Prologue: Throughout the western world, the medical care demands of people have demonstrated a relentless capacity to outstrip the resources available to pay for those demands. As a consequence, these nations, regardless of their systems of governance, have taken steps to moderate the demand. Author Lawrence Brown, a political scientist who is on the faculty of the University of Michigan, has turned his insightful eye on the Italian health system. Brown, a former senior fellow at The Brookings Institution, demonstrated his capacity for analysis in a 1983 book entitled, Politics and Health Care Organization: HMOs as Federal Policy. In this essay, Brown concedes that health reform Italian-style is not likely to come fully into fashion elsewhere, but the interplay its government has engaged in can provide useful lessons for other countries. Take the dynamic, for example, which pits the central government against the interests of localities on the matter of reductions in service. The costs of the health service are borne largely by the central government’s funds, but cuts in service are very visible in local areas. As a consequence, local hospital personnel, politicians, and residents all close ranks to oppose cuts; this phenomenon occurs often in the United Kingdom as well, but there the central government commands more authority. The timing of reform, regardless of country or political system, is important, too. The British Health Service was created, as Brown states it, at “the high tide of support for central planning.” Italy’s new system, on the other hand, was developed during a period when its central government was thought to be suffering from overload. Thus, it reflects decentralization and devolution.
In the last ten years, most Western welfare states have tried to curb sharply rising health care costs. Strategies include budget cuts in Britain’s National Health Service, a law establishing a negotiated ceiling on annual increases in the costs of ambulatory physicians’ services and prescriptions in West Germany, prospective hospital payments based on diagnosis-related groups in the United States and in France, and much debate about increased consumer cost sharing everywhere. The most ambitious effort, however, has been the least noticed by students of health politics and policy—Italy’s attempt, now six years old, to create a National Health Service loosely modeled on that in Great Britain. This inattention to the Italian reform is unfortunate, for although other nations may decline to follow its example, the conditions that pushed Italy in this direction, and the problems it has met in following it, are (or at any rate may become) fairly common. The reform therefore offers a case study in the opportunities and pitfalls accompanying efforts to “do something” on a systemwide scale about much-deplored and possibly generic health policy problems.

Prelude To Reform

Before 1978, the Italian health care system resembled, in broad essentials, those of other continental European nations. Health care was offered to all but about three million Italians by several occupation-based sickness funds (seven of which covered 98 percent of the insured population), financed by large employer and small employee contributions. Italy differed from its neighbors, however, in the traditional reluctance of its central government to standardize benefits and enrollment practices among the funds and to regulate their financial affairs. Coverage varied widely across occupational groups, some categories of employees (industrial workers, for example) gave up larger shares of their incomes than did others (merchants and independent professionals, for instance) for coverage, and some citizens remained outside the system altogether. Regional disparities were superimposed on social groups: the wealthier northern and central areas of Italy were better endowed with hospitals, physicians, and various service amenities than were the poorer cities of the southern and rural areas. And the public health presence was as heterogeneous as the private; for no particularly good reason, regional governments provided hospital assistance, the provinces delivered psychiatric and preventive care and services to the handicapped, and the municipalities ran pharmacies for the poor and offered some preventive services of their own. The system as a whole appeared to many to be

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inequitable, uncoordinated, and needlessly fragmented, and it came under attack in the late 1960s and early 1970s as reform-mindedness spread throughout Italy, as it did elsewhere in Europe.

The major turning point was a law of 1968 that committed new funds of the central government to expansion of the hospital system, thought to be structurally and technically outmoded and too inaccessible to much of the population, especially in the South. The hospitals augmented their beds, equipment, and personnel, and costs rose quickly. The sickness funds could not (or would not) pay the higher bills; the hospitals began posting deficits and then ran to the central government for fiscal relief. In legislation in 1974, the government assumed the hospitals’ debts, but entrusted much of their management to the regional governments, which had been created in 1970 and assigned health care duties in 1972. The creation of the regions and this devolution of health duties to them set the institutional foundation for the reform of 1978. Meanwhile, laws enacted in 1973 and 1974, transferring much of the localities’ taxing powers to the central government, provided the financial foundation for what would later become the national health fund.

Few doubted that reform was badly needed. Indeed, by the middle 1970s virtually no one had a good word to say for the existing system. Representative was a book of 1976 titled The Leaky Umbrella, in which cardiologist Lucia Rosaia argued that in retrospect the measures to expand hospital capacity had turned out to be problems, not solutions. They had done nothing to cure the system’s major difficulties and had used public funds inefficiently. Noting that as of 1974 combined public and private health spending in Italy was approaching 7 percent of gross domestic product, Rosaia deplored the “technical mediocrity and social inequality” of the system and concluded that Italy spent as much as or more than other nations for health care and got less for its money.

Italy might, of course, have followed the example of its neighbors by redesigning the sickness fund system and standardizing and regulating its financing, enrollment practices, and benefit types and levels. This approach, which would have left the central government in the role of umpire and occasionally active bargaining partner in negotiations between providers (physicians and hospitals) and payers (sickness funds and unions), stood, however, sharply at odds with the ideological currents and political incentives of the day.

Ideologically, three general trends in the Italian political discourse of the 1970s converged forcefully in the health arena. First, agitation over institutional reform, which ran at high tide in these years, strengthened the hand of the traditional left, much concerned with restricting the scope of the market and with overcoming inequalities. Their solidaristic principles tended to treat equality as synonymous with uniformity of benefits, and even a reconstituted sickness fund system would reflect in
some degree the economic status and ability to contribute of various occupational sectors. Moreover, sickness funds could, at best, insure against illness, not work positively for wellness; and they were unlikely to generate innovations and alternative forms of delivery, objectives much on the minds of the traditional leftists. These goals required a truly public health system that integrated all major health care activities under governmental auspices. By its nature, such a system must be centrally planned (at least in its fundamentals) and centrally financed. The financial reforms increasing the revenue-raising powers of the center had in fact made this a practical possibility.

Second, many sympathetic critics of the welfare state, predominately but by no means exclusively of the left, were persuaded that its statist, centralist excesses demanded correction by means of decentralization and citizen participation. This conviction, strong in many countries in the 1970s was particularly forceful in Italy, where the central government commands peculiarly little respect in public opinion. These critics endorsed a publicly controlled health system but insisted that it be community-controlled too. The creation of the regions had been a major step in this direction. They might now take a large hand in a reformed system, while new local organizations under municipal authority could be invented to take over managerial duties from the sickness funds. Whatever the tensions about detail, the two groups could agree on a general image of a reformed system, whose essence was a supposedly rational complement between central budgeting, performed by the level of government best equipped to raise money and set broad national priorities, and decentralized decision making about the concrete bases of these national funds by levels of government closer and more accountable to the consumers of services.

Third, across the ideological spectrum of left and right there was growing concern about cost containment. Leftists who had no intrinsic quarrel with budget deficits recoiled from the bottomless pit of provider waste. Rightists who found no inherent fault with a private health care system saw that in Italy it had grown into a sizable public burden and would grow more burdensome in the absence of a firm public constraint. All were impressed – enthusiastically or grudgingly according to ideological taste by the experience of Britain, where a national health service had done much to make access more equitable at a relatively restrained cost, and many observers found the key to British success in global budgeting. Italy too, they argued, should set an explicit upper limit on the money that would be allowed to flow into the system. Policymakers should debate and fix in advance a desirable sum for health care, embodying a tolerable rate of growth and percentage of national product, and health providers should thus be constrained to use the money wisely. By its nature, global budgeting implied central budgeting and planning. If the "regime of total
anarchy” were to end, it would be necessary “to put all the various health activities under one single directive power, capable of leading them along the track of a common program toward a common objective.”

