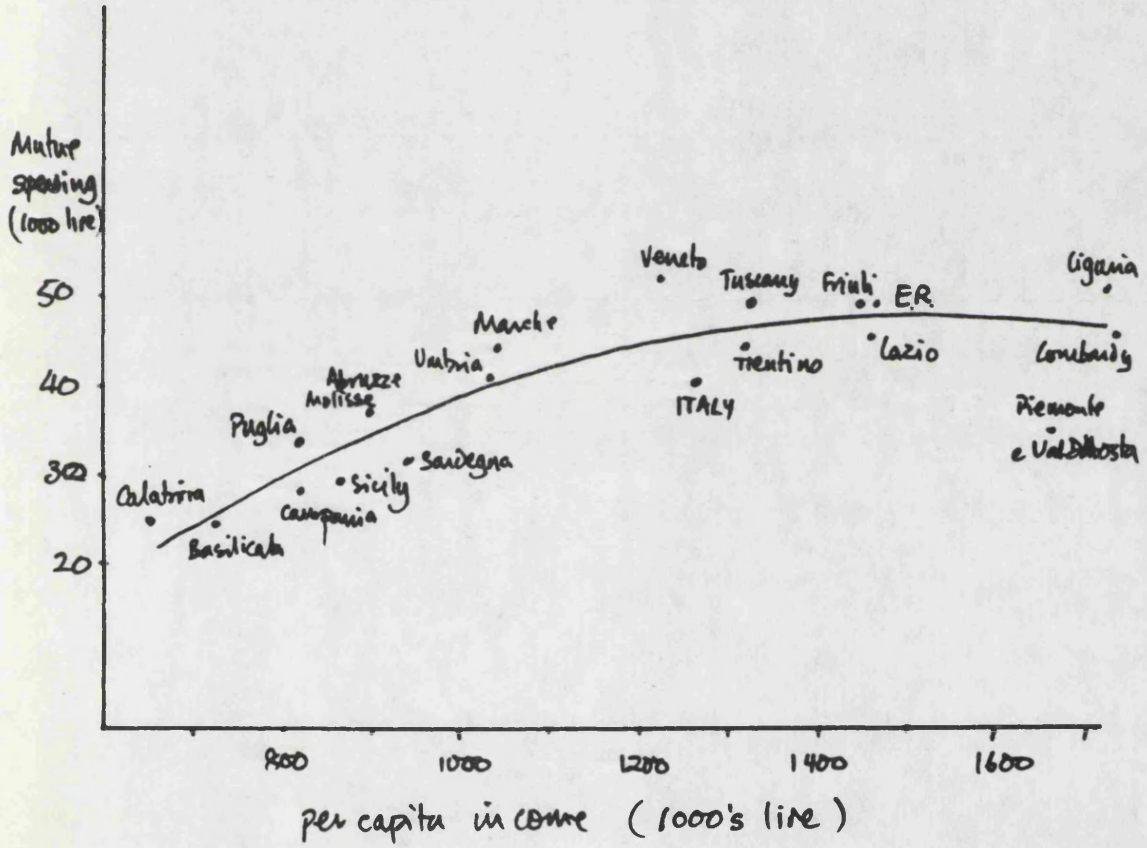
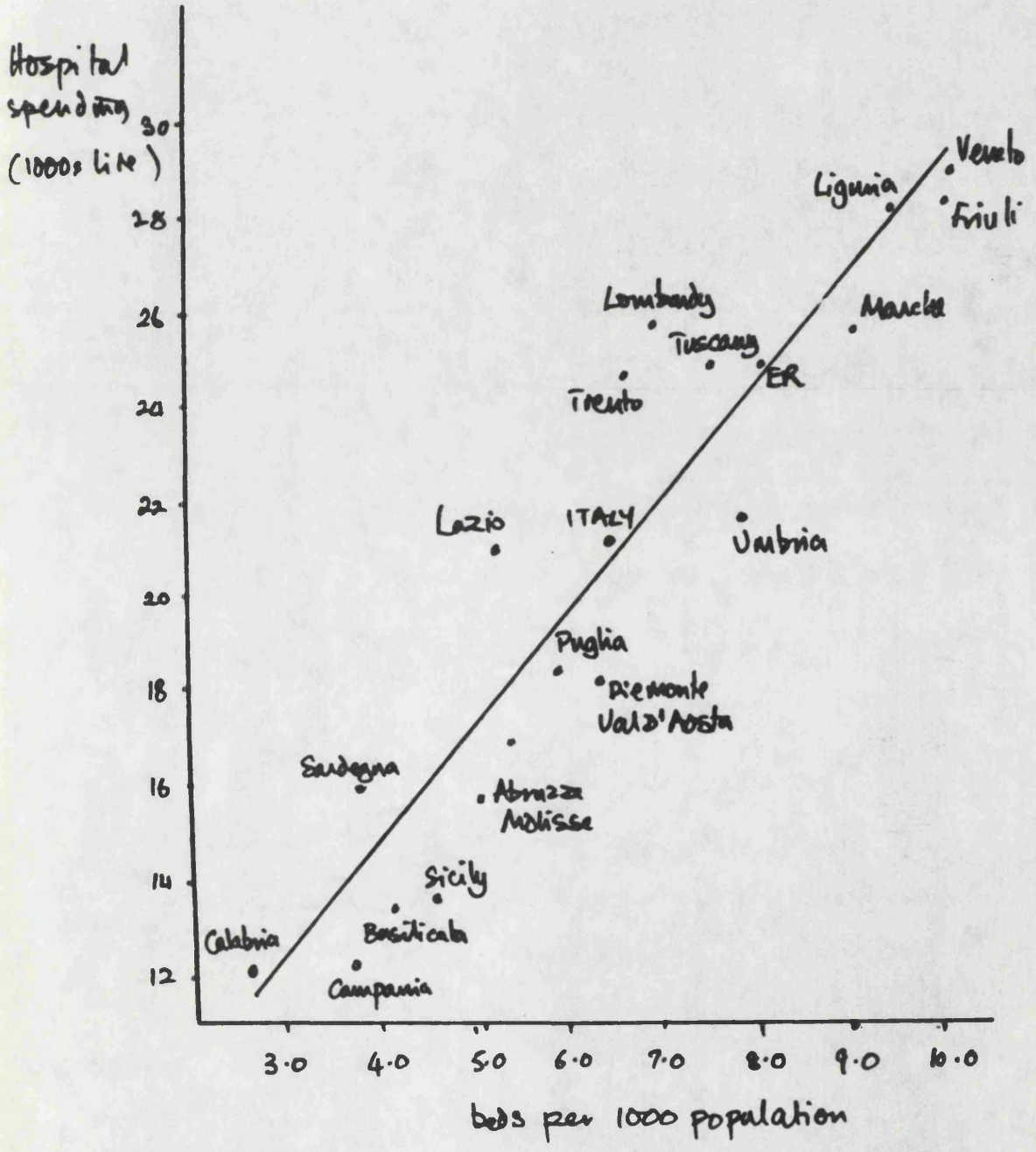


Figure 5.2. Hospital spending and beds per 1000 population by regions, 1970



It took longer than the year prescribed in law 833/78 for the SSN structures to be implemented across the country. Well into the 1980s some USLs in the south were functioning more in name than in practice. This was partly because of the considerable administrative task to define and bring together all the previous scattered insurance and contracted services. Some northern regions had already started to do this before the law was finally agreed by Parliament; but other regions had not been interested to do so.

The broad regional totals of health care expenditure in 1977 were used as baselines for the regional allocations of the SSN. In 1979 and 1980 these historic levels were adapted by a formula which added (or subtracted) one sixth of the difference between the historic levels and 'theoretical' levels based on age and sex-adjusted populations. This attempt to move towards balanced funding levels over six years, however, was too ambitious, and criticism (especially from the southern regions) led to a revised approach for 1982. The new formula funded the general medical services (GP consultations and drugs) completely per capita, and applied the per capita formula to the remaining part (88%, mainly hospitals) of the budget in rising increments - 10% in 1981, 20% in 1982 &c (Mapelli nd). Some of the larger hospitals in cities such as Milan, Bologna and Rome were recognised in the formula is so far as they took patients from outside their own region, but gained no additional national funding for patients from within their region.

A new allocation system was devised from 1987 (CSN 1988: 44-45, Corrente 1988: 65). The national health fund was divided between four areas - collective prevention, non-hospital care, hospital care and

organisational (plus other funds for training, research, health education and 'progetti obiettivi'). The four areas were divided in 1987 respectively 4%, 38%, 53%, and 5%, and were intended to move by 1989 to 7%, 40%, 48% and 5% (CSN 1988:45). For regional allocation, a complex allocation model was used. The model included weighting funds for some non-hospital (eg drugs) and hospital care using three age bands (0-11, 12-59 and 60+), and also by standardised mortality rates. Nevertheless, the model also took into account historical allocations, and adjusted for current patient flows for hospital care, so that the eventual allocations were not dissimilar from the previous years.

The resulting allocations have shown some improvements in equity between the regions (Table 5.6). The richer regions (traditionally the north east and Lazio) have been reduced and the less well off (the north east and the south) have increased. Although the inequalities have not been removed completely, these changes are substantial, and now represents mainly compensation for treatment of patients outside their own region.

An attempt was made in the first formula of 1980 to include an adjustment for the varying levels of health between regions, but this was dropped until 1987. The southern regions do not benefit from standardised mortality ratios since they have lower age-standardised mortality rates than the central and northern regions.

Table 5.6. Regional allocations of national health fund per-capita and percentage compared with all Italy, 1987 (CSN 1988: 58)

	per-capita (thou lire)			% compared with all		
	1977	1982	1987	1977	1982	1987
Piemonte	154	463	896	86.5	92.2	95.2
Valle D'Aosta	161	419	932	90.7	83.5	99.1
Lombardia	168	478	889	94.2	95.1	94.5
Bolzano	166	478	899	93.3	95.1	95.6
Trento	235	570	1007	131.8	113.3	107.1
Veneto	188	527	980	105.8	104.4	104.2
Friuli VG	217	599	1094	121.7	119.2	116.4
Liguria	199	598	1048	111.9	118.9	111.4
Emilia-Romagna	200	552	1055	112.2	109.8	112.2
Toscana	202	551	1025	113.5	109.7	109.0
Umbria	186	507	950	104.5	100.8	101.0
Marche	184	539	1025	103.5	107.3	109.0
Lazio	238	579	1014	133.3	115.3	107.8
Abruzzo	167	499	919	93.7	99.2	97.8
Molisse	116	421	860	65.5	83.7	91.4
Campania	165	471	869	92.8	93.7	92.4
Puglia	157	474	858	88.3	94.3	91.3
Basilicata	136	384	798	76.6	76.5	84.9
Calabria	148	455	873	83.3	90.5	92.9
Sicilia	145	449	923	81.7	89.4	98.2
Sardegna	167	455	894	93.8	90.5	95.1
Italy	178	502	940	100.0	100.0	100.0

Allocations of capital, although only 5% of the total health budget, show a different pattern (CSN 1988: 304). Funds for new hospital building were provided for only four regions, all in the south, and maintenance and equipment grants were not allocated per capita. This sort of expenditure may indicate the influence of individual members of parliament in delivering favours to their local supporters, since equipment or new buildings are much more visible evidence of action than services.

Sub-regional

There are greater variations in per capita resource within regions than between the regions themselves, predominantly because of the distribution of hospitals. In Rome, a survey showed that the per capita expenditure (for all services combined) of the best-off USL was estimated to be ten times that of the poorest (Delogu et al 1985). Of course, these differences are in part mitigated by patients crossing USL boundaries for their care. However, it is usual for populations close to hospital and outpatient services to be higher users than populations further away.

Total annual expenditures by USL are not published nationally, but some regional plans show USL spending projected for the planning period. The national plan suggests that similar criteria to those used nationally should be used by regions to allocate budgets to USLs. Finance is separated into several sub-budgets, for example, administration, primary care, pharmacy etc. Most of these are usually distributed approximately per capita. The biggest differences are for hospitals, where the dominant criterion remains historic spending.

Some regions indicate alterations to this base according to objectives within their plans. For example, Veneto region, which is above the national average of spending, proposed USL allocations for public hospitals as follows: part (actual proportion undefined) according to median costs for current staff and goods; part for patient flows weighted for median length of stay; and a part reduction of resources for certain services that the plan defined are to be closed (Regione Veneto 1984) A retrospective study of USL spending in Lombardia (Mapelli 1986: 203-236) describes in detail the criteria used to distribute resources between the 79 USLs in the region. Over the period 1982-85 there were small reallocations between USLs but the difference in per capita spending between 'richest' and 'poorest' USL still remained more than twenty-fold.

Distribution of spending

The national health fund is distributed across various broad headings in the financial returns. In 1987, staff, goods and services for the public hospitals included 57% of the total, with contracted hospital care another 10%. Non-hospital specialist care took 4% of spending. General practitioners took 7%, and the drugs they prescribed another 17% (CSN 1989: 547).

There are, however, considerable regional variations in these proportions. Table 5.7 compares spending under these main heading in the highest and lowest regions, data for 1988 (CSN 1990: 64).

Table 5.7 Comparison of spending of main headings of national health fund in regions in 1988 (CSN 1990: 64-7)

	spending per capita (thousand lire)		
	lowest	highest	Italy
staff	335 (Sicily)	598 (PA Trento)	431
goods & services	117 (Lazio)	262 (Emilia R)	187
general practice	69 (Piemonte)	86 (Sardinia)	73
drugs	100 (Bolzano)	245 (Sicily)	190
contract hosps	23 (Umbria)	230 (Lazio)	104
specialists	11 (V d'Aosta)	94 (Campania)	48

Control of spending in the SSN

Up until 1975, when the hospitals were transferred to the regions, the Mutue paid per diem reimbursements to hospitals, a system that is more inflationary than predetermined budgets. INAM had changed its payment to general practitioners from fee-for-service to capitation before introduction of the SSN, after deciding that fee-for-service practice created higher consultation rates and more prescriptions than capitation. Nevertheless, rising coverage of the population, and a wider range of services, rising expectations and increasing numbers of elderly people, all put increased pressure on spending.

In the late 1970s there was a reduction in the rate of increase in spending as regional control of the hospitals began to take shape. One strategy used by the government has been to announce a funding level at the beginning of the year that was well below the current level of inflation. Table 5.4 has shown that the national health fund was underbudgeted each year since the start of the SSN. Under-projections

increase the power of the government over the national health fund (which is formally devolved to regions) by allowing the government to respond differentially to actual levels of spending, both in geographical distribution and within health service sectors. Low projections are also a way of trying to limit inflation, since they help limit pay rise demands to the projected increases.

The structure of the SSN does not assist cost control. Calling the problem 'skewed fiscal federalism', Buglione & France (1984) noted that, in the new SSN, central politicians have to take responsibility for the levels of contributions needed for health insurance, while local politicians freely criticise the lack of public resources. Thus regions are tempted to overspend and to claim that they are not being given enough money to do the job they were elected for.

Of strategies tried by the government to contain costs during the first years of the SSN, copayments for pharmaceutical prescriptions and specialist investigations have been the most widely noted, since they fall directly on the consumer of health care. However, copayments have been erratically applied, see Table 5.5, and may have increased total spending on health, by bringing in money from private incomes, rather than restrained the cost of SSN-paid services (Mapelli 1987:191).

5.3. Private medicine

Private financing needs to be distinguished from provision, since public funds can be used to contract from private providers. In strict terms, private provision includes general practitioners and pharmacists, as well as the drugs purchased in primary care. However, since these services are heavily regulated by the SSN, they have been termed 'quasi-public' (France 1988). An estimate of publicly financed health care expenditures is shown in Table 5.8.

Table 5.8. Public current health expenditure, 1987 (France 1988)

	Lire (000 000)	%
Produced directly		
staff	21 526	39.8
goods & services	7 946	14.7
Quasi-public		
prescribed medicines	9 494	17.6
general practice	3 665	6.7
ambulatory specialists	625	1.2
'obligatory' contracted hospitals	2 885	5.4
Contracted private		
ambulatory	3 109	5.8
hospital	2 580	4.8
other	712	1.0
intermediate	1 604	3.0

Among the features of this table are the substantial proportion (one sixth) of the total spent on ambulatory pharmaceuticals; the heading of 'obligatory contracted hospitals' which include public (1.3%) and private (0.4%) research hospitals, 'classified' (ecclesiastic) hospitals (1.9%) and university hospitals (1.3%) (these represent the hospitals that were able to gain special status in the early 1970s when the majority of public hospitals were transferred to control by the regions); 'other' contracted private spending, including reimbursements for uncontracted care in Italy and abroad; and contracted-out

intermediate services including laundary (0.8%), canteen (0.1%), heating (0.2%), data processing (0.2%), maintenance (1.5%) and other services (0.2%).

In summary, about 85% of public finance goes on publicly provided or regulated services. In the period 1977-81, contracted services - as a proportion of the total - appeared to have risen only slightly in the south, but more sharply in the north and central regions (Table 5.9):

Table 5.9. Changes in spending on contractual and private health care, 1977-81 (Mapelli nd: 173)

	1977			1981		
	public (%)	private (%)	total (lire)	public (%)	private (%)	total (lire)
North & centre	87.7	12.3	217 450	84.5	15.5	510 230
South & Islands	88.1	15.2	184 050	84.5	15.5	439 400
Italy	86.8	13.2	205 660	84.5	15.5	485 120

Nevertheless, there remain substantial regional differences. In 1987, spending on contractual hospital provision cost 12 times more per head in Lazio than in Val D'Aosta - table 5.10.

There is also direct payment for health care by users. A small proportion of this is a supplement to public services (co-payments); mostly payment is direct purchase of private medicines and care (which can be through private insurance). It is estimated that this 'private-private' expenditure was 14 218 billion lire in 1988, or 20.8% of total national health expenditure (CSN 1988: 505; France 1988: 13). Table 5.11 shows how these private payments were distributed.

Table 5.10: Regional expenditure per inhabitant for contractual hospital care, 1987 (CSN 1988: 483)

Region	Lire
Piemonte	76 000
Valle D'Aosta	19 000
Liguria	117 000
Lombardia	123 000
Trento	68 000
Bolzano	77 000
Veneto	41 000
Friuli VG	72 000
Emilia Romagna	66 000
Toscana	52 000
Umbria	19 000
Marche	68 000
Lazio	234 000
Abruzzo	65 000
Molisse	44 000
Campania	93 000
Puglia	134 000
Basilicata	38 000
Calabria	59 000
Sicilia	54 000
Sardegna	58 000
Italy	94 000

Table 5.11. Privately financed health expenditure, 1987 (CSN 1988: 505-6)

	billion lire	% total
co-payments	842	5.9
medicines	3 507	24.7
equipment and prostheses	1 871	13.1
doctors'services	4 307	30.3
hospital care	3 691	26.0
Total	14 216	100.0

Private services contracting from SSN funding account for 11.6% of all health care expenditure, while private payment for private services (including medicines) is 20.4%. Thus, added together, the 'private sector' provides about a third of total health care expenditure, while private spending pays for about a fifth (France 1988: 13).

Private spending also appears to have been increasing in the period 1980-88. Data are available from family expenditure surveys undertaken by ISTAT. The proportion of total national health expenditure attributable to households rose from 16.7% to 21.6% over the period (France 1988: 16). This rise was slightly greater for medicines than for medical services and hospital care. The family expenditure data also reveal the differential use of private medicine (including copayments) within society. The broad social groupings provided by ISTAT give averages that are relatively similar (Table 5.2). On average, private spending was divided 40% payments to doctors, 21% medicines and 39% other (Mapelli nd: 142). However, expenditure

according to household income shows greater disparities. In 1982, a family with an average monthly expenditure of 550 000 lire spent an average of 6627 lire (1.2%) on health care; a family with an income of 1 000 000 lire spent 10 537 lire (1.0%); but a family with an income of 1 550 000 lire had an average expenditure of 48 917 lire (3.1%) (Mapelli nd: 142). Thus, private health expenditure is skewed towards richer members of the nation.

Table 5.12. Monthly spending on health care by social group (Mapelli nd: 142)

	lire
Business and professional	16 867
Self-employed	22 580
Managers and white collar	19 671
Workers	15 715
Pensioners & other	17 780
Total	18 306

Censis survey

Data confirming these trends is available from part of a national quota sample survey of 2000 adults in 1987 (Censis 1989: 173-78). Of the sample, 15% reported that they had private health insurance (although the extent of services covered was not described). Private insurance was more common for men (18%) than women (13%), and with a maximum (22%) in the age group 35-49 years. Private insurance showed a clear gradient with level of education - Table 5.13.

Table 5.13. Private health insurance coverage by educational status

Level of education	% private insurance
elementary	5.1%
middle school	13.5%
high school	19.7%
university	28.2%

Of the sample, 53% said they had used the public services only at their last encounter, 9.2% used private only and 37.5% used both public and private health care. However, the authors (Censis 1989: 176) compared these figures with a survey the previous year which, using different methods, had shown a joint public-private use of 20%. Again, both solely private and mixed public-private use was higher for higher social classes. Using data from a smaller survey, Piperno (1986: 20) made a discriminant analysis which showed that people more likely to use a private specialist or private laboratory analysis lived in an area with higher than average numbers of part-time doctors, were women, of higher socio-economic group and were (than the public sector users) more preoccupied with their health.

5.4 Planning health services

Information

The basic source of health information in Italy is provided by the Istituto Centrale di Statistica (ISTAT). ISTAT provides central government with statistics across the whole range of government activity, and the data are usually available for national and regional levels, sometimes provinces, but characteristically not at the level of the USLs.

ISTAT health statistics are an accumulation of annual series started at different times (Morganti 1982):

* Mortality statistics were started in 1887, at the time of the first central government initiative in health insurance. Continuous series of these data have been published for 1887-1975 (ISTAT 1976).
* Notifications of infectious diseases have also been required since 1888; from 1981 the notifications were collated by the USLs rather than the provinces, but they are summarised at regional level before sending onwards to ISTAT.
* Information on the causes of stillbirths have been recorded, using a form attached to the birth registration, since 1931.
* Statistics on spontaneous abortions were required to be collected by a law in 1934, but this was implemented only in 1956. A new series started in 1978, following legalisation of therapeutic abortion, sent by USLs to regions.
* Congenital malformations were published from 1956 to 1973, but the quality of the data were regarded as too poor to continue publication.

* From 1954 data have been collected on hospital numbers, beds personnel, admissions and discharges, with a more detailed examination of a 25% sample of discharges in the first seven days of each month to determine the cause of the illness. Separate data sets are kept for mental illness hospitals.

All regions were charged, within the SSN law, to set up an 'epidemiological observatory'. Most of the northern and central regions have done so, although there is a lack of suitably trained people to do this work. But some work on information systems has been put out to private non-profit research foundations. Piemonte commissioned CRESA (Centro di Recerca per l'Economia, l'Organizzazione e l'Amministrazione della Sanita), a small group working within the University in Turin, to develop a set of indicators to evaluate whether the service in the region was improving. A provisional report (Anonymous 1984a) proposed 121 indicators, which cover the progetti-obiettivi and other areas of health services development in the plan (including renal dialysis, drug dependence, coronary heart disease, tumours). The indicators include resources available, activity, organisational results and health outcomes.

National Planning

Health planning started with the Government's programme for hospital development from 1968. The hospital building plan was part of a proposed comprehensive quinquennial economic plan coordinated by the Ministry of Planning. The SSN law required health plans to be set within the ambit of national and regional economic plans. However, in

practice the national and the regional health plans have been drawn up independently of each other, although both conceived within the limitations of public finance (Grassi & Pellacani 1985).

Regions are responsible for all health services not specifically identified for the Ministry of Health. The SSN law defines that the National Health Plan should set the framework for regional policies. Under the SSN law, a triennial national plan should have been submitted to Parliament, and approved as a law by a majority vote. The first Minister of Health to present a plan to Parliament was Renato Altissimo, a Liberal member within Spadolini's Christian Democrat-led coalition. The plan was presented in 1982, but remained under discussion when the government fell at the end of the year. The plan itself was not particularly contentious, reflecting as much the ideas of senior administrators as of politicians. However, it got caught up in wider debate about the SSN, issues such as the administrative structures of the USLs, control of the number of doctors, and the relative importance of hospital services compared with primary care and prevention.

Although the draft plan itself had no force, some of its proposals became included in the finance plans which Parliament must pass each year. Five 'progetti obiettivi' were identified, concerned with prevention and rehabilitation: maternal and child health; health of elderly people; mental health; handicap; and drug dependence. And although these did not have the force of law within an agreed National Plan, their description in the draft plan and inclusion within the budget allocations, under a separate heading, meant that they were also identified separately in regional plans.

In 1983, Costante Degan, a member of the Christian Democrats, was appointed Minister of Health in a 'centre-left' government. This change of Minister meant new advisers and a complete rewriting of the plan. Instead of a full plan, guidelines for the national plan were included in law 595 passed in October 1985. This included the original five 'progetti obiettivi' and a further five 'action programmes': occupational health; cancer; cardiovascular disease; chronic renal failure; and veterinary care. The law went on to specify the general contents of regional plans, and set certain norms for hospital services, thus getting past the blockage of Parliamentary approval for a national plan (Repubblica Italiana 1985).

The guidelines of law 595/85 indicated that the regional plans should include the following (ISIS 1986: (10) 73):

- working arrangements for implementation of the 'progetti obiettivi' and 'azioni programmate';
- ways of implementing districts within USLs;
- estimates of personnel needs;
- identifying needs for contractual services;
- guidelines for volunteers;
- distribution of health buildings and facilities;
- distribution of emergency care services;
- needs for equipment;
- priorities in health services research;
- organisation of information and health data
- use of resources for specific projects.

The directions for planning hospital services included the following standards:

- 6.5 (acute) beds per 1000 population, of which 1 per 1000 were for rehabilitation;
- in calculating beds, a contractual nursing home bed should be equivalent to half a hospital bed;
- median rate of discharge should be 160 per 1000 population;
- minimum utilization should be 70-75%;
- median duration of stay: 11 days.

Other instructions were: to ensure that hospitals were organised internally in divisions by major specialties - medicine, surgery etc (as a way of improving efficient use of beds); closure or amalgamation of divisions with less than 50% occupancy; improvement of the environment and quality of life of patients in hospital.

A draft second plan, presented in 1986, was more specific about targets of health services to be achieved, and emphasised regional equity. Subsequently, recognising that a national plan could not be passed as a separate law, the government introduced 'standards' of provision of health services within the annual finance laws, a procedure that at least ensured that the resource consequences of proposals could be more clearly gauged.

Regional Plans

The great variation between regions is well demonstrated by their planning activities. In general, as with most areas of administration,

the northern and central regions have made more progress than the south and the islands. Regions are required to make plans for a three-year period. The regional office develops the plan and presents it to the regional council for approval. When the region has voted on the plan, it passes it to central government for ratification.

By the beginning of 1988 only 9 regions had completed this cycle, with plans approved by Parliament. The first region with a fully ratified plan was Emilia Romagna, in February 1981, followed by other regions mainly from the north and centre (see Table 5.14). This region had also had its second plan approved in April 1984. By 1985, Bolzano and Emilia Romagna produced reviews of their first plans, and Piemonte had a second plan approved by the regional council.

Planning remains secondary to politics. Lombardy, the biggest region in the country, put a lot of effort into its health planning, under the direction of a surgeon at the University Hospital in Milan. By 1984 five books of background data, clinical policies and proposals for development had been printed. But the ruling coalition of the regional council fell before the Plan was approved. The new coalition appointed a new regional Minister of Health who decided to start planning again from scratch. In some of the southern regions, making studies has been an acceptable substitute for actual legislation of the health plan in the regional council.

Table 5.14. Regional planning at 31 December 1987 (CSN 1989: 621)

	First plan	Review	Second Plan
Piedmont	approved		approved
Lombardy	in study		
Bolzano	approved	yes	proposed
Trento	proposed		
Veneto	approved		proposed
Friuli V G	approved		in study
Liguria	proposed		
Emilia R	approved	yes	in study
Tuscany	approved		in study
Umbria	approved		in study
Marche	approved		in study
Lazio	in study		
Abruzze	in study		
Molisse	proposed		
Campania	in study		
Publia	proposed		
Basilicata	in study		
Calabria	in study		
Sicily	in study		
Sardinia	approved		

(Val d'Aosta missing in original table)

The regional plans all start with a short series of articles of law and follow with more extensive appendices, to which the articles of the law refer. Most comment on the lack of a formally agreed national plan, but make use of the draft national plan of 1982. The central government did not offer a structural model for the first round of regional plans. Most were based on backgound statistical reports, which varied considerably in sophistication. Some reports from northern regions with well-established information departments (especially Piedmont, Lombardy, Friuli, and Emilia) include demography, epidemiology of diseases, health services provision and use. Others have more limited data bases. Some regions have contracted out the data analysis (eg Veneto, using the Milan-based company SOGESS), and Campania's plan depended on a survey by the private social research agency CENSIS, which also publishes national survey data.

The regional plans use 'standards' (norms) to indicate the levels of provision expected in each USL following the approach used by central government for planning new hospitals since 1969. They are based on 'guesstimates' of need by a panel of experts, and represent a compromise between local pressure for expansion and regional pressure for equalisation. They tend to be higher than equivalent norms in other countries (Morosini and Foli 1985). The financial plans are only broadly integrated with the service norms proposed in the plans but the developments are not costed closely. Indeed, many of the plans lack specific targets of provision for a three or five-year period, and are hence difficult to monitor.

Health service planning is a major part of regional activity. However, relatively little has been written about the objectives or achievements. Fraire and Terranova (1983) provided a manual of planning and statistical methods, indicating information sources, survey methods and ways of presentation. La Rosa (and Zurla 1982, and Minardi 1989), a sociology professor at Bologna, edited two collections of papers about planning and information, but these are theoretical and academic discussions of planning rather than analyses of process and outcome. A detailed report on the development of one regional plan was written about Emilia Romagna (Grassi & Pellacani, 1985). It showed that the region already had a system for health planning ready through developing hospital plans in the 1970s. Because of local circumstances the region chose to adopt hospital provision norms different from (and higher than) the national recommended levels, but these were to be coordinated within a region-wide balance of access. Standards, rather than needs or epidemiological measures, were the basis for the plan, and control of finance the major instrument for effecting change.

Examples

The plans of two regions can be contrasted to indicate the variation in planning across the country. Campania, the region in the south including Naples, is among the poorest provided with health services, and poor even in providing national data for ISTAT. Veneto, in the north east, by contrast, has the highest bed provision per capita in Italy, and has a tradition of good administration.

The plan for Campania (Regione Campania 1984), a region of over five

million population, was still only a draft at the end of 1984. The law presenting the plan to the regional council was ten short articles. There followed a report of ninety typed pages in ten sections (Table 5.15)

Table 5.15. Headings for sections of regional health plan, Campania November 1984:

Introduction

1. Current situation of the regional health service: principal deficiencies.
2. Planning guidelines
3. Personnel
4. Hospital care
5. Specialist care
6. Health districts and primary care services
7. Other health services
8. Criteria for allocation of resources
9. Control of spending
10. Information, control and updating of the regional plan.

