HEALTH LEGISLATION AND THE MEDICAL PROFESSION IN ITALY: 1859-1978

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Abstract: *Covering an extended historical periodisation, this essay examines Italian healthcare politics, comparing them to the increasing influence of medical doctors and their ability to influence the legislature in decision making. The key element to emerge from this study is the substantial continuity of objectives from the period of the construction of the Italian State up to the 1970s. In that phase, public health is to be understood predominantly as 'health policing', that is to say as a branch of the power the executive held over society (epidemics, degenerative illnesses, care for the poor). The increased demand for healthcare from private individuals, in most cases based on insurances, alongside the ability of the medical body to create an identity for itself as the country's critical conscience in terms of sanitation and the spread of disease, progressively widened the responsibilities of public healthcare, thus complicating issues of its organisation and management. The 1978 reform, not without its own quandaries, marks a moment of discontinuity with the previous model, surpassing the limitations of healthcare policing, widening the concept of health and freeing treatment from provident insurances by financing it through general taxation*.
Keywords: history of professions, history of health laws, welfare, medical associations (history), public health, history of public administration, social history.

Introduction

This contribution presents an overview of the evolution of public health legislation in Italy, in the context of its close links with the developing professionalization of doctors and other health professionals. This overview aims to link diverse strands of research, primarily in terms of the historiography that analyses the discontinuities and permanencies within the control and management policies in public health over time and throughout different regimes (Liberal Age, Fascism, Republican Age). Tightly bound to the central strand of historiographical research are other forms of historical and sociological research on the birth and transformations of the liberal professions. Furthermore, other suggestions derive from historical research into public administration, most notably at a local level[1].

The history of health legislation begins with the first measures established in 1859 in the Kingdom of Sardinia. The Kingdom of Italy had not yet been created (this was to happen in 1861), however the outcome of the French and Piedmontese war against Austria had brought much of central and northern Italy under the rule

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[1] As this essay provides an overview of the issues, the bibliography is collated at the end of the essay, footnotes are limited to essential information and quotations from more specific sources.

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of the reigning house of Turin: the House of Savoy, which in turn meant that the laws passed in Turin in that period were also applied to the new territories. The *terminus ad quem* of the period studied in this essay is Law 883 of 23 December 1978, with which a drastic reform of the health service was activated, following over a century of modifications and adjustments that were often contradictory. The 1978 law provided the health service with a new organic structure based on the principle of 'universality' within which all residents on Italian soil were entitled to hospital, health, and welfare assistance managed by the *Sistema Sanitario Nazionale* (National Health Service-NHS).

In order to illustrate the evolution of healthcare politics, reference must be made to the contribution made by doctors to the legislation through their scientific and professional associations. Indeed, a debate was established between the State and medical professional bodies. On the one side were the necessities of 'healthcare politics' on the part of the executive, which were directed toward control and governance of the population and the territory, under the profile of healthcare and also public order; on the other side was the technocratic desire on the part of the doctors to be the representatives of the nation's 'health conscience', and therefore to be the only decision-makers and enactors of all healthcare needs, both in the interest of the population as a whole and of each individual patient.

In the middle of the nineteenth century, medicine was just beginning to benefit from progress in the scientific disciplines that underpin it, increasing its diagnostic and curative efficiency. We cannot speak of modern medicine as yet, which began at the end of the nineteenth century, furthered by the discoveries in histology and bacteriology, but doctors compensated for their limited understanding of the field of disease aetiology with constant observation of disease levels, and of the sanitary and 'moral' condition of the population, often rendered systematic by the prevailing positivistic mentality, by an interest in statistics, and by lively debates in medical journals.

