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Public Health Institutions in Italy in the 20th Century

By Massimiliano Paniga[*]

Only recently studied by Italian historiography, public health is one of the most important sectors of a modern Welfare system. During the Twentieth century Italy faced the hygienic and sanitary problem often with different ways and tools than other European countries. The aim of this article is to understand better the attitude and the development of the main public health institutions, both at the central and peripheral level, during the three great phases that marked the history of Italy in the last century: the liberal age, fascism and the Republic, as well as to highlight the organisations, men and structures that exercised decisive functions in the bureaucratic and administrative State machine. The essay focuses on the most significative legislative measures (for example, the "Testi Unici" of 1907 and 1934) and the turning points that have changed the sector on the institutional plan, from the creation of the Directorate-General for Public Health inside the Ministry of the Interior, and destined to remain for the entire Fascist period, to the birth, in the post-war years, of the High Commission for Hygiene and Public Health, then replaced by the Ministry of Health, until the establishment of the National Health Service in 1978.

Keywords: *Welfare State, social policies, public health, assistance, institutions*

Introduction

Italian historiography has only recently addressed the field of medicine and public health. Until the 1970s historians had shown a substantial lack of interest in the subject, treating it marginally and episodically by those working in economic history and historical demography (especially modernists and with approaches not always integrable to each other), and which had epidemic diseases as their object of privileged research. The only exception is the 1967 volume by Renato Alessi on the Italian health system, published on the occasion of the congress celebrating the centenary of the laws of administrative unification (Alessi 1967). The increase in attention paid to the living conditions of the lower classes and to the links between political, economic, social and cultural issues led to a broadening of horizons and to the development of a strand of studies on public health which were certainly not very rich in contributions but which had an autonomous distinction. The seventies was a turning point, gradual and not linear, accompanied by a thematic expansion and a change in interpretative trends. In particular, the research of contemporary historians has evolved according to trajectories conditioned by political history, with an inevitable reverberation on the modalities and timing of the diffusion in our country of the methodologies of social history.

A fundamental contribution to national historiography was made by Franco Della Peruta, who tried to focus his gaze on a more institutional direction of the

[*]Researcher, Department of Historical Studies, Milan University, Italy.

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problem, through some very important essays on the administrative structures and health legislation of the liberal state (Della Peruta 1980). Other studies (such as those by Cherubini (1977, 1980) and Cosmacini (1980, 1982) have moved along this line. This direction reached perhaps its highest moment with the publication of volume VII, entitled *Disease and Medicine,* of the *Annals of the History of Italy,* published by Einaudi in 1984 and edited by Della Peruta (Della Peruta 1984). According to Maria Luisa Betri and Edoardo Bressan, this work concludes the most vital cycle of studies on contemporary health care (Bressan and Betri 1989, p. 121). A few years later, in fact, a period of stagnation followed. It will be necessary to wait until the early 1990s for a partial resumption of research and, in this case the work of the Institute for Public Administration Science of 1990, on the occasion of the centenary of the Crispine reforms, is very important. This publication reserved a whole volume for the Social Administration, which constitutes an important recovery of institutional issues, in the wake of which other work has resumed, even though numerically rather limited (ISAP 1990).

What emerges from the main studies, even the most recent ones, is the predominant interest in the liberal age, which very often represents the term *ad quem* for Italian historiography, that is, when the political ruling class, this is a well-established opinion among historians, initiated the process of building the Welfare State. It is therefore thanks to Giovanna Vicarelli to have analyzed in an organic way the health policy implemented by fascism, until then little explored except by the essays of Domenico Preti (Vicarelli 1997, Preti 1982, Preti 1987). The more advanced the twentieth century, the publications on health history becomes fewer. Historiography gives inadequate attention to the political and institutional events of public health in republican Italy, which is quite surprising, especially in view of the abundance of coeval sources. If we exclude the work of Saverio Luzzi, who reconstructs, intertwining social history with the history of the institutions, the set of processes and political battles that led our country to modify in the post-war period the hygiene conditions of Italians and health facilities (Luzzi 2004), the whole output is limited to a few brief hints in works of a general nature, of other sectors or of Cosmacini's works, where, however, the heart of the problem is the history of medicine (Cosmacini 1994, Cosmacini 2005). It was only in the last period, thanks to Chiara Giorgi and Ilaria Pavan, that some short but significant contributions were made to the national health service and its establishment in 1978 (Giorgi and Pavan 2018, 2021).