The total of hospital beds for the region is not far short of the national norm. But there is a striking excess of hospital provision in the regional capital and a lack in the surrounding communes. Although the regions have been responsible for hospital planning since 1974, services have been built up where the doctors prefer to practice, rather than nearer to where the population live, and migration from the countryside to the city suburbs has exacerabated this. For the same reason, the private hospitals are also sited in the province with the

most public provision. As elsewhere in the country, there are too many doctors and too few paramedical staff, especially nurses. Staff working in the private sector are still a minority even in this region, but they do not compensate.

The plan proposes to tackle some of these inequalities. New personnel are to be appointed, and construction started, only in 'priority' USLs with a relative lack of facilities. More strongly, polyclinics, private 'convenzionata' hospitals and private nursing homes in the 'excess' USLs are to be transferred to the underprovided ones. A fifty per cent reduction in the private facilities in the 'excess' USLs is envisaged over the three year period.

The first health plan for Veneto, a well-resourced region, was approved by the regional council in April 1984 (Regione del Veneto 1984). The plan is divided into four main headings - proposed changes for the services; the means of change; progetti obiettivi; and financial resources - and followed by summaries of the services provided within each of the 36 USLs. The plan was accompanied by a comprehensive, 500 page report of health information for the region.

The plan proposes substantial reductions of hospital beds, from 9.56 beds per 1000 population to 7.37 per thousand. This was to be effected without significant reduction in the number of patients treated, but by more efficient use of the remaining beds (see Table 5.16).

Table 5.16. Proposed changes in hospital provision, Veneto region.

	1982	1984-86 (proposed)
number of beds	41 540	32 074
beds/1000 population	9.56	7.37
patients treated	783 524	770 000
average length of stay	11.9	11.0
occupancy	62%	73%

Details of the proposed changes, by specialty, are given for each USL (although not details of the implications for closure of small hospitals). These changes are matched by reallocations of resources, with a reduction of the hospital budget and increases in environmental health, veterinary medicine and 'developments' (Table 5.17).

Table 5.17. Proposed changes in budgetary provision, Veneto region 1984-86 (Regione del Veneto 1984: 182-5)

	% of total budget		
	1984	1985	1986
* administration	5.86	5.79	5.73
* environmental health	1.74	1.87	2.03
* veterinary prevention	0.56	0.65	0.74
* primary care	10.35	10.62	10.90
* polyclinic	7.59	7.56	7.53
* hospital	59.25	57.57	56.51
* pharmaceutical	9.50	9.50	9.50
* developments	3.05	4.19	4.56
* other payments	1.96	1.94	2.11
* national tied developments	1.44	1.94	2.11
	101.30	101.63	101.82

5.5 Education

The Italian universities of the middle ages provided an important link between the scholarship and writings of the Greeks and Arabs, and the development of modern science in the renaissance (Haynes 1977). Salerno, just south of Naples, was a notable centre for 'studium generale' from 950 to 1400, with a strong presence in medicine. After the Norman invasion in 1087 these studies passed to Montpelier in France.

Bologna subsequently rose as the first 'modern' university, and by 1200 had a strong reputation for anatomy and surgery. The first teaching by human dissection there was recorded in 1270. Padua, founded through secession of students and teachers from Bologna in 1222, became one of the most famous of all medical schools, especially after 1404 when Venice annexed the city and made it the University for the Venetian state (Bullough 1966). Venetian citizens were forbidden to study elsewhere, and the introduction of salaries for the university staff lessened the problem of students and masters moving away from the older universities to start new ones. The development of methods of discovery at Padua was the basis of later achievements in scientific methods by Galileo.

British physicians travelled to Italy in the Tudor period to complete their education (Haynes 1977). Thomas Linacre, later to become the first President of the Royal College of Physicians of London, studied in Florence in 1489 and Padua in 1493, graduating in 1496. He returned with a double reputation, as a Greek scholar and able physician, to

serve Erasmus and King Henry VIII. John Caius studied in Padua in 1539 and received his doctorate there in 1541. In Padua, Caius shared accommodation with Andreas Vesalius, who was a founder of modern observational anatomy. In Elizabethan England Caius provided a bridge between surgery and clinical methods, and gained for physicians the right of human dissection.

Contemporary medical education.

Major reforms were made in the Italian University system by Parliament after the student revolts of the 1969 'autunno caldo'. The most important was a change in the admission regulations. Before the reforms, only children from selected schools were able to seek entry to the universities. From 1970, all children finishing secondary school were eligible to enter, and 60% of them did so. It was hoped that this regulation would widen the social background of students entering university, although the parents still have costs of supporting the student. However, as far as medical students go, there have been no studies to show whether the proportion of less privileged children starting medicine has increased or not.

The increase in numbers was especially great for professional studies, including medicine. Italy has never formally limited the number of people entering medical education (although regulations in 1987 prescribed a balance between teachers and student places), so by the mid 1970s there was a substantial rise in the number of doctors graduating. Apart from the change in law, other factors contributing to the rising university rolls from the late 1960s included the postwar birth 'boom'

children coming to university age, a higher proportion of children staying on to finish secondary education, and higher aspirations of the population after the post-war economic 'miracle'. But undoubtedly the change in the law was the most significant factor of all (Freddi 1984: 58-66).

However, although the law increased the number of students at universities, the number of teachers and facilities did not expand commensurately. There were twenty five universities with medical faculties, all public except the Catholic university in Rome. By the early seventies most of these universities were grossly oversubscribed. The interest of medical teaching staff in private practice limited the opportunities of students to have direct care of patients. Whereas before the reform it was difficult for medical students to get adequate experience with patients, afterwards the situation was much worse. Added to this, the number of examinations was reduced. Many doctors graduating in the mid-seventies would scarcely have passed in medical schools of other countries.

Some of the criticisms of Italian medical education echo deficiencies in other countries. These include (Coltori 1982) lack of clear educational objectives; lack of verification that the education has been effective; poor staff-student ratios; under-use of modern teaching methods; a low value placed on teaching by staff; and little coordination between different departments, so that subjects are taught with little reference to each other. In the 1980s there has been some reform of the curriculum to encourage study of social sciences, general practice and epidemiology, but these are optional courses. The dominant model of

care remains private practice to the individual rather than care (including prevention) for a defined population.

Medical graduation

The effect of the 1969 university law can be seen in Figure 5.3. (There was no separate degree of dentistry until 1981, so that the numbers shown include about 7500 doctors specialising in 'odontology'.) Medical students entrants rose from 3200 in 1960, only a little higher than the number in Britain (2500), to over 22 000 in 1970 - five times the number in Britain. By 1976 the total medical student population had reached 180 000, and there were 12 600 doctors graduating.

The difference between students entering and graduating reflects 'wastage' because of students failing exams or giving up for other reasons. It is much higher than in Britain, where about 10% of students who enter do not graduate. On the other hand, France has a system of higher entry at the first year and a higher failure rate at the end of the first year. One aspect of the Italian system is that, because university studies are open to anyone with sufficient qualification, some students are attracted to Italy when they have failed to get into medical schools in their own countries. A study by ISTAT in 1973 found that foreign students accounted for 7% of all medical students, with 10% coming from the USA, 13% from Israel and 45% from Greece (other countries included Lebanon, Syria and Jordan) (Fara 1978).

find for themselves a 'recommended' doctor, a policy which produces large numbers of poor-quality doctors only harms the working classes. It is salutory to reflect that the only medical school that maintains a firm restraint on the number of students entering it each year is the Catholic university in Rome, which is a private foundation. The right of students to register at the public universities has led to falling commitment of teaching staff in these universities, given the poor conditions they are expected to face.

Higher production is unlikely even to have an effect on the geographical inequalities of distribution of doctors (Brenna 1984). For many years doctors have tended to be concentrated in the provincial capitals. These towns, that together include one third of the population, include two-thirds of all doctors (table 5.18), and it is unlikely that many of the younger doctors will want, voluntarily, to work in the smaller towns and countryside. It is more difficult to build up either general or specialist practice in these places, and the larger towns have the attractions of more leisure opportunities and closer contact with the more advanced hospitals. No solution is likely to be found for this maldistribution.

Despite unemployment of doctors, there is surprisingly little medical migration within the European Community, although this is permitted by community laws. For example, during the first three years of the 'harmonised' EC regulations (1977-1980) only one in three hundred Italian doctors migrated to work in another Community country, and even fewer moved from another EC country to work in Italy (Deliege 1984).

Figure 5.3. Students entering, and graduating from, medical faculties in Italy, 1970-80.

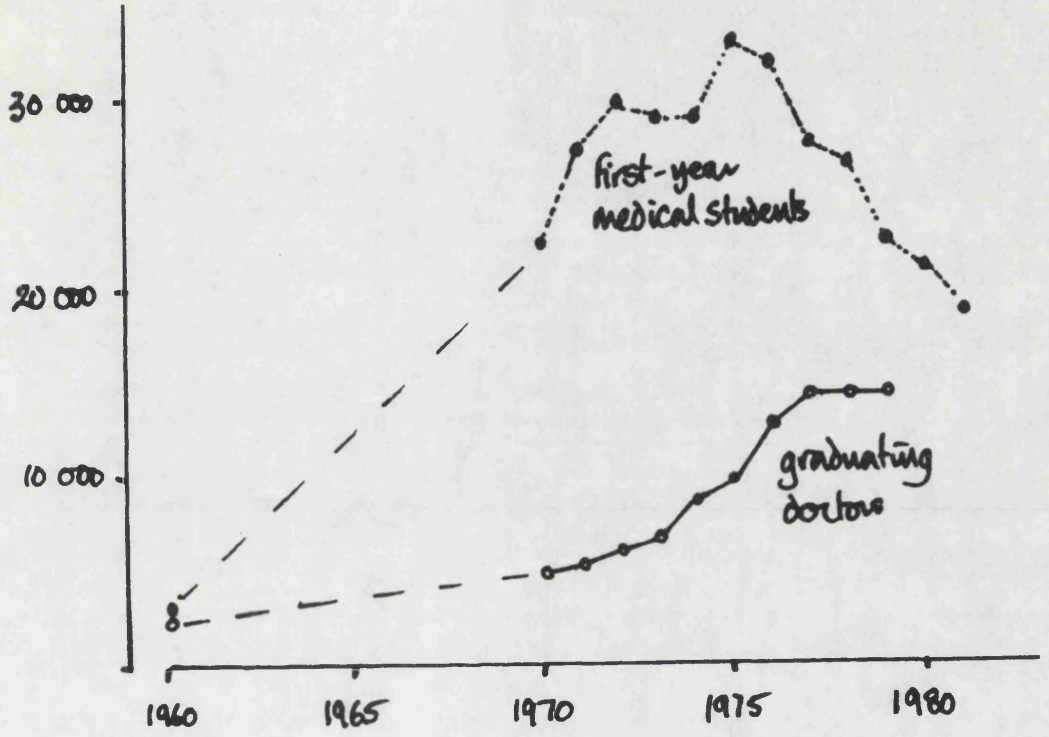


Table 5.18. Concentration of doctors in chief towns of provincial capitals, 1984 (Magi et al 1985)

Region	doctors (%)	population (%)
North-west	60.8	33.3
North-east	60.4	31.9
Central	72.4	46.1
South & islands	51.9	27.9
Total	60.6	33.6

Table 5.19. Medical migration within the European Community 1977-86 (Hurwitz 1990: 60)

Country	doctors leaving	% total	leavers % annual docs (estimated)	country % all EC docs (estimated)	doctors entering
Belgium	1255	11.3	0.64	3.7	273
Denmark	282	2.6	0.30	1.9	72
France	883	8.2	0.10	17.7	651
Greece	1644	15.2	1.56	4.2	43
Ireland	2154	19.9	5.97	0.7	352
Italy	1499	13.9	0.10	28.8	132
Luxembourg	296	2.7	6.83	0.1	95
Netherlands	1114	10.3	0.51	4.4	639
United Kingdom	876	8.1	0.11	15.6	4419
West Germany	845	7.8	0.07	22.9	4142
Total	10818	100.0	0.21	100.0	10818

Hurwitz (1990) reported movement within the EC in the ten years 1977-86 (Table 5.19). Only 1499 doctors had emigrated, and 132 immigrated, the second lowest proportion of doctors graduating in each EC country.

Specialisation.

Specialists are generally believed to earn more money than generalists, and considered to have higher status. Specialists are also able to enter into competitive medical markets where generalists already have

firm control of patients attendances. Specialisation also uses some (though by no means all) of the skills learned in undergraduate medical education, whereas general, non-hospital practice has not been taught to undergraduates. A specialist works in hospital as part of a team, but within the clinic as an independent professional. The sought-after speciality practice is usually a mixture of hospital and private clinic care - the hospital practice being the most rewarding professionally and the clinic the most rewarding financially. However, achieving speciality status can be slow, and the financial rewards during training are much less than in general practice.

Specialisation is achieved by taking a post-graduate course at a university. There were, in 1981, 1089 courses available, with a total of 15 000 places - equivalent to the total number of medical graduates in a year. Yet there were estimated to be at least 75000 requests for places on these courses in the same year (Bompiani 1984). Various factors affect these requests, over and above a simple desire for postgraduate training. For example, an ophthalmology course in Rome had 400 applications for 15 places, whereas a similar course in Ferrara had 25 applications for 24 places (Bompiani 1984). In part, this can be accounted for by the advantages that a particular clinic gives a doctor when applying for a permanent post.

Only anaesthetists and radiologists are required by law to possess a formal postgraduate diploma, but entry to most other specialities depends on having taken a postgraduate course and exam. This qualification may be sufficient for the doctor to gain an appointment as a specialist in a polyclinic; but competition for hospital posts is

intense, and appointments are often made to doctors already working within the hospital. All appointments are by formal appointment boards, the post being awarded to the candidate with the highest points on a set of 'objective' criteria - diploma held, number of publications, years working etc. In practice, the lower posts tend to be filled by doctors who have already worked voluntarily in the hospital, and who already 'know the ropes'. Promotion is also by board recommendation.

Table 5.20 shows the number of registered doctors holding specialist certificates in 1978. Certificates were held by 54% of all registered doctors. However, this table cannot be compared with, for example consultant specialists in Britain: Italian doctors often hold more than one certificate, and may not hold a post related to their specialist training. Also, doctors often hold more than one post. Table 5.21 shows that one in three doctors employed by, or in contract with the SSN, held two or more positions. If the positions held in private clinics and nursing homes (not recorded in the survey) are included, the average number of posts for all doctors would exceed two (Bompiani 1984).

Many laboratory specialists offer private services for ambulatory care, and these services are run by technical staff paid by the specialist. However, the cost of equipment to start a laboratory or radiology clinic tends to limit this form of practice to established specialists.

Table 5.20 Doctors' specialist certificates, 1978 (Bompiani 1984: table 1.3)

	doctors	per 100 000 population.
anaesthetics	2042	3.6
cardiovascular diseases	5409	9.5
communicable disease	679	1.2
dermatology & venereology	1460	2.6
endocrinology	800	1.4
forensic medicine	1388	2.4
general medicine	3283	5.8
general surgery	4894	8.6
general pathology	1707	3.0
geriatrics	524	0.9
laboratory specialties	3373	5.9
neurology & psychiatry	3052	5.4
obstetrics & gynaecology	4833	8.5
occupational medicine	1925	3.4
odontology	7300	12.8
ophthalmology	1615	2.8
orthopaedics & traumatology	2700	4.8
ENT diseases	1863	3.3
paediatrics	9531	16.8
public health	3379	5.9
radiology	4241	7.5
respiratory medicine	3728	6.6
urology	1810	3.2
other specialties	1830	3.2
Total	73 366	129.1

Table 5.21 Activities of doctors in SSN, 1980 (Bompiani 1984: table 1.4)

Activity	Doctors with one post	Doctors with two/more posts	total
general practice	35 100	28 000	63 100
general paediatrics	900	600	1 500
ambulatory care specialists	7750	22 900	30 650
public hospitals	33 500	22 500	56 000
other public sector	--	15 800	15 800
Total - posts	77 250	89 800	167 050
Total - doctors	77 250	46 200	123 450

Whereas in the United States and some other European countries the large majority of doctors have become specialists, the Italian SSN has sustained the role of the 'general practitioner' through its capitation system of payment. Despite the key place general practitioners play in the new service, they still seem to be the poor relations of the specialists. There is no requirement for postgraduate training, indeed there are few courses available - most practitioners update their knowledge through specialist courses at the universities. A small number of general practitioners are joining together to discuss common problems and undertake cooperative research; but these are a minority.

It is still possible to leave university in Italy with the barest clinical experience and enter directly, unsupervised, into general practice. However, the competition for patients means that most aspiring general practitioners start after some years of hospital

experience, frequently unpaid, as a 'voluntario'. Many doctors then go on to work for the guardia medica, who work outside the usual office hours, and get more experience doing 'locums' when established doctors are on holiday or away. Eventually an opportunity may come to start up a small clinical practice, which can be hoped to grow.

Medical staffing

A census in 1978 showed that there were 143 000 doctors resident in Italy and registered with the 'Ordini dei Medici', the official representative body for the medical profession. By 1984 the total had risen to 220 000, a rise of 54% in six years. The 1984 census indicated that about 90 000 doctors were working in hospitals, 30 000 as specialists, working in polyclinics or in their own private clinics in contract to the SSN, and about 70 000 were general practitioners. These figures do not take into account those doctors working in more than one location, and thus underestimate the extent of medical unemployment.

In 1984, 19% of the doctors registered were women, and 22% were aged 30 or less. There was, on average, one doctor for every 258 inhabitants, although this ratio differed between the regional capitals (1:148) and the other comunes (1:403). Regions in the north had relatively fewer doctors, in relation to population, than the south.

In 1987 the government responded to the continuing demands for limiting medical education by issuing regulations relating the number of students to available teachers. This has allowed some of the largest

universities to limit their student entry, and has brought down the student entry. Nevertheless, with even the current rate of registration, there will be more than 300 000 doctors in Italy by the year 2000, a ratio of less than 200 people for every doctor. Some other European countries are heading the same way, especially West Germany. But the overall production is likely to be highest in Italy (Deliege 1984).

In contrast to this is the limited number of nurses and other paramedical staff in training, leading to chronic shortages in hospitals. It has been estimated that the ratio of doctors to nurses is 1:3 or even 1:4 in the United States and Scandinavian countries, but 1:1 or less in Italy (Fara 1978).

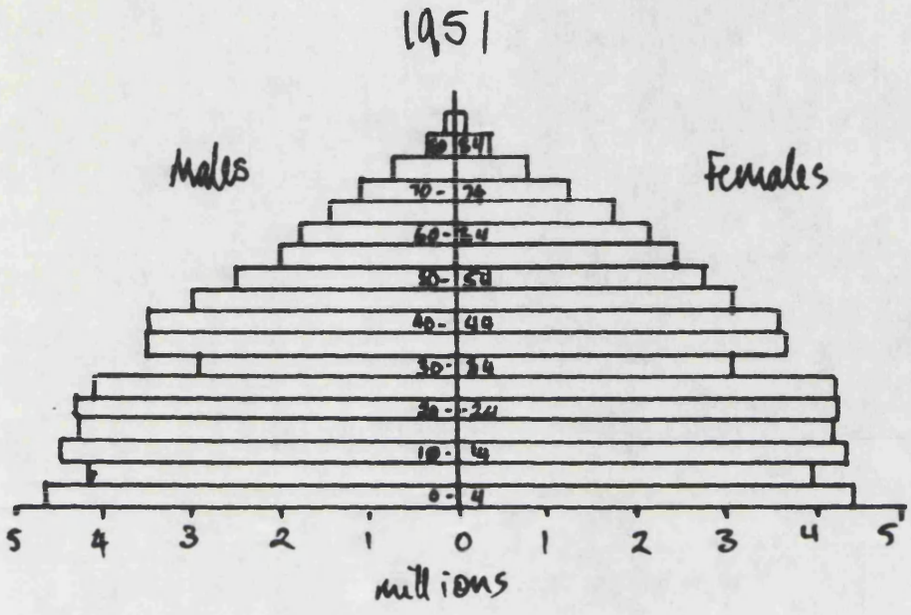
CHAPTER SIX: THE HEALTH OF ITALIANS

6.1. Demography

Italy's population doubled in the century from the start of the new state, from 27.5 million in 1871 to 53.7 million in 1971. By 1989 the total resident population was estimated to be 57.5 million. The increase was due to better survival of children and young adults, associated with improving literacy and material wellbeing. Birth rates fell, but always remained higher than the death rates, leading to the growth in population. There was substantial emigration from the south, especially to America from the nineteenth century up until the fascist period, and after the war, and during the 1950-70s to the northern regions within Italy.

There have also been marked changes in family patterns since the nineteen sixties. More than one million children were born in the peak year of 1964. This fell progressively to 562 265 live births in 1987 in the resident population, a rate of 9.6 livebirths per 1000 inhabitants. (1988 saw a slight upturn again, to 9.9 per 1000). All regions showed a steady decline, but the historical differences between the north (except for the small, German-speaking minority of Alto Adige) and the south continue. Liguria, the state with the most elderly people, has the lowest rate. Births and deaths roughly balance for the country overall, with births still just ahead of deaths. But in the northern and central regions births are far fewer than deaths, and only the reverse of this pattern in the south keeps the country in balance. Representative regions are shown in Table 6.1.

Figure 6.1 Population pyramids, Italy 1951 and 1989 (ISTAT 1989: tavola illustrata no 2.7)



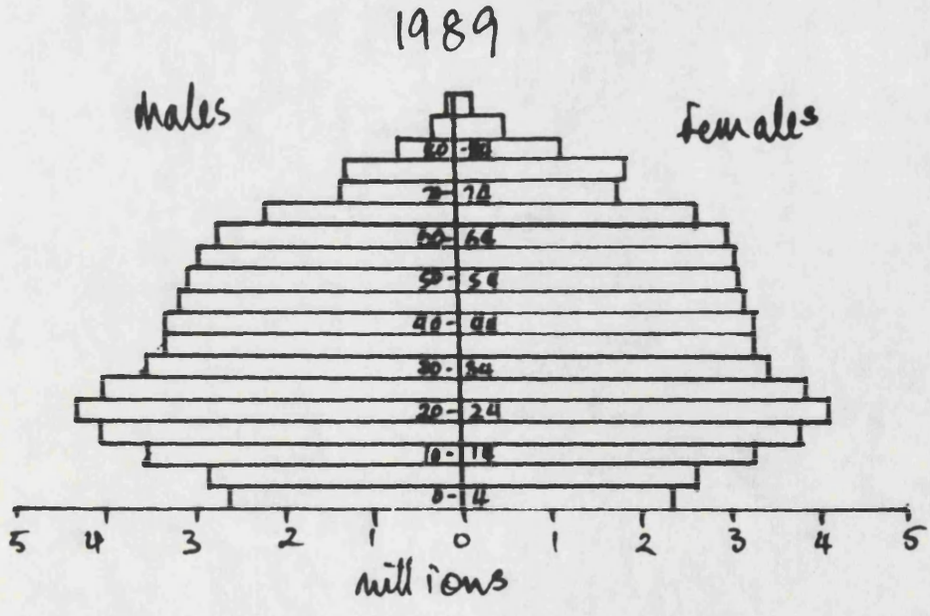


Table 6.1 Birth and death rates for selected regions (ISTAT 1989: 72)

	1961		1988	
	live births per 1000	deaths	live births per 1000	deaths
Lombardia	16.1	10.3	8.5	9.3
Emilia Romagna	14.1	9.7	6.8	11.1
Campania	24.4	8.5	14.2	7.6
Sicilia	22.5	9.0	13.1	8.5
			----	----
Italy			9.9	9.3

To this must be added the effect of internal migration. There was a net flow of people from all the southern regions, except Lazio, to the north during the sixties: and for Molisse and Basilicata, where one person in five emigrated during this period, the high birth rate did not balance the loss. But in the 1970s this position changed: with falling internal migration, all regions, except Liguria, showed a small increase in population.

The age and sex structure of the population in 1951 and 1989 is shown in two population pyramids (Figure 6.1). Apart from the reduction in children, there is an increasing number of elderly people, a feature of many European societies. This demographic change for the elderly is due more to improved life expectancy of children at the turn of the century who have become elderly people now (compared with those who survived to become elderly in the nineteenth century) than to extension of life expectancy of people once they become old. Nevertheless, partly because of the emigration, and partly because of deaths during the last war, the

numbers of elderly have increased less dramatically than elsewhere in Europe. The projections to 2011 are shown in Table 6.2.

Table 6.2. Population projections, Italy, to 2011 (thousands) (ISTAT 1986: 66 (table 2.29))

	1991	2001	2011(millions).
men			
65-	1,318	1,352	1,287
70-	743	1,140	1,183
75+	1,312	1,424	1,664
women			
65-	1,659	1,626	1,520
70-	1,034	1,512	1,544
75+	2,327	2,567	2,908

There are of course regional variations. Friuli and the central regions have higher proportions of elderly people: Liguria, a small region around Genoa with a favourable climate, has 40% more elderly people than the national average, and Campania only half the national average - see Figure 6.2.

Expectation of life

The number of elderly people in a population is a reflection of trends in births and deaths in earlier decades. While there are now far fewer children dying from infectious diseases than ever before the death rates of middle-aged and elderly people have hardly changed. The 'expectation of life' at different ages is shown in Table 6.3.

Figure 6.2. Resident population, age groups by regions, 1981 census.

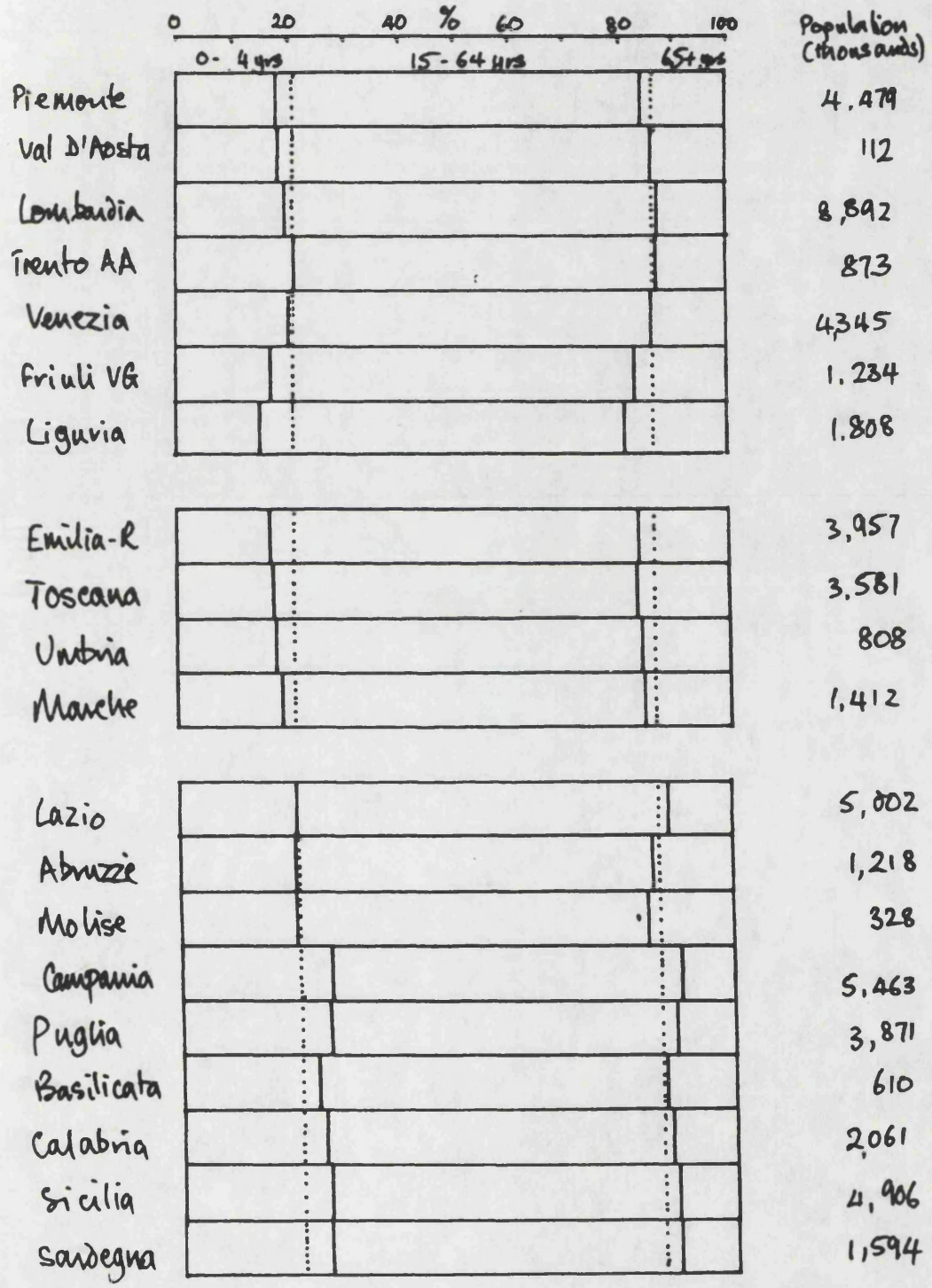


Table 6.3. Expectation of life 1960-62 and 1983 (ISTAT 1989: 79)

	1960-62			1983	
	M	F	M&F	M	F
at age	(years)			(years)	
0	67.2	72.3	69.8	72.0	78.6
15	56.4	60.9	58.6	58.2	64.6
50	24.3	27.8	26.1	25.3	30.8
80	5.7	6.4	6.0	6.2	7.5

The working population in 1988 was estimated to 15.2 million men and 8.8 million women. Unemployment rose sharply in the 1980s, and was estimated to be 8 per cent nationally for men and 18% for women in 1988. Unemployment rates were more than 40% for the age group 14-19 (ISTAT 1989: 235). There is a marked regional gradient, being about twice as high in the south than in the northern regions, with the central regions between.

Of health and disease

The best indicators of health are (paradoxically) the rates and causes of death. Doctors are required to certify the causes of all deaths, as a precaution against unnatural causes. These certificates can be made up into a profile which is comprehensive and accurate, and is in contrast to information gained from surveys, which varies according to the knowledge of the informant.

Just under ten people out of every thousand die each year. The death rates are lowest in the age-group 5-34, at less than one per thousand,

and then rise for each decade. Diagnoses on death certificates are less reliable in elderly people, so it is convenient to review the pattern of deaths in people under 75. The main causes of death are seen in Table 6.4. The commonest cause of death is from circulatory diseases, especially coronary heart disease and strokes. The next most frequent cause is cancer, with lung cancer the most important within this group. Accidents are an important cause of death in younger adults.

These death rates are not uniform. They differ between the sexes and across the country. People die from cardiovascular diseases less often in the centre of Italy than in the north or south, but this comparison hides sex differences. For men, heart disease is commoner in the north, but has similar rates in the centre and the south. For women, the rates in the north and south are both higher than in the centre.