The ideological appeals of a public health system were reinforced by political incentives. In 1978, institutional reform seemed to serve the electoral ends of the major parties on both the left (the Communists and Socialists) and right (the Christian Democrats), who looked ahead to national elections in 1979. In Italy, one prominent strategy of party competition is to enhance local allegiances and electoral attachments by gaining control over, or credit for, the activities of highly valued local organizations emphasizing solidaristic ties or the delivery of services. A renovated system of sickness funds, even in the unlikely event that it worked and the public gave its creators credit for it, might create at best a short-term political windfall; a public system would produce continuing opportunities for machine building in hundreds of localities. Enjoying close, longstanding ties to the sickness funds and the religious hospitals, many Christian Democrats preferred preservation and rationalization of the existing system, but they too could see the other side of the coin. Those very ties gave them a good chance of winning control over new local organizations (necessarily built on the foundations of the supplanted sickness funds in many areas), and, as dominant partners in the national governing coalition, they would have much to say about the writing of the national health plan and allocation of the national health fund. Precisely because the conservatives had close ties to the sickness funds, the Communists and Socialists would not accept renovation of the existing system, and, sensing a growing national weariness with conservative governance, they hoped that a new public health service—and the elections of 1979—would give them new opportunities to consolidate and extend their power at both the national and local levels.

A National Health Service

After years of intermittent debate, the National Health Service was established in law in December 1978, and, after a year of planning and transition, went into operation at the start of 1980. At the heart of the new system were the Unità Sanitarie Locali (USL), local public health units newly established by the law, which were to absorb gradually the functions of the sickness funds, assume managerial control over public hospitals, negotiate contracts (“conventions”) with the private hospitals, and take responsibility for the health needs of geographic areas containing between 50,000 to 100,000 residents. The USLs, about 650 in number, were to offer at no cost to all citizens a wide range of personal health services spelled out in the law.

The USLs served several masters, and each relationship embodied an
important political principle. To honor local control, they were put under the general authority of the mayor of the municipality. To institutionalize consumer participation they were guided by a lay management committee whose members reflected the balance of power among the political parties in the municipality. In tribute to regional planning, the USLs came under the general oversight of the regions, which, moreover, had considerable financial discretion in allocating funds among USLs and were directed to draw up regionwide health plans for the benefit of their local charges. At the pinnacle of the system proudly stood central budgeting and planning; the USLs and regions got their money from the national health fund, allocated according to a national health plan devised for three years at a time by the ministry of health after consultation with a national health council and with other ministries. The plan would gain force of law once approved by both houses of Parliament.

The law was an ambitious adventure in political economy. It gave an astonishing, indeed, ostentatious display of political idealism. The National Health Service brought new coverage to 3.5 million Italians; expanded entitlements for all citizens; emphasized equality, uniformity, absence of fees, and the reduction of regional disparities; insisted on decentralization and consumer participation; and assumed that these could work well in the context of regional and central planning. Yet in its insistence that the USLs live within a fixed budget handed down by the central government— the law forbade them to run a deficit—it embodied a formidable economic hardheadedness, so much so that one observer dourly concluded that the reform fit very comfortably with the “repressive” attitudes of the day toward social welfare spending.” Italy had legislated the stuff that dreams are made of. But would it work?

Implementation Pains

The reform ran into serious difficulties almost from the day it was put into practice. Some derived from the limitations of the central government, unprepared for the tasks newly thrust on it and hamstrung by the need to honor decentralization and regional autonomy. It will come as no surprise to students of the American health planning agencies that the national health plan, issued by the ministry of health after much delay, was largely a wish list, an assemblage of general and prescriptive “priorities,” with little practical instruction on how to realize them or how to make the complex tradeoffs they entailed. For example, the plan called for the Italian system to do more on behalf of preventive care, and virtually everyone agreed that this made sense. No one, however, was prepared suddenly to shift large sums from the hospital (or other) sectors to preventive purposes, and the plan said little on how the new emphasis might be developed. Likewise, there was wide agreement that Italy had,
in aggregate, too many hospital beds (about 7.9 per 1,000 residents, excluding psychiatric beds), but few were prepared to implement locally the plan’s call for a reduction to six per 1,000, which would no doubt mean closing entire hospitals in the most heavily bedded areas in the northern and central regions.

In sum, the reformers had invented no practical means of linking central planning with local control. Any meaningful plan would contain proposals at odds with local trends and interests, and, if local control were to be honored, such proposals could not be enforced. The ambiguity irritated both sides; pointing to the discretion vested in the subregional USLs and to the emphasis on overcoming regional disparities, regional observers warned that the reform strengthened national and local forces at their expense, while proponents of a stronger central role concluded that all the talk of maximum regional autonomy was merely a cover for Rome’s inability to promulgate detailed guidelines. And vague though they were, the contents of the plan proved to be too controversial to secure parliamentary approval. The Senate belatedly endorsed the plan in July 1982, but the Chamber of Deputies has yet to do so. Meanwhile, regional and local planners complain that they cannot get on with their work without an understanding of what the central government will expect and allow.

Decentralization fit equally poorly with central budgeting. Since the inauguration of the national health service, the central government has come forth annually with relatively tight health budgets. The USLs and regions then meet; conclude that the budget underestimates such variables as the rate of inflation, personnel costs arising from Italy’s scala mobile, which indexes wages to the cost of living, and the rising use of hospital care and prescription medicines; declare that the proposed sums are “absolutely insufficient;” and demand that they be raised. The government responds with a modest upward adjustment, but then retrenches in the financial laws (roughly equivalent to appropriation bills in the United States), leaving the difference between budget allocations and incurred costs to be made up by the regions, who swear that they cannot handle it. Parliament then saves the day (at least to some extent) with new upward adjustments. Much time and political energy are consumed annually over relatively small sums, and the outcomes please no one.

In fact, at least by some measures, the new system does appear to be containing costs. One study observed that although new services had been brought to an enlarged covered population, health spending has been growing at a rate equal to or even slightly below that of general inflation. As a percentage of gross domestic product, health spending seems to be leveling off—from 5.66 percent in 1976, it had risen to 6.08 percent in 1979, but then dropped to 5.68 percent in 1980, 5.52 percent in 1981, and 5.24 percent in 1982. Between 1978 and 1981, gross domes-
tic product grew by 79.13 percent, health spending only slightly faster, 83.41 percent. Such figures, however, were little consolation to the USLs, which protested that they were ordered to provide new services to more people with fixed or declining funds. Nor did they cast much credit on the central government, which composes its budgets not in constant but in current lire (inflating annually in the late 1970s and early 1980s at rates often close to 20 percent), and which appears to be sinking ever more sizable sums into the bottomless pit. From the standpoint of casual political impressions, the new system combined the worst of two worlds: new administrative chaos at steadily higher cost.

