The Creation of the NHS in Italy (1961-1978)

Giovanna Vicarelli (*)

(*) orcid.org/0000-0002-9512-2347. Dipartimento di Scienze Economiche e Sociali dell'Università Politecnica delle Marche. m.g.vicarelli@staff.univpm.it

SUMARIO: 1.—Introduction. 2.—The historical roots of the Italian healthcare system and factors for change. 3.—The new social actors. 4.—Health demands. 5.—The new organisational model. 6.—Towards a modern hospital. 7.—The approval of Law 833. 8.—Conclusions.

ABSTRACT: The Italian health system has changed its welfare model three times over the course of its 160-year existence. From a form of «residual welfare» during the liberal period (1861-1921), it became «meritocratic welfare» during the fascist period (1922-1943) and in the years of the first republic (1945-1977). Finally, in 1978, the «universalistic institutional» model of health protection was approved. For a long time, therefore, the main responsibility for citizens' well-being was attributed to families, to the Catholic Church and its welfare networks, to entrepreneurial paternalism, and to the different health insurance institutions associated with employment sectors. Only with Law 833, which established the National Health Service (NHS), did the State recognise full and direct responsibility for citizens' health. This paper describes the complex path that led to the establishment of the Italian NHS, highlighting the diversity of the actors involved, the multiplicity of their social and health claims, the configuration of the public health service designed in the 1960s, and the political and social conditions that led to the effective enactment of Law 833. On the whole, it was a long, non-linear path with various barriers, where the conditions of implementation were determined by the particularity of the Italian political, economic, and social events that characterised the 1970s.

1. Introduction

The Italian National Health Service turned forty in 2018. The law that created it was approved in December 1978, during a particularly difficult period for the country. In that year, Italy was experiencing economic challenges (resulting from the oil crisis) and an institutional crisis following the murder of one of its most important political leaders, Aldo Moro[1] (killed by the *Brigate Rosse*). This situation resulted in the creation of a multi-party government that approved, with the exception of the Liberal Party, a significant and long-awaited reorganization of the healthcare system.

How did this change happen? Which factors shaped the transformation from a mutualistic to a universalistic welfare system? Why did this change happen at the end of the 1970s? In the coming pages some hypotheses will be formulated and tested using first-hand and second-hand data. In particular, after identifying key features of the Italian system in the second half of the nineteenth century and in the early twentieth century, we will aim to demonstrate how the NHS resulted from a coalescence of important environmental conditions in the 1960s and 1970s, involving not only political and economic actors, but also social and cultural ones[2].

2. The historical roots of the Italian healthcare system and factors for change

Throughout the period from the State unification of Italy (1861) to the creation of the NHS (1978), the main challenge encountered by Italian governments was how to limit the inclusion of health care within the tasks

1. Luzzi, Saverio. Salute e sanità nell'Italia repubblicana. Roma: Donzelli; 2004; Maino, Francesca. La politica sanitaria. Bologna: Il Mulino; 2001; Vicarelli, Giovanna. Alle radici della politica sanitaria in Italia. Società e salute da Crispi al fascismo. Bologna: Il Mulino; 1997; Vicarelli, Giovanna. Healthcare: difficult paths of reform. In: Ascoli, Ugo; Pavolini, Emmanuele, eds. The Italian welfare state in a European perspective. Bristol: Policy Press; 2015, p. 157-178; Pavolini, Emmanuele; Vicarelli, Giovanna. Italy: A Strange NHS with its paradoxes. In: Pavolini, Emmanuele; Guillén, Ana, eds. Health care systems in Europe under austerity: Institutional reforms and performance. Basingstoke: Palgrave Macmillan; 2013, p. 81-101.
2. Pasquino, Gianfranco. Political history in Italy. Journal of Policy History. 2009; 21 (3): 282-297; Ginsborg, Paul. A history of contemporary Italy: Society and politics, 1943-1988. New York: Palgrave Macmillan; 2002; Mack Smith, Denis. Modern Italy: A political history. 2nd. ed. Ann Arbor: University of Michigan Press; 1997.

of government and public administration. Liberal governments (1861-1921), the fascist regime (1922-1943) and also republican governments (1945-1978) tried to avoid meeting the costs of healthcare public provision systems. Only after Law 833, which established the National Health Service (NHS), did the State accept full and direct responsibility for citizens' health. Historically, three different phases can be identified in Italy in relation to the approach to healthcare.