From this jarring point of view is the comparison with some foreign experiences, where the government of health and hygiene policies has aroused considerable interest and in several cases has intertwined the analyses in the history of the institutions with a more attentive approach to the history of medicine and health. It was Anglo-Saxon historiography that devoted a very important space to this subject, starting with the approval of the National Health Service in 1946, linking it to the construction of a welfare system and the consolidation of the modern European state.[1]

[1]Among the most significant works on the British National Health Service: Granshow (1988), Honigsbaum (1989), Timmins (1996), Briant (1998), Rivett (1998), Eversley (2001, pp. 53–75),

Research Objectives

This article analyzes the development of public health institutions in Italy during the 20th century. The intention is to better understand the attitude of the Italian State and the measures it has taken in the face of the health and hygiene problem during the main stages of its history, the liberal age, fascism, and the republic years, and to highlight the bodies, men and structures which exercised decisive functions in the relevant bureaucratic and administrative machinery. It becomes, therefore, inescapable to answer some questions: what is the legacy, in the field of health administration, of the previous Kingdom of Sardinia? Are there any elements of continuity or discontinuity between the three historical periods listed above?

This essay inserts this examination into the evolutionary dynamics of the Italian welfare state, which, from the beginning, acquired characteristics quite peculiar compared to other European countries. It consists essentially of four sections. The first addresses the liberal period, with the measures at the end of the nineteenth century that gave the Italian State a more suitable administrative structure to face the economic and social challenges linked to the phenomenon of industrialization. These are the years that see Italy, like other European countries, committed to laying the foundations for the construction of a welfare state, with a series of measures to support the most deprived sections of the population. A straight transition occurred at the institutional level with the creation in 1888 of the Directorate-General for Public Health at the Ministry of the Interior, a body destined to have a long life in the Italian bureaucratic system. During the Giolittian age, the "Testo Unico" on Health Laws was passed in 1907, while another significant moment it occurred in the immediate post-war period, with the failed attempt to create compulsory health insurance.

This objective was achieved by fascism, though only in 1943, when the regime was close to falling. It is precisely the fascist dictatorship that is the focus of the second section, which will highlight the inclusion of health policy in the logic of Mussolini's totalitarian project, as well as its relationship, and that of the more general social activities, with the corporative apparatus of the regime, which is intended to significantly change the profile of the liberal administrative organization. The proliferation of public bodies initiated by fascism was accompanied by a legislative fervor which led in July 1934 to the adoption of the new "Testo Unico" on Health Laws, which replaced the 1907 text mentioned above.

The third section is reserved for the years of the Republic, which had a very important start with the creation, in 1945, of the High Commission for Hygiene and Public Health, replacing the old Directorate-General for Public Health. The law entrusted the newly established institution with the task of coordinating and monitoring the bodies active in the health sector, all in connection with the development of the Italian welfare system. From this point of view, it is almost inevitable to make a comparison with Great Britain, where, at the same time,

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Webster (2002), Steward (2002, pp. 113–134), Rintala (2003), Gorsky (2008, pp. 437–460), Webster (2008, pp. 33–36), Jones (2015, pp. 77–80).

Clement Attlee's Labour government approved the National Health Service. In Italy, such a goal was achieved only in 1978, twenty years after another important result obtained by the Central Health Administration, the Ministry of Health, which put an end to the short, but not secondary, experience of the High Commission.

The fourth and final section of the article contains the conclusions, which will seek to draw up a final and long-term assessment of the evolution and role played by the main health institutions in Italy during the last century, while seeking to maintain a comparative logic with the foreign countries.

The Liberal Phase

In 1861 Italy had 22 million inhabitants, most of them illiterate and dedicated to an agricultural activity that presented elements of modernity only in the area of the Po Valley, while central Italy was dominated by the sharecropping, and in the South by the latifundium. In many rural regions of the South living conditions were at the limits of physical subsistence, with the population often subject to typical nutrition diseases, on all pellagra, and forced to live in small and unhealthy dwellings. The few industrialized areas of the country featured work situations where the use of female and child labor was extensive marked by a high number of work hours per week and in total absence of the most elementary hygiene standards.

The fledgling Italian State largely inherited the administrative structures and legislation of the Kingdom of Sardinia, which, as is well known, had led the process of national unification with Cavour in the previous decade. In the field of public health, the Royal Decree no. 3793 of the Savoy State of 20 November 1859 was extended to the rest of the country, and then replaced, in March 1865, by Annex C to the Law of Administrative Unification. The two measures differed little from each other and provided for a health facility centered in the Ministry of the Interior, where a health office, usually chaired by a doctor, and in the outskirts on prefects and mayors, functioned. The system, thus agreed on, favored the repressive side and police functions, aimed at both controlling the health of the population and reporting potential epidemic outbreaks.