Allocating the global health budget sum was no simpler than arriving at it. Criteria for distributing health funds among the regions were bargained out within the broad framework of the law by an interministerial committee for economic planning, in consultation with a national health council. Data on spending trends, utilization, and need were poor; allocation decisions had political repercussions (different regions were strongholds of different parties); and a change in a decimal point or digit in a budget column could impose large losses or gains. Unable to agree on sophisticated indicators and measures, the budgetmakers took the path of least resistance by relying on simple measures of population and spending trends before the reform was enacted. This, critics pointed out, was an odd way to honor the law’s insistence that regional disparities be reduced. Indeed the decision was irrational twice over, for it penalized not only the poorer areas (those able to spend less) but also the more efficient (those least willing to spend their way into debt in the past).

The frictions unwittingly but inescapably built into the new system were aggravated by increases in both the number of participants in the policy process and their interdependence. Politicizing and centralizing the system summoned the Minister of Health, the Parliament, and various central councils and committees from their traditional place on the sidelines, engaged in limited public health and regulatory activities, to leadership of the national health fund, plan, and service. Since the early 1970s, function upon function had been dumped (“devolved”) on the regions and municipalities, and some commentators feared that Italy had simply exchanged central for regional and local overload. (Between 1971 and 1982, for example, regional councils had approved more than 8,000 different laws. A study of 679 laws approved in a period of about one year found that 10.5 percent involved health assistance, which would extrapolate to an average of more than three health laws per year per region.)

The sickness funds were gradually being phased out, but replacing them were 674 USLs, complex organizations designed to honor diverse principles and to serve several masters, and expected to oversee, organize, and (sometimes) deliver comprehensive care — and in some regions, social services as well — to local communities. The ambitiousness of the reform
and the inability of the central and regional governments to offer clear
guidance, partly out of deference to local decision making, left the USLs
confused about their mission, As one close observer put it in an interview:
“The national health plan specifies that minimum basic standards for
services be guaranteed by the USL. Over and above that, it’s up to them.
So the USL is left floundering. It has this requirement and a budget con-
straint. With the unlimited possibilities in health provision and the rela-
tive nature of appropriate care, it’s a very tough position to be in. The
USL finds it hard to control current spending, and it has a good alibi as to
why.” Understandably, organization-building and task- and role-definition
proceeded at different rates across Italy, leaving clients unsure of the
meaning of their newly expanded “rights” to care.

The most immediately and concretely disturbed participants were the
providers including general practitioners, specialists in private practice,
physicians on salary to hospitals, paramedics, aides, and assistants. These
providers were highly organized, well aware of the tradeoffs and risks of
change, and curious about their place and prerogatives in the new system.
Between 1970 and 1981 the number of doctors in Italy nearly doubled
(from 97,404 in the former year to 190,196 in the latter). Partly as a result
of the expansionary law of 1968, the ranks of hospital personnel had more
than doubled over roughly the same period (total personnel in public
institutions, including doctors on salary, numbered 90,000 in 1969 and
186,000 in 1979). Indeed, the growth of hospital personnel outpaced the
growth of beds-in 1969 there had been 1.9 hospital employees per ten
beds; in 1979 the ratio was 3.9 per ten.17 From this followed the basic
dilemma in health care policy and politics in Italy (and elsewhere): the
greater the growth of manpower, the more it cost to maintain the system,
and the greater the pressure became to contain costs. But the greater the
growth of manpower, the stronger became the organizational strength,
political voice, and local presence of the providers, and the stronger grew
the political resistance to cost-containment measures.

Fearing that something had to give, and threatened by the precarious
payment patterns developing between sickness funds and their hospital
employers in the 1970s, some lower status hospital physicians and work-
ers had supported reform in hopes of finding economic stability.18 This
split in the ranks of providers had advanced the reform politically. By its
very nature as a public system, however, the law of 1978 politicized
negotiations over remuneration. Previously, doctors’ associations had
bargained with associations of the sickness funds and the hospitals, but
now their spokesmen dealt directly with representatives of the national
health service.

The doctors’ responses varied with type of practice and source of salary.
General practitioners and specialists engaged in community practice were
threatened by the shift in the new system to capitation payments for lists
of patients. Some have recouped by augmenting their private practices. Others, however, have apparently made their annoyance clear by post-poning or hurrying the visits of public patients—a trend said to be a source of increased hospital admissions. Salaried hospital doctors and medical technicians protested more directly. Angry at a contract proposed by the Minister of Health, they went on strike in the winter of 1983, and the pattern may well be repeated whenever major contracts are due for renegotiation. Strikes are not unknown in Italy, of course, but when directed against the faltering new health system, they give providers a major publicity tool for blaming the reform and for enhancing among the public the impression that tight-fisted politicians are hypocritically expanding “rights” one day only to curtail them the next.

### Stagnation And Its Sources

By 1983 the spirit of reform had lost force, and the new system was being attacked with the same acerbic vigor directed at its predecessor five years earlier. Progressives were displeased that the government’s tight central budgeting interfered with its promises to fund new services and institutional innovations, while the bloated hospital sector continued to gobble up ever-larger shares of scarcer resources. The Communists in particular complained that the principle of free medicine for all had been violated by the introduction of copayments and “tickets” for drugs. Conservatives charged that such modest cost containment as the reform had produced did not go nearly far enough. High public spending and deficits kept Italy’s economy sluggish and its rate of inflation high; the sole solution was to cut public spending, and health care costs stood near the top of the list for savings.

Leftists were angry that the private practice of medicine had not been abolished outright or greatly curtailed; the coexistence of public and private spheres encouraged physicians to neglect their public patients, which made the public health service less appealing, induced the better off to circumvent it, and tainted it with the stigma of second class care. Physicians, hospital administrators, former sickness fund officials, and some civil servants retorted that the publicly run service was a mess and that any further exchange of private for public responsibility would only make things worse. The local parties, they contended, had to beat the bushes to come up with lay manpower to staff management council positions in the 674 USLs and often chose lumpenproletariat types with little interest and less experience in public administration. Local control increasingly appeared to be a dubious virtue. In the succinct words of one critic, “The politicians are asserting themselves, and the lower you go the less competent and responsible they are.”

Policy analysts quickly joined the chorus of condemnation, sighing
with well-practiced weariness that “nothing has really changed.” Regional disparities were not being overcome—obviously not, since policy makers elected to resort to population size and historical spending patterns as criteria for distributing funds. Intersectoral imbalances were getting worse; the system spent a little more on prevention but a lot more on hospital care, and the fabled alternatives to hospitalization remained remote. The rhetoric of equality, uniformity, and access rang hollow; citizens dependent for care on the vagaries of organization-building and implementation in nearly 700 USLs (some of which existed only on paper) in twenty regions may have been less reliably insured and served than they had been under the old system. Nor was there much hope of fast improvement; five years after passage of the law of 1978, participants were still debating the respective roles of the various regional and local bodies and of consumer representatives in running the USLs. And central budgeting had not meant prospective budgeting, as hoped; in practice, the central government set a figure, waited for the clamoring regions to exceed it, and then revised it upward, engaging in the same a posteriori budgeting the sickness funds had used.