There are also regional differences in deaths from cancer. Cancers overall show a clear gradient, decreasing in frequency from the industrialised north to the more rural south. Lung, breast and most gastro-intestinal cancers show this pattern, but for stomach cancer the death rates in the centre of Italy are as high as in the north, and for cancer of the uterus (including cervical cancer) the rates are the reverse, being highest in the south and lowest in the centre. Deaths from accidents and suicide are more frequent in the north than in the centre or south (Table 6.5), but respiratory deaths are commoner in the south than in the north or centre.

Table 6.4 Causes of death in people under 75 years, Italy, 1980 (Capocaccia et al 1985)

	nos	rates/ 10 000	nos	rates/ 10 000
Cancers	53686	18.9	32776	11.2
- lung	17112	6.05	2109	0.72
- breast	74	0.03	2148	2.26
Circulatory	63478	21.8	39029	12.8
- coronary heart disease	27709	9.69	10927	3.58
- cerebrovascular	16077	5.44	12726	4.16
Respiratory	11537	4.02	4524	1.56
- bronchitis	6730	2.29	2025	0.67
Digestive	15838	5.61	6701	2.29
- cirrhosis	11429	4.06	4235	1.45
Accidents	16673	6.00	6210	2.19
- trauma	7627	2.75	2872	1.02
- intoxication	483	0.17	350	0.12
Total	178221	63.1	103748	35.5

Table 6.5. Death rates per 10 000 population under 75 (standardised), 1980 (Capocaccia et al 1985)

		north	central	south & islands
all causes	M	69.4	57.2	57.2
	F	35.3	31.7	37.9
cancers	M	22.6	18.7	13.5
	F	12.3	11.3	9.3
- lung	M	7.40	5.70	4.28
	F	0.83	0.75	0.52
- stomach	M	2.55	2.47	1.33
	F	1.21	1.24	0.72
- other GI	M	1.95	1.79	1.00
	F	1.43	1.43	0.94
- breast	F	2.60	2.15	1.81
circulatory				
- cardiovascular				
	M	10.80	8.64	8.72
	F	3.76	2.98	3.70
- cerebrovascular				
	M	5.74	4.80	5.40
	F	3.98	3.55	4.86
accidents	M	6.64	5.06	5.66
	F	2.11	1.71	2.54

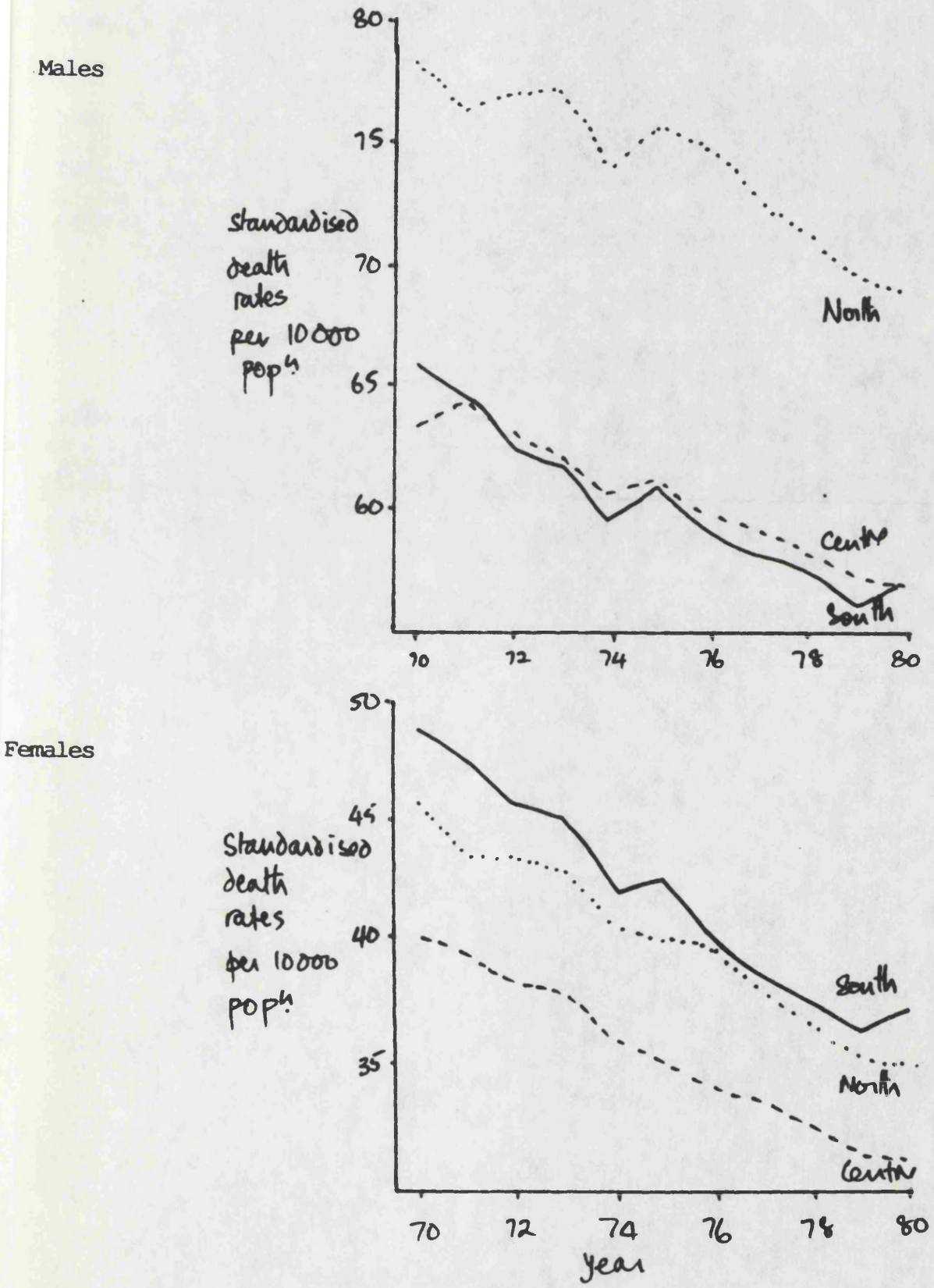
The patterns of lung and stomach cancers can be related, in part, to differences respectively in smoking and dietary habits. Smoking started earlier in northern industrial workers than in southern farmers, and thus shows as higher cancer rates because of the cohort effect. Stomach cancer in the north is probably related to higher consumption of foods, such as meats preserved with nitrites, in comparison with the less well-off south.

The certified causes of death at middle age have changed during the century. In the first decades, most deaths were due to acute and chronic infections - pneumonia and gastroenteritis in children, pneumonia and tuberculosis in adults. Public health measures (education, better housing, clean water and adequate sanitation) and improved nutrition eliminated these as common causes of death. However, new diseases of middle age developed - coronary heart disease, cancer and strokes.

Table 6.6. Deaths by main groups of causes, Italy 1975-1987 (rates per 100 000 population) (ISTAT 1986: 121, ISTAT 1989: 109)

Year	tumours	circulatory diseases	pneumonia
1975	199	476	85
1978	209	471	67
1981	221	457	57
1984	226	429	55
1987	243	409	59

Figures 6.3a & 6.3b. Changes in death rates for men and women by broad region, Italy, 1970-80



Yet the death rates in Italy continue to improve. Figure 6.3 shows the steady fall in the death rates over the decade 1970-80, with the regions keeping their characteristic differences. This fall was reflected in most diseases; only lung cancer in men and women, female breast cancer, heart disease in men and cirrhosis in both sexes show increases. Importantly, during the 1980s, circulatory diseases showed a clear downturn (Table 6.6).

International comparisons

Traditional comparative measures of health in a country are infant and perinatal mortality. In 1980 Italy, along with other Mediterranean countries, had higher perinatal mortality rates than northern European countries, as shown in Table 6.7.

Table 6.7. Infant and perinatal mortality rates per 1000, selected European countries, 1980 (OECD 1985: 131)

	Perinatal mortality	Infant mortality
France	12.9	10.1
FR Germany	11.6	12.7
UK	13.4	12.1
Greece	21.2	17.9
Spain	15.7	11.1
Italy	17.5	14.3

In comparison with 23 OECD countries (OECD 1987), Italy had an expectation of life at birth in 1981 of 70.1 years, just a little below the mean of 71.5 years. Average age-adjusted mortality rates for broad

causes were also similar to the mean, except for rather less digestive disease deaths - see Table 6.8

Table 6.8. Age standardised death rates per 100 000 for selected disease categories, 1981 (OECD 1987: 47-8).

	Italy	Mean OECD	Std Dev OECD
Infectious diseases	5.2	6.3	2.5
Cancers	197	197	25
Circulatory disorders	402	394	62
Respiratory disorders	63	66	25
Digestive disorders	52	34	12
Injury & poisoning	49	60	14
TOTAL	869	855	94

6.2. Special groups

Maternal & infant health

The death rates of young children are higher in Italy than in some other developed European countries (OECD 1985), but have followed a continuing downward trend since the 1950s (Tables 6.9 and 6.10):

Table 6.9. Perinatal mortality, selected countries, 1950-1984 (OECD 1985 and 1990).

	1950	1960	1970	1980	1984
France	36.0	31.0	23.0	12.9	11.2
FR Germany	49.9	35.8	26.4	11.6	8.6
Netherlands	34.0	27.0	18.6	11.0	10.0
UK	39.0	34.0	24.0	13.4	10.1
Italy	51.0	42.0	31.0	17.5	14.5

Table 6.10. Infant mortality, selected countries, 1950-1987 (OECD 1985 and 1990).

	1950	1960	1970	1980	1987
France	51.9	27.4	18.2	10.1	7.6
FR Germany	55.3	33.8	23.4	12.7	8.3
Netherlands	26.7	17.9	12.7	8.6	6.4
UK	31.2	22.5	18.5	11.2	9.1
Italy	63.8	43.9	29.6	14.3	9.6

Perinatal mortality is defined in Italy as stillbirths after 180 days of pregnancy and deaths of liveborn children up to seven days. It fell from 46 per 1000 still and livebirths in 1955 to 17.5 per 1000 births in 1980, and to 12.4 per 1000 births in 1987. Thus, of 565 000 births in 1987, just over 6700 were born dead or died within the first seven days of their life. The regional gradient from north to south persisted in the 1980s (Figure 6.4). Within the total of perinatal mortality, there has been a greater fall in the deaths classified as stillbirths than of children dying within the first week of life: this suggests the influence of improved antenatal and obstetric, rather than neonatal care.

Infant mortality, deaths of liveborn children up to the age of one year, fell from 40 per 1000 livebirths in 1950 to 33 per 1000 in 1968, and more rapidly in the 1970s to 14 per 1000 in 1980 and 9.6 in 1987. As with perinatal mortality, infant mortality in the south is higher than in the north - Figure 6.5 - but major improvements have been achieved in all regions.

Maternal deaths fell from 30 per 100 000 births in 1974 to 18 in 1980. Maternal mortality has shown a particularly rapid fall in the 1970s, from 467 deaths in 1970 to 101 deaths in 1981 (a death rate of 16 per 10 000 births).

Both social and health care factors contributed to these changes (La Vecchia 1985). Social improvements include better standards of food, an improved environment and better education: education only became compulsory thoughout Italy in 1946, and the minimum schooling was

Figure 6.4. Perinatal mortality 1955-59 and 1975-79 by region

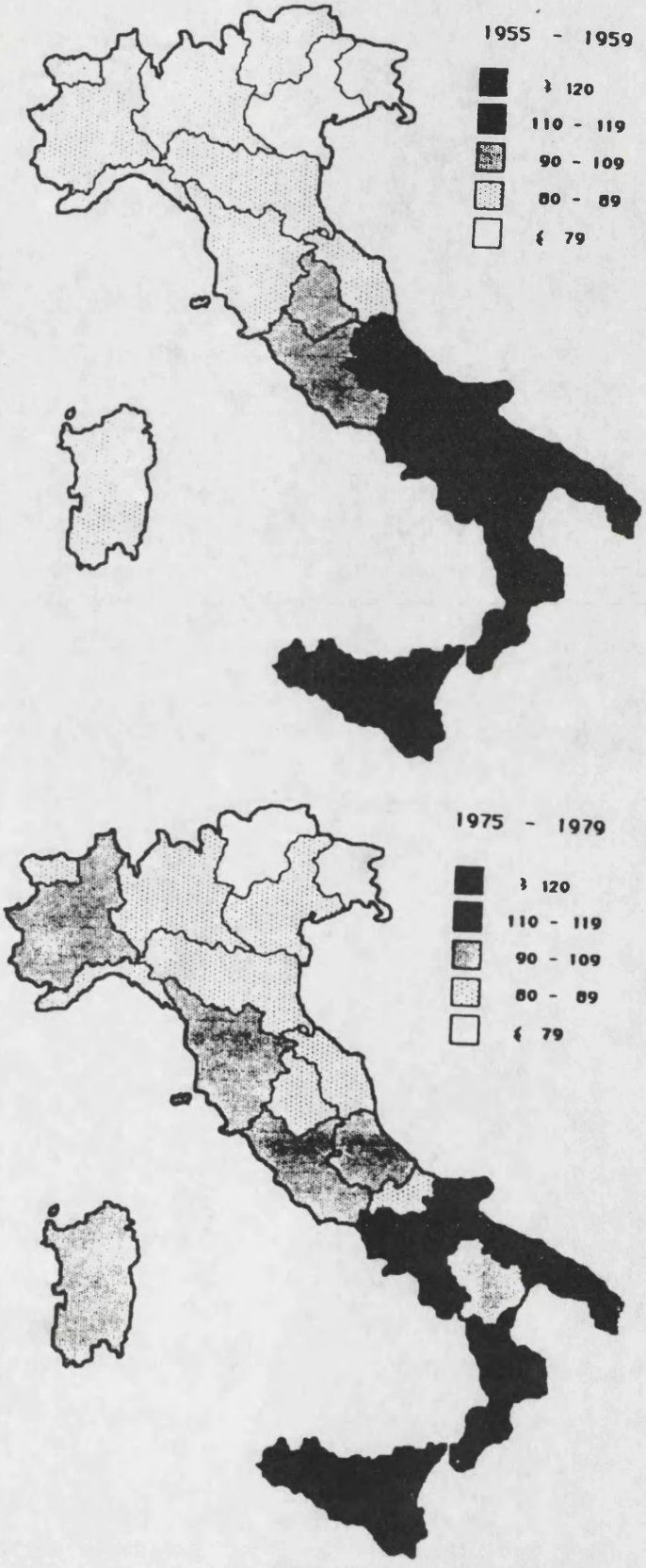
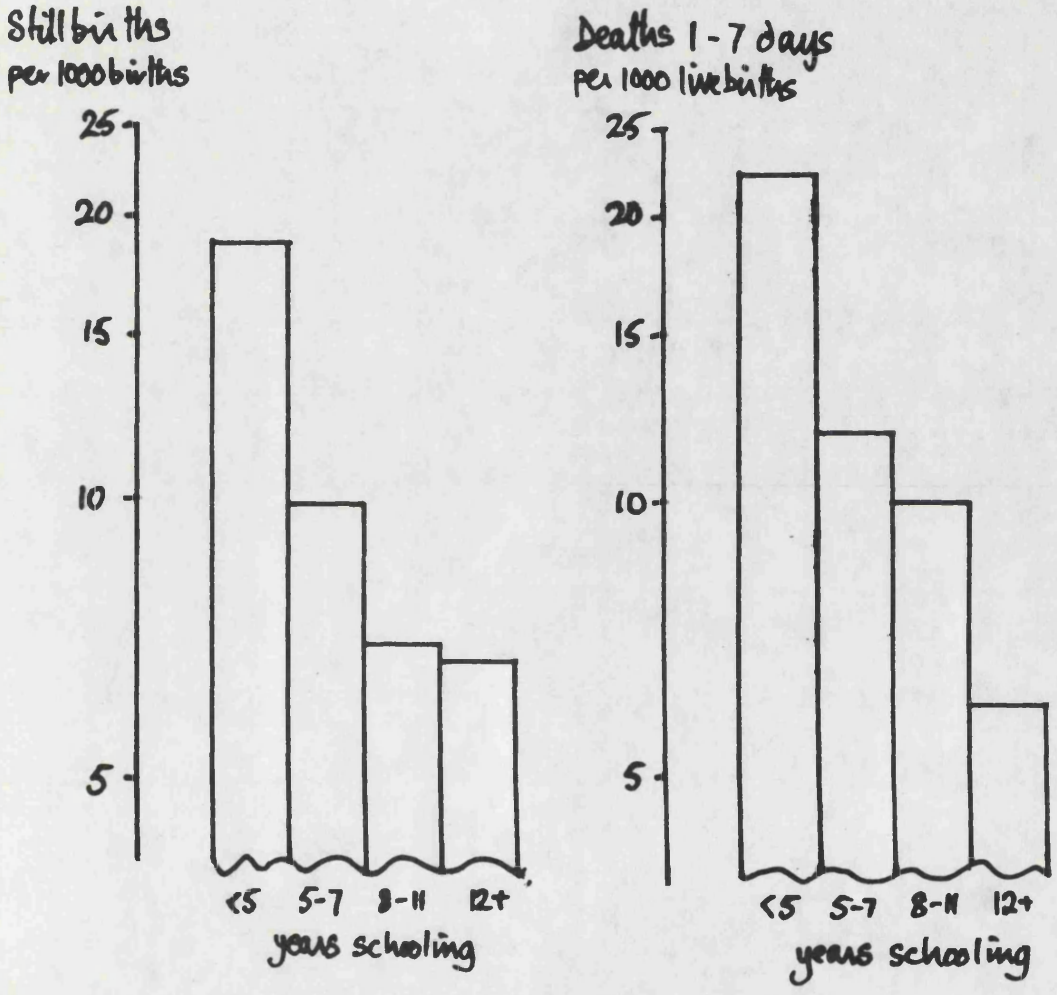


Figure 6.5. Infant mortality by region, 1987 (CSN 1989: table 3.4)

Figure 6.6. Perinatal mortality related to mother's education, 1979 (La Vecchia, Imazo and Pampallona 1985)



extended from five to eight years in 1963. The level of a mother's education still relates closely to perinatal mortality, as Figure 6.6 shows. Since the late 'sixties maternity allowance has been paid for three months pre-natally and for up to six months after the birth.

The improvements of maternal and child health services in the 1970s probably contributed to improved maternal and infant mortality, both directly in antenatal and obstetric care, and also in family planning counselling. Italians were choosing smaller families, and the risks in childbirth are lower for the first three than for subsequent children.

Abortion

Under the abortion law of 1978, therapeutic abortions are legal if within twelve weeks of conception and undertaken within the SSN. It is compulsory for the abortion to be notified to the regional authority, so ensuring relatively good information about therapeutic abortions for each region, by age, gestation, and type of operation.

Prior to 1979 there was no clear idea of the frequency of voluntary abortion. The actual number notified in the first full year after the law was 187 000, rising to 222 000 the following year (Tosi et al 1985). In 1983 the rise had leveled to 230 000 and by 1988 had fallen slowly to 173 000 (Figure 6.7). This represents about 12 abortions for every 1000 women of reproductive age (15-49), and about one abortion for every three live births (CSN 1988: 141). Voluntary abortions are less frequent in the north east and south of the country (Figure 6.8), perhaps reflecting religious patterns, but the availability of services

Figure 6.7. Therapeutic abortions, Italy, 1978-83

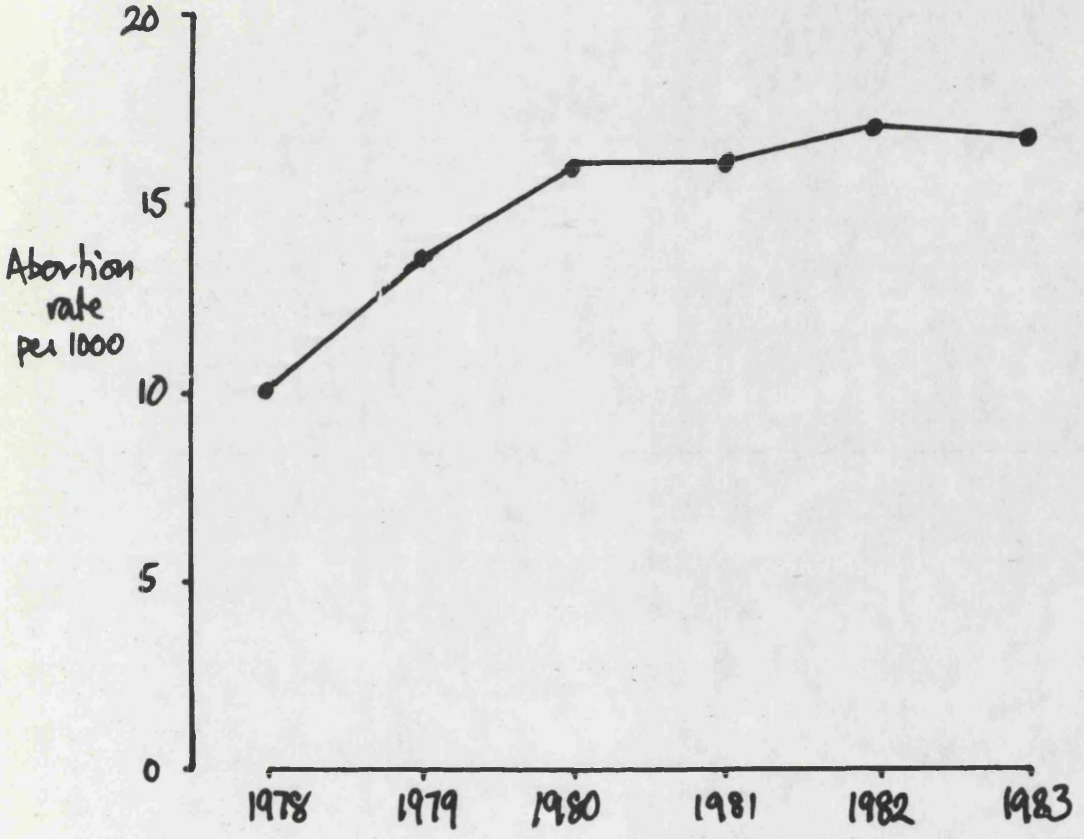
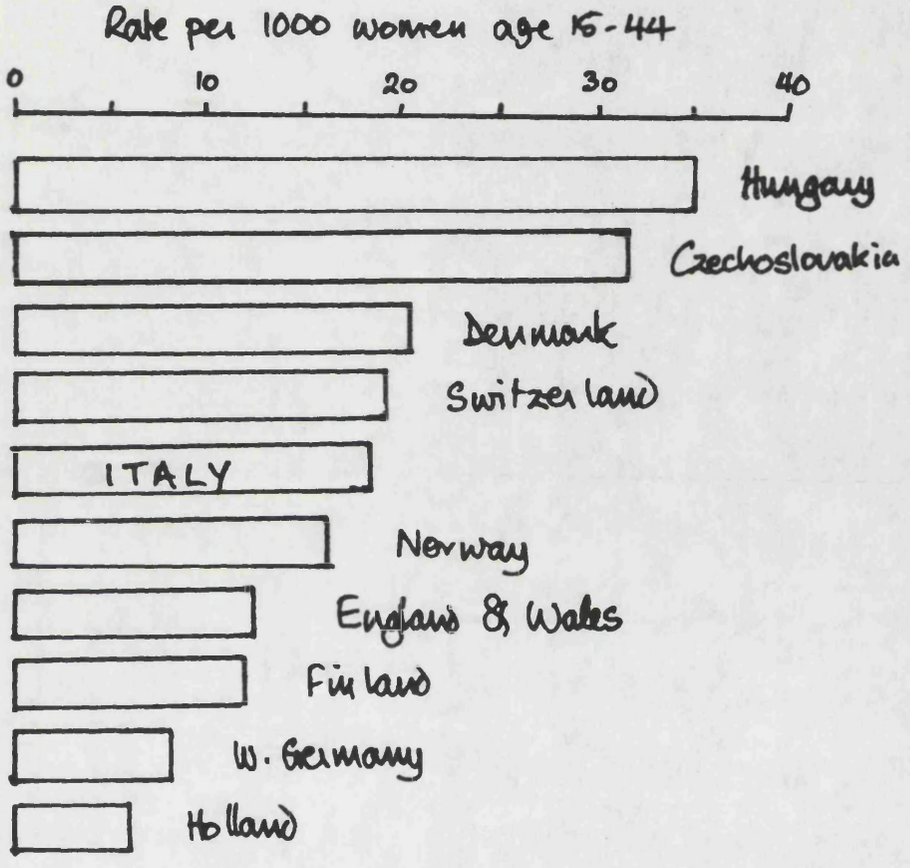


Figure 6.8. Therapeutic abortion by region, rates per 1000 women age 15-44, 1982

Figure 6.9. Therapeutic abortion rates, selected European countries, early 1980s



is also relevant: some women seek help directly from the Consultori Familiari, clinics offering family planning services, and these clinics are much more widely available in the north and centre of Italy than in the south.

Legal abortion rates in Italy are in the middle of the range for European countries (Figure 6.9). Only 6% of abortions are on women under 20: the median age group is 30-34 (Tosi et al 1985). The majority of the women are married; one in five women have had an abortion previously. Although almost half of the women are recorded as being eight weeks or less gestation, this is probably the time of the first consultation, rather than when the abortion is actually performed. Outpatient abortion is still uncommon: only 3% of abortions are performed in polyclinics, although local anaesthetics are used for 17% of all abortions.

Infectious diseases

A 1934 law requires doctors to notify 64 infectious diseases, and notifications are reported in a weekly report by the Istituto Superiore di Sanita (Bollettino Epidemiologico Nazionale). Immunisation is compulsory in childhood against polio, diphtheria and tetanus. Each disease showed a remarkable decline during the 1960s, partly through immunisation programmes but also through better social conditions. In 1983, 3 cases of polio, 11 of diphtheria and 191 of tetanus were notified. In contrast, notifications of other childhood infections, for some of which immunisation is available but not obligatory, are much

higher. The annual notifications vary when there are epidemics: broad ranges are shown in Table 6.11.

Table 6.11. Range of annual notifications of infectious disease cases in Italy (Capocaccia et al 1984)

Rubella : 8000 - 40 000

Pertussis: 8000 - 17 000

Measles: 20 000 - 60 000

Mumps: 20 000 - 60 000

Viral hepatitis: 20 000 - 30 000

Tuberculosis: 3500 falling

Menigitis: around 700

Malaria, a common cause of chronic illness in the south up until the last war, is now completely eradicated within Italy, and new cases are contracted only by travel abroad. Tuberculosis is also much rarer, but 15 000 people were reported to be attending the anti-tuberculosis dispensaries when they were merged into the SSN in 1978. In the 1980s, tuberculosis is mainly present in older people who have held the disease for many years. There were 2919 cases notified in 1987 and 1271 deaths certified with tuberculosis in 1983 (CSN 1988: 396).

Cholera still occurs in the south, with two recent outbreaks in 1973 and 1979. Perhaps the most widespread serious infectious disease, however, is viral hepatitis. Hepatitis was made notifiable in 1986, and in 1987 there were 11 487 cases notified. Some of these patients inevitably progress to chronic liver damage and cirrhosis. Hepatitis A, often affecting children and found especially in shellfish, is more common in

the south, especially on the coast; hepatitis B, passed frequently by drug use through sharing unclean syringes, is more common in the north. In contrast to the north and central regions, death rates from cirrhosis were rising in the south during the 1970s for both men and women (CSN 1988: 168).

HIV infection has grown exponentially in Italy during the 1980s (Greco & Luzi 1988). Recording of AIDS cases started in 1984, and notification became compulsory in 1987. Although predominantly affecting homosexuals at the start of the epidemic, by the end of the decade the majority of cases were associated with drug use. There are large geographical differences in seropositive rates between drug users, with 80% positive in Milan and 15% positive in Naples. At the end of 1988 there were 3-4000 cases of AIDS, while about 200 000 people were infected with HIV.

Cardiovascular diseases

Cardiovascular diseases are the single commonest cause of death in Italy: more than a quarter of a million people die each year from cardiovascular diseases. It is estimated that 110 000 people have a heart attack each year (including some for whom it is the cause of sudden death) and 80 000 people have new strokes. However, coronary heart disease mortality began to fall in most regions from the late 1970s, perhaps related to improvements in acute treatment and preventive care for hypertension (Nicolosi et al 1988).

The regional pattern of cardiovascular disease in Italy is not straightforward. Generally, mortality is higher in the north and centre

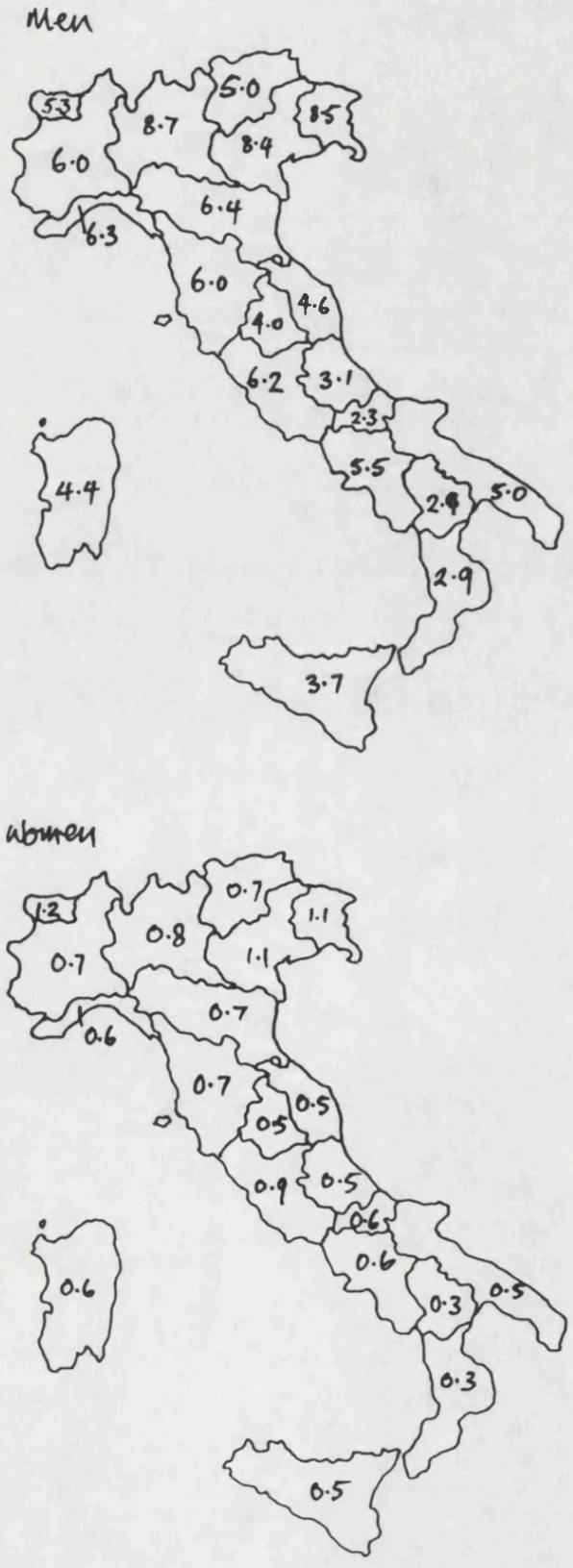
than in the southern regions, but there is not a sytematic gradient. The national medical research council supports an Italian contribution to an international study of heart disease (the Seven Countries Study). Adults aged 20 to 59 have been selected in nine areas to record risk factors for coronary heart disease. Cholesterol levels and blood pressure were found to be lower in the south and islands than elsewhere in Italy, and this was broadly consistent with the pattern in other countries. However, smoking rates for men are higher in the south and central areas than in the north, women in the south have heart disease death rates as high as the north, and rates of strokes in both sexes appear to be inversely related to blood pressure levels. These findings show that the causes of cardiovascular disease in Italy remain unresolved.