In these early years of life there was a lot of criticism of a health system that often worked in a cumbersome way, with several elements of uncertainty and contradictory to each other. It will be necessary to wait until 1888 to see the adoption of a measure that completely overhauls the sector. Law No. 5849 of 22 December constitutes a fundamental hub in the history of Italian health institutions, so much so that it remains in force, in the main lines, until the late twentieth century. It was an integral part of the program to strengthen the State and the government authority put in place by the President of the Council Francesco Crispi.

One of the essential aspects of the measure was the creation of a Directorate of Public Health at the Ministry of the Interior, composed of elements with the necessary technical capacity and entrusted to the skills of the hygienist Luigi Pagliani, professor at the University of Turin and student of Jacob Moleschott.

Among the innovations of Law No 5849 are the reorganization of the system of health boards, introduced at the various territorial levels in 1865, the establishment of two new figures of hygienist officials included in the different steps of the public administration, the health officer and the provincial doctor, dependent respectively on the mayor and the prefect, and free medical care for the poor, which was provided by staff paid by the municipal administrations, usually conducted by a doctor and a midwife or entrusted on pious works and/or other charitable charities.

The reforms implemented by Crispi had the merit of providing innovative solutions to the needs of contemporary society, setting up a hygienic and health system that left, in the words of Giovanna Vicarelli, "a large part of the interventions of health care to the poor to pious works, after their control and rationalization", channelling "on two main tracks, the public and the private-charitable, the Italian health system" (Vicarelli 1997, p. 111). Indisputable was the renewal brought to the hygienic state of the Kingdom, culminating in the realization of works for the restoration of cities, rural municipalities and the countryside as well as for the repression of endemic-epidemic diseases.

However, for some historians Crispi's health care system did not seem to stray too far from traditional logic. In fact, state interventionism, rather than in direct form, remained conceived in terms of monitoring and controlling the center, i.e., the Ministry of the Interior, and the action of local authorities. According to Enzo Bartocci, Crispina law "on the one hand continues to respond to the principles of *lassez-faire*, albeit with greater flexibility and greater controls, on the other hand it pursues the purpose of the painless transformation of traditional forms of assistance inherited from the past" (Bartocci 1999, p. 180).

The conclusion of Crispi's government experience did not interrupt the reform and renewal of the administrative apparatus. A strong driver was provided by the Directorate of Public Health, who pursued a plan of iron centralization of functions and control over the peripheries, making it an experimental laboratory of the interweaving of administrative practice and medical science. Overall, the last glimpse of the nineteenth century is considered by historiographers to be the initial phase of the Italian welfare state[2]. The problems linked to industrialization, with the phenomena of proletarianization and urbanization of the popular masses, convinced a part of the liberal ruling class to look with interest at the Bismark experience in Germany and to put forward more concrete proposals on the subject of social legislation. The decisive date is 1898, when compulsory accident insurance was introduced, the first organic law dealing with safety at work, and a public scheme, still voluntary, for old age and invalidity.

It is therefore of great interest to try to understand the relationship between the reorganization of health systems and the random factors usually identified at the origin of the welfare state, namely industrialization, urbanization and the establishment of the workers' movement, which pervaded Italy at the turn of the two centuries. The impression inferred from the scientific literature is that health

[2]On the origins and the development of the Italian Welfare State see: Ferrera (1984), Ascoli (1984), Paci (1989), Gaeta and Viscomi (1996, pp. 227–276), Girotti (1998), Saraceno (1998), Conti and Silei (2005), Ascoli (2011), Ferrera et al. (2012), Mattera (2012), Giorgi and Pavan (2021).

policies were not so much a reaction to the social and living conditions of the population as a useful tool for creating the conditions for the process of modernization.

During the Giolittian age, the expansion of social policy continued, accompanied by the consolidation and extension of health functions and apparatus in the public administration, with a tangible increase in staff both at central and peripheral level. From this point of view, the most interesting aspect to highlight is the strong continuity in the staff found at the top of the health administration, all officials trained in Pagliani's time. No substantial alterations were introduced into the hierarchy of competencies and the internal articulation of ministerial offices. This continuity can be extended to the more general role of the public authorities in this field. Despite the commendable efforts made in the social field in the first fifteen years of the twentieth century, the state administration was always rather defiladed. Most of the burden of hygiene and public health interventions continued to weigh on local authorities, leaving the central power with tasks of simple superintendence. This situation emerged above all with the promulgation of the "Testo Unico" of 1907, that, in an attempt "to put order in the congeria of decrees, regulations, laws and instructions that had seen the light of day since 1888" (Cea 2019, p. 108), strengthened state bodies on the periphery through a better definition of the competencies of the health officer, the creation of consortia for the management of pharmaciesand the conferral of additional powers, and therefore an increase in expenses, to the municipal administrations in the field of home care medicine and midwifery of people in need. The "Testo Unico" of 1907 also had the merit of officially recognizing the Directorate of Public Health at the legislative level, who in the meantime was elevated to the rank of Directorate-General.