The privileged place for the construction of this empirical knowledge of medicine was the *condotta sanitaria*. This was an institution of ancient origin, through which the *Comuni* (municipal governments) paid one or more health workers (usually doctors or surgeons, often also midwives, and sometimes vets), who regulated the healthcare of the poor, often to the benefit of the majority of the population. At the time of the unification of Italy, around three quarters of the *Comuni* in Italy had *condotte mediche* in place, although the contractual agreements between healthcare providers and town councils varied greatly, as did the quality of care provided, of which around one third of the new State of Italy's inhabitants benefitted. It was in the *condotta sanitaria* that doctors also developed a particular professional conscience and began to reinforce this conscience with the creation of associations, which began in the 1840s, in areas where the ruling State permitted it. These associations, however, were not able to enter into a dialogue with governments before the era of the constitution, but once the Kingdom of Italy

was established, the majority of these associations merged into an early national organisation, the *Associazione medica italiana* (Italian Medical Association-IMA). The aim of the IMA was primarily the reform of healthcare legislation, following a project of scientific management; to this purpose the need of a 'risorgimento sanitario' (healthcare resurgence) was spoken of, based on the responsible direction of a specific expert for every articulation of the health service, central and local[2].

The Liberal Age: 1859-1910

The first comprehensive legislation on public healthcare and on the regulation of the primary professional market of doctors, that is to say the *condotta*, was Law 3797 of 20 November 1859. This law was an emergency measure, passed without discussion in parliament thanks to the concessionary mandate to the Sardinian government, presided over by Urbano Rattazzi, on the occasion of the 'second war of independence'. The law was conceived as an appendix to the reform of administrative structure that had been approved some weeks prior to this date[3], and which was to be progressively extended throughout the newly-emerging Kingdom of Italy. Italy's health care, therefore, was included within the duties of local administration, which hinged on the Mayor appointed by the Kingdom, who was the 'healthcare official' of the *Comune*, followed by an administrative hierarchy of peripheral functionaries who were supported by Health Councils. These councils were appointed by the government and called upon to provide non-binding opinions to the administration. The summit of this pyramid was the Ministry of the Interior, which was also advised in medical matters by a Higher Council of Healthcare.

This organisation offered perfect continuity within the Savoy tradition and furthermore reflected the pervading conception of public health as a problem of policing that was shared across Europe. Problems arose due to the weakness of the last link in the chain: the Mayor. In addition to being appointed by the State as responsible for enforcing public health and safety, the Mayor was also responsible for the scarce financial resources of the town council. The tangible measure necessary to provide sanitary conditions, healthcare and treatment weighed hard on the coffers of the *Comuni*. Furthermore, as the financial state of local authorities was highly varied, healthcare law could do nothing but leave the institution of the *condotte mediche* to the discretion of the administration. From these conditions, thus emerged a loose net of medical and surgical care that was unevenly distributed across the country with large gaps, particularly in rural areas, where the majority of Italians lived.

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[2] *Atti del congresso costituente dell'Associazione medica italiana tenutosi in Milano nei giorni 1, 2, 3, 4 e 5 settembre 1862. Preceduti da cenni storici circa la fondazione dell'associazione stessa*, Milan, Chiusi, 1863.

[3] Law 3702 of 23 October 1859.

This landscape saw no alteration even with the new municipal and provincial Law 2243 of 20 March 1865, the *Appendix C* of which concerned public healthcare[4]. In truth, there was in fact an element of change; it became *obligatory* for the *Comuni* to provide for the healthcare expenses for those in poverty. Later regulations (ratified on 8 June 1865), however, did not prescribe clear directives on how this obligation was to be applied, and no measures established the obligatory presence of doctors on the consultative health committees, as medical presence had been introduced at a municipal level.

These two critical points within Italian healthcare legislation mobilized medical associations and gave direction to their cause. Highly sophisticated analyses from the field of medicine rejected first and foremost the representative concept of healthcare legislation, characterised by the pre-eminence of politics over technical competence[5]. To this end they requested that consultative bodies working alongside political authorities could be made operative and heeded to. Other sectors concentrated their efforts in a more realistic manner with pressure on the *Comuni*, the linchpin of the healthcare service, but also the nucleus of healthcare provision through the *condotte*. The *Associazione Nazionale dei Medici Condotti* was established in 1874 with the aim of securing the effective application of the *condotte* healthcare system based on adequate salaries, which were not humiliating to the professional competences of doctors, and which allowed prevention and treatment of illness in the underprivileged to be undertaken, as the law dictated. The Association of *condotti*, in an analogous way to the IMA, developed an intense agenda of epidemiological and sanitary enquiry within Italy, using 'field notes' from doctors to report the critical points of public health and healthcare. It was from these very enquiries that emerged the earliest reports on child labour, on the lack of urban and domestic sanitation becoming vehicles for the spread of disease, on the health dangers of marshy areas.