The first phase was from the creation of the Italian state in 1861 to 1921, at which time private philanthropic care played a major role. At this time public provision was residual and relatively general, and healthcare was still in a pre-modern stage of development (residual welfare). In 1890, Italian Prime Minister Crispi tried to impose state control over the so-called *Opere Pie*; these were Catholic Church run institutions, devoted to offering relief to the population (Law N. 6972 of July 17, 1890 *Norme sulle istituzioni pubbliche di assistenza e beneficenza* [Rules on public assistance and charitable institutions]). The *Opere Pie* ran 955 «hospitals», which served as hostels for poor sick people rather than as genuine healthcare institutions. Crispi's Law aimed to replace the boards of the hospitals, which consisted of representatives of the Catholic Church, with local authority representatives. Liberal governments after Crispi, however, never strictly implemented this law.

During the second phase, the Fascist government (1922-1943) reversed the direction of the prior period, opposing the presence of Church representatives on the *Opere Pie* boards. This had a significant influence on healthcare structures, and in particular on the modernization processes undertaken by hospitals, at a time of great technical and scientific transformation. In addition, the flow of private charity, on which hospitals depended, was variable in quantity, differing widely from region to region. For example, hospitals in the richer regions of northern Italy could rely on generous donors sensitive to new medical and technological developments, while hospitals in the poorer south of Italy received far less generous contributions[3]. However, in the third decade of the twentieth century the hospital sector underwent another notable transformation: the users of its

---

3. Vicarelli, Giovanna. La politica sanitaria tra continuità e innovazione. In: Storia dell'Italia repubblicana, Volume III, L'Italia nella crisi mondiale. L'ultimo ventennio, Torino, Einaudi; 1997, p. 569-619; Soresina, Marco. Dall'ordine al sindacato. L'organizzazione professionale dei medici dal liberalism al fascism (1910-1933). In: Istituto Lombardo per la Storia del Movimento di Liberazione in Italia, ed. Cultura e società negli anni del fascism. Milano: Cordani; 1987.

services became less and less the «poor», as hospitals started to receive clients under the *Mutue* (Mutual societies). These were created in 1928 by the Fascist government[4], applying sector-based rather than mandatory logic. In fact, by offering job contracts in all job sectors, it was possible to create (or not to create) a *Mutua* for workers, covered by taxes paid by the workers themselves and their employers. In the same period, hospital provision increased and improved in quality, although this phenomenon occurred mostly in the industrial areas of the north and the principal urban areas of the centre-north (meritocratic welfare).

Subsequently, from 1948 to 1978, republican Italy was governed by centre and centre-left parties, led by the Christian Democracy as a majority party. Hence, in the 1950s and 1960s, the Christian-Democrat governments chose to perpetuate the mutualistic fascist model, implementing criteria increasingly reliant on nepotism and political patronage, although in a new context, characterised by huge investments in hospital care facilities and a mandatory mutualistic system[5]. At the end of the 1960s the State introduced a new law regarding hospital provision (Law N. 132, 1968). One of the main issues raised in the discussion that led to the bill was the need to rationalize hospital care provision and to reduce fragmentation: there were too many actors and institutions providing services and adopting different criteria for accepting paying beneficiaries[6].

At a certain moment in the discussion it became apparent that «nationalization» of the entire hospital sector was desirable. However, thanks to the lobbying activity of the Catholic Church, the role of private Catholic hospitals was maintained under a specific regulation. Many were defined and «classified» as retaining a private and independent profile, despite being considered equal to public hospitals (also in terms of funding). This explains the largely private character of services and health care structures until the second half of the 1970s, when the creation of the NHS entered a new phase, no longer based on the predominance of the private health services over public ones, but rather the opposite.