It was the outbreak of war that imposed a more direct role of the State in social policies, which, instead of being interrupted, suffered "a multiplier effect", destined to continue in the post-war years, with an even greater flow of legislative measures which opened a new phase in the development of the Italian welfare state. Public health doesn't seem to participate much in this copious legislative production, with the plan for compulsory health insurance finding no place on the government agenda. The issue had been the subject of discussion in the palaces of politics since the Giolittian period and had its main support from the medical class and the union, both of which were conscious of the undignified health conditions in which the poorest population found themselves. Innovative proposals were tabled in Parliament and working groups were formed to study the problem, but these initiatives, especially the reform provisions envisaged in 1919 by the Abbiate Commission[3], met with strong opposition from the most conservative circles of society, from the agricultural and industrial business class to hospital administrations, to the political formations very sensitive to the significant financial outlay that the State would have incurred. In particular, the hostility of the clerical world stood out, controlling, in an almost monopolistic form, the complex system of public institutions of assistance and charity. Against the idea of compulsory sickness

[3]Appointed shortly before the defeat of Caporetto and chaired by Mario Abbiate, the Commission completed its work in the last weeks of 1919, producing two draft laws, one more innovative and advanced, the other of a more limited scope, but which were not taken into account by Parliament.

insurance there was a large concentration of political, economic and social forces, which prevented the achievement of a very difficult and laborious goal to be crossed even for the fascist regime (Sepe 1999, pp. 190–192).

Fascism

> The physical health of the people must be in first place ... we must seriously watch over the fate of race, we must take care of race, starting with motherhood and childhood ... not fundamental but preliminary data of the political and therefore economic and moral power of nations is their demographic power.[4]

These are the words used by Mussolini in the famous ascension speech given to the Chamber of Deputies on May 26, 1927. The advent of fascism in power, following the march on Rome in October 1922, impressed on the state's health policy a marked ideological curvature in the framework of a totalitarian political project that aimed to bring Italy back to the glories of imperial Rome, restoring it to a central role among the great Western powers. According to Mussolini, numbers were synonymous with power and formed the indispensable premise of a nation's greatness. For this reason, fascism put in place a whole series of initiatives in support of the birth rate and the family. These initiatives achieved some results. Very visible was, for example, the reduction in the mortality rate in the first decade of the regime. From 1922 to 1933 the rate was reduced from 18.1 to 13.7‰, lower than that of the French and Spanish, and remained constant during the 1930s, until Italy's entry into World War II, when an increase occurred that reached 15.2‰ in 1943. In fact, the reasons for such a trend did not seem to be linked to the effects of the health policy of the regime, but to the gradual improvement of people's standard of living and the overall health and hygiene situation of the country. The measures introduced by fascism had a limited effect on the health of the population and became impressive social achievements (on all the reclamation works of large national territories and the fight against malaria) for the propaganda carried out by the regime and for representing urgencies largely disregarded by the liberal ruling class.

Unfortunately, a favorable trend in the state of health of Italians was matched by an increase in inequalities linked to social position and place of residence. The populations of the Mezzogiorno, the workers and the peasants were the subjects who, over the years, saw a deterioration in the quality of life, especially in urban areas and in certain locations in Sicily and Sardinia, where ancylostomiasis and echinococcosis maintained high levels of contagion and mortality (in the South also malaria and trachome continued to be very dangerous pathologies) (Vicarelli 1997).

If we broaden the horizon of reasoning to the social policy of fascism and its methods of implementation, it is evident how much the assumptions on which it was based, in the words of Domenico Preti, "were such as to empty and frustrate

[4]Parliamentary Acts, Legislature XXVII, Chamber of Deputies, *Discussions*, sitting of 26 May 1927.

the achievement of many of those objectives that publicly the propaganda of the regime was pointing to as safe destinations of the measures taken ... and for which valuable economic resources were used. The protection of work and health in Italy in the twenties confirmed the inconsistency of fascist social policy, both with regard to the traditional means used and with respect to the purposes intended, vehemently when demagogically, to achieve" (Preti 1987, p. 110).