Reinforcing these ideological and analytical critiques were daily instances of bungling in the health service on matters large and small, abundantly rehearsed and dissected by the Italian press, “one of the world’s best, most lese-majeste and idiosyncratic. . . .” Some vignettes from the summer of 1983 may suggest the picture the Italian man on the street was forming of his public health service. In four regions (and later more), pharmacists decided to begin imposing small charges for all but “life-saving” medicines. Apparently the national health fund had budgeted too little for drugs, the regions had been given too little money to meet public demand, and therefore had fallen months behind on payments to pharmacists. When long lines formed at the municipal pharmacies, where medicines are free by law, their employees complained of too much work and threatened to strike. In Emilia-Romagna, allegedly severe staff shortages in hospitals provoked the mayors, with the acquiescence of the regional government, to trigger a minor constitutional tempest. An article of the central government’s financial law of April 1983 prohibited new hiring of hospital personnel, even to replace those who vacated their jobs, but the mayors contended that they had emergency powers to issue ordinances for the hiring of more than 1,000 new paramedics. The central government replied that such ordinances were illegal and therefore null and void. The sides negotiated. In Rome, the Red Cross and emergency services and hospitals generally were said to be imperiled by lack of personnel and funding. In Naples, expectant mothers lay on beds lined up in the halls of overcrowded hospitals while maternity wards elsewhere in the city ran below capacity. In Verona, heart surgery, formerly practiced at a rate of fifteen operations per week, fell to five per
week for lack of personnel. A doctor warned that of 1,000 patients remaining on the waiting list, 100 would die before their turn for surgery arrived. The press commented that this was but one example of the “blackest crisis” besetting the health system. In Rome, a hemodialysis center was driven to the brink of closing for want of prompt payment. Scandals surrounded contracts awarded to health services in Catanzaro. In Cosenza, unjustified absenteeism by doctors and paramedics was said to be rampant. The president of Locri’s USL allegedly helped launder ransom money from a kidnapping. And so it went. Small wonder that Cavazzuti and Giannini titled their critical book, The Sick Reform: A Health Service in Need of Reformulation, or that a study in 1982 wrote of the need for “radical corrective intervention” in the system.

Of course such reactions are a staple of Italian political rhetoric. In Italy, non funziona is the doleful predicate of many institutional subjects, public and private, and the more dramatic the indictment, the purer the pleasure of laying it at the door of an opposing party, coalition, ideological faction, or personal rival. In the case of the health reform, however, the grievances far transcend rhetoric as usual, and one cannot avoid concluding that in several respects the reformers underestimated the difficulty of the reorganization they set in motion and misunderstood the lessons of the British National Health Service, their precedent and inspiration.

First, the political structures that formulated and implemented the reforms in the two systems were quite different. These structures are important because by its nature, the reorganization strategy tends to appeal to a fragile coalition of the left, eager to rebuff traditional medicine, eliminate fees for services, and insulate disadvantaged citizens from brutal market forces, and of the right, hoping to find in tighter public budgeting new efficiencies and means of containing costs. As legislation is formulated, this coalition produces the classic “something for everyone” reform package—for example, central budgeting mixed with consumer participation, pledges that new services will be mandated but funds for existing ones will not suffer, and maximum regional autonomy conjoined to a reduction in regional disparities. Inevitably, the tensions and tradeoffs grow clear in the implementation process; a clear head and steady hand at this stage may be the last chance to avert failure.

Great Britain developed the legislation of 1946 that established its National Health Service in a very different structural context from that of Italy in the 1970s. The proposal for a national health service was incubated by the coalition government that ran Britain during World War II, but the legislation of 1946 was the handiwork of the Labour Party, which had won a decisive electoral victory the year before. The National Health Service was the top priority of the winning party in a two-party system that expected parties to be “responsible” and to live up to their clear and
distinct stands once in power. The need for “Christmas tree” legislation was suppressed and the government (that is, the Labour Party) was in a strong position to guide the reform through its early difficult days of implementation.

Relations between the central governments and subnational units differed too. Italy could not detach the reform of 1978 from the conviction that the central government suffered overload or from the temporary passion for decentralization and devolution. The British health service was and remains unitary; created in the high tide of support for central planning and intended to introduce coordination and central direction into what had been a chaotic health insurance system, it works through lower administrative levels (reorganized from time to time) but not through regional and local governments. In Italy, the new system, formulated by a coalition whose members were drawn to it for dissimilar ideological reasons, was implemented by officials much concerned about the allocation of funds among red (Communist), white (Christian Democrat), and mixed regions and municipalities, and sometimes bent on enhancing the local party base by turning the USLs into political machines. This institutionalized local party competition built into the system a continuing stimulus to charge and countercharge, which inflamed the original ideological principles folded uncritically into the system, and left Italy’s central governing coalitions – which change on average at a rate of about one per year – a weak hand in implementation. 39

Second, the political economies of the two systems differed considerably. The reorganization strategy tends to aggravate conflict in the health care system by transforming interorganizational battles (for example, between sickness funds and providers over payment levels) into intraorganizational struggles (for instance, between government spokesmen and provider “employees” in a new unified health service). In the reformed Italian system, lay administrators, local consumer activists picked by the political parties, full- and part-time general practitioners, specialists, hospital physicians, paramedics, and more must negotiate to find ways of living within the central and regional governments’ budgets and plans. Conflicts easily flare over status, interest, and principle and are resolved only slowly, if at all. 40

When the objective of reform is not to apply gentle brakes to the growth of a moderate-sized system, but, rather, suddenly to contain costs and impose efficiency on an overdeveloped one, organizational coherence and harmony are all the more difficult to attain. In this respect, too, the British system of the 1940s varied enormously from the Italian system of the 1970s. By most indicators Italy has a well-developed, indeed, in some respects overdeveloped, health care system, and the reform of 1978 encountered it in full flower. In 1970, the doctor-to-population ratio in Italy was 1:561; by 1981 it had dropped to 1:301, the lowest in Europe
and half that of Britain (1:610). In 1974, Italian doctors stood second only to the Dutch in median income per capita as a percent of GDP. Visits to general practitioners were rising sharply, from an average 4.3 visits per insured person per year in 1954 to 11.2 in 1974 and an estimated 13 in 1980. Visits to specialists rose from 2.39 per insured in 1968 to 3.55 in 1976, and laboratory examinations rose from 16 million per year to 54 million in the same period. Italian physicians prescribe drugs for their patients at a rate two to three times higher than do the British; indeed in Italy “almost every contact with the doctor ends with a prescription.” In 1978, Italy had almost eight nonpsychiatric beds per 1,000 residents, well above the six per 1,000 its national health plan deemed adequate and twice the ratio the federal government in the United States recommends to local planners. In 1975, the rate of admission to Italian hospitals was 162 per 1,000 residents, which tied Italy with West Germany for first place in the European Economic Community (England had 115 per 1,000, Holland 106, France 91).