The stimulus of medical associations and scientific journals together with the presence of some eminent clinicians in parliament, in various years produced a number of proposals for healthcare reform, none of which, however, ever concluded in success. Nonetheless, a number of resolutions for reform were collected by the *Regolamento generale* of 6 September 1874, which reformulated the implementation criteria from the Law 2243 of 20 March 1865, adding to the healthcare obligations of the local authorities (the Mayor), and surveillance over the sanitary conditions of dwellings, workplaces, foodstuffs, burials, and hospitals.

A significant turning point towards a more modern health legislation came about during the early governments of the Left (1876), guided by Agostino Depretis. In 1880, the member of parliament Agostino Bertani, a famous doctor

[4] See *L'Unificazione amministrativa (Legge 20 marzo 1865, n. 2248) e l'evoluzione post-unitaria*, special issue of "Storia Amministrazione Costituzione. Annale dell'Istituto per la Scienza della pubblica amministrazione", 2015, n. 23.

[5] See Carlo Zucchi, *La riforma sanitaria in Italia*. *Memoria*, Milan, Dumolard, 1888.

and follower of Garibaldi, was assigned the task of developing a new legal bill. At that time, Bertani was undertaking an important enquiry into the state of healthcare in the *Comuni* throughout the Kingdom that was based on the observations and analyses of the *medici condotti*[6].

Embracing that experience and the debates that were taking place in the medical associations, Bertani drew up the guidelines for his legislation that was founded on the concept of the State's *duty* towards protecting public health, by coordinating preventative and curative works. With scant legal precision but with great semantic flair, the health and medical press called Bertani's bill 'the Code', because it was envisioned as a comprehensive overhaul of all aspects of healthcare be it preventative, curative, or the safeguarding of healthcare professionals. This description reverberated with a centralist and efficiency-driven design that saw in the medical class as the grassroots in the territory (with the *condotti* depending not on the *Comuni* but on the State), and being the exclusive consultants to political power. The bill did indeed envisage a hierarchy in healthcare that was almost completely autonomous from political power and from the rest of the extended administration of the State, a sort of common thread, if you will, of experts acting as steadfast custodians of public health, culminating in a chief Magistrate for public health. It was important that the role went to a Magistrate, that is a functionary, and not to a Minister, who would be subject to political oscillations and parliamentary majorities, and thus rather unstable in terms of agenda.

The initial intentions were, however, downsized over the course of the long journey of preparation for the reform which was finalised only in Law n.5849 of 1888. Within the scope of this remarkably thorough and well-structured piece of legislation, further extended by practical guidelines[7], the 1888 law regulated a vast series of questions pertinent to sanitation and public health. The overall aspiration was one of incrementing the medicalization of society thus, indirectly, reinforcing the healthcare professional sector, and their social prestige. Indeed, the law made provision for the obligatory payment of the salaries of one or more doctors and obstetricians by the *Comuni* (there was no obligation for the *condotte* in the fields of pharmaceuticals or veterinary practice). This same law also established job stability for healthcare workers after a probation period. This constituted a great step forward, although it took an additional decade before the processes were in place to allow Prefects to directly intervene on the finances of those *Comuni* that refused to make use of the support of the *condotta*[8].

[6] See Mario Panizza, *Risultati dell'inchiesta istituita da Agostino Bertani sulle condizioni sanitarie dei lavoratori della terra in Italia. Riassunto e considerazioni*, Rome, Stabilimento tipografico italiano Perelli, 1890.

[7] The *Code of Conduct* was approved with the Decree of Law 6442 of 9 October 1889, then reviewed in the Decree 45 of 3 February 1901; the next coordinate revision appeared with the Bill of Law 57 of 25 February 1904.