From the mid-1920s, under the pressure of fascist ideology, there was a progressive absorption into the public sphere of social activities and their connection with the corporate apparatus of the regime so strenuous that it significantly changed the profile of the administrative organization of the previous liberal period, up to distinguish the path of the Italian welfare state from that of other Western countries.

One of the characteristic features of the health system established by fascism was the high degree of fragmentation and the subtraction of competencies from the central authority, which continued to revolve around the Directorate-General for Public Health of the Ministry of the Interior. With this in mind, the ministry that most absorbed health activities was that of the Corporations. Instead of calling for the improvement of the municipal and provincial hygiene offices, the General Regulation on Occupational Hygiene, approved by Royal Decree No 530 of 14 April 1927, created at that Ministry a medical labour inspectorate, with the respective organs and factory doctors, for the discipline and hygiene and health surveillance of industrial, commercial and agricultural companies. The Ministry of Agriculture, by reason of the Law of 24 December 1929, was reserved functions in the field of integral reclamation, including corrective works aimed at preventing the spread of malaria and protecting workers. Also in 1929 the sanitary and renovation works, for example the construction of social housing, was assigned to the Ministry of Public Works, limiting to the simple opinion of the Superior Health Council the intervention on the projects, and not all, of the Health Administration, while in 1938 health service was created at the Ministry of Colonies independent of the apparatuses of the Directorate General. An even more negative impact in 1942 came from the formation of the Directorate-General for Food within the Ministry of Agriculture, which extended its powers to public health sector.

Fascism created a considerable number of offices and public bodies, outside the Directorate-General and with budgetary and action autonomy with respect to the health surveillance bodies of the Ministry of the Interior, hindering any hypothesis of coordination of the sector. The category included, for example, the provincial antitubercular consortia, provided for by a law of 1927 with diagnostic and prophylaxis tasks. Also in 1927, the fight against tuberculosis was strengthened by the establishment of compulsory insurance. Both instruments soon showed significant limits in terms of insurance coverage and financial resources, generating a serious and progressive disparity in treatment between those assisted by consortia, often belonging to the poorest classes, and insured at the Cassa, lower in number and privileged, destined to drag on until the years of Republican Italy.

Speaking of public bodies, in 1925 the National Opera for Motherhood and Children was born, with the intention of providing assistance to pregnant women, mothers in need and abandoned, infant and children from families in difficulty.

These objectives had to be achieved through the creation of institutions on the territory, the financing of existing ones and the coordination of all public and private entities over which the ONMI exercised supervision and control. It was up to the body to disseminate standards and methods for prenatal and child care and hygiene, a fundamental objective which was well integrated into the demographic policy of fascism[5].

The process of institutional de-strengthening initiated by fascism through intense legislative production and which diverted the trend towards the reunification of health activities under the leadership of a single body, the Directorate-General for Public Health, also involved local authorities, facilitated by the radical and authoritarian changes made to them in the late 1920s. In particular, the municipalities were taken away from all opportunities for initiative and responsibility in the prophylaxis of important social diseases and narrowed the scope to assist poor citizens, a formal detection of infectious diseases and little else, putting the figure of the health officer in crisis.

The legislative fervor of the regime led in July 1934 to the "Testo Unico" of the health laws, approved by Royal Decree No. 1265. The most important aspect, since reading the first article, was the strong continuity with the previous legislation, especially in the way of understanding health, which was still linked to a police function and the protection of public order. The "Testo Unico" showed little adherence to scientific progress and changed social conditions, bringing together in a somewhat disorderly way the laws previously enacted by the Ministry of the Interior. The consideration will be confirmed several years later by Giovanni Petragnani, university professor of hygiene and bacteriology and Director General of Public Health from 1935 to 1943, in an article that appeared in the journal "Annals of Public Health":

> The "Testo Unico" of the health laws of 1934 was drafted without in the mind of the minister of the interior at the time having born the conviction that it was the responsibility of the Health Administration to direct all the services of care and that all activities linked with the defense of health should be under its direct control. The reason for this is that, as recently as 1934, the powers relating directly to the fight against infectious diseases appeared to be preeminent and, I would say, sufficient for the health administration. It was not warned, even by the most senior medical officials, that the health and social progress, which had already been achieved and in impressive evolution, required the adaptation of the health administration to the new situation (Petragnani 1955, pp. 762–763).