Cancer

Deaths from cancer accounted for 22% of all deaths in 1980, coming in second place after cardiovascular diseases. In contrast to the picture for coronary heart disease, death rates for cancer continued to rise during the 1980s. The recorded diagnoses show epidemiological distributions that are similar to other developed western countries. Lung cancer is commonest in men, breast cancer in women, and both these cancers are becoming more frequent. Only deaths from stomach cancer, second commonest in both sexes, and uterine cancer in women, are falling.

Studies of cancers within regions and provinces have shown some

Figure 6.10. Lung cancer: age standardised death rates (<75 yrs), by region, 1980



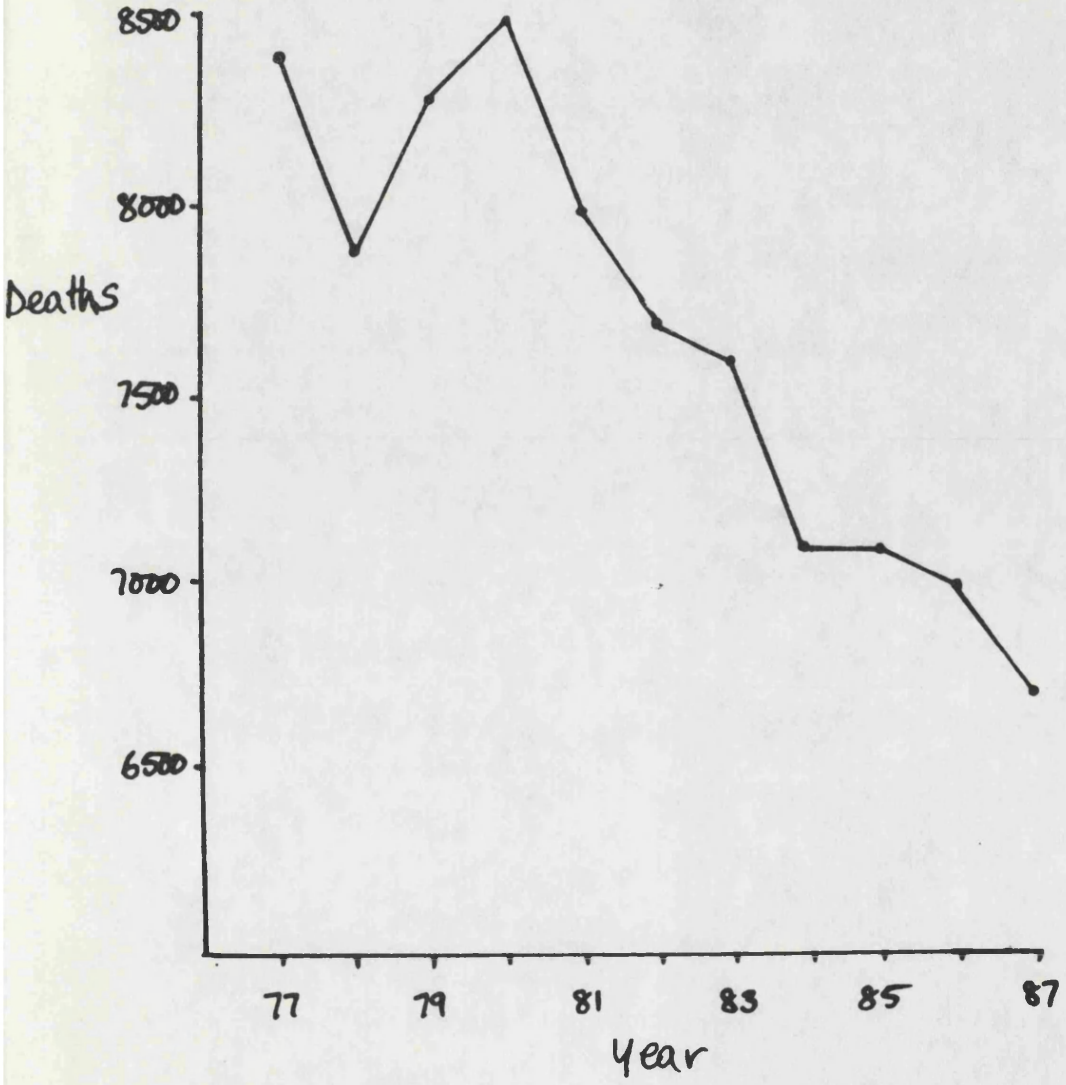
unexpected variations (Facchini et al 1985). Although tobacco-related cancers are commoner in the north of the country than in the south (see Figure 6.10) the difference is greater for younger people than older. Yet smoking rates, which (according to sales figures) three decades ago showed regional variations, are now fairly uniform across the country for males, and certainly would not explain the higher cancer rates in the north compared with central regions.

Cancers of the stomach are also more common in the north and central regions than in the south, contrary to the usual European pattern of higher stomach cancer rates in poorer areas. A protective effect of the southern diet, perhaps the higher amount of fresh citrus fruits eaten, has been suggested (Facchini et al 1985). Cancers in the north are not only higher in industrialised provinces, but also in rural ones. The levels of cancers now recorded in young people in the north appear to be amongst the highest in any industrialised country. This may represent the effects of exposure to hazards from industrial agents or atmospheric pollution.

Accidents

Deaths from accidents occur broadly from three causes: from traffic, in the home and at work. There were 6784 road accident deaths and 217 000 people injured in 1987 (CSN 1989: 285). As in several other European countries, death rates from road accidents have been slowly falling (Figure 6.11). Italy's yearly rate is about 30% higher than Britain but lower than Germany.

Figure 6.11. Road accident deaths, 1977-87



There are estimated to be between three-quarters and a million home accidents each year, and 4000 deaths. Home accident deaths are more common in children and elderly people. Two thirds of those dying are female, reflecting the greater number of women than men who make up the elderly population.

Deaths from accidents at work are less frequent than on the roads or at home. Temporary disability is recorded where it lasts beyond three days. Industrial diseases are recorded where there is at least 10 per cent permanent loss of ability (Table 6.12). Half of all accident claims occur within the construction and metal engineering industries, and 40% of industrial diseases are also within metal engineering.

Table 6.12. Occupational accidents and diseases accepted for compensation, 1987 (CSN 1988: 269)

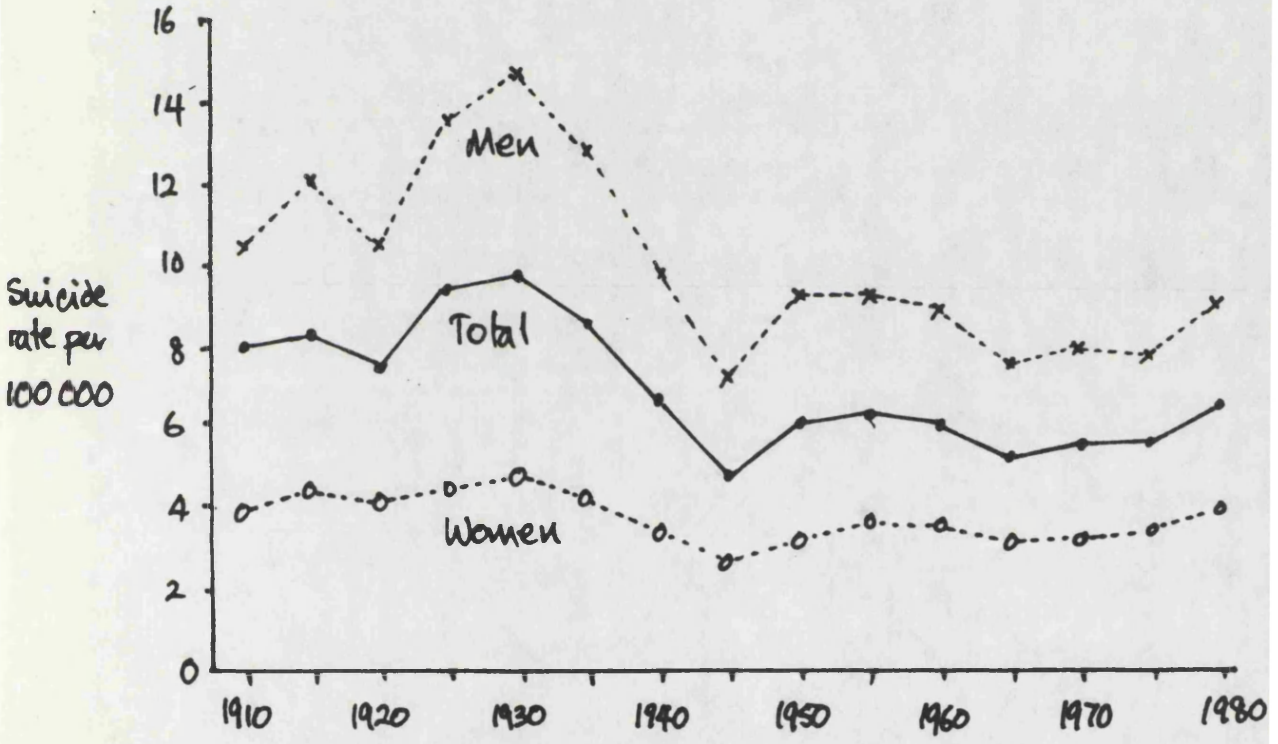
	Industrial	Agricultural
Accidents	650 455	222 662
- deaths	1 002	434
Diseases	14 397	2 530
- deaths	591	9

Suicide.

Suicide and attempted suicide continue to be condemned by the Catholic church, but the practical consequences for believers are much less than previously. Regional rates are lower in the traditionally Catholic areas - see Figure 6.12.

Figure 6.12. Suicide death rates per 100 000 population (unstandardised) by region, 1980-83 averaged (Anonymous 1984b)

Figure 6.13. Suicide death rates for men and women, 1907-81 (5 year averages, unstandardised) (Anonymous 1984b)



Although completed suicide rates have been rising in recent years, but higher rates were recorded earlier this century (Figure 6.13). The characteristics of suicides in Italy appear similar to those of other European countries (Cecere & Florenzano 1984). Rates are higher in males, and rise with age in both sexes: the highest rates are found in elderly men. At all ages physical means of hanging, jumping and shooting are the commonest methods employed (Table 6.12). Poisoning and gassing account for only 10% of completed suicides, but are much commoner for attempted suicide.

Table 6.13. Methods used in completed suicides in young and old Italy 1982.

Method	age 18-24 (%)	age 65-74 (%)
poisoning	5	5
hanging	36	38
suffocation	5	18
firearms	27	14
knives etc	2	2
drowning	20	23
other	5	5

6.3: Population surveys.

Knowledge about health attitudes and health services use in Italy expanded in the 1980s through surveys of representative samples of the population. They have been commissioned by national agencies, and conducted either directly or subcontracted. This section describes information from two surveys, but data on use of health services is also described in Chapter 5 (private/public mix) and Chapter 4 (GP surveys).

ISTAT surveys - health status

Three surveys, in 1980, 1983 and 1986, by the Central Statistical Institute (ISTAT 1982, 1984, the last is unpublished) have sought to describe the level of perceived health in the population. Asked 'Are you in good health?', 14% in 1980, 19% in 1983 and 32% in 1986 replied 'No'. This is a substantial rise, but may be explained by the period of reference - one day for 1980, two weeks for 1983 and four weeks for 1986.

The broad categories of causes of illhealth given by respondents in the second survey in 1983 are shown in Table 6.14. This pattern of morbidity contrasts with certified causes of death: chest and rheumatic conditions take on a much larger role as symptoms in minor illhealth, and heart disease is less prominent.

Table 6.14. Broad categories of ill health given in 1983 morbidity survey.

Age group	% total population	% reporting illness	% main complaints by goup		
			respir -atory	muscu- lar	circu- latory
0-13	15.0	18.0	67	1	<1
14-49	14.1	50.0	43	10	3
50-64	25.3	18.7	28	18	10
65 +	35.3	13.3	31	15	15

There is no formal scale of 'social class' in Italy equivalent to the Registrar General's classification in England. However, the 38% of the sample of the first survey that were in paid work were divided into four occupational groups, which can be compared, very roughly, with social class groups, Table 6.15:

Table 6.15. Social grouping in Italy compared with British social class.

Italian	% of sample	Translation	Comparison
Imprenditori e liberi professionisti	2%	Owners, professions	SC 1
Dirigenti e impiegati	23%	White collar emplyees	SC 2 & 3a
Lavoratori in proprio e coadiuvanti	28%	Self-employed	SC 3b
Operai e assimilati	47%	Blue-collar employees	SC 4 & 5

The working population are also described by broad sector (commercial, manufacturing, transport &c) but these are not useful as they do not

differentiate the various employment levels within the sector. There is a similar problem with the broad divisions into agriculture (12%), industry (42%) and 'other' (46%).

Replies to the question 'Are you in good health?' show gradients by employment group (Table 6.15):

Table 6.16. Self-perceived state of health (1983 survey)

	good	not good	don't know	
Owners, professions	92.1	7.0	0.9	%
White collar	93.3	6.2	0.5	%
Self-employed	87.5	11.8	0.7	%
Blue collar	88.4	10.7	0.9	%

The method of allocation also divides the workers into 'independent' (the first and third groups) and 'employees' (the second and fourth groups). Being self-employed requires greater self-reliance, so there could be selection of the less fit from self-employed to employee jobs. This may explain the lower illness rates described by the self-employed workers, although the comparison of health services utilisation does not show this.

For the whole sample, the regions show little broad difference, although northern people feel a little more healthier than the people in the south (Table 6.17).

Table 6.17. Self-perception of health by broad regions (1983 survey)

North	86.2	13.1	0.7	%
Centre	84.6	14.8	0.7	%
South & Islands	83.6	15.0	1.4	%

People describing themselves as not in good health were asked to grade their level of disability. 'Independent' workers were less constrained by their disability than employees (Table 6.18):

Table 6.18. Perception of disability by social group (1980 survey)

	Not constrained	homebound	in care
Owners, professions	77.3	22.7	--
White collar	71.8	22.8	5.4
Self-employed	80.7	17.5	1.8
Blue-collar	73.8	23.4	2.8

A question was asked about accidents occuring within the previous four weeks and which were serious enough to need medical attention. These, expectedly, show higher accident rates for younger adults on roads and at work, and for retired people at home (Table 6.19); and despite the greater proportion of younger people in the south, work accidents were most frequent in the north and home accidents in the south - the central regions had lowest overall accident rates (Table 6.20).

Table 6.19. Place of self-reported accidents by age group (1980 survey)

accident rate per thousand people

age	work	roads	home	other	total
<13	-	0.6	2.9	1.7	5.2
14-29	4.4	3.3	2.1	2.6	12.4
30-59	7.3	1.6	3.9	2.3	16.1
60+	1.0	1.3	6.7	4.6	13.7

Table 6.20. Place of self-reported accidents by broad region (1980 survey)

accident rate per thousand people

	work	roads	home	other	total
North	4.6	2.2	3.8	2.3	12.9
central	3.5	1.3	2.5	2.2	9.5
South & Islands	3.8	1.3	4.4	3.2	12.7

ISTAT surveys - use of health services

The ISTAT surveys also studied the use of medical care. People were asked whether they had been admitted to hospital in the period from the beginning of the year up to the time of the survey in the second week of November. These showed a clear gradient by occupational group (Table 6.21).

Table 6.21. Hospital admissions (per thousand population) by social group (1980 survey)

	total admission rate	people with at least one admission
Owners, professions	48.3	43.3
White collar	52.7	44.0
Self-employed	62.9	53.9
Blue collar	84.5	71.0

People were asked whether they had seen a doctor in the previous four weeks. The replies showed the expected J-shaped variation with age, and an overall rate of 14.6%. No information by occupation was published. However, use of diagnostic tests was recorded: these show no clear pattern for occupational group, but higher use of blood and urine tests in central and south Italy than in the north (Tables 6.22 and 6.23).

Table 6.22. Use of diagnostic tests by social group (1980 survey)

	tests per thousand people		
	X ray	Blood	urine
Owners, self-employed	63.6	76.3	61.1
White collar	53.5	105.0	81.8
Self-employed	62.3	93.0	73.8
Blue collar	71.4	95.9	75.8

Table 6.23. Use of diagnostic tests by broad region (1980 survey)

	tests per thousand people		
	X ray	Blood	urine
north	54.9	87.1	64.6
central	70.1	129.1	107.9
south & Islands	60.0	119.6	103.5

DOXA Survey

Finally, a health survey by the commercial survey agency DOXA has also been reported (Zincone 1986: 95-143). No details were reported about the numbers or composition of the sample, but it may have been adults age 18-55 (Censis 1989: 174). The first questions were directed towards beliefs about keeping healthy, and showed the expected positive valuations of good food, little alcohol, enough exercise. The survey then went on to ask about recent use of health services for a specified minor health problem: 'in the last 3 years, have you had influenza or a similar winter complaint such as a sore throat, cold or cough with fever?' Rather surprisingly, this question elicited a yes from fewer older people (61% of over 65s) than younger (86% under 24), and positive replies were commoner in the south than in the centre or north of Italy. It is probable that these survey answers relate to attitudes towards minor illness. Nevertheless, there were interesting differences in use of health services for this influenzal illness. The sample was divided into social strata 'upper', 'middle' and 'lower' (Table 6.24).

Table 6.24. Use of health services for minor illness by social group

	upper	middle	lower
Did not consult doctor	47%	41%	37%
Doctor came to house	31%	29%	32%
Patient went to doctor	17%	23%	26%

Lower strata people consulted more, but a doctor's attendance at their homes (presumably for more serious illnesses) was similar across the strata.

A further analysis recorded whether the consultation had been with a public or private doctor. There were no differences by age and sex, and rather more patients in the centre and south of Italy (10%) using a private doctor than in the north (6%). But social strata differences were more marked (Table 6.25):

Table 6.25. Use of private doctor by social group

	% using private doctor
Self-employed - non-agricultural	12
Self-employed - agricultural	--
Employee - non-manual	8
Employee - manual	2
Pensioner	9
Housewife	8
No employment	18

CHAPTER SEVEN: SPECIAL SERVICES

The structural reform of the Italian general health care system was linked with developments in three areas of special services - mental health care, occupational health and dependencies.

7.1 Mental health

The mental health law of 1978 is one of the more widely discussed aspects of the Italian health reform. Several general reviews have been written as well as descriptions and evaluations of services. The picture, as elsewhere in Italian affairs, is clouded by political rhetoric, geographical variation and lack of resources for the innovations proposed. In Britain, some populist articles in the early 1980s (Ramon 1982, Jones 1984; Lacey 1984) polarised a debate for or against the reform, but there is now greater consensus about its strengths and weaknesses.

The first Italian laws on psychiatric care, in 1904 and 1909, were directed towards the formal admission and care of patients in mental hospitals (Maj 1985). Patients could be committed by a relative or, in emergency, by the police. The admission was authorised provisionally by a magistrate on a doctor's certificate, and could be accepted definitively by a court after one month's observation. Mental hospitals at the time of the law were usually private. The regulations required sufficient space, sanitation and work for the patients, limited the use of mechanical restraints and required people with epilepsy and mental handicap to be admitted to 'institutes different from mental hospitals'.

In practice, the laws appear to have been used repressively (Maj 1985). Admission by the police was frequent, the clinical progress of patients was inadequately reviewed after the first month, and patients with all forms of social and behavioural disorder were grouped together in crowded hospitals. The Penal Code even required that mental hospital admission had to be recorded on the court register as if it were a criminal conviction. There was no reform during the period of fascist government, while public mental hospital building proceeded and inpatients rose to 95 000 in 1940 (Ramon 1985: 174).

Only after the second war was there an opportunity for new legislation. Several proposals were presented to Parliament from 1951 onwards, while hospitals provided the only real option for professional care. Yet 'the Italian hospitals were heavily overcrowded and often insanitary; staff ratios were low and the majority of nurses untrained' (Ramon 1985: 175). The 'centre-left' coalition of the sixties introduced a partial reform in 1968. This law encouraged voluntary admission on the advice of a doctor alone, allowed outpatient care, set minimum acceptable levels of staff within the hospitals and repealed the requirement for court registration. Nevertheless, the service continued to centre on the large mental institutions. Patients with milder neurotic illnesses were often cared for by neurologists and general physicians, in clinics and private nursing homes.

During the 1960s, psychiatrists and other mental health workers led by Franco and Franca Basaglia, first in Gorizia, near Trieste, and later in

Trieste itself, founded a group calling themselves Psichiatria Democratica (Ramon 1985). Experiments in new forms of mental health care, based on social models of cause and management of mental symptoms, were established in several parts of Italy. The group sought to open mental hospitals to community influences, and to re-establish mental hospital patients in ordinary community settings. The grim reality of institutional care was given wide publicity through the press and television. A debate in the parliamentary commission on public health and hygiene on 16 May 1974 failed to initiate political change. In 1977 a petition by the small Radical party to repeal the longstanding mental laws gained almost three quarters of a million signatures. To prevent a national referendum that appeared to threaten the Christian Democrat party's 'historic compromise' with the Communist Party, and in line with the larger proposals health service reforms that were before Parliament, a new mental health law (Law 180) was passed rapidly in May 1978 and later incorporated into the SSN Law 833.

The new mental health services

Law 180/78 required major changes in the organisation of psychiatric care, moving the emphasis of hospital admission from protection of the public towards better meeting the patients's own needs through community care. Mental health services were to be provided for every USL population and coordinated by a department of mental health. The law immediately stopped admissions of new patients to psychiatric hospitals and required readmissions to stop within two years. Acute care is provided in general hospitals, in units with no more than 15 beds. Most treatment is voluntary, and normally provided in community mental health centres. Compulsory admission to hospital, on a doctor's request, has

to be approved by the commune mayor within 48 hours, and lasts only seven days before renewal is required.

Psychiatrists in Italy define the patients suitable for their services rather more narrowly than in Britain. The majority of patients have diagnoses of either schizophrenia or affective disorders (anxiety and depression) (Marinoni et al 1983). Patients with alcoholism, drug dependence and mental handicap are less commonly seen by Italian psychiatrists. Elderly patients tend to be treated in general hospital wards or, for long term care, placed in homes run by the communes (istituzioni di pubblica assistenza e beneficienza) or in private contractual residences. As yet there is no independent specialty of psychogeriatrics in Italy, and day hospitals are rare. This is an important difference from the picture in Britain, where half of all people now in mental hospitals are over 65 years old, and helps to explain how psychiatric services in Italy can exist with a lower provision of beds than in Britain. Nevertheless, the remaining institutional population in Italy is now also aging.

A serious deficiency is the poor training of mental health staff. University courses for psychologists and social workers are theoretical and taught as lectures rather than in clinical settings. The courses are overfull because there are too few of them. Indeed, there are only two courses for psychologists (in Rome and Padua), so that students working in other cities are necessarily divided between their studies and their practical work. In service training for employed staff is often also lacking. The university polyclinics supervise specialist

training in psychiatry, but here private practice is a favoured model. Psychiatrists need courage to leave this sheltered environment to work in local district services.

Although the hospitals are formally closed to admissions, many long-stay patients remain within them. These patients are being cared for by staff who have also chosen to stay within the hospital. The law forbids the psychiatric hospitals to recruit new staff, although it is possible to circumvent this by temporary appointments. In a sense, therefore, the most dependent patients continue to be looked after by the most institutionalised staff. But the main criticism of the reform has been that, while the psychiatric hospitals have been closed, too few alternative services have been provided.

Trends in mental health services

The number of people resident in psychiatric hospitals in Italy reached its highest postwar figure, 91 200 people, in 1965. The rate per thousand residents had stabilised a decade before (see Figure 7.1). Both indices began to decrease during the middle sixties, before the first (1968) psychiatric reform law. The number of psychiatric hospital beds fell in line with falling numbers of residents. This was achieved both by reducing the number of beds in each hospital and formally closing some hospitals. Private hospital bed numbers also fell, although proportionately a little less than public hospital beds (see Table 7.1). Hospital admissions fell by two thirds in public hospitals and one third in private hospitals (admissions of patients previously in hospital are still allowed under some regional laws). In 1987 there

were 115 public mental hospitals, with an average of 264 beds per hospital, and 71 private mental hospitals with an average of 170 beds per hospital (CSN 1988: 487-8).

Table 7.1 Public and private psychiatric hospital beds, Italy, 1977 and 1987 (CSN 1985, 1988).

	Public psychiatric hospitals		Private psychiatric hospitals	
	1977	1987	1977	1987
Beds	70 070	30 397	24 177	12 053
Admissions	150 657	53 602	69 245	47 606

Although in the early seventies the proportion of the population in psychiatric hospitals in northern and central Italy were up to three times that in the south, these rates fell steadily and are were almost equal throughout the country by the mid 1980s (Morosini et al 1985). The number of general hospital units has increased very little since the 1970s: in 1987 there were only 204 acute hospital units for 667 USLs. Development has been somewhat greater for community facilities such as residential homes and day treatment centres. As Table 7.2 shows, there are substantial regional variations in services.

Table 7.2 Psychiatric services by region, 1987 (CSN 1988: 498-90)

	Territorial services	Homes	Day treatment	Acute units
Piemonte	76	29	4	17
Valle D'Aosta	1	-	1	1
Lombardia	86	43	120	36
Trento	9	3	2	4
Bolzano	7	3	3	1
Veneto	10	20	17	32
Friuli VG	26	50	9	2
Liguria	20	2	0	3
Emilia Romagna	41	135	141	4
Toscana	32	60	5	14
Umbria	14	33	6	-
Marche	31	14	2	10
Lazio	47	28	4	3
Abruzzi	13	1	16	3
Molisse	3	-	4	3
Campania	46	-	-	14
Puglia	52	17	2	12
Basilicata	5	8	8	4
Calabria	13	4	2	11
Sicilia	34	3	74	27
Sardegna	23	18	1	3
Total	598	471	437	204

Three forms of mental health service.

Three styles of mental health service emerged in the 1980s (Boswell 1986). Some, for example in Trieste, Verona and Arrezzo (De Salvia and Crepet 1982) were developing for several years prior to the law along the principles developed by Psichiatria Democratica. They have a comprehensive range of local provision and are able to respond both in and out of normal working hours. These services, using a 'social' model of care, have the community mental health centre as their focus. A centre usually serves a catchment smaller than a hospital, so larger USLs would have two or more centres, with one supporting the administration. The centres are in residential areas, with premises converted from other purposes such as offices, a house or a vacant hospital wing, and not newly built. Hierarchical differences between patients and staff are minimised - there are sometimes no separate offices for staff, only side-rooms for consultations and a general office in which patients come and go freely. The centre may not appear to be busy because many of the patients are visited in their own homes by the staff.

The transfer of patients out of the old psychiatric hospitals has usually followed the path laid by Basaglia (Dell'Acqua 1985). In preliminary work, groups of patients and staff discuss the aims and practice of the move. Discussions with the commune lead to greater acceptance of patients moving freely about the town, and the commune is encouraged to provide personal allowances for the patients. Some of the ward blocks are converted into group-homes, run independently by the residents with only limited staff support. Some patients leave to go

into ordinary flats or houses. Some are organised to form work cooperatives, taking up contracts with the commune for services such as cleaning or laundaries.

This pattern explains the varied structure of services in the many districts. It is common, for example, for some residents still to be living in the grounds of the old hospital, although their villa is formally independent from the the hospital and its staff. Some districts use hotels to house groups of ex-patients, recognising that continuing contact by a mental nurse is facilitated by this (McCarthy 1985). Critics of the Italian reform point to these forms of lodging to suggest that the hospital wards remain, in another form. But the difference is the greater degree of autonomy, and therefore normal living, of the ex-patients.

A second, 'medical', pattern of service to develop since law 180/78 has seen a slow transfer of psychiatric practice from the mental hospital towards community care, initiated as a partnership between the local health district administrators and the psychiatrists. These developments, however, are patchy, and frequently constrained by lack of community support staff such as social workers and occupational therapists. The focus of these services, instead, is the psychiatric ward in the acute hospital. The psychiatrists suggest that there are too few beds, and that the time allowed for compulsory admission by the law is too short; they would prefer to work, as they used to, with more frequent, and longer, admissions.

The purpose in Law 180/78 of having small wards was to limit the likelihood of patients being neglected, and to encourage their return to community care. The actual provision of acute units is only half the provision planned, based on a norm of 15 beds per 100 000 population. With too few acute units, the wards are under heavy pressure to admit patients, without being able to give sufficient time for their diagnosis and treatment. Compulsory admissions, which can only be made through the acute hospital ward, form up to half of all the patients. The staff complain, rightly, of overwork and inability to sustain follow-up on patients admitted from districts distant from the acute hospital. The solution lies in extending the number of acute units, but progress in some regions has been slow.

A third group of services, a substantial minority, are in USLs that have managed to ignore the law, and maintain services based on the traditional mental hospitals. These services tend to be in the south, have less direct public provision and more use of public funds to reimburse care from private institutions (Scala & Gritti 1985, Caserta et al 1984). The regional authorities have been slow to create regional laws and slower still in disbursing money to develop the new services. Rome, for example, has only three acute units, a total of 45 beds, for the whole province of 3 million people, and many patients are admitted to private care under contractual payments. Much of the psychiatric service in Bari, Puglia, is provided by a private (religious) mental hospital of over 3000 beds, where the last wards were built in 1974 (Boswell 1989: 21, 36). Many university hospitals continue to teach students on patients with less severe problems in outpatient clinics while professors see higher social class patients in private clinics.

The picture of the Italian mental health services that emerges is of substantial variation across the country, with some highly innovative services matched by some very traditional, unsatisfactory ones. The reforms described by Ramon (1985) and others (Crepet and De Plato 1983) have depended on innovations by a minority of progressive psychiatrists in favourable political circumstances. Jones, on the other hand, found poor quality services, and concluded that the reform 'has failed' (Jones & Poletti 1986). Perhaps the descriptions reflect what each visitor wanted to see.

But the rejection of these innovations may be linked with a misunderstanding, and perhaps fear, of community psychiatry itself. Members of Psichiatria Democratica suggest that most mental illness has social and environmental origins, and that Western societies have sought to exclude people with mental illnesses through institutional care: they propose care in the community as a means of liberation. Traditional psychiatrists are cautious about treatment in the community because it reduces their control over their patients, and might perhaps indicate their acceptance of an environmental aetiology. Where the medical model of cause and treatment is strong, the psychiatrist feels safest next to his medical colleagues in the district hospital or polyclinic.