4. Ministero delle Corporazioni. Carta del Lavoro dello Stato corporativo. Roma: Provveditore Generale dello Stato; 1928.
5. Law 11 Janaury 1943, n.º 138, Mutualità fascista-Istituto per l'Assistenza di malattia ai lavoratori. [Fascist mutuality-institute for disease assistance to workers]
6. Luzzi, 2004, n. 1.

It is necessary to evaluate previous studies and research focused on the transformation of welfare systems to understand the factors that prompted the transition to the third phase (creation of a universalistic welfare state). Two approaches are adopted in earlier studies. The first highlights the impact of economic growth and the related demographic and bureaucratic-administrative phenomena during the nineteenth and the early twentieth century[7]. The second casts light on factors related to social and political conflicts and the requirement of legitimation in contemporary mass democracies[8]. These approaches, functionalist and conflictualist, were not mutually exclusive; rather, they can complement each other, as demonstrated by the work of researchers such as Peter Flora and Ian Gough[9]. In fact, they acknowledge the crucial role played by the interconnection between politics and markets in the birth and development of the welfare state[10].

However, this means that some socio-cultural factors do not appear dominant or connected to political shifts. This happens in the context of religious belief, which is crucial in some territorial contexts, because it is related to possible conflicts and competitions involving non-religious and religious parties or different confessional parties[11]. In Flora's work, for example, the conflicts and level of overlap between religious and political powers would only be explained if the state were in a position to assume educational-welfare functions and structures, which are traditionally characterised by a confessional-oriented organization through social policies[12]. With this in mind, it has been observed that, in traditional economic and political analyses, a social dimension should be included, focused on orientations, values and the collective identities that form the social fabric and have the capability to

7. Wilensky, Harold. The welfare state and equality. Structural and ideological roots of public expenditures. Berkeley: University of California Press; 1975.

8. Alber, Jens. Le origini del welfare state: teorie, ipotesi e analisi empirica. Rivista Italiana di Scienza Politica. 1982; 13: 361-421

9. Flora, Peter; Heidenheimer, Arnold. The development of welfare in Europe and America. New Brunswick: Transaction; 1981; Gough, Ian. The political economy of the welfare state. London: Macmillan; 1979.

10. Wilensky, Harold. Comparative social policy: theories, methods, findings. Berkeley: Institute of International Studies, University of California; 1985.

11. Therborn, Göran. What does the ruling class do when it rules? State apparatuses and state power under feudalism, capitalism, and socialism. London: Verso; 1980; Ferrera, Maurizio. Modelli di solidarietà. Politiche e riforme sociali nelle Democrazie. Bologna: Il Mulino; 1993.

12. Paci, Massimo. Pubblico e privato nei moderni sistemi di welfare. Napoli: Liguori; 1989; Vicarelli, 1997, n. 1.

effect (much like economic and political factors) the decision to instigate and maintain a welfare state. However, Titmuss himself seems aware not only of the importance of the feelings that can emerge under certain social conditions, but also of how they can be manipulated by the ruling classes[13]. Therefore, Titmuss highlights what will become, in the domain of feminist approaches to welfare, both an analysis of the role played by women's associations and feminist movements in filtering and obtaining favourable social policies and a study of women's family conditions that justify and support certain choices in the realm of social politics.

Also writing from this perspective, Baldwin[14] maintains that there are many actors able to propose and endorse different public policies within the political arena, and that they are not necessarily members of dominant élites or workers' movements. In different historical and territorial situations, other groups such as women's movements; interest groups such as public administrative staff, liberal professions, industrial and insurance lobbies, organised groups of citizen-consumers, religious and not-for-profit associations, the elderly, and mentally ill people have played instrumental roles in change. Given risk categories and social classes did not necessarily coincide, the resulting aggregations of interests might complicate and add diversity to relations, which have generally been understood in the dichotomic and reductive terms of proletariat versus the bourgeoisie and poor people versus rich people. After all, the needs associated with a call to introduce social policies are not necessarily expressed by those in disadvantaged social positions. Therefore, identifying and retracing the complex interactions between social classes and risk categories in historical and territorial contexts is the objective of any history of welfare systems research focused on social bases. This means that the combination of public and private resources, in every society, and in every historical situation, aimed at fulfilling welfare needs can be based either on the dominant role of the state or of the community and market networks. Furthermore, the resulting balance can be broken and recreated by different political, economic and socio-cultural pressures, which themselves need to be investigated in historical and comparative terms[15].