[8] This happened with the Law 317 of 14 July 1898.

From the point of view of local healthcare administration, the 1888 reform introduced two positions: the *Medico provinciale* (Regional Medical Consultant) and the *Ufficiale sanitario comunale* (Local Health Official). These expert posts did not substitute prefectural and mayoral authority in healthcare, however they did at least have explicit *advisory* duties rather than simply a consultative role. Furthermore, they could receive a mandate to act *in place of* administrative authorities on issues of healthcare. The administrative organisation, however, did not always coincide with the intentions of the legislator. The *Ufficiale sanitario*, for example, was a municipal employee and therefore subordinate to the Mayor, but by law this role also reported directly to the *Medico provinciale*[9]. The *Ufficiale sanitario*, therefore, was subject to two hierarchical structures, and this situation, in many circumstances, was the cause of jurisdictional conflict or indeed allowed room for personal rivalries[10].

The reform was only marginally relevant to the functions of pharmacies (the preparation and sale of pharmaceuticals), which was liberalised[11]; whilst no innovations were introduced in treatment sites, that is hospitals. In Italy, the hospitals were prevalently owned and managed by charitable organisations, and were managed in a great variety of ways from a scientific and healthcare prospective. Another important measure introduced by the Crispi government in 1890 was that of subjecting these organisations to more scrupulous and regulated administrative criteria, without, however, establishing any healthcare standard[12].

With regard to healthcare professionals, the 1888 law confirmed public interest in the regulation of medical professions, and established the obligatory registration of qualifications with municipal authorities, who were obliged to compile lists of approved practitioners, what is more, practising medicine without the relevant qualification became a criminal offence. The law established under Crispi's government, therefore, recognised the central role of doctors in the protection of health and sanitation, but also put an end to the utopia of 'medical power' that had driven healthcare associations as this law reiterated the subordination of experts under the political responsibilities of the Ministry of the Interior and its local representatives. From the end of the nineteenth century, the

[9] In 1904, this role was termed as "ufficiale governativo" (government official).

[10] See Antonio Labranca, *Ufficiale sanitario*, in *Nuovo digesto italiano*, edited by Mariano D'Amelio, Turin, Utet, 1940, vol. 12, part 2.

[11] By abolishing any form of the restrictive system that had characterised legislation in the previous Italian States and also the legislation of the early decades of the Kingdom of Italy, this law aimed to create widespread pharmacy services extending even to the remotest areas. In reality, these new pharmacies were concentrated in the major cities. In order to overcome the problem of distribution of pharmaceuticals in rural areas, in 1904 pharmaceutical assistance for the poor was made obligatory, at the *Comune*'s expense. The first law concerning pharmacy practice was Law 468 of 1913, which reintroduced a mandatory request to the State for permission to open a pharmacy. Alberto Soldi, *Origini ed evoluzione della legislazione farmaceutica in Italia*, Milan, Guadagni, 1976.

[12] The control of healthcare standards remained with the Mayor and the Prefect. The 1890 law mentioned is n. 6972 of 17 July.

process of professionalization of healthcare workers met with more prosaic objectives. One of the most common problems was the definition of the respective expertise of various healthcare professionals. An important outcome was reached in this regard in the Royal Decree 6850 of 1890 when a new law ceased the legal existence of phlebotomists and other medical roles that practised without any university qualifications, and furthermore imposed a degree in Medicine and Surgery for those practising dentistry, even though over the following half century many exceptions were to be granted[13].

At the same time, the pitfalls of the professional market, from competition and the persistence of unlawful practice pushed those in favour of the medical associations towards an explicit request for more stringent regulations concerning legal safeguarding of the profession, within a framework of self-governance akin to the system accorded to the legal profession in 1874 with the establishment of the Bar Associations. By the end of the 1880s, many local sections of the IMA reorganized themselves into '*Ordini dei sanitari*' (Healthcare Professionals Associations) on a voluntary and private basis (Milan, 1887; Naples, 1888; Venice, 1889). The aim of these organisations was to maintain the guilds of doctors, vets, and pharmacists who were qualified to practise, to resolve legal disputes amongst members and with the public, and to exercise political pressure against illegal practices in healthcare, which was still widely tolerated in legal hearings. These early associations had few members (on average 25-30% of professionals), and therefore were of modest influence. Their arbitral role between professionals or between doctors and their patients was a failure, and their efforts to impose a minimum tariff had a minimal effect. Some commendable results were obtained in the drafting of the shared codes of practice[14].