7.2. Occupational health

At the end of the seventeenth century, an Italian court physician, Ramazzini, made the first systematic description of the hazards of work (Ramazzini 1700). He noted that prisoners were put to work in mines not only because the work was hard but also because it was dangerous. Pietro Verri founded a society in Milan "to combat intoxication and phithis from lead, and to seek controlling legislation" (Terranova 1975: 49). Accidents during mining of the rail tunnel under Monte Bianco led to the first Italian university clinic for occupational medicine to be established in Milan in 1910 (Reich & Goldman 1984).

During the early decades of the present century legislation and State agencies for occupational health in Italy developed in a rather piecemeal fashion, following trends in other European countries. However, in the 1960s the trade unions created a new preventive approach that is unique to Italy. The 1978 SSN law brought these two different streams of occupational health practice together: control of employers through legislation and inspection, and involvement of workers in improving their working conditions for themselves.

Two approaches to occupational health.

1. The employers' system

Before the 1978 health reform several State agencies held responsibilities for occupational health:

* The Ispettorato del Lavoro was created in 1912 to ensure the application of the growing body of employment legislation. Its

structure followed the usual pattern of the State, with a central body and provincial offices. It was controlled by the Ministry of Labour. The inspectors were empowered to act as 'judicial police', that is, they had the right to visit workplaces covered by the law without prior notice and without special authorisation. They made a report to the employer on the changes needed, and could take the employer before a magistrate if these were not implemented within a defined period.

* Other smaller agencies developed during the inter-war period continued. For example, the Associazione Nazionale per il Controllo della Combustione (ANCC) was responsible for inspection of furnaces and another looked after caves and mines.

* The Ente Nazionale per la Prevenzione degli Infortuni (ENPI) was built on a voluntary association started by industrialists in Lombardy in 1894. Its functions varied during the fascist period, having powers of inspection from 1926 until they were passed on to the Inspectorate in 1932. It was reconstituted in 1952, with duties to 'study, promote, develop and defend the prevention of accidents and industrial and diseases'. There was specific responsibility to inspect lifts, cranes, gantries and aerial walkways. Again, control was centralised, with a single research department and sixty provincial offices. ENPI was suppressed by the SSN law in 1978, and its duties passed to the occupational health services of the USLs.

* The Istituto Nazionale agli Incidenti del Lavoro (INAIL) continues as the central body controlling sickness insurance. The

premiums payed by employers were proportional to the level of danger of the individual manufacturing processes (Bagnara et al 1981).

2. The employees' system

Up to the early 1960s the workers themselves were relatively passive in occupational health. The factory doctors were paid by the employers, and the employees felt, with justification, that the allegiance of the doctors was with the owners of the factory. However, the increasing size and sophistication of industry in northern Italy was matched by the growing strength of the trade unions. During the sixties the unions adopted occupational health as a focus for education and action.

Union activity came to a head in the 'hot autumn' of 1969. In May 1970 Parliament passed a 'Statute of Employees Rights' which included under article 9: 'Workers have the right to supervise the application of legal requirements for the prevention of accidents and occupational diseases, and to encourage research, development and implementation of measures to protect their health and physical wellbeing.'

Building on the experience already developed in some factories, the law allowed the newly established regions to create preventive occupational health services, bringing doctors, psychologists and technical experts to work alongside (and with) employees and their unions at a local level. Emilia Romagna, Tuscany, Umbria and then Lombardia, Liguria, Friuli and Veneto were the main regions to develop these services.

The health reform of 1978 brought occupational health into the mainstream of preventive medicine and health education of the national

health service, as a responsibility of the USLs. The law lays down in detail the preventive approaches to be used, following the experience of the pioneer services in the north, and transfered the powers and responsibilities of the Ispettorato del Lavoro to the USLs. The work of the USLs is supported by multizonal centres which provide expertise and advice on toxicology, scientific investigations and chemical analyses. A new Institute for prevention and safety at work was also established in Rome.

The workers' model

The roots of the workers' model of occupational health were based in the rapid industrialisation and mechanisation of factories in the fifties. These brought both known and unrecognised hazards for workers, and the traditional approach, usually agreed between employers and union representatives, was to compensate workers with up to 10-15% extra wages proportionately to the level of hazard (Reich and Goldman 1984: 1034).

The new factory processes were studied by several research groups, bringing knowledge of industrial psychology together with political analysis. A series of studies of working conditions, published each week in the Communist Party newspaper Rinascita (Bagnara et al 1981: 438), brought occupational health on to the political agenda. The most significant study, because of the methods that were developed, were the investigations at the Farmitalia chemical plant in Turin. The researchers found that the structure of the workforce within factories had changed. Where, previously, various skills would be collected within one part of a factory to produce a specific product,

mechanisation had led to sections of the factory each specialising in a part of the overall production. These 'homologous groups' of workers were the natural groupings for new union organisation, and they were also likely to be uniform in their occupational health experiences.

But the working group had bargaining power with management. Working on mechanised production lines, rather than in smaller craft groups, the immediate concerns of these working groups were with the speed, rhythm and monotony of their work. If they could identify aspects of the production process that were harmful to their health, they could chose to demand changes in the process, rather than accept the traditional approach offered by management - to raise the price for the job. The Farmitalia workers coined the slogan 'health is not for sale'.

Because the workplace groups had special knowledge of their own factory processes, and it was their own health that was at risk, a political view also developed - that there should be no delegation of responsibility for the improvement of health from the workers to others. The experts from outside, even those who the workers directly asked to help, could only be advisers: the workers themselves had to understand the hazards and if they were to make the proposals for change themselves.

To assist the process of analysis, the Farmitalia researchers developed a simple scheme of four groups of hazards and four sources of information. The hazards (Table 7.3) were grouped according to the methods of assessment, moving from objective to subjective. In the first group are factors of the natural environment and in the second

group agents of the physical environment: although these are evident on ordinary observation, both these groups can also be assessed by technical recordings. The third group includes factors causing physical fatigue, and the fourth factors that cause monotony: both these groups have only subjective measurements. These simple and clear groupings quickly became widely used.

Table 7.3. Scheme for workers' evaluation of health hazards (Bagnara et al 1981: 440-1).

Group 1. Harmful factors which are also present in the environment outside the place of work - light, noise, temperature, ventilation, humidity. They can be readily evaluatd by the worker and are measureable with instruments.

Group 2. All physical and chemical characteristics of the workplace - dust, smoke, vapours, vibrations, radiation. They have maximum safety limits that need to be measured with instruments: the workers' sense organs are an inadequate guide.

Group 3. Factors of physical fatigue - position, movement, lifting. The fatigue can be measured by physiological measures, but the best method is subjective assessment in relation to each individual.

Group 4.
Factors distinct from physical effort that produce tiredness - monotony, rhythms, repetition, anxiety, responsibility. They can only be evaluated subjectively.

At the same time, it was necessary to make systematic records of the health hazards and their effects. Four types of information were proposed. For individuals, a record card could be kept which described the exposures (risks) within the work section, complemented by the record of personal illness. Similar information, registers of envionmental risks and biostatistical data, could also be collected for the working group. These provide documentation for discussion with management, and a memory against which to evaluate change.

Following a major conference at Rimini in 1972, the combined trade unions CGIL-CISL-UIL incorporated these new principles of occupational health practice into the mainstream of industrial bargaining, countering the claim by management that the factory doctor and inspectorate system was sufficient. National negotiations led to legislation requiring employers to release workers for up to 150 hours of study time, over three years, to each worker. These study periods were often used for teaching the 'workers' model' of occupational health so that there could be smoother cooperation between the teams who came into the factory and the shop floor workers.

Occupational health services in practice: two examples.

The region of Emilia-Romagna was among the first to start occupational health services in the early seventies. An introduction to the new organisation of occupational health services has been written by two staff at the regional office (Martignani & Tonelli 1981). The service is comprehensive, covering the whole region. Each district has a local office, the servizio di medicina preventiva e igiene del lavoro (SMPIL), and there are second-level specialist centres in each of the provincial capitals. One SMPIL in Bologna, the regional capital, is also a resource centre for information on work hazards and risks.

An example can be given of a SMPIL in a rural area. The USL serves a population of 50 000 people. The SMPIL office is sited administratively near the USL office, in the centre of the main town. There are five full-time staff, a doctor (who is the director), a chemist and three non-graduates who have technical experience in electrical, chemical and

mechanical engineering. The responsibilities of surveillance taken over from the Ispettorato di Lavoro are integrated into the mainstream of the work. Indeed, in a rural area such as this, where agriculture and food industries are the main productive sectors and large factories are few or absent, inspection provides the only practicable way of gaining entry to the firms: the employees are not unionised and not alerted to their own health needs.

The SMPIL is responsible for surveillance of 1700 industrial firms with 10 000 employees, 8,000 people working in farming, of whom rather less than half are employed labourers, and 8500 employees in the tertiary sector. In 1984, 65 firms were visited, covering 941 employees. Because of the priorities chosen by the SMPIL, the majority of firms, and workers covered, were in the category of 'metal engineering', which includes light production as well as heavy foundary work. There were, on average, eleven recommendations made for each firm visited, predominantly for accident prevention, and a total of fourteen reports to the magistrates for failure to implement previous recommendations (Regione Emilia Romagna 1984).

There are several other ways that the SMPIL keeps contact with local industry. The law requires newly established firms, or those wishing to expand or change their manufacturing process, to send plans of their production process to the SMPIL for agreement before they are allowed to proceed. Industrial accidents have to be reported to INAIL by law, partly to ensure compensation for the injured worker. Sometimes the magistrate takes the initiative and asks the SMPIL to investigate and

report on a firm after a serious accident. Four reports were made in 1984. The SMPIL also employs a part-time doctor and a part-time nurse, who provide the clinical health services prescribed by law for workers in certain occupations. These clinical services are paid for by the firms: some choose to buy them through the SMPIL rather than privately.

The occupational health service in Turin, however, is very different in its style and its setting within the USL. Much of the union activity of the 'sixties was led from the big factories in and around Turin - Fiat, Olivetti, Farmitalia - and the city established a Servizio Medico di Lavoro after the 1970 Statute of Employees Rights allowed workers as well as managers to call on occupational health services. Until the SSN legislation, the SML could only enter a factory at the request of the workers - the legal rights for entry remained with the Inspectorate. In Turin, the occupational health services are all within a 'Servizio Igiene Sicurezza Lavoro', but they are not integrated. There are four sectors: 22 employees continue the work of ENPI and ANCC; 12 continue the Inspectorate; 16 continue the SML, working in five 'Unita di Base' and there are 42 people in the directorate and administrative staff.

The Unita di base are sited in the periphery of the city, near to the factories they work with. The unions in Turin are divided into three large zones, having offices which are shared between the three union groups of the main political parties - CIGL (Communist Party), CISL (Christian Democrats) and UIL (Socialist Party). The Unita di Base work closely with the unions in setting priorities - they need the unions' cooperation to be able to enter the factories.

The Turin Unita di Base have made full use of the 'risk maps' in the

workers' model of occupational health. A complete list of factories exists by law because all have to be registered with the municipality. A committee, including occupational health staff and union officials, makes an initial assessment of the likely health risks in each factory. The factories are graded in three categories A, B and C. Factories of category A are considered to have serious risks, and are already under surveillance by the occupational health service.

In 1984 there were 7700 factories in Turin employing 132 000 workers. There were 13 category A factories with a total of 15 000 employees: two thousand of the workers in these factories were exposed to one or more of the defined risks. Category B includes those factories where the risk is possible, but incompletely assessed. There were 35 large or medium sized factories, employing 65 000 workers, with 15 000 thought to be exposed to health risks, and 5000 small factories in this category employing 33 000 workers. Category C includes those factories and workplaces thought to be of low risk, 2800 factories with 20 000 workers.

The category of each factory is reviewed twice a year, jointly between the unions and the Unita di Base, taking stock of changes within the factories. It is evident that the largest number of potential workers at risk are in the large and medium sized category B factories. The Unita di Base service concentrates on these, rather than on the smaller factories, for practical reasons: the gain from an intervention is likely to be greater in a large factory than in a smaller one, and the level of unionisation likely to be higher.

Although the decision on which factory to review is made principally by the local union office, the information about the potential health risks is gained directly from the workers. Initially, members of the occupational health service meet with the shop stewards of the factory council. At this meeting, after defining the processes of the factory, an assessment is made of the potential hazards at the work sites. This stage allows the traditional methods of recording data, both for individuals and the environment. The work hazards are described in six groups - silica, asbestos, bronchial irritants, carcinogenic agents, noise and accidents - that have been agreed between the unions as priorities.

The occupational health staff then meet again with the factory workers on the shop floor, using a visual diagram to present their findings. At this point, discussion turns towards what might be done to lessen the risks. It is the workers who decide what changes will be asked from the management, based on their own understanding of the risks, the alterations that could be made to the production processes, and the demands that are politically practicable. The Unita' di Base staff are aware that demands for substantial changes in production run the risk of reducing jobs or of the management simply closing the process down. The recommendations tend to be incremental, seeking improvements year by year, rather than single, major demands.

This cycle of investigation and recommendation forms the work of the Unita' di Base. It is recorded diagramatically, in a way that is both accessible to the worker themselves and also keeps a record for

evaluation.

Occupational health services were an important part of the health reform. They have become established, and effective, in some northern and central regions, but remain underdeveloped elsewhere. Further discussion is made in Chapter 8.1.

7.3. Tobacco alcohol and drugs

Prevention was seen as an important aspect of the health reform. The law sought

'(1) the formation of a modern health consciousness based on an adequate health education of the citizen and the communities;

(2) the prevention of disease and accidents in every living and working environment...' (Article 2)

Major preventable disease are caused by the consumption of tobacco, alcohol and drugs. Production, consumption and prevention of each of these in Italy are described here. It is fair to say that the health reform law had little impact on any of these, an issue which will be taken up in Chapter 8.1.

From the point of view of health, the main difference between cigarettes and alcohol in that any level of smoking is dangerous, even one cigarette, whereas 'moderate' drinking is thought to be harmless (it is excess of alcohol consumption that leads to harm). Use of opiate drugs is illegal except under medical supervision, and this legislation is unlikely to change in the near future. But the principles of controlling these three addictions are the same. There needs to be a framework of laws to control access, national and local education about the effects of the substances, and local services to assist giving up.

Tobacco

The clearest health consequence of cigarette smoking is lung cancer. Although the overall lung cancer death rate for men in Italy is still lower than in those countries where cigarette smoking became widely established earlier in the century, Italy has now the highest lung cancer rate for middle-age men for all countries in the world. The heavy current smoking patterns suggest that "a massive epidemic of lung cancer in the first two decades of the 21st century can be expected in Italy, just when lung cancer deaths are expected to be falling in British and American men" (La Vecchia 1985: 163).

Smoking is also one of several factors contributing to coronary heart disease, along with high blood pressure, high animal fat diet and lack of exercise (Nicolosi et al 1988). The proportional contribution is less than with lung cancer - cigarette smoking doubles the risk of coronary heart disease compared with non-smokers. However, because coronary heart disease is widespread, and the commonest cause of death in men under 65, smoking contributes to as many premature deaths from coronary heart disease as it does from lung cancer.

Cigarette smoking also has serious consequences of morbidity. Coughs and colds, and bronchitis, are exacerbated by smoking and form part of the load of general practitioners. Smoking-related diseases causing hospital admissions include lung cancer, bronchitis and heart disease and peptic ulcers.

Production.

Italy is the second largest producer of tobacco in Europe after the USSR, (although Greece has more land under cultivation), and sixth largest in the world. Italy's production has been expanding in the 1980s.

Raw tobacco, and finished tobacco products, are imported to a cost of 700 000 million lire (ISTAT 1984: table 219). Some raw tobacco is also exported, but at much lower price than the imported tobacco. Few finished tobacco products are exported. The world tobacco trade is dominated by five multinational companies based in the USA and Britain. The Italian tobacco industry is State-owned, and appears to be content to produce low grade tobacco for a home market.

Table 7.4. Tobacco production in selected countries, 1987 (ISTAT 1989: 661)

	area: hectares	production: billions of quintals
FGR	3	80
France	15	380
Italy	77	1621
Greece	95	1450
Spain	22	380
USSR	194	3810
USA	244	5590
India	488	5250
China	769	15230

Consumption

Cigarette advertising was banned in Italy in the 1930s when tobacco production was nationalised under the Monopoli Statali. Two thirds of legal sales are for State-produced cigarettes, of which more than half is for the leading brand 'MS'. The other one third of legal sales are of imported tobacco, often made up into cigarettes inside Italy. However, cigarettes are also brought in illegally from Switzerland and Austria, and sold openly on the streets in southern towns. It has been estimated that the number of 6.9 cigarettes smoked per adult per day, based on official sales, would be raised to between 8 and 9 per day when illegal sales are included (La Vecchia 1985: 160).

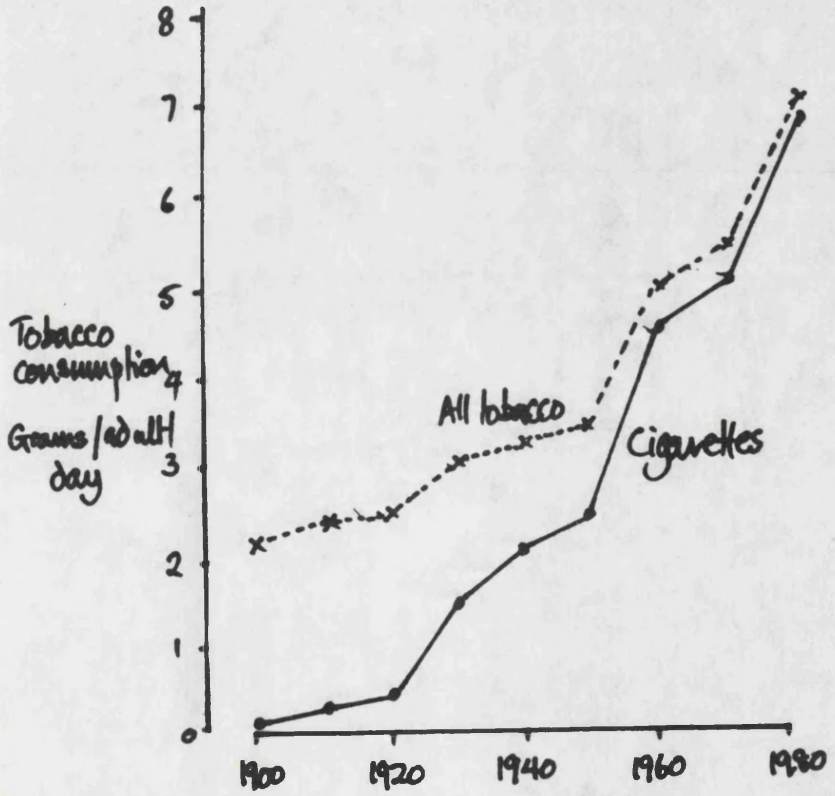
Figure 7.1 shows the steady rise of cigarette sales from 1900 to 1980. The increase persisted in the early years of the 1980s. However, in 1984 tobacco sales by the State Monopoly began to fall, and in 1987 total sales fell - markedly - for the first time, and continued to decline in 1988 (CSN 1990: 39). These figures are supported by a fall of 5.3% in quantity of tobacco purchases recorded in the family expenditure surveys (CSN 1989: 225).

The Central Institute of Statistics (ISTAT) have made three national population surveys of health, in 1980, 1983 and 1986, which have included questions on smoking habits (Cellerini & Geddes 1989). More men than women smoke. The proportion of smokers appeared to have fallen in men over the six years, but not in women (Table 7.5):

Table 7.5. Changing smoking habits, Italy, 1980-83 (Cellerini & Geddes 1989: 66).

	men			women		
	1980	1983	1986	1980	1983	1986
	%	%	%	%	%	%
smokers	54.3	45.6	40.8	16.7	17.7	17.3
ex-smokers	9.9	13.5	15.2	1.4	2.3	3.4
non-smokers	35.7	40.9	44.0	81.9	80.0	79.3

Figure 7.1 Cigarette sales, Italy, 1900-1980 (La Vecchia 1985)



In 1986, smoking rates were lower for men in the north (38.7%) than the south (43.8%) but the reverse was true for women - north (19.6%) and south 13.3%. Smoking prevalence is highest for both men and women in the age group 30-39. No analysis is available by social class. Smoking is not related to years of education for men, but smoking rates are higher in women with more education.

Prevention

The government has a serious conflict of interests in tobacco. Manufacture and distribution is in the hands of the state monopoly, and the profits contribute to the government's income. This income is quite small: 5.7 billion lire out of a total of direct and indirect taxes of 147 billion in 1988, and compared (for example) with 23 billion lire from taxes on petroleum products (ISTAT 1989: 589). Tobacco used for cigarettes is mostly home grown by farmers in central and southern regions. The taxes could be increased to try to reduce cigarette consumption, but this would be resisted by employees of the Monopoli and by the farmers.

In practice cigarettes are cheaper in Italy than in most European countries. In March 1985 a packet of 20 MS (one third of all sales) cost 1400 lire (equivalent to 60 pence UK). By April 1990 this price had risen to 2500 lire, about one pound twenty five pence at the current rate of exchange. Foreign brands, mainly American tobacco, imported raw or as packets of cigarettes, are near the prices in other countries. The price difference reflects partly the better quality of American tobacco, partly higher profits, partly taxation. Nevertheless, despite their higher prices, imported cigarettes appear to hold at least a third

of the total market, and be growing in sales.

A small but increasing amount of health education is now visible against smoking. Smoking in public places, such as on publictransport, has been banned since the fascist period. Education is beginning in schools, for example, using materials developed at the Centre for Health Education at the University of Perugia, and a television series has been produced. The Government has published an international literature review of health, economic and educational studies of smoking (Gaudino 1988). The effects are, perhaps, now beginning to show in the public trends of falling smoking rates.

Alcohol.

Cirrhosis is the most specific disease caused by alcohol, (although hepatitis is another cause). Deaths from cirrhosis have been rising: from 14.1 per 100 000 people in 1953 to 34.8 per 100 000 in 1976 and 35.1 per 100000 in 1987 (Davies & Walsh 1983: 112; CSN 1989: 224). The distribution across the country is varied: the rates are highest in the north-east, the regions of Veneto and Friuli, recognised for their high consumption of locally-produced wine (La Vecchia et al 1985: fig 2).

Alcoholism was given as a primary diagnosis in 10.8% of psychiatric hospital admissions in 1977. Admissions are predominantly in men, but become almost as common also in women in the age group 50-64 (ISTAT 1981: table 3.20). Trends for alcohol admissions will have changed after the mental health reform law of 1978. In one prospective study in Lombardy, alcoholism admissions had fallen to 2% of patients (Contarese et al 1984). Nevertheless, there appears to be little recognition of the need for the SSN to coordinate a range of services for drinking problems, and no detailed information exists on such services.

Production.

Italy is the largest producer of wine in the world. Wine grapes are grown, and wine is produced, in all regions - in contrast to olive oil, for example, which is a product only of central and southern regions. The largest producing regions identified in the third census of agriculture in 1982 were (Table 7.6):

Table 7.6. Main wine production regions, 1983 and land use for vines, 1982 (ISTAT 1984: 123 and 137)

	thousand hl	litres per capita	% land used
Puglia	10 140	626	16.4
Sicilia	11 956	486	16.3
Veneto	10 366	489	8.3
Emilia R	10 356	537	7.5
Lazio	6 383	259	6.2
Toscana	4 693	269	7.9
Piemonte	4 505	183	6.6

There are few controls on wine production, which has always been an integral part of agriculture in Italy. It was estimated that of the 77 million hl of wine produced in 1983, 52m was for the Italian market, 14m for export and 11m for 'other uses and losses' which, in the national statistics, are noted as 'for seeds, animal feed and non-alimentary use'. The main countries of export were: FGR: 4.1 million hl, France 3.9m, USA 2.6m and Switzerland 0.6m. Only 171 hl of wine was imported. About 10 thousand hl of beer was also produced, with 800 hl exported and 1700 hl imported (ISTAT 1984: table 219).

There is a steady expansion in wine produced for export. Nevertheless, wine was relatively less profitable than other agricultural sectors in prices in the 1970s, and its value fell from 13.9% to 10.9% of total agricultural income. In 1983 exports gained 1100 billion lire, just

under 1% of the total value of exports in the year (99 230 billion lire).

Consumption

Alcohol consumption per head in Italy in 1984 was estimated to be the second highest in Europe at 28.1 g/day, following France (29.1 g/day) (Figure 7.2). Wine remains the commonest beverage, but spirits and beer are forming an increasing proportion.

Regional consumption is higher in the north and centre of Italy than in the south. Figure 7.3 shows the average annual consumption per family in each region (and its close ranking with deaths from liver failure). The data come from a national survey of family expenditure in 1982 (ISTAT 1983). The average consumption per family for the north and centre was 92.4 litres of wine, compared with 64.8 litres for the south.

Figure 7.2 Alcohol consumption per adult (15+ years) 1950-78 (Davies and Walsh 1983).

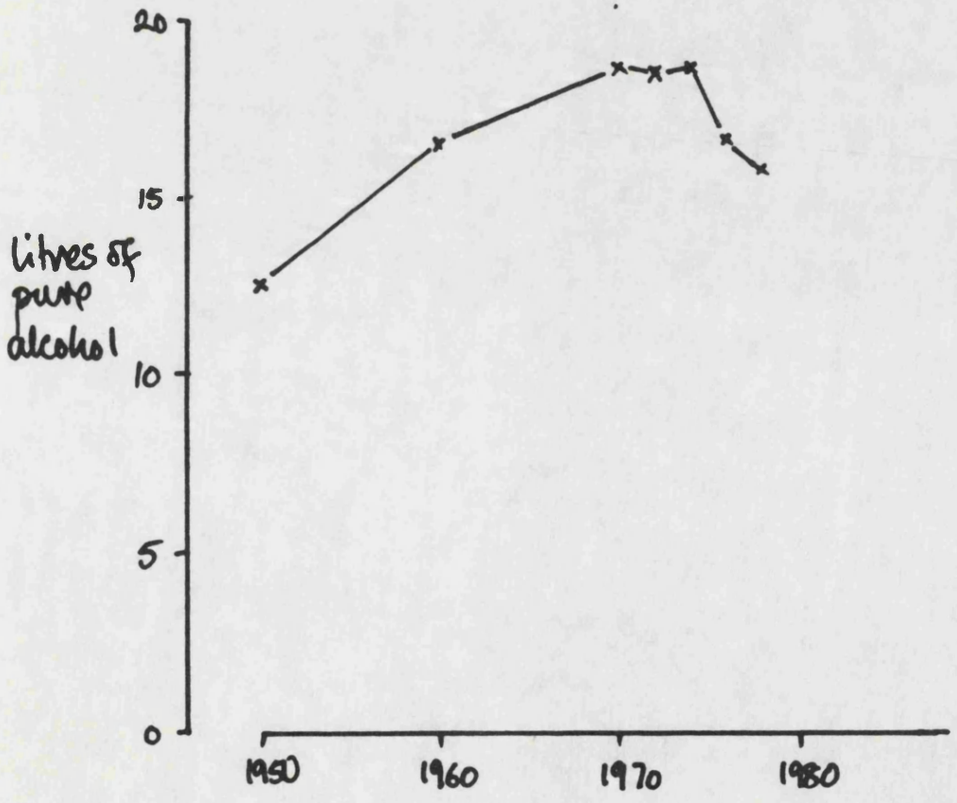


Figure 7.3. Consumption of alcohol (litres/year), and liver failure deaths (per 100 000 population), by region, 1982 (ISTAT 1984)

Prevention

Wine is grown in all regions of Italy. It is a staple crop of many areas and makes a major contribution to exports. It is also distributed by thousands of small distributors, reflecting local variations in character and quality. Drinking wine is a social and cultural habit.

The extent of alcoholism in a population is directly related to the total quantity of alcohol drunk. Alcoholism may be visible acutely as drunkeness, or more invisible as chronic heavy drinking. It is much more common in men than women. The effects of chronic intoxication appear at work, on the roads, in domestic and social relationships. It would seem that Italy is least concerned with alcoholism of the three addictions discussed in this chapter, but that does not imply that it is objectively the least problem. Wine drinking is deeply established in the culture, both socially and economically, and the relatively slow presentation of the effects of chronic addiction make alcoholism difficult to recognise.

Drugs.

Data about illegal drugs are less readily available than for other addictions. A valuable source is the Ministry of Health's annual report for Parliament (Anonymous 1984c).

Needs and services

Drug use, and its consequencies, has been a major new issue in the 1980s. Notifications for drug dependence have risen from 4139 in 1978 to 28 629 in 1988 (Mariani 1990). Deaths from opiate use showed a steady increase during the 1980s, reaching 792 in 1988. These are relatively small numbers of deaths compared with other addictions, but they occur among younger adults. There are substantial differences between regions (Figure 7.4).

There were 25 000 people using therapeutic services in 1985 (CSN 1989: 236), of which one person in three was a new attender. Three forms of provision are recognised for drug addicts. Public services are available through the USLs. These are more common in the north and centre than the south. Figure 7.4 also shows the provision of centres per 100 000 aged 15-39 identified in a survey by Censis in 1982. The centres are intended for the acute assessment and treatment of dependence. They are under the direction of doctors. Prescribing is usually with methadone, a synthetic opiate that has a longer-lasting effect than heroin and can be taken orally.

Figure 7.4. Death rates from overdose and services for drug dependence by region, 1982 (Anonymous 1984c)

The social-therapy response for drug dependent people has been residential communities. Most therapeutic communities are independent associations or cooperatives, getting direct support from the regions and payment for their residents from USLs. The CENSIS survey indicated 125 in 1982, all but 20 of these in northern regions and only three in the south. The Ministry of the Interior identified 320 communities in 1987 (CSN 1989: 235), with 57 in the South and 6114 residents in care.

A report of the work of therapeutic communities for drug dependent adults in Italy has been given by Owen (1989). Seventy communities are organised by Communita Incontro. The organisation was founded in the 1960s by a Catholic priest, Don Pierino, and now provides for 2500 residents aged 18-30, more than half of whom are HIV infected. Selection for entry is made by the founder. The residents all undertake work in pairs, a senior resident supervising a junior, developing skills of use within the communities - building, bricklaying, agriculture, cooking, administration. Among the 'few rules' of the regime laid down are:

"total obedience to the orders of Don Pierino
an 8 hour work day
no leaving the centre without permission of Don Pierino
no coffee, cigarette or alcohol (except one glass of wine on Sundays)
no methadone or drugs except prescribed by Communita Incontro doctors
no sexual intercourse for 3 years" (Owen 1989: 212).

There were also, in 1982, 34 private agencies offering various different services, including advice, individual or group therapy, rehabilitation

and assistance with work or penal issues. None of these services prescribes opiates.

Production.

To judge from sequestrations by the police, the main illegal drugs available in Italy are heroin, cocaine and hashish. In 1982 the customs and police together recovered 229 Kg of heroin, 105 Kg of cocaine, and 5000 Kg of cannabis. In contrast, the quantities siezed through illegal possession were 0.5 Kg of heroin, 0.2 Kg of cocaine and 11 Kg of cannabis. Amphetamine and barbiturate, produced legally by the pharmaceutical industry, are also used as addictive drugs.