---

13. Titmuss, Richard. Essays on the welfare state. London: Allen and Unwin; 1958.
14. Baldwin, Peter. The politics of social solidarity: class bases of the European welfare state 1875-1975. New York: Cambridge University Press; 1990.
15. Immergut, Ellen. Health politics: interests and institutions in Western Europe. New York: Cambridge University Press; 1992; Scott, William Richard; Ruef, Martin; Mendel, Peter; Caronna, Carol.

In conclusion, it is true that the debate about modern social protection systems is led by economic-political paradigms. However, it is also the case that contributions focused on social dimensions are growing despite having less resonance and often a history of being marginalised. By adopting this approach in the following pages, we will try to sustain the hypotheses that in Italy, during the 1950s and the 1960s, a multiplicity of social actors developed calls for change in the healthcare domain, which found a response during the 1960s and 1970s as a result of the economic and political conditions in that period.

Specifically, the article addresses three different sets of questions:

1) Which collective actors played a relatively dominant role in the creation of the Italian NHS?
2) Which ideas and cultural orientations prevailed?
3) Which economic, political and social conditions led to the approval of Law 833, that created the NHS?

3. The new social actors

The first imaginings about health reform (specifically with a view to establishing an NHS in Italy) can be traced back at least to the late 1950s, although arguably further, to the projects initiated in September 1945 by a group of intellectuals who participated in the resistance against fascism. At the University of Padua, the group formed the «Health Council» of the Triveneto National Liberation Committee (NLC). Their writings stressed the need for a reconstruction of the country that would completely regenerate the health system by returning to the values of the reform attempted in 1876, at the time of the last cholera pandemic, by the left-wing governments (Agostino Depretis, President of the Council, Agostino Bertani, proposing). The 1876 reform was strongly focused on decentralisation, the role of local authorities and the development of a prevention culture. This approach was modified by the law subsequently approved in 1888 (Law n. 5849, 22 December 1888: *Tutela dell'Igiene e della Sanità Pubblica* [Protection of Hygiene and Public

Institutional change and healthcare organizations. Chicago: University of Chicago Press; 2000; Scott, William Richard. Reflections: the past and future of research on institutions and institutional change. Journal of Change Management. 2010; 10 (1): 5-21.

Health], known as the Crispi-Pagliani Law), which, although leaving to the municipalities the front-facing role in the health sector, introduced elements of centralisation with the responsibility of the Prefects (dependent on the Ministry of the Interior). Over time, the law of 1888 was supplemented with a mutualistic system of fascist imprint[16] that accentuated the different forms of health protection guaranteed on the basis of job typology. The commission of the Triveneto NLC had, therefore, sought in the post-unification legislation the foundation for a new modern and democratic health system. A system that first found recognition in Article 32 of the New Italian Constitution on the «right to health», the draft of which was given decisive support in the example of Great Britain, with its National Health Service implemented in the same year, 1948.

However, throughout this period and until the late 1960s, the Italian health system reform project remained limited to a close circle, the members of which were found in a very active but rather small group of doctors and hygienists whose ideas and visions for reform were driven by their contact with foreign and international health organisations[17]. The same presentation of health projects by the confederal trade unions (CGIL – Italian General Confederation of Labour, and CISL, the Federation of Italian Trade Unions) and the PCI (Italian Communist Party) between 1956 and 1958, had no effect on legislation. This was due to the weakness of the actors, and the rooting and extension of new ideas that remained mostly the prerogative of a minority intelligentsia which considered Italy to be backward compared to more advanced nations (specifically Great Britain, and to some extent the United States) and which launched a cultural mobilisation in order to generate and reinforce the energies capable of realising the desired change. In 1961, this mobilisation gave birth to the «movement for reform», led by some enlightened presidents of the Orders of doctors (similar to the British Royal College of Physicians). In 1964, a conference was held jointly by the two hygienist schools of Milan and Perugia, whose leaders, Giovanardi and Seppilli, were considered amongst the most committed architects of reform[18].