Another factor that further weakened the efficacy of these Associations (brought together in a National Federation from 1898) was rivalry between different components. The *medici condotti* constituted the most politically active element and directed the majority of Associations, which acted as trade unions, particularly in pursuing claims, in negotiations with *Comuni*. Independent practitioners had a diverse range of needs; they were particularly concerned with the repression of illegal practice, with the control of the new problem of medical advertising, and often with the aim of being able to control the professional market itself, reining in what many were referring to as the 'plethora of doctors' (which in reality was a strictly urban phenomenon).

[13] Only in the 1940s, following the Law 1469 of 27 December 1941, medically-trained dentists began to be listed in registers.

[14] These codes often drew on foreign examples. Among the oldest, there was the code adopted in Milan in 1890, which was already in use in the British Medical Association, see: Jukes De Styrap, *Codice di etica medica, con precetti generali e speciali per la condotta del corpo medico e del pubblico nelle complesse relazioni della vita professionale, versione italiana sulla terza edizione inglese di L. Coulliaux*, Milan, Tip. Fratelli Rechiedei, 1889.

In the Giolitti government, this composite movement was flanked by the consolidation of an active interest group in Parliament, which for the most part sided with radical democracy and socialism. As a whole, medical activism, in all its many forms, was able to exert significant pressure on the legislature that led to the creation of the *Ordini dei sanitari* in 1910[15]. In every region, three *Ordini* were created, which were separated into doctors, pharmacists, and veterinary surgeons. These associations were organisations that enforced professional codes of conduct and held the registers of qualified practitioners. Registration was obligatory for liberal professions, whereas employees in local or State administration were excluded. The law also stated that the presidents of the three *Ordini* were directly made members of the *Consigli sanitari* (Health Council). The law was not a healthcare plan, however, the creation of the *Ordini* institutionalised healthcare administration as a collective social agent, that is to say, the doctors, who acquired another vehicle through which to enter into the debate on the laws regarding healthcare reform. In theory at least, as over the following years collegiate doctors found themselves substantially marginalised from the formative processes of healthcare politics of governments.

The Fascist Period

The activity of the medical associations ceased completely during the First World War; when in 1919 the elections were held to re-establish the managerial authorities of the *Ordini*, nationalists and fascists were elected to the presidency of colleges in a number of important cities; firstly in Milan, then in Rome, Florence, and Bologna. One of the seductive factors used by Fascism was the revival of the historical perspective of health associations, as a promise that there would be a healthcare reform that would be entirely based on the expertise and management of doctors.

Once Fascism gained power, the normalization of the other medical associations, be they scientific or unions, was quick to follow the *Ordini* and in the space of a few years all came under fascist control. The *leggi fascistissime* in 1926 that dismantled all union rights throughout Italy, only allowed fascist organisations union representation; later on, in 1929 free elections for the president and elected members of the professional associations were abolished, transferring the appointment to the Ministry of the Interior. Lastly, in 1934-35, the *Ordini* were abolished, transferring the conservation of guilds of liberal professions and the code of conduct committees to fascist unions[16].

With regard to healthcare administration itself, the fascist regime adopted the same political premises as in 1865 and 1888, developing a centralised organisation[17],

[15] This happened following the ratification of Law 455 of 10 July.

[16] The Decree of Law 2027 of 1929 (then Law 414 of 31 March 1930) abolished the election of the managerial structures; in 1934 the Association of Pharmacists was abolished, and the Decree of Law 184, then Law 983 of 27 May 1935, abolished the Associations of doctors and veterinarians too.