Sicily is one of the worlds' intermediary stations for processing opiate drugs from producing centres in Turkey, Afghanistan and Pakistan and Thailand to Europe and America. Increasingly in the 1980s there was also a new flow of cocaine from South America to Italy. In Palermo, the health authorities recognise that large quantities of drugs are smuggled through the main airports and ports. The mafia is considered to play a central role in the distribution. A few clandestine laboratories for processing opiates have been discovered in Sicily, but many probably continue uninterrupted.

Consumption.

Of just over 5000 people were notified to the police and health services in 1982 as drug addicts, 90% were for heroin addiction. Another 4500 were identified as possessing drugs, but over 50% of these people were

using cannabis. Thus the official number of people recognised using drugs was 9828. This figure has risen steadily since inception of the present law: in 1977 there were 2538. Another estimate can be derived from people accused of selling drugs - 15 184 people in 1983, rising to 21 542 in 1987 (CSN 1989: 214), of which 50% were for heroin and 30% for cannabis.

But these figures must considerably underestimate the total drug users in the population. A 'snap-shot' picture of drug use in young adults is gained by examining the urine samples of 18-year olds registering for national service in 1982. This showed that 1.7% had evidence of using opioids. Extrapolation to the national population of 17-25 years men would mean 67 thousand men, and possibly another 16 thousand women of this age who used illegal drugs. It is estimated that, nationally, opiate users have risen from 65 000 in 1978 to 350 000 in 1988 (Mariani 1990).

Prevention

Drug use is seen by Italians as their greatest problem of addiction. There are daily reports in newspapers about addicts and distributors, and the government has identified drug dependence services and research as a priority for funding. Drug use spreads through youth culture, and efforts for health education have to be directed towards a capricious teenage group.

The government's response to drug addiction has been to provide treatment services. This is based on the British experience during the sixties, when a small number of addicts were relatively well controlled

by special outpatient clinics in the main towns. The expansion of heroin distribution in the seventies in Italy means that addiction is now a far larger problem than in Britain before. Heroin and cocaine are also being used 'recreationally' - by people who are interested in occasional use but not in a lifestyle totally concerned with drugs. Prevention is possible through limiting distribution - but because this is clandestine, it is much more difficult than for tobacco and alcohol. So far, the distributors appear to have been much more successful than the customs and police: distribution internally from Sicily and a weak administrative system are pointers suggesting that drugs will continue to be widely used in Italy in future years.

CHAPTER EIGHT: EVALUATION - THE SERVIZIO SANITARIO NAZIONALE IN REVIEW

The reform of the Italian health system described in this study started in the 1950s, made some headway in the 1960s, was introduced in the 1970s and became established during the 1980s. Giovanni Berlinguer, a doctor, a parliamentary deputy closely associated with the reform, and brother of the leader of the Italian Communist Party during the 1970s, published an early critique of the Italian health system in 1958 (see Chapter 2). As a brief assessment of change, the issues raised in the seven chapters of his book can be reviewed from the perspective of some thiry years after writing and ten years after the reform.

Chapter 1: Overlap and multiplicity of systems for funding and provision. Broadly, this has been overcome. The SSN unified both funding and provision, ensuring private medicine within the unified system through contractual payments.

Chapter 2: Inequality of services. The 1960s saw a substantial increase in hospital provision in the south. The imbalance reported by Berlinguer, a ratio of 8 beds per 1000 in Liguria to 0.7 per 1000 in Basilicata, had changed to 7.0 and 5.2 respectively by 1984. Much of this development was started by the 1968 hospital plan and funding from the Cassa del Mezzogiorno.

Chapter 3: Medical education - 'the great sickness of Italian universities'. The university reform of 1969, if anything, relatively worsened medical education. The large rise in students in the 1970s was

not matched with an increase in teaching staff, leading to less direct laboratory and clinical contact. The failure rate, considered as the proportion graduating of those entering the Faculty is higher in the 1980s than in the 1950s. Perhaps all that can be claimed as successful is research: Italian clinical research, partly through active multi-centre cooperation and partly related to an innovative pharmaceutical industry, has achieved prominence in the 1980s.

Chapter 4. Pharmaceuticals. Prescribing by Italian doctors remains higher than in Britain. Pharmaceuticals are about 16% of the SSN expenditure. But the number of pharmaceutical products circulated, 11 5000, is not at the high levels of some other industrialised countries (for example Germany 70 000, USA 60 000, Japan 40 000, Switzerland 35 000), and is comparable with the United Kingdom (11 000). France is lower at 9000 (Farmindustria 1987).

Chapter 5. Individualised work. There has been little change in the style of practice of GPs, who, while they may share offices for financial convenience, still mostly practice individually rather than in partnerships. The guardia medica provide their out of hours services. Districts have not been implemented widely within USLs and 'primary care teams' are infrequent.

Chapter 6. The divided financing system and unnecessary sickness certification. Health insurance premiums and benefits have been standardised, although there remain differences in contributions between salaried and self-employed workers, and higher rates of pay are charged proportionately less. There have not been changes in the requirements

of doctors to provide sickness certificates.

Chapter 7. Poor health indices. By the criteria of the 1950s Italian health has substantially improved. Stillbirths have fallen, from 22 per 1000 in Aosta and 51 in Basilicata in the 1950s to 3.5 and 7.2 respectively in 1985, but inequality around the Italian mean (6.6 in 1985) persists. Notified polio cases have fallen from 4452 to none; diets are substantially better; mental health care is less rigid.

In his final chapter, Berlinguer's called for a health care system with total population insurance cover, financing through single a insurance fund, tax support for the financing, hospital planning and greater control by the Ministry of Health. All these changes were incorporated in the reform.

Criteria

In Chapter 2.3, four criteria were established for evaluating health care. These are now reviewed under the four headings - effectiveness; efficiency; equity; acceptability - taking into account the principles guiding the health reform in its historical development, while the last section of this chapter reviews the impact of the separate mental health law 180/78 that was subsequently incorporated within the SSN law.

8.1 Effectiveness.

Mortality

Trends in age standardised mortality for the main disease groups 1970/83 are shown in appendix figures A1 to A11. Overall, there has been a steady fall in death rates, although differences between broad regions of the country persist. The benefits were greater at all ages for women than men. In men, the benefit was most appreciable for young adults, while in older age groups a falling trend only began in 1978. As the reverse of falling mortality rates, expectation of life improved between 1970 and 1980, although the gap between men and women (found in all industrialised societies) remained (Table 8.1). The improvement in adult expectancy was larger than in previous decades (1950/60 and 1960/70) (OECD 1985: 131).

Table 8.1. Expectation of life at birth, 40 years and 60 years, Italy, 1970 and 1980 (OECD 1985: 131)

	females		males	
	1970	1980	1970	1980
at birth	74.6	77.4	68.6	70.7
at 40 yrs	37.9	39.5	32.9	33.7
at 60 yrs	20.1	21.3	16.4	17.1

These trends cannot be only ascribed to an improved medical care system, as they also reflect economic and educational improvements. Nevertheless, extending health insurance cover for the whole population, increasing numbers and quality of health care staff, developing more accessible facilities and reducing unnecessary institutionalisation are likely to have contributed. Similar trends during this period are to be found in all OECD countries, including neighbouring mediterranean

countries such as Portugal, Spain and Greece, (OECD 1985: 131), that were simultaneously undergoing rapid industrialisation and extending their access and quality of medical care. (In contrast, health indices in some Eastern European countries were stagnating.)

By individual diseases, infectious disease deaths fell substantially, with the south catching up with the north and centre, presumably a response to improved housing and hygiene. Cancers, which show substantially higher rates in the north and centre than in the south, showed rises in male cancers and slight falls in female cancers. The falling stomach cancer rates and rising lung cancer rates are similar to other western countries, and have been related respectively to changing patterns of food preservation and rising cigarette smoking.

A sharp rise is seen in diabetes deaths from 1979 (the actual number of these deaths is low in relation to other categories shown in the graphs): the explanation for this is not clear, but may have been due to a change in 1978 in death certification coding. There were falls, from about 1976, in circulatory system deaths, especially in males and in the north of the country, and a steady fall from the beginning of the 1970s in respiratory deaths: these benefits may well reflect improving standards of hospital care.

Infant mortality fell from 29.6 per 1000 live births in 1970 to 14.2 in 1980 and 9.8 in 1988. Table 8.2 shows the indices for 1968, 1980 and 1987 by region. All regions show substantial improvements, but most southern regions continue to be behind the central and northern regions:

Table 8.2. Infant mortality by region, 1968, 1980 and 1987 (CSN 1983: 54; ISTAT 1989: 114)

	1968	1980	1987
Piemont	33.4	12.5	8.4
Valle d'Aosta	40.2	9.9	9.5
Lombardia	26.9	12.4	7.9
Liguria	25.2	15.1	8.3
Trentino Alto Adige	21.3	8.9	8.4
Veneto	23.9	11.9	6.6
Friuli VG	25.4	9.1	5.8
Emilia Romagna	28.0	12.7	8.9
Toscana	21.9	11.5	8.3
Umbria	22.8	10.7	8.9
Marche	23.6	12.3	9.9
Lazio	26.6	12.8	10.2
Abruzzo	26.3	12.5	9.7
Molise	36.4	9.8	6.6
Campania	47.7	16.8	11.0
Puglia	43.7	17.0	10.1
Basilicata	44.6	12.9	11.4
Calabria	41.9	17.2	11.2
Sicilia	37.5	18.2	11.8
Sardegna	34.7	14.6	7.0
Italy	32.7	12.2	9.5

the exceptions, Molise and Sardegna, are unexplained. The range in 1968, 21.3 to 46.7, has proportionately reduced a little by 1987, 5.8 to 11.8.

Prevention

Prevention was always seen as an important part of the health reform, and was written into the SSN law in Articles 1 and 2 (see Chapter 7.3). Nevertheless, much of the prevention work described for the USL (Articles 20-24) concentrates on occupational health: there is little mention of broader prevention stategies, either as population health education or as individual preventive medicine through general practitioners.

The Ministry of Health had a stronger position in government affairs after the Reform than before. National health education programmes were led by Dr Carlo Vetere, a senior medical administrator committed to traditional public health aims but insufficiently supported or funded. The Ministry provided funding for media advertising, while its content and message is strongly controlled by the Ministery of Health. Health education in schools, however, is the responsibility of the Ministry of Education, and is undertaken without health service participation (Briziarelli 1987). One reason for the lack of development of preventive strategies through the SSN has been the lack of a body independent of central government to encourage disease prevention and health promotion: there is no single national health education agency.

Health education against cigarette smoking started in the 1980s. There are some small educational initiatives in schools, some in conjunction with the national television network, and most doctors appear to be aware of the potential harm of smoking. But it is a problem only beginning to be tackled seriously. Alcoholism also began to be addressed by the Ministry of Health, which supported academic research and conferences on alcoholism. At local level, however, alcohol problems are usually treated by hospital physicians in general medical wards from a physical rather than behavioural point of view. The available literature on alcoholism is orientated towards supportive care, rather than prevention. In contrast, heroin addiction has received continuous national publicity. Money has been found nationally, and in most regions, to set up drug treatment centres, and to pay for 'rehabilitation'. This active approach may well have helped limit the spread of opiate use; still, the death rate from heroin addiction is only a fraction that from the effects of tobacco and alcohol, both areas with substantial legalised State interests.

There has also been insufficient action in road accidents. Italy has a relatively high death rate from road accidents, and was one of the last countries in Europe to introduce compulsory crash helmets for motorcyclists (Anonymous 1986) or seatbelts for car drivers (Vannucchi 1989). Changes in road behaviour are needed if the rates are to be reduced.

The second reason for poor performance in prevention has been lack of knowledge within the health professions. Cervical screening is practised by general practitioners, but young low risk women receive

more tests than older high-risk women and there is little understanding of the need for population-based surveillance. General practitioners are only beginning to practice opportunistic screening for hypertension. Compulsory registration of every resident by a single commune (continuing from Napoleonic measures for social control) offers the opportunity for sytematic population screening, but is not yet used.

One area that will need attention is health surveillance for elderly people. Because of the favourable doctor-to-population ratio, the SSN should be good at areas of preventive medicine such as this. A survey of elderly people in 1987 in Pavia, Lombardy (Amoretti et al 1989), indicated that respondents regarded regular medical assessments as their single greatest unmet need (Table 8.3). The authors of the study comment: 'The elderly people themselves stressed the importance of preventive medical care to avoid their condition worsening or being admitted to hospital' (Amoretti et al 1989: 124). This survey finding, in a favoured part of the country several years after the SSN was established, suggests that general practitioner services are not yet meeting the wants of their elderly patients for prevention.

Table 8.3. Positive answers to the question: 'Do you have need of any of the following services?'

Regular medical assessments	31.6%
nursing care	25.4%
a transport pass	25.5%
domestic service	16.5%
sheltered accommodation	16.0%
financial assistance	13.4%

Nevetheless, the SSN was an administrative reform, not a clinical one. The structure of personal GPs for the whole population, and population-based health authorities, provides an excellent framework for improved preventive medicine. What may be needed is to revise the GPs contract of employment and system of payment to give greater incentives for prevention, as has recently happened in Britain.

Occupational health

Occupational health services were central to the thinking about prevention in the debates on the reform law. Thus, the journal 'Bollettino di documentazione sulla sicurezza e igiene del lavoro' (Bulletin of safety and hygiene at work) changed its title in 1987 to 'Bollettino della prevenzione'. Establishment of occupational health services within in the SSN was a success for the trade unions, and the Communist party. But they are not yet as successful as was hoped - for several reasons.

The first is financial. The new services have usually been able to call on growth money in the regions' budgets, and are often identified as special projects in the three year plans. Yet the scale of the task is enormous. USLs have to chose between working in depth with a small number of factories and workplaces, as the workers' model requires, or providing a wider but less detailed service. Added to this is the lack of staff suitably trained for the detailed work at factory level. In contrast, it is easier to recruit staff for technical work in the multi-

zonal laboratories.

The addition of the work that the Inspectorate previously undertook has formed a further burden on the stretched resources. Inspections can be difficult and time-consuming if the employer is unwilling to cooperate, and may require action through the magistrature. The activist occupational physicians of the seventies are now responsible for the routine clinical examinations in prescribed occupations required by the law, admittedly preventive medicine but with little involvement by the workers themselves.

Added to this is the fact that many of the staff who should have transferred from the previous agencies have simply stayed on. The Ministry of Labour (and indeed the Minister) has argued to retain the Inspectorate on the grounds that the new USLs are unable to do the job properly. Although ENPI and ANCC are formally abolished, they continue in fact where staff - or politicians - are resistant to integration with the USLs.

But the underlying issue has been the changing labour market of the 1980s. The economic strength of Italian capital has diversified from the centralised factories of the north-east to smaller factories in the north-east and central regions. The large factories have restored their profitability by large redundancies and re-equipping for smaller work-forces (Ginsborg 1989). Chronic unemployment has reduced the will of unions to press for health changes when basic economic issues are outstanding. And it is often the smallest, least unionised workplaces,

with the most hazardous working practices, that are at the margin of economic viability. Occupational health care in Italy has taken innovative steps: its future will depend on the continued interest and political support of the union movement.

A possible development for prevention could be the increasing concern in Europe for environmental issues. Until now, national environmental policy has been a low priority for the Christian Democrat party (Reich 1984). The environmental health services were transferred piecemeal from the communes to the USLs. There has been an increase in staff, but data do not exist to conclude whether this work is directly improving the nation's health. The Communist party has proposed a Department of Prevention within each USL of the SSN (Parlamento Italiano 1988). This department would integrate the existing public hygiene (environmental) services, occupational health services, veterinary hygiene and health education. Such coordination would be likely to strengthen each partner, and could improve the position of prevention for power within the USL. The Government has not, however, responded with similar proposals.

Summary. The absolute trends of mortality indices have continued to fall steadily during the period of the Reform. Nevertheless, while occupational health received particular attention, broader areas of preventive medicine and health promotion were not addressed by the reform. A new initiative will be needed for prevention to attain the place on national political agendas it needs.

8.2 Efficiency

"It is easier to define a theoretical criterion for economic efficiency in health care than to show what is and what is not an efficient use of resources in practice.... What is important is that the effects of particular policy measures should be monitored in the local situation to see what effects the measures are actually having after they are introduced" (Abel Smith 1984: 4-5).

Funding the service

The SSN created complete population coverage for health care through pre-paid compulsory insurance managed by the government and supported with government subsidies - although there has been erosion of the principle that all services are free to the user. Insurance cover had been growing since the War, and continued to rise during the 1970s when the SSN was being debated. At the end of 1979, before full coverage for the population under the SSN was implemented, just over 2% of the population were without insurance; the gradient towards the south indicates that these were likely to be disadvantaged people rather than the rich. Private health insurance has not been of importance in the 1980s, and mainly covers 'additional' expenditures charged by private hospitals where the patient is paid for through a SSN contract.

Nevertheless, the idea of meeting all health needs through a national health service developed during the 'economic miracle' of the 1960s,

while expansion of hospital provision and extension of population coverage in the early 1970s coincided with financial constraint. The SSN was actually born in very different economic circumstances, and, from its inception, central funding was tightly controlled rather than liberally expanded.

Table 8.4 shows estimates by OECD for public and total expenditures on health care as a proportion of GDP for several European countries. It can be seen that the SSN was successful in limiting the total proportion of GDP spent on health services in the 1980s. Since expenditure control was a major spur in the early 1970s to the health service reform, this must be counted a success. Whether this is the correct level of expenditure is another matter: more money could make hospital and GP facilities better, but the government would need to invest wisely in developing better quality of care, and not simply pay staff more or provided 'more of the same'.

Table 8.4. Expenditure as proportion of GDP, selected countries (OECD 1987: 55 and 1990:30).

	1970	1980	1987
France	6.1%	8.5%	8.7%
W Germany	5.5%	7.9%	8.1%
Netherlands	6.0%	8.2%	8.5%
Spain	4.1%	5.9%	6.0%
UK	4.5%	5.6%	6.1%
Italy	5.5%	6.8%	6.9%

Despite the intention of the Reform, the government did not 'fiscalise' the National Health Fund, that is, to transfer it from a separate fund (based on insurance supplemented by taxation) into general government funds derived from taxes supplemented by insurance contributions. Such a law was expected as the final structural step of the SSN, but was never completed. The new health insurance remains partly regressive in fiscal terms, as Table 5.3 showed: there are percentage rates up to an upper limit, after which lower contributions are required. Self-employed workers pay lower contribution rates than waged and salaried employers, and the self-employed may not admit the full extent of their earnings. However, in contrast to the former system of the Mutue, the rates charged, and benefits received, are standard for the whole population, and there is no debate between different potential payers (Mutue, Commune, Ministry of Health) for services. There has been an increase in the central tax contribution to the fund: between 1970-1984 the proportion of the health budget derived from insurance fell from 65% to 51%, while that from central funds rose from 31% to 45%.

Private contributions to total financing of health care did not fall because of the SSN. The contributions of private finance from 1970 were estimated by Mapelli (1987: 165) to be: 1970 - 14.5%; 1975 - 14.7%; 1980 - 13.3%; 1984 - 15.8%. Of this, about one third is 'obligatory spending', including copayments and services not available within the SSN, such as dental care and over-the-counter prescriptions; the rest is expenditure for services in the private sector. Private health insurance expanded to some extent in the 1980s, rising (not adjusted for inflation) from 132 billion lire in 1981 to 237 billion lire in 1984 (no details are available on how many people are covered). But almost all

private insurance is provided as a fringe benefit with managerial or professional employment. Much of the legislation following the SSN law 833/78 has been concerned with copayments (see Table 5.5), but in 1984 copayments only contributed 2.3% to the national health service budget (Mapelli 1987: 166).

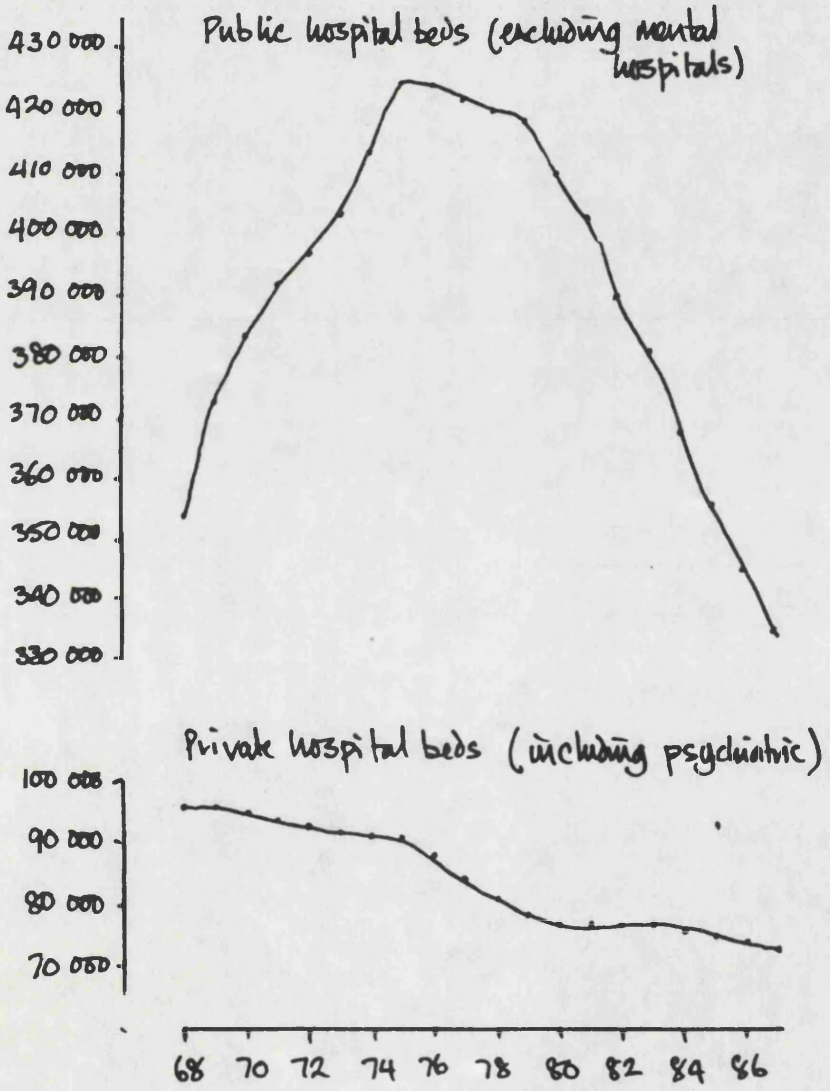
Health services provision

The 1968 hospital act was the first major public reform of health service organisation since the beginning of the century, and hospital data, collected by ISTAT, were recorded in a new series from this year. Two broad aspects of provision can be reviewed - hospital beds and use; and staffing.

Figure 8.1 shows the trends in public and private hospital beds 1968-86. The 1968 hospital plan led to an expansion of hospitals that was rapidly curtailed in 1975 by the transfer of control to the Regions, and after 1979 there has been a steady fall in total beds. On the other hand, there has been a move towards geographical equalisation, by increasing provision in the south and decreasing in the north east. In the south, general hospital admissions continued to rise until 1980, with a fall thereafter.

ISTAT data on hospitals distinguishes public hospitals from private (the latter includes some 'contracted' university and specialist hospitals, and a proportion of beds used for psychiatric care). Private beds were falling quite rapidly during the later part of the 1970s, but fell proportionately less in the 1980s than public beds.

Figure 8.1. Hospital public and private beds 1968-86.



Both control of hospital provision and redistribution of facilities were objectives of the Reform. In the 1960s, there was a general agreement of the need to improve hospital provision to take advantage of the revolution in diagnosis and treatments of the period; and also, the Cassa per il Mezzogiorno offered a means of reducing the disequilibrium of facilities between north and south. The regional differences are shown in 5 representative regions, Table 8.5. In general hospitals, Lombardy, Veneto and Tuscany followed the national pattern, with peak in the early 1970s, whereas Lazio and Campania continued to grow up to the end of the 1970s (there is, of course, a time lag between the decision to build a hospital and its eventual use).

Table 8.5. Beds in general hospitals, selected regions, 1968-87

	1968	1973	1979	1984	1987
Lombardia	62562	72277	63354	54236	52368
Veneto	40681	46999	46265	38769	33754
Tuscany	27533	30199	30511	26710	23314
Lazio	25712	28322	32571	29123	25923
Campania	18525	22435	26258	22750	19915
Italy	354711	404731	419021	368239	335636

In the private sector, the largest reductions in hospital beds have been in the northern regions and Campania. Only Veneto and Tuscany have shown a clear reduction in admissions: in Lombardy private beds fell but throughput was maintained; in Lazio provision and throughput remained roughly steady; while in Campania there was a large fall in beds - from

12513 in 1968 to 6593 in 1987 - yet a substantial increase in admissions.

Chapter 4.2 has already noted questions of efficiency in the private sector. Table 8.6 shows the throughput (admissions per patient) for each region. In private hospitals in 1968 Tuscany had the highest throughput. By 1984 neither Tuscany nor Lazio had changed in efficiency, while Lombardy and Veneto had improved and Campania had changed from being the least efficient to being by far the most. The general public hospitals, however, tell a different tale. All had a higher throughput in 1968 than private hospitals, and all except Campania in 1987. The anomalous high private hospital throughput in Campania may be due to few SSN hospital beds combined with falling private beds; but the figures might also be inflated to enhance private remuneration. Overall, public hospitals within the SSN appear to have succeeded in increasing efficiency whereas the private sector has stagnated.

Table 8.6. Throughput (patients per bed per annum) in general hospital beds in five regions, 1968 and 1987 (ISTAT 1989)

	1968		1987	
	public	private	public	private
Lombardy	18.7	13.2	26.2	18.8
Veneto	17.1	10.7	21.6	18.2
Tuscany	18.1	16.9	24.1	16.2
Lazio	18.6	11.6	23.7	11.7
Campania	18.6	10.9	25.9	28.4

The national allocation of funds for 'priority care groups' (the

'progetti obbietivi') has also allowed regions to plan and implement services for these groups. Local public health and social services for drug dependent people rose from 312 services in 1982 to 460 in 1987. There was a larger expansion for voluntary and independent contracted therapeutic communities, from 127 centres with only 2% in the south (some large regions such as Campania and Sicily not recording any) to 320 registered therapeutic communities in 1987 providing for over 6000 drug dependent people (16% of the communities were in the south) (Ministero della Sanita 1984: 380; CSN 1988: 235). There has also been a substantial increase in family planning and advice centres: in 1979 there were around 1000 centres (data were missing that year from Molise and Sicily), whereas in 1987 there were 2995 centres. Only 44 family planning centres in 1987 were contractual (10 of these in Sicily); typically, voluntary activity in the social welfare sector is supported by the Catholic church, but contraception is very much a lay concern.

Public psychiatric hospital beds were falling in number from 1968, and continued to fall after the 1978 mental health reform law. Admissions fell more rapidly after the law than after it. The patchy development of mental health services has been noted in Chapter 7, and it is clear that 'progetti obbietivi' money did not always result in new community services. The limited central surveillance of regional spending may have made it possible, in some regions, for the money to be used to prop up the traditional forms of care, rather than develop new ones.

In the high technology areas of medicine, planning appears to have had less influence than local initiative. Renal failure treatment is an

example. In 1987, renal dialysis was available in all regions, with the highest per capita number of places in the main southern regions of Campania and Sicily (CSN 1988: 495). On the other hand, renal transplantation was available in 20 centres, but only two (Bari and a small clinic in Naples) in the south (CSN 1988: 518). Renal dialysis requires less expertise than transplantation and can be readily provided in contracted hospitals.

There has been an increase in the number of general practitioners in all regions during the 1980s. Their average list size is low in comparison with the United Kingdom, but they often also work in SSN ambulatory or private clinics. This potentially allows a longer time for discussion with patients, but no data are available to determine if this actually happens. Small independent associations of general practitioners are beginning to propose criteria for high quality general practice in Italy, but there is little emphasis on this within the SSN as yet. There has been financial encouragement of more specialist consultations within hospital premises ('outpatients') rather than in polyclinics; but the present system, while probably leading to excess investigation and prescribing, supports many doctors financially and would be hard to alter.

Personnel

Staff information is only available for public hospitals: as there is much overlap in staff between public and private sectors, this at least avoids double counting (Table 8.7). Between 1976 and 1987 full time doctors rose more than part time; trained nurses changed from being a

minority to a majority of all nurses; there was a 50% increase in social workers, a 70% increase in technicians and a slight fall in administrators or porters. These figures indicate a predominance of patient care (and thus doctors) over administration; but it is not clear that this represents the best choices for efficiency or quality of services.

There has been some legal control on personnel, but of doubtful effectiveness. For example (Mapelli 1987: 191), the 1974 law no 386 introduced controls on personnel, but from 1975 to 1982 there were 77000 new staff added to hospitals. In 1983 there was a complete block on new appointments, but in that year overtime was equivalent to 33000 people. The main control of manpower has been financial: USLs cannot employ staff if they cannot pay them.

Table 8.7: Personnel in public hospitals, 1976, 1984 and 1987.

	1976	1984	1987
doctors			
- full time	26408	43363	50516
- part time	24376	30969	27697
nurses			
- qualified	51819	100961	128123
- assistants	106553	81541	60404
technicians	15067	24324	26084
administrators	33359	34140	32809
porters	95687	90715	87975

Doctors in Italy historically have had a pyramidal power structure - often known as a 'gerarchia' (hierarchy) (Freddi 1984: 22). A few senior hospital doctors had immense power; their assistants waited for them to retire before competitive promotion to their positions. Since the 1970s there has been a gradual move towards 'departments' in hospitals sharing senior responsibility and training junior staff. Nevertheless, the large number of applicants for junior positions, and willingness of many younger doctors to work as 'volunteers' until an established post becomes vacant, has ensured that the senior hospital staff retain considerable power.

The position of general practitioners has, however, improved under the SSN. They have clearer financial arrangements, being contracted with a single agency (the USL) rather than with a range of Mutue. Their contracts have been negotiated centrally and are very favourable: not only were substantial increases in income achieved between 1979 and 1981, but also the terms allow a range of extra practice - in polyclinics, private clinics and hospitals, or even as part time public hospital doctors. They are fully covered outside 'ordinary' working hours by the guardia medica, a large reserve pool of younger doctors who are also ready to provide daytime locum care. And, despite the increasing sophistication of hospital medicine, the status of general practice within medicine is slowly improving as professional groups seek to develop standards of practice and postgraduate training.

The oversupply of hospital doctors has given little encouragement for the SSN to use doctors efficiently, for example in using less specialised staff or alternative forms of care. Full and part time

doctors working in public hospitals rose from 51 000 in 1976 to 74 000 in 1984 (a rise of 45%) whereas nurses increased from 158 000 to 183 000 (a rise of 16%). It is true that nurses changed from 33% to 55% trained staff over these 8 years, suggesting an improvement in quality of practice. By comparison, in England in 1984 there were 328 000 hospital nurses, of whom 47% were qualified, and 43 000 hospital doctors (including part time). The ratio of doctors to nurses in Italy working in public hospitals in 1984 was 1: 2.4 compared with 1: 7.6 in England.