Instead of trying to slam the lid on a system that had exploded, the British in 1948 imposed their health service on a much smaller system and then worked to control its expansionist tendencies gently but firmly. The British feared uncontrolled expansion and acted while there was still opportunity to succeed. Until the early 1960s, “the prime concern was to constrain the rate of growth of expenditures.” In the 1950s, policymakers declined to enlarge the ranks of British medical schools on the ground that expert forecasters predicted an adequate supply of physicians into the 1970s. When these estimates came to seem too restrictive, enrollment was increased but on nowhere near the Italian scale. Capital spending for hospitals was constrained until the early 1960s. As criticism of the aging and poorly distributed bed stock mounted, Britain began modernizing and expanding, as did Italy in 1968. Unlike Italy, however, Britain improved efficiency in the use of beds; by reducing the average length-of-stay, British planners managed to treat more patients over time with fewer beds per thousand. As an Italian source remarked, between 1960 and 1975 Britain steadily decreased the supply of hospital beds available to the population; indeed the British bed-to-population ratio in the latter year was almost identical to the Italian ratio in the former. By 1973, the British had achieved a hospital bed occupancy rate of 76.7 percent; Italy’s rate was 67.8 percent in 1980. Had the British tried to install their national health service in the Italian setting of the late 1970s it might very well have failed to take root.

A sudden effort to slow and redistribute the growth of an “exploding” health care system would accentuate conflict under the best of circumstances. The Italian effort to do so within the framework of a unitary national health service ensured that conflict would become the stuff of daily decision making in organizations at several governmental levels.
Ever-fresh quarreling among organizational partners over pride of place and zero-sum budgetary allocations have endangered the conscious coordination and cooperation demanded in large doses if the system is to take shape.

Given the large and growing number of physicians, pharmacists, hospital beds, and personnel it inherited, the Italian national health service must choose among three strategic options: it can cut some claimants sharply and abruptly, freeze aggregate spending and sectoral shares near their current levels, or continue to nourish existing claimants at slower rates of growth. Only the last of these options begins to be politically feasible, and the central government’s commitment to local decision making may make it utopian, too. In the meantime, money for “alternatives” will become available only if growth in the hospital sector is slowed very sharply. The British faced similar difficult choices, but the comparative underdevelopment of their system when the National Health Service began and the comparatively centralized structure of their policy making eased the political pain.

Third, Italy pursued reorganization in a normative context that was quite different from the British and much more insistent on preservation of a thriving private medical sector alongside the public. When Britain adopted its National Health Service forty years ago, the driving force was a sense of social justice. The problem with the national health insurance scheme that had been adopted in 1911 was not that it cost too much, but that it offered too little protection for too few people. Insurance covered only about half the population, wives of covered workers received no benefits except for childbirth, only generalist care was included, and poor coordination and “creaming” for better risks by the carriers created financial instability. Concern about inequalities among social classes ran high, and it was agreed that a well-designed public system could redistribute resources equitably without going on a spending spree, in short, that equity and efficiency could be positively related. In this normative setting the Labour government had little trouble formulating a public system that supplanted private arrangements almost entirely. The strength of public support in favor of the new system and divisions of opinion within the ranks of physicians themselves soon persuaded the leaders of the British medical profession to cooperate

Italy’s national health service came to life in very different circumstances. By 1978, 92 percent of the Italian population had health insurance coverage, which typically extended well beyond generalist care for heads of households. To be sure, there were disparities in coverage among occupational groups and regions, and these were of major concern to the left. But the sense of class grievance was fairly muted in the indictment of the old system, and concerns for basic social justice were subdued in the campaigning for the new one. The main motive for
reform was a consensus that health care, like many other services in Italy, was essentially a waste of money, costing too much and delivering too little. Italian public opinion, therefore, was quite intent on having its cake and eating it too. Everyone wanted both free access to a fine new public system and a strong private sector continuing to exist alongside it. The reformers complied.

The British health service bought up or absorbed most private hospitals, leaving only a small stock of private beds for the wealthy. In Italy, about 35 percent of beds remain in private (especially church) hands. Nor was there any prospect that most Italian doctors would be obliged to work exclusively for the public health service. Rather they retain wide scope for mixing employers (community practice in their own studio, under contract to the USL, in a hospital), commitments (full- versus part-time), and payment method (capitation, fee-for-service, or salary) which has led to arcane legal definitions of, and much public debate about, “incompatibilities.” As one observer commented: “Britain faced this problem at a different period. In 1978 in Italy you couldn’t compete with private sector salaries. So there was a political tradeoff. The medical lobbies accepted the public system and its low salaries in order to keep the private system alive in Italy.”

As the public sector ran into difficulties, the private looked more attractive by contrast. A recent analysis cited several reasons for this trend. As disposable incomes rise, Italians grow less tolerant of waiting for care in the public sector and can more often afford to abandon the queue. In Italy, as elsewhere in the 1980s expectations of service are shaped less by a “culture of sickness” and more by a “culture of health,” which emphasizes activities and treatments—sports, massage therapy, acupuncture, macrobiotics, bioenergetics, and so forth—that the public sector can hardly be expected to fund. The growing fascination with self-management and self-diagnosis likewise generates a larger demand for lab tests and other services than the public service can accommodate. Equally or more important, however, some Italians question the worth of the new public service. One survey found that those who use the service tend to do so not because they think it has excellent professional staff and equipment (only 11.4 percent of a sample of users thought so), but because it costs little or nothing (43.8 percent gave this reason). (The finding calls to mind surveys of satisfaction in the United States among health maintenance organization (HMO) enrollees, who tend to trade off satisfaction with access and amenities for the financial benefits of prepaid group practice plans.) Apparently citizens accustomed to private coverage do not easily banish from their minds the second-class connotations of a public system. Thus, high on a list compiled by an organization working to improve hospital care is a demand “characteristic of Italy these days: they ask that patients be treated like paying users and not like...
Rationalizing The Reform

To say that the creators of the Italian national health service underestimated the complexity of their task is not to dismiss the effort as utopian or necessarily doomed to fail. In the first place, although it is easy to expose the inconsistent objectives of the project and urge that goals be sorted out, the fact is that both cost containment and a reduction in social inequities in the health system are important public objectives, and it is doubtful that political support can be sustained in the 1980s for programs that address one of these goals in isolation from the other. The fee-for-service national health insurance systems of continental Europe and (to a smaller degree) the mixed public and private system in the United States have improved equity but not efficiency. Health spending in these nations has neared or passed 10 percent of gross national product; a “crisis” is widely acknowledged, but they have not effectively slowed the rise of spending and appear to have few promising ideas for doing so. For all its faults the British system alone has managed to promote equity while holding costs to about 6 percent of its GNP. Bent on reform, Italy was arguably both cogent and courageous in emulating the British.

Although institutionalizing zero-sum decisions on the allocation of constrained resources in a unified, multi-interest organizational framework like the USL increases conflict, the new era of budget limits compels providers, consumer spokesmen, government officials, and other “interests” to develop integrative structures within which to negotiate tolerable strategies and procedures. Bargaining is the political order of the day, generating such experiments as the American health systems agencies and West Germany’s Concerted Action body, a multimember council recommending annual ceilings on physician charges. Italy’s USLs are not the only or best frameworks for bargaining, but they cannot be dismissed a priori.