---

16. Ministero delle Corporazioni, n. 4.
17. In 1954, for example, the *Centro Sperimentale per l'Educazione Sanitaria della Popolazione* [Experimental Centre for Population Health Education] was established at the University of Perugia as requested, and supported by the World Health Organisation.
18. Comelles, Josep M.; Riccò, Isabella; Perdiguero-Gil, Enrique. Seppilli, Tullio. L'éducation pour la santé et la fondation de l'anthropologie médicale italienne. Curare Zeitschrift für Medizinethnologie. 2014; 37 (2): 85-99; Comelles, Josep M.; Riccò, Isabella; Terrón Bañuelos, Aida; Perdiguero Gil,

From 1963 onwards, the need for reform began to be acknowledged in the institutional setting. In the first instance, the CNEL (National Council of Economy and Labour) presented its own report on the need for revision and rationalisation of the health system. On 2 June 1965 the third draft of the *Progetto di programma di sviluppo economico per il quinquennio 1965-1969* [Economic development program for the five-year period 1965-1969] (known as the Pieraccini Plan) was finally approved by Cabinet. On the one hand, the plan contained a proposal for the decentralisation of services across regions, on the other it provided for the unity of services in terms of prevention, treatment, and rehabilitation[19]. Furthermore, in December 1967, the General Advisory Committee for Primary Health Reform, which had been established a year earlier within the Ministry of Health, unable to achieve unanimous consensus, delivered two (instead of one) final reports; the first, with majority approval, was signed by Professor Alessandro Seppilli.

At the end of the 1960s, however, following the economic and social transformation of the country[20], there were changes in the balance and constitution of various social groups, which was reflected, to a significant extent, in the movement for reform. New actors joined, and others reinforced their membership, together creating a vast and previously unseen political and social basis for the realisation of an NHS. On one hand, doctors and hygienists were joined by other professional categories in the health and social sector (including psychiatrists, psychologists, social workers, teachers, and pedagogues). To a large extent, these were emerging professionals who, in the idea of reformulating the health system, sought a cultural identity and operational space of their own. On the other hand, the mobilisation of technicians and health professionals was also accompanied by that of the working class, which in recent years had achieved a considerable degree of power and initiative. Whilst the trade unions put forth strong arguments for reforms to the government, going so far as to call proclaim a national strike in support of an NHS, the Communist Party intensified its own actions by

          Enrique. Health education and medical anthropology in Europe: the cases of Italy and Spain. Salud Colectiva. 2017; 13 (2): 171-198.

19.   Bassetti, Piero. Il programma di sviluppo economico. Parte I. Aggiornamenti Sociali. 1966; 1: 19-30; Bassetti, Piero. Il programma di sviluppo economico. Parte II. Aggiornamenti Sociali. 1966; 2: 95-110; Levi, Fabio. Repubblica: lo sviluppo economico. In: Levi, Fabio et al. eds. Storia d'Italia vol. III. Firenze: La Nuova Italia Scientifica; 1978, p. 1035-1043.

20.   Tarrow, Sidney; Scardino, Alba. I movimenti degli anni '60 in Italia e Francia e la transizione al capitalismo maturo. Stato e Mercato. 1984; 12: 339-362.

proposing itself as a legitimate representative of proletarian conflict and as a natural spokesman for the demands of the middle classes. However, none of the above actors would have succeeded without the support of the feminist movement and the movements for psychiatric reform. These movements emphasised the necessity of large groups of end-users having their needs fulfilled within new healthcare structures[21].

The health reform, which began as the expression of the views of a small group of intellectuals, during the years 1960-70 was supported by growing groups of actors: health professionals, the trade unions and the working class, left-wing parties, and the end-users identified by the feminist and anti-psychiatric movements.

4.   Health demands

This change and growth in the number of actors necessarily transformed the contents and the shape of the debate on health reform. Political motivations became prominent compared with technical ones.