The large number of doctors available for general practice, however, ensures smaller list sizes than in Britain. This is probably beneficial: the time for each consultation appears to be longer than in Britain, and there is less sense of pressure, either for the doctor or for the patient. But average consultation rates are higher than in Britain - partly because doctors ask patients to return for follow-up more often after an illness, partly related to higher investigation rates. Italian general practitioners are estimated to have high prescribing rates, a result partially of item-of-service reimbursement in the years before the SSN - estimated at 21 medicines per capita per year in Italy in 1975-7 compared with 7 (in 1982) in the United Kingdom (Abel Smith 1984: 12, OECD 1987: 77).

In 1986, per capita spending on drugs in Italy was 191 537 lire compared with 117 260 in the United Kingdom (Farmindustria 1987: 292), with high consumption but relatively cheap cost through a competitive pharmaceutical industry market. Hospital outpatient referrals in 1981 were estimated by OECD to be 36% higher than the mean for OECD countries at 8.3 per capita per annum; but hospital admissions, 15.4% of the

population per annum, are close to the OECD mean (OECD 1987: 75, 69).

Although a form of limit has existed since 1987 on the number of medical students entering, because of regulations between student numbers and staff levels, introducing a formal 'numero chiuso' would probably still benefit the SSN. It would improve the doctor nurse ratios; it would improve standards of qualifying doctors, since teachers could give more attention to training fewer students; and it would help the bottlenecks for promotion within specialties. Yet Italy, in common with several other European countries, appears to be able to accept the present level of overproduction of doctors, partly because the central funding of health services has ultimately limited the ability to employ them. Unemployment of doctors is not the political problem that it would (be likely to) be in Britain, and central wage bargaining appears to have maintained satisfactory income levels for employed doctors.

Planning

The management consultant advisers to the Italian Ministry of Health for the health service reform were the American firm of McKinsey & Co, who had been deeply involved in the British NHS reorganisation in the early 1970s. Better planning for the new SSN was seen by most political parties as an important objective, because of the criticisms of muddle and bureaucracy in the old system, and the desire for better value for money. In the 1970s, planning was thought to create efficiency, much as the belief in the 1980s has been that a 'market' will ensure efficiency.

A criticism of the health reform has been the government's failure to produce the triennial National Health Plan that is clearly described in the SSN law. This requirement, that the Plan should be a law voted by Parliament, continued a tradition of centralist control. Two provisional national health plans failed to be passed by Parliament because, at crucial stages of debate, the Government coalition fell, leading to changes in Ministers of Health. The plans also became submerged because they were too technical and too detailed. The principle of national planning was eventually saved by its incorporation into the annual fiscal law for 1986 (law 595/85), and which has meant that it is more closely related to resource decisions. Monitoring the effectiveness of health care has improved through regular reports on the State of the Public's Health published by the Consiglio Sanitario Nazionale.

An early commentary on the planning system was made by a surgeon who advised the Lombardy region during their first period of planning (Colombo 1983). He recognised that regions, for political reasons, prefer to take credit for trends which already exist, and ignore those that do not change, and he gave as an example neonatal care. Rational policies would be to limit these high-cost specialist facilities to a few centres, such as provincial hospitals, where they can be used effectively and economically. However, paediatrics is one of the four 'basic' specialities expected to be available in every district hospital. It is possible for paediatric wards to have incubators on them ... and so almost all of them do. Closing services of hospitals is complicated, and needs political will power without an eye for votes - an unlikely event in Italy. He suggests that plans work only when they

describe the trend of current clinical practice - for example, in shorter stays or the development of new specialities. When they are against the inclinations of clinicians - for example, serious efforts to redistribute or even close facilities that are overprovided - then they can't be implemented (Colombo 1983: 9).

Yet, if central planning has been limited, there has still central support for planning through the determination of a senior official at the Ministry of Health, Dr Sergio Paderni. Every region has made a review of its services, and recorded the imbalance between the large cities and their surrounding suburban and rural areas. Some regions have proposed changes that are inevitably opposed by self-interest groups, and the intimate contact of USLs with local politics make change difficult. One may expect to hear complaints about planning where the planning process is being effective. This noise is not a 'crisis' for the SSN, but part of decision-making in a public system.

Two regions, Emilia Romagna and Piedmont, produced reports by the mid 1980s looking back at the implementation of their first plans. The reports were not very analytic, and mainly described the extension of personnel and services rather than the reasons for success or failure of the plan. The first plan in Emilia Romagna set many qualitative, and a few quantitative, objectives for the services under the progetti obiettivi. Among those defined for maternal and child health were the abolition of maternal deaths in labour, and reduction of infant mortality to 10 per 1000. The evaluation report says that the maternal mortality objective was not achieved, although it doesn't give a current

death rate. For infant mortality, the evaluation compares the 1978 rate of 14 per 1000 deaths with the 1982 rate of 10.9, close to meeting the objective stated for 1983. No information is given about the success in less clearly defined objectives, such as 'the prevention of home accidents'.

On the other hand, some success was made in Emilia Romagna in moving towards the national target level of hospital bed provision. The outline law for the National Plan, eventually passed by Parliament in October 1985, required regions currently with more than 8 beds per thousand to reach the standard of 6.5 per thousand by 1990. In Emilia Romagna, there was a substantial fall in numbers of public beds between 1976 and 1982; there were with smaller but similar changes in private hospital beds, with rising occupancy but longer lengths of stay (Table 8.8).

Table 8.8. Changes in use of hospital beds, Emilia Romagna, 1976 and 1982.

	beds	length of stay	occupancy
public			
1976	34 337	14.0	77.6
1982	29 186	10.9	71.7
contractual			
1976	6 298	15.0	75.4
1982	5 558	14.2	77.2
total			
1976	40 635	14.1	77.2
1982	34 744	11.3	72.6

A review of the distribution of budgets within the region of Lombardy has also been published (Mapelli 1986). This study showed that the Region took several years (1985) to implement a formula for resource redistribution. Before allocation to USLs the region held back finance for services in the regional capital USL (Milan, USL 75), provincial 'multi-zonal' hospitals and all pharmaceuticals. In result, only 43% of the original regional allocation was included in the USL formula (Mapelli 1986: 209). Thereafter the formula divided USL allocations into three groups of spending. The first group -

salaried staff
goods and services
contractual services
administration
drugs

comprised most of the spending, and was included in the allocation on historic levels since these were regarded as necessary to continue existing care. The second group -

energy
equipment
food

were corrected to historic averages, since it was considered that these should be similar thoughout the USLs. The third were based on resident population -

GPs
preventive service.

Mapelli found that the redistributional impact of this formula between 1982 and 1985 was minimal. After applying the formula, the richest USL (Sondrio) still had a per capita allocation 8 times that of the poorest USL (Sondalo).

Nor, within the USLs, was there much evidence of fundamental reallocation during the period of study. Mapelli suggests that 'the politics of the region in these first years after the reform appear therefore directed at consolidation and continuation of existing services, rather than a territorial re-equilibrium or greater equity in access to services' (Mapelli 1986: 207).

Summary: The Italian health system is 'efficient' in comparison with other countries as it spends a relatively low proportion of the nation's GNP, and contributes taxes to social insurance for funding. Planning, mainly at regional level, has reflected the variation in commitment to public services of Italian political life. During and since the 1970s there has been a redistribution of beds towards the underprovided south, increase in ambulatory provision (family and mental health centres), greater availability of general practitioners and improvement in quality of staff.

8.3. Equity

Equity is sought by the SSN through a system of comprehensive provision and nationally distributed resources.

Access to care

The SSN provides comprehensive health care. Everyone has the right to a general practitioner's consultation and treatment, referral for specialist outpatient consultations and inpatient care for physical and mental illness admissions and long-term care. (Access is, however, limited to legal residents who have registered with a general practitioner, and depends on production of a card: illegal residents, now increasing in Italy with migration from Africa, have as yet limited access). At the same time, the SSN covers public health and preventive care, occupational health and veterinary services. Ambulatory dentistry, ophthalmic services and orthopaedic appliances are also free in principle, but in practice there are limitations in access to dentists within the SSN and only a small range of spectacles available on SSN prescription.

The concept of a 'territorial' service was important to proponents of the SSN, who associated the idea with decentralised participation in management and greater local recognition of needs and priorities. The USL represents this idea as a management structure, and defines the relationship between GPs and hospitals. Since medical practice is clearly separated (in contrast, for example, to the mixed ambulatory and

inpatient care provided by doctors in the USA), an arrangement that allows dialogue between GPs and hospital specialists is likely to be beneficial to the organisation of care.

The SSN recognises the idea of 'pluralism', meaning the right of either patients or doctors to choose private care if they so wish. This is made possible through the contracting system, which accounts for fifteen per cent of the hospital budget nationally, and a similar proportion for clinic consultations. (Even in Communist-led regions, such as Emilia Romagna, recognised for efficient administration, private contractual bed use by the SSN has been sustained while public beds - a much larger total - have been reducing.)

USLs may value the flexibility of making use of a service that is not available locally and that can be readily provided privately. A study in Lombardia (Mapelli 1986: 232) showed that, between 1977 and 1983, there was a shift away from direct hospital services towards contracted service: the regional budget staff, goods and service fell from 61.5% in 1977 to 58.5% in 1983, while contracted hospitals and clinics rose from 8.0% to 12.3%. This could be interpreted as an opportunity for the USL to respond to new needs for services. On the other hand, growth in expenditure for private clinic investigations may have been in conflict with the USL's planned priorities. Without the service 'in house', there is the risk that private services (perhaps in collusion with colleague hospital specialists) will encourage GPs to request high levels of utilisation. This can be a major problem for specialist consultations and investigations, where there is no pre-paid budget in the way that the SSN contracts with the majority of private hospitals.

In 1988 the Constitutional Court ruled that citizens could expect to be reimbursed by the SSN for any service, whatever the source, if it was considered indispensible. France (1988) has noted that this 'absolute right to health' defined by the court raises the personal interest above that of the collectivity, and threatens the objectives of redistribution and rationing - indicated as planning, territorial equity and ensuring effectiveness and efficiency - written in the SSN law. It is unclear whether this ruling, which came about because of claims over single cases, will have an impact on planning and control of USL budgets.

Better local provision was also the reason for introducing the 'fourth' tier described in the SSN law - the districts. Districts were to be the means of organising home care services bringing together GPs, child care, nursing and other community staff. They also allowed local provison of prevention, though hygiene, environmental and occupational health; veterinary services; specialist ambulatory clinics; and administration (Rodolofi 1986). In practice, districts have been implemented in a minority of USLs, and have received little active support by GPs. Yet controlling GPs remains difficult. A study of a rural USL (50 000 population) in Lombardia described the particular concern of one ex-medico condotto, responsible for administration of 48 GPs in 11 communes, that there were no regulations for the hours that a GP had to run clinics. "There are doctors who live locally but do not shine with assiduity in being present, and others who live outside the USL and whose presence is nothing but salutary" (Salamone 1986: 83).

Geographical

The most widely discussed inequality in Italy is geographical, deriving from centuries of different political control and cultural development. Interestingly, as noted earlier and in Chapter 6,absolute and standardised mortality is lower in the south of the country than elsewhere - the 'benefits' of industrialisation are yet to take effect in the south. On the other hand, perinatal mortality remains higher in the south, although (in contrast to total mortality) there have been steady falls in all regions over the past forty years.

In health services provision, most regions in the north spend more per capita on hospital services than those in the south, although there are more general practitioners, working outside hospitals, in the south than the north. It is not only that the north has more acute hospital beds; the range of services in the north and central regions is more complete. For example, Figure 8.2 shows the distribution of special services for people with epilepsy in the country. There is also greater provision of renal transplant services in the north. Other service inequalities include a greater use of private contracted care in the south and weaker development of 'social' health provision such as community based mental health services or family advice centres.

Figure 8.2. Special centres for people with epilepsy (CSN 1983: 211).

The issues of redistribution are complex. In some parts of the country, such as Campania, surveys by ISTAT are only now beginning to describe comprehensively what services are available. Until the 1980s, health planning had been based more on total budgets than on identifiable provision. Per capita budgets are, on average lower in the south than the centre or north, but they are growing closer.

While the criteria for annual regional resource allocations have included criteria of supply as well as need (Chapter 5.2), there appears to have been a substantial reduction in resource inequalities by region, with the percentage for the lowest region (compared with the national average) rising from 65% in 1977 to 84% in 1987, and the highest region falling from 133% to 116% (Table 5.6). The inequalities within regions are often greater than between them, and regions in the north that are being pressed by the central government to reduce their total hospital provision (for example Emilia and Veneto regions) are also trying to improve the distribution of beds internally in the region.

Socio-economic inequalities

Social class information in Italy is difficult to draw together. ISTAT does not publish a report on deaths according to individual occupations, and the traditional grouping of occupations is not similar to social class groupings in Britain. A symposium on health inequalities in Europe (Fox 1989) mentions Italy only twice in the index, and has no discussion of the occupational classification systems used in different countries.

There has been no equivalent in Italy to the English 'Black Report' on social inequalities in health, except, perhaps, in the writing of Giovanni Berlinguer. In 1972 he published 'La strage degli innocenti' ('The Slaughter of the Innocents'), a polemical book designed to influence progress of the SSN proposals in Parliament, which drew on British and American epidemiological studies, but also presented some Italian data. He quoted a study of infant mortality in the southern city of Bari, in 1965-67, which showed a range of deaths per 1000 children under one of 15 in 'middle-upper' families, 37 in 'lower non-agricultural', and 95 in 'lower agricultural' families. Drawing on his own work, Berlinger described early postwar infant mortality rates in different quarters of Rome, from less than 30 per 1000 to more than 60 per 1000, which persisted (at lower levels) in a repeat study in 1958-61 (Berlinguer 1972: 44-5). He also pointed to the geographical variation in provision of maternity beds in 1967, from 0.86 per 1000 population in Val D'Aosta to 0.19 per 1000 in Campania, at a time when around 40% of births in Italy were at home. In another book four years later, 'Malaria Urbana', Berlinguer (1976) described the effects of industrialisation, and especially urbanisation, on health.

In the same year Tunio (1976), a doctor who trained in Britain and returned to work in the Policlinico dell'Universita in Perugia, described several small studies of inequalities. He reported infant mortality rates from a study in Chiassio, Puglia, for 1965-67, ranging from 16 per 1000 for magistrate's families to 42.3 per 1000 for agricultural workers. Examining the hospital records of 1252 children with rheumatic joint disease (resulting from infections known to be

affected by housing conditions) in Perugia, he found only 1.2% of the cases were in children of managers and professional people, compared with 30.1 % in semi-skilled and 43.8% in unskilled families. And he reported admission rates between 1961 to 1970 for Perugia's psychiatric hospital ranging from 846 farm workers ('contadini') and 823 industrial workers ('operai') down to 57 professional people and 19 businessmen ('industriali'). (However, denominator comparison populations for these latter two studies were not presented.)

Nevertheless, rather than pursuing social inequalities, the political energy of the labour movement in the 1970s went into towards getting a national health service, specific improvements in legislation and services, such as mental health and abortion, and developing the occupational health services. Because no data existed on occupational inequalities, the debate for reform emphasised geographical inequalities both within Italy and comparing Italy with other European countries. A representative social medicine text of the early 1980s (Bert, 1983), written for "social workers and USL staff" starts a chapter 'Health and Social Classes' with a description of differences in economic development between the Italian north and south, briefly mentions perinatal mortality gradients between regions, and then goes on to discuss mortality differences by occupation using English data with the Registrar General's classification. At its close, the chapter notes the lower provision of hospital beds in the south of Italy. The paradox that standardised mortality ratios are lower in the south than the north was not mentioned.

Some data on differential use of health services by social groups prior to establishment of the SSN is available through analysis of health insurance fund expenditures, since the funds were divided between different occupational groups. The data include the 8 major funds covering over 80% of the population (INAM, Casse mutue provinciali di Trento e di Bolzano, ENPAS, ENPDED, INADEL, Federazione Nazional delle Casse Mutue dei Coltivatori Diretti, Federazione Nazionale delle Casse Mutue degli Artigiani, Federazione Nazionale delle Casse Mutue dei Commercianti). The data show that, in 1972, employed workers ('lavoratori dipendendenti') used substantially more insurance per capita than self-employed ('lavoratori autonomi', which includes both artisans and small farmers). The differences were greatest in insurance payment for pharmaceuticals (Table 8.9).

Table 8.9 Health insurance fund spending (in lire per capita) for different insured groups by health care sector (Parlamento Italiano 1975: 31).

Sector	Employed	Self-employed
GP	9 409	13 254
pharmaceuticals	1 889	894
hospitals	35 316	25 965
specialists	7 761	5 772
Total	65 740	34 522

Chapter 6 described the information available from a 1980 ISTAT population survey of perceived health. The working population, about 37% of all people in the survey, are divided by ISTAT into four groups. The groups have rather small differences in their self-perception of illhealth, and a more marked gradient for their use of medical care,

especially hospital admission. This suggests that the poor may have worse health than the rich in Italy as well as England, but it also suggests that the Italian health system may provide health care proportionately to need.

The improving trends for stillbirths also suggest a contribution from better health services. The largest improvements have been in the social group 'others' which, in the 1950s had the worst rates of stillbirths and, by the late seventies, were below the national average (Table 8.10):

Table 8.10. Stillbirth rates per 1000 births, 1955-59 and 1975-79 (La Vecchia 1985).

	1955-59	1975-79	Change
Managerial, professional, & clerical	19.5	7.7	-11.8
Independent workers	25.6	10.7	-16.9
Manual and unskilled workers	28.0	9.7	-18.3
Others	31.3	8.8	-22.5
All (crude)	26.2	9.9	-16.3
All (age/standardised)	25.7	10.6	-16.1

Social inequalities in mortality are not provided by the central office of statistics (ISTAT), perhaps because there is no classification of social position similar to the British Registrar General's Social Class ranking. The decennial census provides a potential denominator. In

Piedmont, the Regional Epidemiological Observatory has set up a longitudinal study to overcome this lack (Costa & Demaria 1988), but no results of socio-economic differences have yet been published.

For smoking, the trends of middle class people giving up, that have been a feature of the United States and Britain in the past two decades, are hardly visible in Italian statistics. The highest occupational group, owners and professional people, have the highest rate of smokers and also smoke more heavily. Smoking is far less common in women than in men, but it is rising. Smoking is also commoner in the south of Italy, where average wages are lower, than in the centre or north, possibly associated with growing tobacco in the south. Yet there are contrasts within the south: 67% of men aged 14 or older smoke in Campania, compared with 49% in Sardinia.

Summary. The Health Reform ensured access to comprehensive health care for all residents at both primary and secondary levels. There has been an extension of hospital care in the south, where it was less available, and increase in general practitioners in the north, where they were less frequent. Socio-economic health gradients persist, but, as in all European countries, are substantially determined by factors other than direct health care.

8.4. Acceptability

Despite a protracted public debate about the law, the ordinary person may have seen little change in direct patient services through introduction of the SSN. The benefits are predominantly organisational, and most noticeable to central and regional governments. The SSN did not challenge clinical practice, nor the internal administrative arrangements of the polyclinics or hospitals where patients come into contact with the 'bureaucracy' of health care. General practitioners, previously paid by the Mutue and now by the SSN, continue in much the same way as before. Patients may still have to go to a central office to make an appointment to see a specialist, who often still works in a polyclinic. Waiting lists continue, the quality of service is not visibly altered. Although the practice of medicine was very much seen to be in need of change by supporters of the reform (Berlinguer 1976; Bert 1983), the legislation has more readily changed structures than professional practice.

The USLs were designed to be the main opportunity for involvement of local people in decision-making within the SSN. They have been successful in this to the extent that they are recognised within local political structures. Members of the USL Management Committee were, until changes in 1986, appointed from among the ranks of commune councillors, and not elected directly nor chosen for their expertise in health care. Management Comittee politicians appear to dominate the USL administrators, and may to bypass them in their dealings with the health service staff. This is part of the culture of local government, but has

not been conducive to improving the competence of the administrators or of recruiting better ones. However, the political parties are reluctant to give up the opportunities for clientlism that this system bestows.

A second layer of participation exists through the Regions, but the span of control is too large for regions to monitor USLs closely: there are on average 34 USLs per region, and Lombardy has 79. Cooperation is diminished when there is opposition in the political configuration of the coalitions at USL and regional levels.

From the viewpoint of the 1980s, the reform gave little opportunity for consumerism. Italy does not have a tradition of lay organisations, such as the Community Health Councils in the UK, except in certain identifed fields such as family welfare and the Red Cross. Since 'participation', in the meaning of the SSN reform, has to be chanelled through political parties, it is mainly participation through clientelism. And, since the reform is strongly identified with the Communist Party, constructive improvement has come less often in areas where the Christian Democrat party was in control.

Some information on the public's views of the SSN is available from three surveys. One was undertaken by the commercial Milanese survey company, DOXA, at the request of the Italian private hospitals association AIOP (Associazione Italiana Ospedali Private) (Censis 1986). There were three parts. First, a survey of 1385 adults from the general population, of which 101 had private insurance; second, a survey of 435 people who had been in hospital within the previous two years, which were divided as 225 people in public hospitals and 210 in private

hospitals; and an analysis of data on hospitals gained from the Ministry of Health and from AIOP's own records.

Since the survey was commissioned by bodies sympathetic to private hospitals, the survey company would be likely to pose the questions and present the results with this bias. The actual methods of the study are also poorly described. The study appears to have been drawn from 147 'representative' electoral lists, partly by random allocation and partly by quota samples. There are no details of response rates, how the sample compared demographically with the Italian population, or the characteristics of refusers. Since users of hospital services are strongly skewed to the elderly and infirm, even a random sample would not have been fully representative or their views. Lastly 'private' describes all hospitals not directly managed by the SSN - including University and Specialist hospitals - in the survey, but not in the comparative price data.

The survey asked a general question to assess the respondents' support for a 'mixed' health system: 'If you had to pay from your own pocket for hospital admission for surgery, investigation or [medical] treatment, would you chose a public or private hospital?' This gave almost equal answers (Censis 1976: table 10) for public and private, although a subsample of 101 people who had private insurance were twice as likely to say private than public. Since people do not have to pay from their own pocket for the NHS, except for copayments, this was not so much a question of 'which do you prefer' as 'which would you chose if you wanted to go private'.

Looking to the future, 38% of the sample wanted a solely public system and 60% a mixed system - this latter particularly in the younger, northern middle class groups.

Private hospitals were thought to be better for environmental aspects - cleaner, quieter, more curteous, and with better food and better rapport with medical staff. Public hospitals only scored outright on better equipment (Table 8.11).

Table 8.11. Perception of public and private hospitals: care (Censis 1986)

	public better %	private better %
Experience of doctors	27	17
Overall care	18	35
Nursing/ancilliary care	7	58
rapport	4	60
tidiness and cleanliness	4	62
quiet	4	67
medical equipment	48	18

For the people who had received hospital care, waiting times for admission to private hospitals were no shorter than for public hospitals (Table 8.12).

Table 8.12. Perception of public and private hospitals: waiting times

	public	private
under a week	64%	54%
7-30 days	25%	37%
31+ days	11%	9%

The survey also recorded the preferences of the patient for their place of treatment (Table 8.13): these were affirmative answers (Censis 1986: 78):

Table 8.13. Perception of public and private hospitals: preference of place of treatment (Censis 1986)

	public better %	private better %
only place in the commune	8	6
only place with beds free	8	12
only place with private rooms	2	6
place for specialised care	33	30
particular doctor	62	74
better care	59	53
a comfortable place	40	70

Satisfaction with hospital care was high for both groups, although with a definite lead for private care (Censis 1986: 73). 80% of public and 86% of private were satisfied, 45% of public and 59% of private were very satisfied; 125 of public and 6% of private were dissatisfied. This latter figure could be compared with a similar survey made by DOXA in 1976, when 15% of public and 8% of private were dissatisfied. The details of the 1976 survey are not given, so it is not clear that this is a true change: but it suggests, at least, that the SSN did not bring a worsening of patients' views of public care or a divergence between public and private.

There have also been changes in the reasons for admission of the 10 years, most notably for the private sector a fall in maternity and a rise in surgery (Table 8.14).

There were a number of general questions around self care and use of health services. One asked: 'In the last year, did you consult a doctor paying as a private patient'. The response was 26% yes (Censis 1986: 58).

Table 8.14. Changes in reasons for hospital admission. 1975 and 1985 (Censis 1986)

	public hosps		private hosps	
	1975	1986	1975	1986
Reason	%	%	%	%
treat an illness	27	26	18	23
surgical operation	38	40	42	53
maternity	16	13	30	13
investigation	19	13	10	9

Two further surveys have been reported. The first was undertaken by the regional committee of the Communist party in Emilia Romagna (a region with a Communist majority) in 1982 (Cocchi 1983). 650 000 copies of a questionnaire were distributed to the general public and 50 000 to employees within the USL. The study is based on 90 882 usable replies from the public and 8575 from the USL employees. While the replies overrepresented skilled working men and underrepresented business and professional people, analysis was made within different working groups.

Just under 60% of the public thought there had been an improvement in health care since the reform, 16% thought no change and 10% a worsening. There was a social class difference, with 63% of working classes giving favourable responses and 55% of middle classes being satisfied. Workers within the USLs were less enthusiastic - 45% an improvement, 18% no

change and 31% a worsening. The allegiances here were more split: 70% of manual and auxilliary staff thought that the system was not worse, compared with 51% of administrators and university doctors.

USL employees were also asked their views of the management committees: 53% were negative in general about them, and 80% were negative about the relationship between Committee and workers. The main criticism was the excessive role of the parties in the management. 68% of public respondents wanted more participation in the management of the SSN, but only 17% said they had done so. There was dissatisfaction with their work in 47% of employees, and up to 59% for part-time doctors. The main requests were for more opportunities for training and better organisation of their work. Only the full time doctors gave less emphasis to these factors than to raising their incomes.

The other study was organised through 552 CGIL-CISL-UIL union staff (including 33% who were pensioned) throughout the country (Conclave and Stanzani 1983). The study showed systematic regional gradients from north west, through the north east and centre, to the south and islands. One positive point for the south was that 30% of doctors there were thought to listen to their patients more than they used to, compared with 15% in the north west. But 79% of people in the north west found their doctor's domiciliary visits satisfactory compared with 66% in the south, and the guardia medica was regarded efficient by 67% in the north west, dropping to 31% in the south. A majority of respondents (57% in the north west, 78% in the south) were dissatisfied with the staff of their USL, but this dissatisfaction was much more marked in the large (urban) USLs than in the smaller (rural) ones. The USL polyclinics and

laboratories were thought to be worse since the reform by 38% in the north west and 56% in the south. Similarly, 39% in the north west and 55% in the south thought that the bureaucratic procedures had got worse. 56% of these (union) respondents said they sometimes used private care, most commonly a specialist but also a private GP or laboratory.

Managers

There has also been a survey of managers' views of the SSN in Lombardy (Invernizzi 1986). The study describes 159 replies from presidents and vice-presidents, medical coordinators, and administrative coordinators of the 79 USLs who were sent a postal questionnaire.

There was assent, and agreement between the groups, on the general role of the SSN to integrate prevention, treatment and rehabilitation, and to integrate better the levels of care of the service. There was broad agreement on the benefit of districts, although the politicians were more favourable than the officials. The politicians and administrators were more in favour of the need to improve efficiency than the doctors. No group found the SSN greatly improved since the reform , although politicians were most positive, administrators next and doctors least positive. One third of both doctors and administrators indicated that the health service was less efficient since the reform. Two thirds of doctors said that quality of health services were moderately improved since the law, one third said that it was worse. However, a majority of both doctors and administrators were against the present mechanisms of representing collective concerns through political means.

Summary: Participation has not been easy to achieve in the reformed SSN. Its surrogate, political control of the USLs, appears disliked inside the service because of interference and poor decision making, and outside because of the politicisation of what many people regard as a politically 'neutral' issue - provision of health care. The few consumer surveys available ae likely to be biased by their sponsors and samples, but there is the suggestion that working class people perceive greater benefits than the middle classes. A mix of public and private health care seems to be widely supported.

8.5. The mental health reform

The mental health reform was a separate strand of the health reform of the 1970s, and was achieved through separate legislation. There have been many reports, both Italian and internationally, about the Italian mental health reform (De Girolamo & Tumminello reviewed 160 papers in the international literature up to 1986).

Some of the initial judgement of the benefit, or defects, of the new services was observational. Based on two visits of a few weeks, Jones wrote several critical articles on the existing pattern of care and concluded that there was "nothing to learn" from in Italy (Jones and Poletti 1985, 1986). Boswell (1986), from a single visit of two weeks supported by prior reading of the existing literature, provided a deeper assessment which emphasises the variety in implementation of the law and the range of experience to learn from. Ramon's extensive observations on the psychiatric reform were synthesised in a multi-author volume on mental health care in the European Community (Ramon 1985), and extended in a British-Italian comparative account (Ramon 1988). Ramon concluded that 'the overall impact of the reform seems to be positive in that living conditions have improved materially and socially, avenues for new and more enriching opportunities have been opened up, and more clients are treated with respect' (Ramon 1985: 189). However, she recognised remaining problems, especially the difference in implementation between the north and south, and the lack of adequate rehabilitation for patients and family support in many areas.

A psychiatric case register was established in Verona, covering a population of 75 000, in 1978. It has been possible to evaluate the services in this USL since the reform (Balestrieri et al 1987). A comparison of existing long-stay hospital patients with patients receiving long-term community care (defined as psychiatric service contact without a break of more than 90 days) showed decreasing long-stay patients and a U-shaped curve for community care - that is, a fall in the early 1980s with a rise in the mid 1980s. The long-term community care patients did have, on average 40 days of acute (psychiatric ward) hospital care, so these patients were certainly severely ill. The authors suggest that the study shows the ability of new services to care for chronic patients with new patterns of care.

Another study contributes to evaluating the outcome of the reform (Contartese et al 1983). The psychiatrists in a health district in the suburbs surrounding Milan identified 400 patients seen in the two years preceding the new law, and recorded how many were still in contact with, or known to, the psychiatric services four years later. Two fifths of the patients were still in contact, but these were not equally distributed according to diagnosis. Four out of five schizophrenics were still in contact, but only half of those with neurotic diagnoses and one third of people with alcoholism were. This study does not support the view that the new psychiatric services have deliberately discharged large numbers of highly dependent people.

Crepet (1990) reviewed the quantitative studies that are available to evaluate the reform. The trends in hospital beds show continuing falls in both the public and private sectors. A decrease in private sector

beds suggests that there has not been a major shift from public to private hospitalisation. Nevertheless, in 1987 there were an average of 14 private mental hospital beds per 100 000 in the north and central regions compared with an average of 57 in the south (Crepet 1990: 27). There is also an 'asylum residue' of 25 000 patients, some of who have physical or social handicaps, brain damage, or dementia, or are simply aged chronic mental patients. Crepet suggests that the attrition of services has left a 'quality of care provided by the psychiatric hospitals ... even worse than that ... which existed before the reform' (Crepet 1990: 29).