Together with the drafting of the "Testo Unico", the other major aspect in the field of health policy on which fascism concentrated, or perhaps it would be better to say did a little, was that of establishing a compulsory health insurance scheme. The problem, as we have seen, had been dragging on for years and was an unsolved legacy of the liberal age, which had not been able to deal decisively with the widespread expansion of the mutual assistance funds of the various professional categories, distributed in a disorganic way throughout the territory, with duplication

[5]On the National Opera for Motherhood and Childhood see above all: Minesso (2007).

and waste of all kinds. It was the promulgation of the Labour Charter in 1927 that rekindled interest in the issue and opened up a heated political debate within the regime that dragged on until the war years, when Parliament debated, in May 1942, a bill approved by a Council of Ministers, that had recognized the urgent need for a coordinating body and the unification of sickness funds. Ending a long-running affair, with Law No. 138 of 11 January 1943 the "Ente mutualità fascista" - National Institute for Sickness Assistance for Workers (INAM) was born.

Unfortunately, thanks to a general situation close to catastrophic, with Italy increasingly in difficulty in the Second World War, the ambitious INAM project remained "little more than a simulacrum", devoid of concrete effects (Sepe 1999, p. 217). Moreover, the plan for health insurance had a scope that transcended the sphere of health policy and extended to the welfare sector as a whole, steeped in conservatism and hegemonized by clerical forces. For Domenico Preti, the two things went hand in hand and no modernization of public health could have taken place "without a simultaneous refoundation on a lay basis, and no longer voluntarist and charitable, of the welfare system", including the hospital network, which had to be subtracted "from the particularisms, inequalities, anarchy in which the legislation on IPAB[6] continued to maintain it" (Preti 1987, p. 251). The outcome of the affair was also influenced by the many uncertainties of fascism with regard to the establishment of compulsory health insurance. The regime preferred not to deviate too far from the liberal model that had progressively supplanted the system focused on mutual aid societies in favor of one marked by company sickness funds. Fragmentation of interventions, disparities between categories, areas of the country and in the collection of contributions, duplications, clientelist use and inopportune of mutual structures ended up strengthening and becoming almost ordinary elements of a system destined to drag on in the years of republican Italy, heavily conditioning the future of the sector.

The Republican Years

A few weeks after the end of the war, in the midst of enormous political, economic and social and material difficulties, a major innovation came to the administrative apparatus of public health. The Italian Government issued a decree, number 417 of 12 July 1945, which established the High Commission for Hygiene and Public Health, ending, after almost 60 years of life, the Directorate-General for Public Health[7]. The legal system and powers were governed by Legislative Decree No 446 of 31 July 1945, which gave the institution essential tasks in the protection of health, coordination and supervision of health organizations and bodies set up with the aim of preventing and combating social diseases. The new institution aimed to meet the need, manifested above all by the medical class, for greater autonomy of the health administration and its reconstruction on a basis more in line with the growing development of welfare services and the increasing powers of public authorities in the social field.

[6]IPAB: "Istituzione Pubblica di Assistenza e Beneficenza".
[7]On High Commission for Hygiene and Public Health, see: Paniga (2021).

In truth, the choice made by the executive only partially fulfilled the autonomy claims, without significantly affecting the disparity of guidelines and the disorder that resided in the sector. Decrees Nos 417 and 446 only increased in rank the Directorate-General for Public Health, placing it halfway between the simple Ministerial Division and the structure of a Dicastery and immediately highlighting, for the High Commission, a series of significant shortcomings. It could not, for example, take part in meetings of the Council of Ministers, unless explicitly invited (and in any case without the right to vote), and sign the draft laws which he himself formulated, which were to pass under the Presidency of the Council. Limitations were reserved for the activity, with considerable powers in the field of hygiene and public health remaining in the hands of ministerial apparatuses, certain parallel administrations, prefects and local authorities such as municipalities and provinces. The limited powers of ACIS[8] and the deterioration in the quality of many services provided corresponded to an inadequate distribution of financial resources, insufficient to cope with the social and health conditions of post-war Italy. The years saw a gradual increase in appropriations for the High Commission, but these remained always less than necessary. The spending of time did not even change the proportions between the different budget items, with a preponderant position occupied by antitubercular care and motherhood and childhood.

The need for its modernization was also evident from the comparison with those countries where there was already a central and truly autonomous entity, in short, a Ministry of Health. Looking more broadly, it was the Italian welfare state itself that was taking on a different appearance than in the rest of western democracies. In Britain, an inescapable post-war term of comparison in the field of social security, Labour Prime Minister Clement Attlee decided to mark government activity with a welfare policy focused on building a free and universal national health system. Italy, on the other hand, continued along the path mapped out by the recent past, strengthening the mutual system, which caused profound differences in treatment between the various professional categories. Protection against diseases remained entrusted to an insurance scheme, without proceeding, in Cosmacini's words, "towards a courageous and responsible choice on the part of the State in defense of its biological heritage", which took into account the epidemiological changes taking place.