Although a public health service imposed on a health-conscious and demanding populace may be scorned as too slow and lacking in amenities, and sometimes deserted in favor of the private sector, a public-private mix may be the only practical way of guaranteeing accessible, reasonably uniform medical care for all if the more familiar fee-for-service-based national health insurance systems become too expensive to sustain. Rising public deficits make it difficult for modern welfare states to maintain a high level of basic care for all their citizens, let alone entitle them to all the progressive possibilities medical science invents and opinion demands. Protecting the basics while containing the demand for new medical procedures may universally become the central health policy problem of this and the next decade, and mixed systems may be the only
practical solution.\textsuperscript{59} The public core of the system honors both equity and cost consciousness—at least in theory; the private sector alternative gives a range of choice of providers to the fastidious, access to extras to the extremely health-conscious, and a source of additional professional income and activity to providers who will not rest content with public earnings. Whatever their theoretical and ethical impurities, mixed systems will probably continue because they offer the best, perhaps only, practical balance among the competing imperatives of equal entitlements, cost containment, consumer choice, and professional satisfaction.\textsuperscript{60}

Conceivably the conflicts now plaguing the new Italian system will be resolved by dispensation from above: pressures from the regions and localities, from party cohorts, from strike-minded physicians, from the incessant adverse publicity of a skeptical press, and from public opinion may persuade the central government to loosen the purse strings, allowing health spending to resume its unconstrained contribution to Italy's double-digit annual rates of inflation. Dispensation is likely to be partial at best, however. The reform is widely regarded as a miscarriage, but there is also a strong general sense that the older system had grown absurdly costly and inefficient. There is little sentiment favoring a return to the days of yore and much agreement that efforts should be made to reform the reform before there is serious discussion of abandoning it.

Three major “rationalizing” suggestions are now prominent in today's political debate-economic, organizational, and regulatory. Economic solutions are of two types, governmental and individual. In the former category, some students of public finance have concluded that the “skewed” or “one-armed” fiscal relations between the central government, which provides most of the funds, and the regions and municipalities, which bear most substantive responsibility for their use, cannot fail to invite trouble.\textsuperscript{61} The center complains that its revenue is used for parochial or ill-conceived purposes, but cannot impose corrections. The regions and localities counter that they are told to stand accountable to the citizenry for services that the center mandates but refuses to fund adequately. In theory, the division of labor reconciles the center’s superior revenue-raising powers with the locals’ closeness to the people. In practice, write Cavazzuti and Giannini, it “maximizes the defects and inconveniences of the theoretically possible systems (centralized and decentralized); the result is thus to aggravate the conflict between center and periphery.”\textsuperscript{62}

“The question is,” one observer declared, “is it going to be a national health service or a regional-local service? We have to choose.” One solution would give the center more substantive power to match its financial dominance; the other would return to the localities greater taxing authority to match their scope of decision making. Such changes, however, would violate the philosophy of devolution and sorting out of functions
that produced in the 1970s the regions, the tax reforms, and the national health service itself, and would upset the political coalitions that supported these measures and do so still. Such solutions are too generic and far-reaching to stand much chance of adoption out of pique with the health care system alone.

More directly targeted on the problem of health spending, and therefore more prominent in the current political debate, are economic measures changing the coverage and incentives of individuals. One possibility is to vary entitlements with income, that is, introduce a means test. The rationale was recently summarized by economist Sylos Labini, who asserted that in the health sector, “We seem to be going backward not forward. It is no social triumph to give an industrialist free hospital care. Rather, what’s needed is to secure better the basic needs of the population.”63 The election platform of the Christian Democrats in the summer of 1983 called for a “responsible social policy,” which meant ending programs that give “everything free to everyone.” Instead the party favored coverage for the “basic needs” of all citizens, and only those needs.64 The government formed after the elections by Bettino Craxi, head of the Socialist party, spoke of the “introduction of criteria . . . proportionate to income”65 And increases in the use and size of controversial copayments, referred to in Italy by the English term “tickets,” continue to be debated.66

Means testing would be a momentous change indeed, a retreat from the universalistic social philosophy at the heart of the Italian and other European welfare states. That politicians should be so willing to discuss departures from the principle that health care is a right to which all citizens should be entitled regardless of income is a suggestive measure of the degree of discontent with health care spending. Tickets too have their problems: they fall more heavily on the less-well-off than on the affluent, may deter timely resort to inexpensive preventive or primary care while failing to check, the use of expensive inpatient and specialist care, and are administratively cumbersome. The Communists will fight such proposals bitterly, and they will be joined by “progressive” elements in the other parties. Public opinion and the press will want to know why the people must bear costs that could be reduced by improved administrative efficiency in the public system and by less generous remuneration for provider elites. Means testing and tickets may well prove to be ideas whose time eventually comes, but years of anguished debate will very likely intervene before then.

Some critics would redesign the organizational character of the USLs to reduce the roles of local consumer activists chosen by the parties. There is fairly general agreement that the direction of local health affairs is now too politicized. The Christian Democrats’ election platform looked forward to “health services removed from the hands of politicians and
entrusted to experts.”\textsuperscript{67} The Minister for Regional Affairs in the (then outgoing) Fanfani government spoke of cutting the ties of the USLs to the management committees and of giving administrative tasks “to some small body of experts, chosen exclusively for their competence and professionalism.”\textsuperscript{68} The incoming Craxi government anticipated reducing the municipalities’ role and “assigning management to health bodies and competent administrators.”\textsuperscript{69}

Having escaped from the bottle, the genie of consumer participation will not easily be driven back in. Leftists will seek to preserve the role of the citizen, presumably devoted to alternatives and innovation as providers are not, and conservatives may wonder whether more dominant providers and bureaucrats will necessarily be more efficient and cost conscious. Depoliticizing management also threatens the local party coalitions and machines in the USLs. Because there is much agreement that organizational reform is desirable, a determined central government might push it through, yet; given the high opportunity costs of political capital in the fight to contain health costs, one wonders how much it will choose to invest in managerial reforms lacking an immediate savings coefficient. Even if the USLs turned overnight into models of rational, professional administration, all the hard tasks and choices they-and the central government -must confront would remain as difficult as ever.

Some reformers argue that the USLs, regions, and central government all ought to develop stronger regulatory capabilities in dealing with providers and with each other. A nation in which hospital admissions rates are high and rising and stays are long, in which almost every encounter with a doctor ends with a prescription; and in which 30 percent of physicians account for 67.1 percent of clinic investigations (and 20 percent of doctors order 54 percent of investigations) might be expected to be in hot pursuit of utilization and peer review systems and medical profiles and protocols.\textsuperscript{70} A system with 7.9 hospital beds per 1,000 residents and an average occupancy rate of about 68 percent, and in which fifteen of twenty regions have a bed surplus (and seven of twenty have 30 percent or more beds than they need) should presumably hurry to install certificate-of-need controls to block new construction and apply pressure for mergers, consolidations, and closures.\textsuperscript{71}

Such controls might indeed prove to be useful in the way that regulatory controls generally are – not as comprehensive and lasting policy solutions but as means of holding a lid on systems inclined to explode while politicians try to build consensus for firmer and more durable budgetary controls.\textsuperscript{72} Be this as it may , they will not be easily implemented in Italy. Piperno notes that in Italy the discussion of medical protocols has lagged behind other nations, and even a highly sophisticated study somberly warns that drug protocols for physicians “have the risk of becoming codes to refer to, definitively removing from the doctor all autonomy in
his choice of treatment.” The Craxi government proposed “development of structures to ensure the real necessity of hospital admissions,” but physicians will resist such efforts.