A British psychiatrist asserted that there were many more homeless people around the main railway stations after the reform (Benaim 1983), but provided no data to substantiate this view. It is not known whether these people either came from a mental hospital or would wish to return there. His suggestion that there has been a transfer of patients from mental hospitals to prisons is refuted by Crepet (1990: 34) who indicates a fall of 36% in the number of inpatients in forensic hospitals between 1970 and 1985.

Suicide rates have increased since 1978, although from a level (around 6 per 100 000 population in 1983) which is low in comparison with most other developed countries (Biggeri, Stefanini and Ferrera 1989). Investigating this, Williams et al (1986) showed that falling mental hospital bed provision antedated the rise in suicides, and that there was no relationship, region by region, between loss of rising suicide rates and loss of mental hospital beds or provision of community

services. However, a significant (negative) relationship was seen between regional suicide rates and provision of hospital beds in general hospitals - that is, lack of acute hospital beds was associated with increases in suicide. This finding may be explained by the known relationship of suicide to severe depression and the requirement of Law 180/78 for compulsory admissions to be to general hospitals.

Nevertheless, the proportion of compulsory admissions fell after the Law from 39% to 18% (the latter figure is estimated on data from fifteen regions, CSN 1983). Compulsory admissions fell in the north and central regions, but appeared to remain steady in the south - Table 8.15.

Table 8.15. Compulsory admissions to mental hospitals, 1977-81 by broad region

	1977		1981	
	% of total admissions	rates/ 100 000	% of total admissions	rates/ 100 000
North	37	71	15	35
Central	32	38	12	21
South	48	50	45	52
Total	39	57	18	36

A detailed study of services in Lombardy, the largest region with a population of 8 million, showed that the number of psychiatrists increased over the four years 1978-81, but - worryingly - psychiatric nurses had declined by 11% (Morosini et al 1985). By 1981 still 70% of these nurses were working in psychiatric hospitals. A review of the general hospital discharge system, active in Lombardy since 1976, showed

that discharge of patients under the care of psychiatrists rose sharply from 1978 onwards in patients with diagnoses of schizophrenia and affective psychoses. Patients with diagnoses of neuroses were mainly discharged from general medical wards by the end of the period, having seen a substantial fall in discharges from neurology wards.

The Comitato Nazionale di Ricerca (CNR) supported early research on the reform, which resulted in mainly descriptive accounts of the changes in the pattern of services (Zerbetto 1985). Further projects (eg, Muscettola et al 1987) were more analytic, seeking to show the effects on patients. Bollini et al (1988) compared the characteristics of patients admitted to hospital acute wards with those currently in mental hospitals and attending community care facilities. The study services were mainly in the south of the country. Patients of lower educational level, unmarried, having a more severe diagnosis, longer psychiatric diagnosis and poorer prognosis, were more likely to receive mental institutional treatment than other patients, and were more commonly present in southern services (whether institutional or community) than north/central.

Relatively few of the hospitalised patients had been seen previously by the community services, and they were likely to have been in hospital before (Muscettola et al 1987). There may be two independent levels of care operating in these services, community care and hospital admission respectively, without the full range of provision being used for each patient. This could reflect different styles of care: psychiatrists in the better developed community services may rarely use hospital

admission for their patients, whereas psychiatrists with a medical model of treatment use hospital admission more frequently.

Boswell (1986: 41) supports this broad interpretation of the results of the mental health law reform. He suggests that, while parts of Italy show 'institutional decay and neglect of discharged patients', there are two positive lines of development. One approach 'starts from the work of multidisciplinary teams, on-call, with an emphasis on domiciliary visiting and a range of activities and services for different sorts of clients'. The other is more central, with professional care in mental health centres, less domiciliary contact and more use of acute hospital beds. He comments that domiciliary staff time in the former services, and hospital staff time in the latter, both relieve the acute situation and may appear equally beneficial. But, as Ramon says (Ramon 1985: 199) 'people who live in the south...judge the reform by its local results'.

Summary. The mental health reform was needed because - as in countries across the world - new ways of treatment have developed for mentally ill patients: voluntary rather than compulsory care; outpatient and home care rather than inpatient care; therapeutic communities as well as drug treatment. However, the reform sought to make these happen by law rather than by setting a facilitating environment. Reforms - reduction of inpatient stays, treatment in local centres, multidisciplinary care - developed where there was local leadership, but not in places where the local psychiatrists, or the commune, were against such changes. The law has been widely admired outside Italy, but it has not achieved a comprehensive reform. Full implementation will only occur when all regions give it unequivocal political and financial support.

CHAPTER NINE: HOPES FULFILLED?

9.1 Evaluation from a UK perspective.

Evaluation of the health reform has suggested substantial improvements in the health system during the 1970s and 1980s: the service covers the whole population, is free or at low cost at the time of use, financed from standard social insurance rates and taxes, and accountable to local political bodies.

Yet views of the system in Italy are ambivalent, as is shown by quotations from two general descriptions of Italian affairs by English-speaking authors:

* "And who would not despair over the national health service? As reorganised in 1979, it was well planned in theory but from the start became embroiled in political patronage at every level, damaging its reputation and effectiveness. After the reform, just as much as before, if the average patient was to receive proper meals and nursing care, his family had virtually to move into the hospital with him to provide it." (Spotts & Wieser 1986: 134)

* "The sentiments behind both the reformed hospital system and the Law 180 are admirable. But as there is neither the structure nor the finance to support either of them, they have produced a crisis which is damaging not to the rich or the powerful but to the families who have been asked to bear the burden of relatives who are mentally ill, and to the patients and medical staff who, above all, they are designed to

help." (Haycraft 1985: 248-9)

What broader factors influence these perceptions of Italy?

An anti-State culture

Whereas Italians have looked towards Britain for a model to develop a national health service, the British view of Italy seems clouded by history. Byron and Keats, travelling through Italy to recapture the spirit of antiquity and the Renaissance, were dismayed to find many of the archeological treasures decaying and unprotected. During the last war, after the northern centres of tourism had become well developed, British forces landing in southern Italy again found poverty and disease in societies that were still predominantly peasant and feudal. There is a view of northern Europeans that Italy is a land of incompetence and corruption, relieved only by a treasure-house of great art and an enviable climate.

This caricature is fed by the Italian tradition for self-deprecation. Although their school history is strongly nationalistic, Italians are the first to point out the deficiences of their politicians and public services. 'Non funziona' is a ready phrase, for the trains when on strike, for the interminable processes of the courts, and sometimes also for the Servizio Sanitario Nazionale. It is the stock view, it lessens frustration and it may, indeed, have a grain of truth. But the foreigner must guard against listening to that alone.

The Italian view that public services are inefficient and inferior has deep roots. Northern Italians recall the old liberal values of individual freedom and minimal state powers, while southerners recall

centuries of repressive colonialism. The fascist period, when many activites were brought under public control, is remembered by all. In contrast to the surge of post-war nationalisation in Britain, the spirit of Italy after the war was to deregulate, to limit the power of the central bureaucracy, to encourage individuality. Neither the Christian Democrats nor the Communists wanted more state control along fascist lines.

These attitudes persist. A cross-national survey in the early 1970s, using multistage probability samples, asked adults 16+ in eight countries their attitudes towards public services (Pescosolido et al 1985). Asked about the government's performance in medical care, Italians were the least enthusiastic (Table 9.1).

Table 9.1. Public evaluations of government performance in medical care (Pescosolido 1985: 282).

	Evaluations (row %)			
Country	very good	good	bad	very bad
US	9.3	51.9	29.1	9.7
Italy	3.8	34.6	39.0	22.6
Finland	8.2	62.8	25.3	3.8
FDR	17.4	63.2	16.6	2.8
GB	27.2	58.1	12.2	2.5
Austria	28.4	50.5	19.3	1.7
Netherlands	15.7	68.2	14.5	1.6
Switzerland	11.8	60.1	24.5	3.5

Support for public services was greater from disadvantaged than middle class people, and from older than younger. There was also more positive

evaluation in Italy (and the United States) from supporters of conservative parties (DC, Republicans) than left parties. Respondents giving negative evaluation of medical care did so also for other areas of government performance - in other words, the survey represented attitudes to government welfare provision in general.

Yet Italy has followed the pattern of other western European countries in the past three decades towards welfare provision. Public ownership increased, through state-owned 'agencies' and 'independent' companies with majority public holdings which offer possibilities for delivering favours as jobs and contracts. The prewar public sector agencies, such as the Tobacco Monopoly, were not denationalised. The 1970s saw the expansion of regional governments. Although there has been some divestment of public sector ownership in the 1980s, the public sector still accounts for half of the Italian economy.

Pressure to nationalise health care came for both economic and for political reasons. The expansion of hospitals in the late 1960s fuelled the rising expectations of doctors and the public for more, and more sophisticated, medical care. The Mutue had chronic debts that had to be supported from public funds. At the same time, the new regions provided an opportunity for the redistribution of power. Transfer of the hospital funds to the Regions in 1975 relieved the Mutue of their most difficult expenditures, while continuing to protect the independence of the general practitioners. The eventual creation of a full NHS depended on the unusual political balance of the late 1970s.

But as people working in the British NHS, who have seen four reorganisations since 1974, well know, there are conflicts within the very nature of health care that cannot be resolved by changes of structure. These include the limits of resources and the ever-widening expectations of medicine; the changing social relationship between doctors and patients; and the conflict between continuity of care and the doctor's need for free time. It is not surprising that, after a honeymoon period with the new SSN, grumbles about health care started again: and, as is the nature of Italian politics, were magnified by the political parties.

Politics

A major difference between northern and southern European societies is the relation between politics and administration. The northern European social democracies have developed a clear distinction between the development of policies and their implementation. In southern European countries politicians appear to have more direct involvement in the affairs of individuals as well as setting broad strategies. There is no differentiation in Italian between the words 'policies' and 'politics'.

The northerners who came to Rome to run the country in 1870 introduced a central structure, rather than the federal one that other countries with similar regional differences, such as the United States and Germany, found workable (Clark 1984). But there were practical obstacles to communication, such as the difficult terrain and the variety of dialects. Local government, by the communes, was subject to the control of the Prefect, a State appointee.

Italy lacks a tradition of 'Oxbridge', or an Ecole Nationale, to provide a source of graduates for the senior civil servants. Under the fascists, the central bureaucracy grew, and ministries recruited southerners of lower social standing and less wordly experience than their political masters. By the 1960s more than three quarters of civil servants were from the south, often graduates from the overcrowded law faculties. This education has perpetuated a legalistic rather than a managerial view of government. Effectiveness is also limited by the strict rules of hierachical promotion, and the lack of career movement of officials between the different ministries, let alone with the private sector (Slater 1984).

The contrast between politicians and administration is well seen in the USLs. Management Committee members are selected by the parties of the ruling coalition. Committees meet weekly. Although the members may have very little technical experience of health services, each takes close responsibility for a sector of the service, and is available for direct intervention between the SSN employees (especially doctors) and the Committee. Each USL has two managers, one 'technical' (usually a doctor) and one an administrator. Both appointments are influenced by political considerations. Below these, there is an office. But members of the Management Committee bypass this office, leaving it to simple coordinative tasks, rather than developing a dynamic 'head office' in control of the USL's policy and budget.

Political intervention is also seen nationally. The Servizio Sanitario Nazionale law required the Government to set out a triennial national

health plan (formally, in coordination with other elements of a national plan, but the other parts have never been presented). Parliament debated the plan, in committees (where minority parties can join in formulating new laws) and, eventually, in full session. Because the plan was presented by an individual Minister, and had to be approved by Parliament like any other law, it was open to political confrontation. In practice, three national plans were presented by three successive Ministers of Health, and not one was passed by Parliament before the coalition cabinet fell. The notion that the plan could be drawn up by civil servants in the light of the Minister's wishes and implemented down the line of the SSN by administrators without recourse to Parliament is both unconstitutional and also a foreign idea. Yet this is a country where one party, the Christian Democrats, has held office in coalitions continuously for over forty years.

Although the USL is where the action in the SSN is played out, probably the greatest single locus of power is the region. The SSN budget is over half of the total for each region, and while they do not spend it directly, they have substantial powers for planning and direction - if they wish to use them. It was the creation of the regions that was the spur to the SSN: paradoxically, it is also regions that now hold the SSN back. The great variations in quality and provision of service are not due so much to resources (which are redistributed from north and centre to south) but to their use. The lack of implementation of community mental health services in the south, for example, is for lack of political will. A more centrally controlled service might, in theory, achieve more; but might also achieve less.

Legislation

Health service legislation sets the framework for medical care. Most developed countries have recognised access to good medical care as a right for all citizens, although the structure of financing and services varies between countries. The historic pattern has been a move from independent funding to state-regulation and support, and from individualised care through to cooperative provision. States have born an increasing responsibility for funding because they can redistribute the resources available within a society to those who need them. Other agencies, such as insurance companies or employees, are open to problems of selecting in the fitter members, leaving the more sick disenfranchised or only covered by 'residual' state insurance.

Italy's postwar constitution is weak: proportional representation has led to coalition governments that are internally divided, making decisions by the lowest common denominator. Also, it is over-legalistic, with some administrative business (for example, the National Health Plan) needing formally to be passed by government. This holds up executive action, and encourages people to bypass the official systems. On the other hand, the state has taken an increasing part in the economy and in providing public services. Private is still regarded as better than public in principle by many, but increasing numbers of people depend on public funds.

The eighteen months in 1977-78 when the Christian Democrats governed only with the support of the Communists - who abstained or voted with the Christian Democrats, although they were never formally admitted into

the cabinet - saw several important social reforms: the extended abortion law, the mental health reform and the new national health service law.

Some laws were passed because they regularised what was already happening. This was certainly true for the divorce law of 1970, and in a way for the abortion law: abortion was undoubtedly practised in Italy, or in neighbouring countries for Italians, before the law made it legal. However, the law eliminated a financial barrier, and the ambivalent position of the doctors.

The mental health law was no more contentious at the time it was passed, but has proved more difficult to implement. This is mainly because the main beneficiaries of the legislation - people with severe mental illnesses - are not articulate and voters do not identify with them. The media, and some politicians and professionals, are able to imply that mentally ill people would really be better off back in 'safe' institutions, rather than in daily society. Further, the law was idealistic, proposing a service for the future rather than the period of transition. It has been resisted by local governments that do not want change. Five years after the mental health reform 180/78 eleven proposals for change had been placed before parliament, from all the major parties (Polizzi 1985). But, as Jones and Poletti (1986) commented: 'this time there is no pressure group, no public campaign, and no threat of a referendum'.

Structures

Just as the SSN reform did not directly challenge the clinical practice of doctors, criticism of the reform has focused on managerial issues (Freddi 1984, Mapelli 1987, France 1989), especially the functioning of the USLs. Issues include the competence of USL administrators; competition between the two senior officials - the administrator and the doctor (and, where present, also the director of social services); and the way Management Committee politicians appear to bypass the the officals and deal directly with health service staff. This legacy of clientelism is not conducive to improving the competance of present administrators or recruiting better ones.

Reform to give more power to the non-political administrators, and to limit the role of the Management Committee, was proposed in the first years of the SSN (Freddi 1984), and became the policy of the socialists in the mid 1980s. Neither the Communists nor the Christian Democrats wanted to give up the opportunities for political favours that the present system allows, but introducing 'managers' from the world of commercial business onto the management committees would be more favourable to Christian Democrat interests than to the Communists.

Regulation of public services in Italy is limited by the Napoleonic administrative systems using downwards control rather than self audit. There are about 22 000 administrators within USLs (averaging 30 per USL) and around 2000 financial auditors (Mapelli 1987: 182). Beyond these, at least five more agencies review the actions of the USLs - the regional control committee, the regional inspectorate, the court of

accounts, the State Advisory-general and the standards control nucleus. Central government has tried to control the health sector through legislation, but the effectiveness of these laws is doubtful. In 1985, the rise in 'temporary' staff to 80 000 (out of more than 600 000 in the whole SSN) led to revised legislation (207/85) for recruitment of staff (Greco 1986: 48). A law of 1984 required the closure of departments with less than 50% occupancy, but there appears to have been little action. Copayments in 1982 (for drugs) and 1983 (for investigations) did not lead to sustained control of demand (Mapelli 1987: 191).

Reviewing these managerial problems, Mapelli, an economist, suggested four possible lines of action:

- to change USLs from direct bodies of the communes into 'aziende speciali', a structural change that could lead to a change in administrative mentality from bureaucratic control to one of initiative and results;

- to finance USLs for agreed levels of services at average levels of costs. This could encourage inefficient USLs to improve to target levels and let the more efficient have freedom to use their resources in other ways;

- to create incentives for personnel within the public service;

- to train managers to be concerned to satisfy customer's wishes.

The tiered SSN structure of Ministry - Region - USL chosen for the SSN was rational. It allows regional referral centres to be built up, necessary for services which need specialised staff and equipment.

The USLs themselves are an opportunity for local involvement. They are responsible for the whole range of health (and in some regions social) services, as well as veterinary and occupational health. This range is wider than in the British NHS. The USLs also have competence across hospital and community care, with defined populations, to relate their services to and to organise preventive services for. Again, this is a better structure than the British NHS, where historically the family practitioner committees were independent of the district health authorities.

The unified management of local health services by the USLs offers possibilities for better integration. The USL has three levels of medical care - GP, specialist referral and hospital admission. The arrangements for hospital consultants to provide outpatient sessions within the hospital (for extra payment) should lead to a reduction in contracted private specialist referral, especially for laboratory and diagnostic services, and build up the hospitals own facilities. But rational assessment of the delivery of care could also lead to a reduction of hospitalisation and expansion of primary and domiciliary care.

Some USLs are too small. There may be up to 70 USLs within a region, far too large a span of control for adequate monitoring. At the same time, one in five USLs do not have a general hospital, and a major building programme would be needed to 'rationalise' the present cross-boundary flows, which would be costly in capital and ultimately in

revenue for staff. Nor, indeed, would it be appropriate: the hospitals in small USLs would not be large enough to support a full range of emergency services, and therefore inefficient. Although the USLs were created along convenient political boundaries, a smaller number are needed. This could probably happen by amalgamation, but will certainly test the strength of regional governments in the first country in Europe to develop 'city states' (Whaley 1988)

Comparison with the NHS

A journalistic cross national comparison (Payer 1988) has contrasted clinical practice in four countries (United States, Britain, France and West Germany) according to characterised cultural patterns - aggressive therapy for the Americans, economy for the British, 'le terrain' for the French and 'herzinsufficienz' for the Germans. Italy's Latin roots are more similar to France than to anglo-saxon countries, and the history of Napoleonic and Bourbon rule, together with national unity built from the Piemontese Kingdom, increases the link with France. Yet, in Canada, the French speaking province of Quebec had a health service reform similar to Britain whereas the English speaking province of Ontario did not. So, Italy chose to create a health service structure more similar to Britain than to France.

The SSN has many differences in detail from the British NHS, but is derived in many aspects from the British model. In the late 1960s and early 1970s the NHS was the subject of two green (consultative) papers and a (definitive) white paper. To caricature, perhaps, the differences

between the two countries, the Italian service combines Napoleonic legalism with Mediterranean relaxedness, whereas the British service reflects Beveridge wartime uniformity linked to northern European empiricism.

At a national level, the Department of Health has had a far greater influence on the NHS than the Ministry of Health on the SSN. This is partly a matter of history: the Department of Health was established in 1921 and during the interwar period the Chief Medical Officer was a vocal proponent of local authority public health services. Before the NHS in 1948, systematic information on hospitals was collected, and a structure of regions was created based on the location of medical schools rather than any natural political boundaries. In contrast, the Ministry of Health was established only in 1958, while responsibilites for health services were distributed between other Ministries including the Ministry of Interior, the Ministry of Employment and the Treasury. The health service structure was based upon strong political control of regions.

At the local level, the British 1974 NHS reform created districts that brought together one or more hospitals to serve a defined population. This 'territorial' structure was perhaps the key reform in both Britain and Italy. It established a population for which to define needs and evaluate the effectiveness of care. In Britain the specialty of 'public health' was transformed into 'community medicine' and these 'administrative doctors' were drawn into management with the hospital consultants within the new service. The SSN also created single

territorial units serving a defined population, although smaller than the NHS and with districts at a lower level. The SSN could have achieved more integration, through unified responsibility for primary and secondary care, occupational health and even veterinary health, but in practice there is not much evidence that the integration is greater than in the NHS.

While the two services have similar levels of funding, around 6% of public expenditure within similar GDPs, there are differences in practical resources available. The Italian SSN has fewer nurses and administrators and more doctors than the NHS. Without information from direct comparative studies being available, the Italian service appears open to the criticism of poorer quality of nursing care. There is more high technology equipment in Italy: for example, in 1979 there were 70 whole body scanners compared with 18 in Britain (France 1986: 31). On the whole, hospital facilities are similar, with a range of old and new hospitals, reflecting policies of upgrading within existing buildings as well as new construction.

Italy also followed Britain in developing a national resource allocation formula. However, the Italian formula substantially maintained existing spending patterns, and political pressures leading to annual changes in composition of the formula each year in the early 1980s further devalued its effectiveness. Thus, in contrast to RAWP in Britain, the Italian formula has not resolved the substantial inequalities in provision and standards between the north and south of the country.

Planning, believed in both countries to be a vital step towards rational

provision of services, has been more effective at regional than national or local levels. The British Department of Health attempted indicative planning in the 1970s using standards of provision, but these rapidly fell when the resource consequences were recognised. In the 1980s the Department of Health has not published an overall plan, but Ministers have indicated priorities through Parliamentary statements, and the Department and regions have developed a variety of methods (short term plans, performance indicators, annual reviews) to regulate districts better. Nevertheless, the fundamental tension in Britain has been between innovation and service development in inner city (especially London) teaching hospitals compared with the rapidly diminishing population base to ensure per capita finance for these hospitals. The result has been to propose a different system of 'money following patients' in the internal market.

In Italy, national planning was encumbered with political constraints, while regions were freer to implement change. The national hospital information system has improved, and the Ministry of Health and regions at the end of the 1980s was better able to identify inefficient provision than ten years earlier. Planning has been directed more through financing new services, especially the 'progetti obbietivi', than through major redistribution. The amalgamation of USLs into fewer larger units, proposed by the goverment in 1989, would offer an opportunity for rationalisation of hospital services.

9.2 Further reform?

The mid 1980s were a relatively stable period in Italian political life. A centre-left coalition was forged between the left wing of the Christian Democrats and the rejuvenated Socialist Party. From 1985-87, Bettino Craxi, the Socialist leader, held the post of Prime Minister for one of the longest periods in Italian postwar history. The Minister of Health in Craxi's administratration, and also in the subsequent Christian Democrat led coalition, was Donat Cattin, a senior Christian Democrat party leader from Turin. He had a political position towards the left of his party, but had been in partial eclipse (his son had been convicted of being a 'brigate rosse' terrorist). Donat Cattin was a much more signficant political force than previous Ministers, and appeared concerned to use his Ministry to return to the political front stage. His age, it was said, gave him extra strength: he worried less about opposition than younger Ministers might.

The government passed a 'mini-reform' in 1985. This introduced direct selection of the members of USL committees by communes, rather than through the cumbersome and rarely meeting Assemblies. It also cut the number of Management Committee members from 7-14 down to 5-7, and required higher standards of relevant experience for their appointment. These changes were promoted by the government as improving efficiency, and criticised by the opposition as reducing democratic participation. Within the SSN professional staff broadly welcomed the changes. Management Committees were able to make decisions more effectively, while the influence of members in day to day business was reduced.

Continued criticism of health care, however, spurred Donat Cattin towards more reform. A number of proposals were made in discussion, and in proposal laws (the Italian equivalent of a White Paper). These received little priority, perhaps because full debate would be likely to raise protests from the unions and the Communist Party. But Amato, Minister of the Treasury, and the most senior member of the Socialist party within the Council of Ministers (cabinet), was under pressure to control the government's rapidly worsening budgetary deficit. This gave Donat Cattin the opportunity he needed, early in 1989, for a political deal. The Council of Ministers agreed a Decree Law (23/3/89) which sought both to decrease the direct costs (to the state) of the health service and, at the same time, to propose structural reforms.

The main aspects of the decree law were:

1. To increase Ministry of Health control over the health budget by creating a Commission to decide on distribution of the health fund. The Commission included 7 representatives of regions, two members from the Ministry of Health, two from the Treasury and one from the Ministry of Budget and Economic Planning.

2. To increase the size of USLs to 200-400 000 population, making them more directly responsible to regions. The USL would be managed by a director general, with an advisory council, President and government auditors.

3. Specialised hospitals, and those with more than 500 beds, would be taken out of the USL system and given independent management under a

medical director (estimated in the Law text to be 120 hospitals).

4. University hospitals would be allowed to have private beds, and all public hospitals would allow up to 10% of beds to be for private practice and 'adequate' space in the outpatient clinics. On the other hand, regions would not be allowed to take on new contracts with private hospitals.

5. There would be greater control over training of paramedical and technical staff.

6. Copayment charges ('tickets') would be increased on laboratory and radiological investigations, and phamarceuticals (to 30% of the actual cost); and there would be a daily charge to the patient for hospital admissions of 10 thousand lire (about five pounds sterling) in public hospitals and 15 thousand lire in private contractual hospitals.

The decree law tried to meet several existing criticisms of the SSN. Regional participation in distribution of the budget was hoped to improve control and to limit overspending. The USL and hospital reforms were aimed at greater 'efficiency': the concept of general managers had been widely discussed since the British ('Griffiths') NHS reform in 1985. Decisions to loosen controls over private practice within public hospitals, yet limiting private contractual services, are evidently economic. Private practice within SSN hospitals would reduce demands on public services and balance the control of expenditure on private contractual facilities.

These proposals were substantial alterations to the character of the

Italian SSN, but the proposal that brought most public comment, and political fire, was the placing of daily charges on inpatient hospital care. Indeed, at a time (April 1989) when the political balance in Italy was moving towards a reshuffle within the Christian Democrats, the direct charges brought an opportunity for open conflict. The government resigned in May, and Giulio Andreotti took over as Prime Minister, appointing a Liberal, De Lorenzo, as Minister of Health.

De Lorenzo's proposals to Parliament in 1990 (DDL 4227) are as radical as those of Donat Cattin, but take a structural and managerial approach rather than financial. A major theme is to reduce political intervention and increase managerial control. The national health fund (FSN) will be devolved into regional budgets by criteria decided by the Consiglio Sanitario Nazionale: a manoevre intended to allow greater central control of how money is spent. USLs themselves will be taken out of direct control of the communes, and constituted as independent agencies. This will reduce local political influence, and perhaps also patronage. There will be fewer, but larger, USLs, and each will be guided by a board of 5-9 people, directly appointed by the region, with an executive general manager. Larger hospitals will become independent of the USL structure. Substantially more attention will be given to education and training for management.

A European dimension

Its 30th anniversary, in 1987, set a new momentum for integration of the European Community. A timetable for a 'single European market' by 1993

was set. The direct implications for health care are limited, since the Single Europe Act is concerned with goods not services. Of the 340 measures identified by the European Commission in setting up the single market, 13 concern pharmaceuticals and one each relate to free circulation of professionals, medical goods and commercial medical insurance (Roberts 1990).

One set of implications arises for patients seeking care outside their own country. Arrangements already exist for reimbursement between countries for emergency care, and for non-emergency care if this has been agreed beforehand by the paying country. This is most relevant in border areas, for example, in the Benelux countries, and in Italy in the German speaking province of Bolzano, and the French borderland in the north west. (An account of Italian patients seeking care abroad is provided by Guerrieri (1987), who describes 33 children brought to Paris for nephrological consultation. He divides the families' 'social condition' into three levels, 'comfortable' (6 children), 'middle' (15 children) and 'modest' (12 children), and indicates that the richer families were more likely to make the journey though their own choice, or that of a friend, whereas the poorest were all referred sent by a doctor in Italy.)

Deregulation of health insurance markets will have less effect in Italy than in other countries (for example, Netherlands), since only a small proportion of health care is paid through private, commercial insurance. In border areas it will allow doctors to receive reimbursement from a single insurer in two (or more) countries, facilitating cross-border

care. But countries with publicly controlled insurance, or national health funds will not be affected by these regulations.

However, more relevant is whether, after 1992, patients will be able to claim discrimination if medical services available in another country are not available in their own. To some extent this is already acknowledged in Italy, since some patients are reimbursed for care provided outside Italy where it has been demonstrated that equivalent care is not available locally. (In practice, this 'demonstration' is full of value judgements and political issues.) As travel and employment mobility increase, governments may come under increasing pressure both from the public and from health care providers to yield to greater flexibility in regulations. Pressure is most likely to come in high cost areas, such as high technology imaging and unusual forms of surgery, which could lead to distortion of locally agreed priorities. Italy already has a substantial flow of patients between regions, and not all for care unavailable locally: it is probable that international exchange will be accepted in the same way.

A way forward?

This study has followed the development of health services within a single European country. The regional differences within Italy are probably smaller than between Italy and other countries. The cultural and political characteristics of Italy have been taken into consideration in understanding the system and developments described. Among these are the influence of coalition politics dominated by the Christian Democrat party at national level; the mistrust of public

services; and a willingness to look outside Italy to learn from other countries.

Ten years after the start, the Servizio Sanitario Nazionale has broadly the same structure as originally envisaged, but a rather different way of functioning. On the side of financing, insurance is controlled by the State and, while not integrated with other public funds, it is regulated to maintain an acceptable balance of private and employer contibutions with subsidy from public taxes. While the government has sought ways of increasing direct contributions for services through copayments, these have not been a major disincentive to seeking care, and there have not been the major annual crises of funding that were common in the 1960s and early 1970s.

On the side of provision, the SSN has also managed to improve the distribution of services while maintaining the historic balance of private and public provision through contractual arrangements. Consumer surveys indicate that private contractual hospitals are perceived to have better 'hotel' services, but not better clinical standards. Private hospitals are only 13% of total hospital provision at present, and include major non-profit specialised and teaching institutions as well as smaller hospitals with a predominant interest in profitable private surgery. Perhaps the main area of concern is the expansion of private investigation clinics subsidising new equipment from contractual fees, as a result of slow capital funding in the public and University sector, leading to conflicts of interests and eventual over provision.

It is not in structure that change is needed: it is in skills. Public services, and especially the health service, need more professional management, which will require greater investment in training programmes, more inter-professional cooperation, more understanding of competing priorities (Bonodonio & Scacciati 1990). Doctors need to improve the links between hospitals and primary care and to increase their competence in communication with patients and in prevention. This would be possible through limited entry to medical school, allowing students more exposure to clinical teaching, and improved postgraduate training. Nursing needs to expand in numbers as doctors diminish, and to receive greater social recognition.

It is likely that a 'centrist' government, dominated by the Christian Democrats and Socialists in coalition, will be evolutionary rather than revolutionary in its policies for health care in Italy in the 1990s, seeking to improve managerial efficiency without much upsetting the power of the doctors. Indeed, the health service is not now especially visible on the political agenda. The conflict between public and private provision (if not financing) of health care may continue to be an issue. The main difficulties include geographical and social inequalities, lack of efficient managerial control and varying political views of how the system should develop. But in these Italy is little different from other European countries.

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