One of the key points of the health reform concerned the establishment of «local health units», which were conceived as an instrumental tool of the Municipality. This idea arose in the United States at the end of the 1950s and sought the unitary management of public health and hygiene interventions. This idea gained traction in Italy and was adapted to fit the proposals already put forward by hygienists within the Health Council of the Triveneto, who had developed and initiated a project specifically aimed at the reunification of health services in local units[22]. It is on the idea of the local health unit that, in the early 1970s, the plan for the realisation of a national health service was based, as a replacement for the health insurance institutions that delivered different health services for different worker categories, often duplicating services at both the peripheral and central level. As a result, the aim of the health reform became to unify and integrate all the existing services within

---

21. De Leonardis, Ota. Dopo il manicomio. Roma: Il Pensiero Scientifico; 1982; Ergas, Yasmine. Allargamento della cittadinanza e governo del conflitto: le politiche sociali negli anni settanta in Italia. Stato e Mercato. 1982; 6: 429-464; Gallio, Giovanna et al. La libertà è terapeutica? Milano: Feltrinelli; 1983; Micheli, Giuseppe. I nuovi Catari. Analisi di un'esperienza psichiatrica avanzata. Bologna: Il Mulino; 1982.
22. Barro, Giovanni. Usl e grandi città: da ente istituzionale a strumento funzionale del Comune. Prospettive Sociali e Sanitarie. 1983; 16: 1-3.

a framework of territorial decentralisation[23]. It is no coincidence that the reform movement initially identified general practitioners as the category that was most prepared to take on and perform the new tasks. They would have to work alongside pharmacists, veterinarians, and other non-medical health categories; together they would develop new ways of working, in the newly designed health reform[24].

Meanwhile, from 1967 onwards, and intensified by the struggles of students and the working class in 1968 and 1969, the growing consciousness of the working class found expression in requests to participate in the social and economic leadership of the country. The working class demanded a bottom-up participatory democracy and an expansion of citizenship rights. Within the health framework, this meant refusing to put their health in the hands of doctors and health institutions or, worse, of the «bosses». They sought the right to decide and to intervene by means of forms of direct and democratic participation; this also included a claim for equal rights to health protection for all citizens, and a change in working and social conditions. This meant favouring forms of preventive medicine, the benefits of which would extend to the whole population rather than just the working classes. The confederal trade unions found, in the pursuit of such ideas, not only a confirmation of their political tradition, but also the possibility of positioning themselves as representatives of wider interests, taking on activities typical of political parties[25]. The latter, on the other hand, especially the left, approved the role of trade unions. In fact, the PSI (Italian Socialist Party) ratified the reform policy unsuccessfully pursued in the 1960s[26]; the PCI viewed it as a tool with which to reach the goals of a progressive democracy and further transformation of Italian society.

Curiously, the trade unions found themselves operating at the halfway point between civil society and political actors, far from the interests of the health professions. The latter requested services programming and integration, teamwork and collegiality within management. All these proposals sought

23. Trevisan, Carlo. Per una politica locale dei servizi sociali: la lunga marcia di avvicinamento all'unità locale. Bologna: Il Mulino; 1978.

24. Seppilli, Alessandro. La rivoluzione della salute. Un impegno trentennale. Roma: Il Pensiero Scientifico; 1985; Tousijn, Willem. Il Sistema delle occupazioni sanitarie. Bologna: Il Mulino; 2000; Giarelli, Guido. Il malessere della medicina. Milano: Angeli; 2003.

25. Pizzorno, Alessandro. I soggetti del pluralismo. Bologna: Il Mulino; 1980.

26. Regalia, Ida; Regini, Marino. I sindacati nel sistema politico ed amministrativo. In: Ascoli, Ugo; Catanzaro, Raimondo, eds. La società italiana degli anni '80. Bologna: Il Mulino; 1987, p. 96-123.

to create a structure that was neither bureaucratic nor vertical, but rather professional and horizontal, capable of enhancing the skills and autonomy of health professionals and, at the same time, meeting the requests of end-users. However, similar questions of an organisational and administrative nature were relegated to a marginal position compared to the most openly political motivations. This was, in large part, due to the attitude of the trade unions and the left-wing parties in regard to specialised work and professions in general. From the point of view of the trade union movement, for example, there had been a general and repeated devaluation of the medical sector, which they considered to be a service for the working class, whereby it had been diminished to a merely technical area. The political action of the PCI was guided by this same logic, theorising a tendency towards the proletarianisation of the middle class, precisely when there was a strong opposite tendency toward the professionalisation of new categories of work (psychologists, social assistants, etc.)[27]. In addition, a strongly negative attitude towards traditional health structures and medical professions underlay the demands for innovation made by the feminist and anti-psychiatric movements. These movements called for a new cultural orientation of the health system, which should have demonstrated the ability to implement interventions dictated by a holistic view of the individual, rather than specialised and fragmented skills aimed at the treatment of individual diseases.