A moratorium on new hospital construction was imposed until the national health plan is approved, but enforcing bed reductions, mergers, and closures in the three-fourths of the regions with surplus beds will be difficult. As George France points out, the costs of the health service, met largely by the central government’s funds, are concealed locally, but cuts in service are visible indeed. Local hospital personnel, politicians, and residents all close ranks to oppose cuts. The central government in any case has little power to force them on the regions or localities and is well aware that firm measures will upset local multiparty coalitions, impose severe economic hardship, and cause organizational chaos as hospitals and other institutions struggle to adapt to change. Ironically, the national health plan, influenced in this as in other respects by the uncritical equation of equality with numerical uniformity, projects expansion of hospital capacity in southern regions that now have fewer than six beds per 1,000 residents. That occupancy rates in the “underbedded” South—a dismal 68.3 percent in 1978—ran about equal to the national average and far below the 80 to 85 percent average occupancy deemed optimal by the plan itself, evidently made little impression?

Even if these regulatory strategies could be adopted and implemented well, however, the hard work of policy making would have only begun, for the strategies point beyond themselves, beyond combating profligate provision and waste and abuse, to evaluating the price of progress in medical care and society’s willingness to pay it. Reductions in admissions or lengths-of-stay brought about by utilization review or medical protocols in Italian hospitals would simply highlight the overcapacity in a system that allows almost one-third of its beds (on average) to go unoccupied. A logical answer would be to close some of this capacity, but the political obstacles are obvious. Closures strike not only at community expectations of service and access greatly enlarged of course by the promises of the reform—but also at the interests of hospital personnel, whose ranks have been deliberately expanded by government policy, some of whom hoped to secure their incomes and positions by working for the national health service, and most of whom are unionized and quite capable of paralyzing hospitals in the regions or all across Italy if sufficiently antagonized.

No serious effort at cost containment can dodge this problem indefinitely, however, for hospital spending and, above all, the personnel component within it are the hard core of the Italian cost problem. Between 1977 and 1981, hospital spending rose from 57 percent to 60 percent as a share of total health expenditures. Between 1977 and 1979, personnel costs as a share of total hospital spending rose by an amazing
five percentage points—from 71 to 76 percent.\textsuperscript{78} Worse, in the short term, pressures to expand hospital personnel will intensify. In 1970, Italy had 1.62 doctors per 1,000 residents; in 1990 the ratio could reach almost four per 1,000.\textsuperscript{79} These new entrants will demand work and financial stability, and many may well prefer the salaried hospital sector to the competitive chaos of community care.

What might be done? Italian planners could try to convert a portion of unneeded acute care beds to the needs of the aged population for long-term care.\textsuperscript{80} This would use capacity more rationally, but, alas, would do little to shrink the system or save money. Policymakers could try to negotiate lower rates of pay increase for hospital workers. Unionization, strike readiness, and wages indexed to the cost of living, however, suggest that they might find it easier to close hospitals and lay off workers in one fell swoop than to endure periodic negotiations with the existing work force at full complement. They might emulate the bed reduction plan in Michigan, where a governor’s task force on bed reduction was established to help dismissed workers make the transition to new jobs. This approach too might be difficult in Italy, where unemployment runs close to 10 percent nationwide and local opportunities and mobility are often constrained.\textsuperscript{81}

Perhaps the most important constraint, however, is public sentiment. Experience with the strongest personnel containment measure taken to date, the freeze on hiring new personnel or replacing vacancies in hospitals, suggests that the public does not yet believe that it is necessary to learn to live with less. The decision of the mayors and regional government in Emilia-Romagna to disobey the order by issuing emergency decrees for new hiring was noted earlier. Lombardy’s regional government denounced the freeze too, calling it an indiscriminate prohibition “ignoring the diverse realities of the health situation of the various regions,” and hospitals in Venice and Ferrara dramatically closed wards and units for want of funds and personnel.\textsuperscript{81} Astute as it may be, the Italian press has failed to impress its readers with the interconnectedness of things; quick to conclude that such “crises” demonstrate the malfunctioning of the new system, it nonetheless declaims censoriously whenever the latest figures show that the health budget has again “gone through the roof” or into the “bottomless pit.” That the former traumas may be the price of avoiding the latter is seldom acknowledged.

Even if certificate-of-need or other programs aimed at reducing hospital capacity could be made to work, however, expanding technology, itself a major source of demand for more and better-trained hospital personnel, will continue to drive costs up. George France warns Italian planners against excessive preoccupation with the supply of beds (leaving aside the many political obstacles to addressing the problems), for about 70 percent of hospital costs, including most personnel costs, are fixed
and therefore will not be directly lowered by the elimination of beds in hospitals that remain open. (Closures and mergers are another matter.)[83] Moreover, research by Salkever and Bice on certificate-of-need efforts in the United States suggests that capital diverted from new bed construction may be channelled into the purchase of new equipment, thus cancelling savings, for the repeated use of small items acquired at low capital cost can generate high current costs.[84]

Italy has done little to adopt a technology policy and even seems to be encouraging diffusion of new equipment in hopes of overcoming regional disparities and modernizing hospital plants. Meanwhile, private physicians under contract to the national health service go on buying the latest equipment as a matter of presumed professional right, without opposition by the public authorities.[85] The problem, an observer explained, is that “the public sector has a budget constraint, while the private sector, partly under contract to the public, has a profit motive to get more technology. So the public sector starves while the private amortizes its equipment through tariffs, including ones charged to the public. So either the public sector bitches and fights for equipment or there’s a flight to the private sector while the public system degenerates.” One response would be a policy forbidding public payment of charges generated by beds or equipment that have not received prior governmental approval. Such certification, however, presupposes both a defensible set of criteria and standards and the political will to impose and honor them in practice. Neither condition will be easily met in Italy.

Even if the costs of hospital personnel and technology could somehow be brought under control, however, the aging of the Italian population will increase costs, demonstrating the wisdom of Pirenne’s view that demographics is perhaps the most important of all the social sciences.[86] The size of the elderly population is growing steadily in Italy—from 13.1 percent of the whole in 1950 to 17.4 percent in 1981 to an estimated 22 percent in 2001.[87] Italians above the age of seventy are admitted to the hospital at a rate twice that of the population at large, and they tend to stay an average of ten days longer.[88] These trends spell trouble for both the demand for services—the elderly suffer from chronic respiratory conditions, nervous ailments, and other disorders that require continuous assistance and sustained intervention—and for society’s ability to supply them—a rising ratio of seniors to working taxpayers strains the financing of the national health fund.[89] Nursing homes in Italy seem to be no more pleasant than elsewhere, and the national health plan speaks vaguely of alternatives—improved services and care for the elderly at home, and more emphasis on prevention and rehabilitation, for example.[90] But in Italy, as elsewhere, most alternatives remain poorly defined and untested, and those that are better understood—home health services and congregate care housing, for instance—can be very expensive.[91]
Western welfare states with extensive public health insurance systems or services will be grappling with the rising costs of hospital personnel, technology, and demographics long after they get waste and abuse under control. That the Italian health care service, inspired by the British but set down amidst the problems of the 1980s can reconcile equity and efficiency with greater success than other Continental systems (or the American) have had is an important (albeit implausible) hypothesis. Health reform Italian style is not likely to come fully into fashion elsewhere, but students of the interplay between health politics and policy may find useful insights and lessons in its trials, errors, and corrections.