[17] See the full text of the healthcare bill, Law 1265 of 27 July 1934.

and therefore reducing the autonomy of the local authorities (particularly the *Comuni*) in favour of centralised administration and new organisations that were created to manage healthcare insurance. The creation of social and health insurances in Italy began at the end of the nineteenth century[18], as it did across most of Western Europe, and it was increased in the war years. Fascism further developed this phenomenon, widening the field from financial compensation for injuries at work to medical intervention, firstly in cases of diagnoses of particular social alarm (tuberculosis or syphilis for example), and later for demagogic reasons and to respond to the increase in healthcare demand from private individuals to whole categories of citizen and for any and all diagnosis. This was termed 'socialization of medicine' and it was exalted by the regime as a vehicle of modernization of society avoiding social conflict. But what sort of socialization was this? In reality, there was no health service extended to the entire population, the State did not actually finance the extension of medicalization, but promoted, based on agreements with unions and according to the insurance model, the proliferation of organisations, known as *mutue* that distributed treatment to workers in a particular manufacturing sector and sometimes to their families. The resulting coverage across the Italian population was mottled and only around 35-40% of the population could make use of this insurance fund[19]. As for the other citizens, if they had the wealth, they could seek medical assistance privately, if they did not have the means to pay, they continued to be assisted through the work of the *medici condotti*.

In terms of efficiency, the most obvious inconvenience in such a confused creation of institutions was the discrepancy of the systems, to the extent that every insurance fund (*mutua*) enforced different conditions regarding contribution schemes, the length of time of contributions, and the ways in which medical, hospital, and pharmaceutical care was distributed. A centralised institute was created in 1943 (later named INAM)[20], in order to unite the various organisations operating in the healthcare sector. The unification process was only partially undertaken, and a plurality of insurance companies and local funds continued to run autonomously outside the law, retaining their own characteristics.

The insurance fund system also remodelled the organisation of the national hospital provision to suit its needs, according to methods that were destined to

[18] Law 80 of 1898 established insurance against accidents at work; insurance was compulsory but the choice of insurance company was at the employer's discretion. Again in 1898, Law 350 was passed that introduced a National Insurance Fund for voluntary insurance against invalidity and old age, with a contribution from the State. From 1917 to 1921 compulsory accident insurance was extended to the main productive industries, and invalidity insurance was also made obligatory.

[19] The majority of doctors worked for these new insurance fund organisations; towards the end of the 1930s this figure reached almost 90% of doctors registered to guilds, some worked for them for their entire career, others only for a few years until they had established their own private client base. This 'socialization' however, reduced the fees charged by doctors to below the minimum limits established by the medical unions.

[20] Abbreviation of the Istituto Nazionale Assistenza Malattia (National Institute for Assistance to Illness), the name that it took in 1947. The merger was established by Law 138 of 1943.

endure long after the end of Fascism and of the Second World War. Hospitals found in their agreements with insurance funds a means of removing their chronic financial difficulties that were caused by the insolvency of the municipal authorities, who were, by law, responsible for funding any periods of hospital stay of the poor, and that constituted an ever increasing number of beds. Clinical assistance, therefore, took on the logic of profit making from the mid-1930s, and this logic ended up shaping the entire organisation of hospitals, promoting departments that had the greatest added value, such as surgery and, for example, limiting admissions for contagious diseases[21].

Post World War II until 1978

The social security model outlined in the Fascist era was substantially applied for decades in the Republican period. This was based on the progressive extension of the right to healthcare through the insurance system to new social sectors. The holder of the insurance was not the citizen, but the employee and, ideally, the employee's family. In addition to reducing professional freedom (that is a patient's free choice of doctor), the system was based on weak financial assumptions, and the republican legislature decided very early on to integrate public funds into the *mutua* system, highlighting the total insufficiency of equal contributions from workers and employers to finance insurance fund organisations.