Public health continued to show major shortcomings in coordination, overlapping of skills, operational slowness, duplication of personnel and equipment: all situations that generated a great waste of energy and financial resources, making healthy organization impossible. The Italian political leadership was aware of the difficulties, but very few measures were taken to overcome the existing framework, perhaps because of the technical and financial obstacles that the government saw linked to the establishment of a Ministry of Health. Hundreds of laws and decrees were issued, which, although important, did not constitute the pieces of an organic and rational project of renewal of the sector, but rather the tiles of an incomplete, disjointed and confused mosaic. The appointment of a considerable number of parliamentary committees responsible for studying certain

[8]ACIS: "Alto Commissariato per l'Igiene e la Sanità Pubblica" (in English: High Commission for Hygiene and Public Health).

aspects of health did not lead to any concrete results, apart from the drafting of miles of paperwork (reports, draft bills and various proposals) left in the drawers of Parliament's offices.

The 13 years of activity of the High Commission for Hygiene and Public Health show, in essence, a physiognomy of the institution characterized by obvious elements of transience and legal uncertainty, almost as if the sector was waiting, and in fact it was, for a definitive reform. And this reform came in 1958, when the Italian Parliament approved, after years of political discussions and in the medical press, the law that sanctioned the birth of the Ministry of Health. All parties, albeit with different accents, agreed to support the bill presented by two Christian Democrat senators. The basic idea was to provide the health administration with a technical aspect, in the sense of entrusting it to elements with proven specialist skills, and to unify the services belonging to ACIS and other ministries into a central body, while ensuring their sufficient decentralization on the territory. Unfortunately, the measure approved by the Houses was less advanced than the great expectations that had formed in previous months, especially within the medical class, which had fought so hard to achieve such a result. The complex political negotiations linked to the law did not conceal the perplexities and resistance of sectors opposed to change, starting with the ministries which were deprived of competences for the benefit of health. It was a pretty moderate turnaround. The handover with the old management of the High Commission took place gradually, without excessive jolts. There were many constraints imposed on the sphere of activity of the new Ministry, indispensable for an effective action to synthesize and regulate what was related to health care. At the local level, several control functions remained with the prefect, i.e., an official of the Ministry of the Interior.

It was also true that these limits were the consequence of a situation historically determined in our country, with the old charitable institutions never completely replaced by more modern state organizations, and whose responsibilities were blamed on in full to the choices of the past and the current ruling class. Once again, the discourse was linked to the development of a genuine social security system and to the choices made by what was the dominant party on the political scene, the Christian Democracy party. On the subject, in fact, the positions within the Catholic party were never unequivocal. While the members closest to the Church's social doctrine showed courageous tendencies towards universal welfare, the more conservative and major wing of DC persisted in showing reluctance to take an overly aperturist line, in which it saw a danger to the hegemonic role exercised by church institutions in the health and assistance fields.

This is not the only factor, but it is one of the main reasons for the delay in Italy in training a national health service, approved by the Chamber of Deputies in December 1978. This is a very important date for our country, which concludes a long process that began thirty years earlier, capable of involving, but not without difficulty, different knowledge and actors. A boost certainly came from the change, in the 1960s, of the political scenario, with the rapprochement between the Christian Democracy Party and the Socialist Party and the birth of center-left governments, which distinguished themselves for some significant economic and

social reforms. In the field of public health, a marked improvement was introduced by the Mariotti reform of 1968, which transferred the powers of control and supervision of hospitals from the Ministry of the Interior to the Ministry of Health, putting a minimum of order in the sector. The national health service was also the result of original experiences realized in a decentralized form in the territory (on all the Experimental Demonstration Center for the health education of the population of Perugia led by Alessandro Seppilli), which contributed to the elaboration of a new welfare model and at the same time to modifying the concept of health.

The establishment of a universal system had the merit of finally sanctioning the practical implementation of Article 32 of the Constitution, which guaranteed the entire community a free health service hitherto reserved for individual categories of workers, with the aforementioned inequalities in the case (Taroni 2011, p. 199). The law assigned important functions to the Regions and created local health units, public, autonomous companies with legal personality, which had the task of providing services on national soil.