NOTES


4. Lucio Rosai et al., L’ombrello bucato: Introduzione alla riforma sanitaria (Roma: Edizioni delle Voce, 1976) 50-58. Translations here and throughout this paper are mine.


7. Rosai, L’ombrello bucato, 22; Cavazzuti and Giannini. La riforma malata. 149-51.

8. Rosai, L’ombrello bucato, 60.

9. For an excellent study of this competition see David I. Kertzer, Comrades and Christians: Religion and Political Struggle in Communist Italy (Cambridge: Cambridge University Press, 1980).

10. These complex organizational structures are described in Giuseppe Carnevale and Carlo Perucci. Guida pratica ai nuovi servizi sanitari (Roma: La Nuova Italia Scientifica, 1980), especially p. 15. table 2.


13. This summary is a compressed “ideal type” drawing on individual years that differed in detail. See Fondazione CENSIS, XVI Rapporto 1982 sulla situazione sociale del Paese (Roma: Franco Angel, 1982). 338; and Cavazzuti and Giannini, La riforma malata, 145-47.


16. Ibid., 398-400; and for a detailed account of the progress of the regions and localities, see Consiglio Nazionale dell'Economia e del Lavoro, Osservazioni e proposte sullo stato di attuazione della riforma sanitaria, Assemblea, 20 ottobre 1982, no. 190/138 (Roma, 1982).


20. For example, Il Masuggero, 25 July 1983.

21. See for instance, the views of the head of the Bank of Italy, reported in Il Messaggero, 1 June 1983.

22. On the drawbacks of this approach, see Cavazzuti and Giannini, La riforma malata, 17-19.


24. Cavazzuti and Giannini, La riforma malata, 143-44.


27. See, for example, the Corriere della Sera for 25 and 28 July 1983 and la Repubblica and Il Messaggero for 26 July 1983.


29. Il Mattino. 16 July 1983. Unclear, however, are the relative contributions of the stinginess of the health service and the timing of summer vacations.


31. Ibid., 10 July 1983; and la Repubblica, 12 July 1983.

32. Il Messaggero, 7 June 1983.

33. Ibid., 25 July 1983.

34. Ibid., 13 July 1983.

35. CENSIS, Rapporto 1982, 305.

36. Partial exceptions of course are the Christian Democrats, who, having led Italy’s governing coalitions for most of the post-war years, counter that things run better than opponents charge and blame the other parties for blaming them for everything that runs poorly.

37. In the United States, the central government’s very modest effort to reorganize the system by promoting health maintenance organizations (HMOs) met a fate quite similar to that of the Italian reform: the initial coalition of antifee-for-service liberals and efficiency-minded conservatives fell apart as the difficulties of defining and developing “pure” HMOs and of realizing large budgetary savings in the short term became clear. See Lawrence D. Brown, Politics and Health Care Organization: HMOs vs Federal Policy (Washington, D.C.: Brookings Institution, 1983), especially chaps. 5 and 6.


39. Such summary data are misleading, however, for “although Italy’s governments may be unstable, its political leadership is very stable.” Sabino Cassese, “Is There a Government in Italy? Politics and Administration at the Top,” in Richard Rose and Ezra N. Suleiman, eds., Presidents and Prime Ministers (Washington, D.C.: American Enterprise Institute, 1980), 171-202, quotation at p. 202. The stability of electoral preferences and the continuity of the officials who shift roles within the various governing coalitions gave Italy “more or less the same government for the past thirty-eight years, a European record.” Harvey, “A Kind of Stability,” 4.
40. In the American HMOs, too, reconciling the professional autonomy of physicians with administrative control by laymen has been a chronic problem, and the role of consumer elements in management has been much disputed. See Brown, Politics and Health Care Organization, especially chap. 3.

41. CENSIS, Rapporto 1982, 366, 368.

42. Piperno, “Medici e stato,” 61.

43. Ibid., 59.

44. Corriere della Sera, 26 May 1983.


47. Carnevale and Perucci, Guida pratica, 71.


49. Carnevale and Perucci, Guida pratica, 65.


54. There is a helpful explication in Brenna, “Alternative Methods,” 4144.

55. CENSIS, Rapporto 1982, 377-84.

56. Ibid., 313.


59. The problem in microcosm is captured in an article in Il Messaggero of 18 July 1983 on Rome’s emergency medical services. Eighty percent of calls each night requesting a home visit come from lonely or anxious people who claim to need a doctor when in fact they do not, an official said. As a result, the telephone lines are continually blocked and private medical associations have sprung up to handle the excess demand.

60. As matter of logic, Aaron Wildavsky may be right in arguing that only “pure” public or private systems make sense in the long run. As matter of practice, however, “mixed” public-private systems will remain, seeking to improvise new modes of mixture. See “Doing Better and Feeling Worse: The Political Pathology of Health Policy,” Daedalus (Winter 1977): 117-23.


62. Cavazzuti and Giannini, La riforma malata, 140.

63. Quoted in Il Messaggero, 7 June 1983.

64. la Repubblica, 1 June 1983.
65. Ibid., 28 July 1983.
66. For an instructive and sardonic analysis of the Italian experience with tickets see Alberto Mucci. “Per ora è solo psicologica la funzione del ticket,” (“For now the function of the ticket is merely psychological”) Corriere della Sera, 6 July 1983.
67. la Repubblica, 1 June 1983.
68. Il Messaggero, 10 July 1983.
69. la Repubblica, 28 July 1983.
70. Between 1978 and 1980, admission rates climbed from 154.8 per 1,000 persons to 158.2, and although length-of-stay dropped from 12.1 to 11.4 days, this rate is considered higher than necessary. Figures from CENSIS, Rapporto 1982. 355; and Renieri and Piperno, “List Size of General Practitioners,” 337-38.
74. la Repubblica, 28 July 1983.
76. Carnevale and Pcrucci, Guida pratica, 73. The average nationwide occupancy rate in 1978 was 69.2 percent. By 1980 it had fallen to 67.8 percent. CENSIS, Rapporto 1982, 355.
77. On the components and implications of the two models, see Brown, Politics and Health Care Organization, 525-25.
78. Cavazzuti and Giannini, La riforma malata, 68. 116.
80. Bruce C. Vladeck recommends that this be done in the United States. See Unloving Care: The Nursing Home Tragedy (New York: Basic Books, 1980), 221-29.
81. The same problem arises in curbing spending on drugs, which runs second only to hospitals. The CENSIS study observes that there is of course overuse, but that it cannot very well be stopped now. Doing so would trigger a crisis in a very important industry with a large work force—if only West Germany, the United Kingdom, the United States, and Japan have more employees in the pharmaceutical industry than does Italy— and a declining job picture in the 1980s. Rapporto 1982, 347-49.
89. CENSIS. Rapporto 1982, 456.
90. See the article by Rosy Gargiulo, “L’anziano, dimenticato, beve,” (“The old man, forgotten, drinks,”) la Repubblica, 3 July 1983; and CENSIS, Rapporto 1982, 458-59.
91. For experience in the United States, see Vladeck. Unloving Care, 215-18, 230-37.