In 1958 a Ministry of Health was established for the first time (with the Law 296 of 13 March), however, this Ministry did not have overall jurisdiction over the health and welfare of the country, as the social insurance system was excluded because it was by its very nature insurance and contractual, and therefore privatised. At the same time, also in 1958, the legislature intervened and refinanced the INAM and numerous other sector-based organisations that had continued to function (for state employees, certain categories of professionals, and so on). The equal distribution of services amongst the various categories of insurance holders headed by INAM was also established, however the underlying problem of the coordination, the utilization of the health structures, and services that headed up the various organisations, so that they could meet the healthcare demands of citizens, was not tackled. In the absence of an overall plan for public health, even the State funds became by necessity dispersed in sectorial initiatives, which were often dictated by electoral popularity rather than an overall plan of reconstruction and enlargement of healthcare structures.

And what of the Italian doctors? Did they continue to constitute a stimulus towards reform and improvement of healthcare politics in Italy as they had tried to do in the Liberal Age? Substantially the answer is no, they did not, at least not as a group and through their historical groupings, since the market had by this time segmented the identity of the profession and its aspirations.

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[21] Hospital doctors became shareholders in this new *company* of healthcare with the Decree of Law 1631 of 1938.

In 1944 in liberated Italy, the Fascist corporative system was abolished and within a few months the *Ordini* of doctors were reconstructed in a provisional form based on the 1910 law. The comprehensive reconstruction of the collegial system occurred in 1946[22], when the first collegial elections took place, in which, however, less than 30% of doctors voted. Interest was to increase over subsequent years, when the various components within the profession gave rise to numerous unions with varying objectives, all interested in gaining the majority in the *Consigli degli Ordini*, and at that point around 80% of those eligible voted. The objectives of the healthcare organisations and their associations were, however, for the most part defensive. In particular, the *Ordini* and the main unions of doctors criticised the progressive extension of insurance funds to citizens who were not in financial need, which corresponded to the insurance organisations gaining great contractual power over tariffs, with the risk of transforming doctors from professionals into employees.

The insurance fund model of the *mutua* for healthcare continued to be pursued, and by the beginning of the 1970s it covered the needs of around 92% of the population with a further 4% whose medical needs were met at the expense of the *Comuni* (residents in poverty) or by the provincial authorities (those confined to mental hospitals, psychotic minors, suffers of Parkinson's disease, illegitimate minors). Considering that some figures overlap, the population who were not covered by insurance was reduced to around two to three million; these were self-employed workers who were just above the poverty line, unmarried housewives, unemployed youth, the wealthy, and some of these categories did, however, have their own privately arranged insurance with the main mutual insurance provider.

With the panorama of care and prevention being so fragmented, the Ministry of Health was reluctant to undertake the role of main instigator and coordinator of healthcare policies for the country. In 1968 a huge step forward was made with the introduction of Law 132 of 12 February 1968 which, in terms of healthcare, brought to a conclusion the process of rationalization of hospital structures that was initiated in 1890 but was never completed. By virtue of this reform, the Ministry of Health launched a national plan for hospitals, in harmony with the social care organisations and local organisations (the *Comuni* and the Provinces, as the Regions were only established in 1970). The law recognised the hospitals as being public organisations, public property, which were therefore open to treat anyone who was ill, leaving aside the *mutue* and insurance funds and that upheld collaboration with other institutions in order to safeguard the nation's health, through, amongst other things, training for healthcare staff. Furthermore, the law determined legislation on sanitation and plans for hospitals, the minimum numbers required for equipment and personnel, with managerial and inspectorate power lying with the Ministry of Health. In reality, neither the law nor the ministerial coordination scratched the surface of the inequality of availability of hospital beds

[22] This was achieved through Decree 233; the legislation relating to the application of the decree was only passed in Decree 221 of 1950.

and equipment between the richer regions who were able to finance greater development in hospitals, and the other regions who could not afford such development, however they constituted fundamental premises in order to redesign the health service in a uniform way throughout the republic.

Italian doctors, via the *Ordini* and a myriad of unions, were in dialogue with the government in the passing of the hospital reform law of 1968. They particularly fought to limit the risk of the dreaded bureaucratization of health workers' roles in hospitals, and to safeguard the right to offer private consultations within the hospitals themselves, obtaining a substantial victory in terms of freedom to practise and also important economic recognition in their work as employees. Once again, however, doctors were excluded from the financial and organizational management of hospitals, this exclusion took place at the time some of the more radical trade unions (and some of the *Ordini*) had reprised and modernised the traditional watchword of 'doctors in power' at the head of all organisations dedicated to healthcare and public sanitation.