If the national health system represented a goal of considerable depth for Italy, considered for many to be one of the most advanced institutions on the international scene, we must not forget the defects that distinguished it, evident from the stage of discussion in Parliament of the bill. On the other hand, its drafting came after a long and laborious compromise between the different political formations. The text found indeterminateness as to the assumption of citizens' participation in health choices and in the management of services, as well as in the way in which the USLs are implemented. Less than a year after it came into force, Massimo Severo Giannini noted that the law was littered with references to future measures by the State and the regions, with the risk, which in fact happened, of creating organizational problems (Giannini 1979). And the situation did not improve in the years to come. On the contrary, the most innovative elements were too often obscured by the malfunctioning of the administrative machinery of the State, by the clientele use made by the parties of the management of the various USL and by the progressive, and perhaps exaggerated, devolution of competences to the Regional authority, a subject, at least for Italy, still very topical (Giorgi and Pavan 2018, pp. 113–116).

Conclusion: Under the Sign of Continuity

This essay offers some firm points about the development of public health institutions in Italy in the last century and of the more general process of building the welfare state. In the latter respect, the idea of a development of social policies characterized by numerous elements of continuity, even in the transition from fascism to the Republic, has gradually developed in national historiography. In this regard, for Michela Minesso "the choice of the republican political ruling class was not to replace fascist institutions of a social nature, but in all possible cases that of conversion, changing men [not always] and above all the ends" (Minesso 2006, p. 310). Minesso's reference is mainly aimed at assistance policies, and even more

specifically at motherhood and children, but it can be without problems extended to the field of public health.

In order to try to better understand the distinctive features of health institutions in twentieth-century Italy, it is therefore necessary to take a step back and examine the legislative measures and administrative structures operating in the second half of the nineteenth century. A decisive impact was provided by Crispine reforms, destined, in their main provisions, to remain in force until late twentieth century. The Directorate of Public Health of the Ministry of the Interior, founded in 1888 and transformed into a "general" in 1902, went through, almost unscathed, the three final decades of the liberal period and the entire chronological arc of the fascist regime. Men and apparatuses remained in many cases the same, managing to adapt to quite different historical situations. And even when, in July 1945, the High Commission for Hygiene and Public Health was created, the institution immediately appeared more of an elevation of rank of the aforementioned Directorate, than a new subject in the bureaucratic and administrative landscape of the Italian State. A similar observation can be made for the Ministry of Health, which in 1958 inherited, to a large part, the configuration of the High Commission, which in the meantime had organized itself in a more similar way to a Ministry.

In the suburbs prefects, mayors and provincial doctors continued to play a leading role in the sector for decades, certified by both the "Testi Unici" on health laws of 1907 and 1934. There were no major differences between the two provisions. This point is more important when one considers the decidedly antithetical contexts from which those norms came from. In addition, the "Testi Unici" show a similar way of understanding health, still linked to a police function and the protection of public order and far from the progress made by science and changed social conditions, as well as by an organizational model that reserved to the health administration the management of all care services and activities competing with the protection of health. Lack of coordination, overlapping of competencies, operational slowness, with a waste of energy and financial resources, became issues on the agenda, dragging themselves well beyond the start of the Republican phase.

Thus articulated public health ended up contributing decisively to direct the construction of the Italian Welfare system along an axis that differed from the experiences of the main Western countries. Moreover, the maintenance of the mutual system and the weight exerted in the health and welfare field by the ecclesiastical world also pushed in an alternative direction from the path usually traveled by a modern welfare state.

Not that the passing of the years had not seen any improvement in medical knowledge, hospital facilities (think of the Mariotti reform of 1968), welfare benefits, etc., but this progress remained part of a context where aspects of continuity with the past prevailed, and by far.

And then the real moment of breakdown of this structure can be identified in the establishment, in December 1978, of the National Health Service, a fundamental step that gave effective substance to Article 32 of the Constitution, on the protection of health, and completely reorganized the sector in the center and on the periphery. For Saverio Luzzi, despite certain weaknesses and errors of

perspective, it is "one of the most important reforms in the history of republican Italy" (Luzzi 2004, p. 315). Law No. 833 placed Italy on an equal footing with other international countries, such as Great Britain, and made the Welfare system more modern and democratic, providing those elements of universality that were previously lacking. All this advancement came with a paradox. Italy was coming to the meeting with the National Health Service just when in Europe we were beginning to talk about the welfare crisis and the financial sustainability of a system that, in widening public functions in the field of social security, had highlighted considerable problems of bureaucratization and centralization. In fact, between the end of the seventies and the beginning of the following decade, a heated political and academic debate opened on the need to reform and introduce corrective instruments to European Welfare, a dispute destined to heavily influence the application of future social policies and drag on, leaving unresolved several issues, almost to this day.

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