Once the hospital sector had been reorganised, the next step of the reform of public health was tackle the chaos of the insurance funds. From the many possible avenues of reform that were discussed, Italy decided on a choice that was discontinuous with regard to tradition. With the utter impossibility of coordinating and harmonizing the various health care and preventative care systems that were financed and managed in a variety of ways, Italy decided to adopt a *universal* system of healthcare that was available to the whole population, regardless of working conditions and of wealth. At the end of the 1970s, for that matter, universal systems of healthcare organised by governments were prevalent in European countries, even those with different social systems, and in total around one third of the world population had access to a similar system[23].

The road to reform was not without pitfalls. Some theories were put into action in the mid-1970s, but were not discussed in Parliament. In 1973, for example, the fourth government of the Republic, in which Christian Democrat Prime Minister Mariano Rumor led a centre-left coalition, added his own programme of universalistic public health reform, and presented it to Parliament in 1974. The principal obstacle to the law being passed could be found in the large financial interests connected to the practice of gradual extension over a thirty year period from the *mutue* to new groups of insurance companies, as opportunities arose, and the colossal national institutes that coordinated the *mutue*, which became key places of nepotistic power for the major Italian parties. Law 833 of 27 September 1978 was passed which established the National Health Service. The Italian NHS, funded through income tax contributions, was intended to substitute the insurance-based model with an all-encompassing system of health and welfare care and prevention that was available to all those

[23] Cf. Milton Terris, *The Three World System of Medical Care: Trends and Prospects*, in "American Journal of Public Health", 1978, vol. 68, pp. 1125-1131.

living on Italian soil. Initially, however, this new system ended up being superimposed over the previous model as the former insurance funds remained active and the management organisations were to continue to remain active for decades to come. The change of perspective in the organisation of public health also concerned the local authorities, as the traditional role that previous legislation (1859, 1868, 1888, 1934) reserved for local organisations (predominantly the *Comune*) was diminished; indeed a network of *Unità Sanitarie Locali* (Local Health Units) was created for the organisation and management of social and health intervention, which, on a national level, constituted a structure that functioned in an entirely separate and unrelated way to local governments.

The structure of Law 833 of 1978 in many of its aims greatly resembled the health reforms that the associations of doctors had been calling for since the mid-nineteenth century. The perspectives of the medical profession and of their associations, however, had become a much less determining factor from the 1920s onwards following a series of vertical divisions with regard to the prospective income determined by the professional market. The medical associations had voiced strong resistance to the passing of the reform bill. The negative aspect, from their perspective, was the model of public health management, which was a modernized form of the traditional 'polizia medica' system, adapted to a democratic context, in which political power made decisions and the experts had to carry them out. The 'healthicization' of society was, however, obtained as was the universalization of a right to healthcare for all, both of which were in the general objectives of the medical corporation. Following this, associations and unions turned their attentions to other objectives. Their primary claim was the exceptionalism of doctors within the healthcare system, who could not and must not be confused with other healthcare workers, which resulted in a great deal of autonomy given to NHS doctors (including maintaining their right to practise privately), and important economic recognition of their role. From this situation the accusation emerged that medical professionals, and for some the entire political class, had caused the degeneration and failure of the system introduced in 1978, bringing it towards organizational and financial collapse.

There is no doubt that the institutionalisation of healthcare incentivised an increasingly intense and at times imprudent use of the rights to healthcare (particularly in the areas of diagnoses and treatment), and that the doctors themselves played a determining role in this persuasion toward healthcare consumerism. However, analysing the 1978 reform in the correct historical context, it is clear that this reform was an attempt to rationalise a chaotic situation in which the very same cultural and commercial factors inducing people toward increasingly availing themselves of healthcare services were already operating and were already widening their influence. In general terms, it is true to say that no definitive public health policy could ever exist that could be perennially considered as well-founded, and it is a necessity that at any given point in time and with any economic and socio-political context there are calls for reform of the existing system.