The peculiarity of each social group should not lead one to assume that there was a clear split between the different demands for innovation. By contrast, the objectives tended to blend and merge, as well as to find common ground in such wider appeals as the repossession of the territory or the realisation of a new social and community health dimension. In the early 1970s, the problem of territorial imbalances was acute, and, although typical of the development of Italian society, it reached a high level that was, in many ways, problematic. The transformations of the previous decade had, in fact, widened the gap between the northern and southern regions and had proposed new forms of dualism (between the mountains and the plains, between the city and the countryside, between small towns and big cities, between the historic centres and the suburbs). This had highlighted the progressive deterioration of particular areas and increased economic and social inequality in the population. Moreover, the 8,000 municipalities and

27. Berlinguer, Giovanni. Gli anni difficili della riforma sanitaria. Bari: De Donato; 1982.

their extreme demographic heterogeneity (from a few hundred inhabitants to a few million), made it very difficult for them to manage the new health system[28]. According to the reform project, the «local health unit» was meant to represent an element of territorial homogeneity: the small-size municipalities should have merged and the larger ones should have been split. In this scenario, the local units would have been suitable for both the services provided and for the end-users' needs. Based on these guidelines for territorial reorganisation, other social actors, some distant, such as urban planners and architects, and some very close, such as the regional and municipal administrators, gave their support for the health reform. The latter, in particular, became the promoters of a vast and fundamental process of experimentation with new ideas that began to take place in the early 1970s. Moreover, the establishment of the Consortium of Mountain Municipalities (*comunità montane*) and Regions in the 1970s was a positive development in this regard, as they provided the institutional tools to start the decentralisation of health services. It should be noted that the innovation processes carried out by some municipalities and regions were primarily focused on central and northern Italy, while the south was almost completely excluded. The diversity of the actors involved, and their demands reflected not only specific social areas but also very limited territorial frameworks.

5. The new organisational model

The new health reform principles mentioned above led to a reformulation of the local health unit model, as initially proposed by the hygienists in the post-war period. It was no longer viewed as a means of rationing resources and services within a territory, but as a completely new tool that could be used at both the political and organisational levels.

The local unit, marking the decentralisation of services management through the attribution to the municipality of the direct and sole responsibility for their organisation, ensures, first of all, the unity of the service providers aimed primarily at ensuring the wellbeing of the population. This means, on the one hand, enhancing the role of the municipality, and on the other, proposing a real reform of the health system in order to create a more

_____

28.   Trevisan, n. 23

efficient and effective structure that is not parcelled and duplicated, not dispersed and bureaucratised, and designed with recognition of the actual and specific needs of the population involved. According to the reform, the territorial delimitation, the unitary management, and the capacity of the local government to perceive and satisfy citizens' needs, would have constituted the political-institutional assumptions of a technical and organisational change. This would have originated from the global nature of the interventions carried out, in other words, those aimed at providing health and assistance, work, education, and leisure. The complexity of services and resources offered would have required methods of planning, coordination, and integration of the various activities of the operators, as well as a precise and conscious knowledge of the needs of the population served by the local unit.

It should be noted that the above political and organisational system ignores the predominance of medical figures. The quality and quantity of the services would have been dictated by political choices, relating to those goals that, at a specific time and in a specific territory, would be more convenient to the community. The participation of users also provided a political solution to the need for effectiveness and efficiency in the new system. On the one hand, it is assumed that, through an analysis and discussion of problems, citizens, operators, and politicians would have reached a harmonious agreement on the best solutions[29]. On the other hand, it was believed that the great battle on the prevention front could not be delegated to the experts, but must be fought first-hand by all citizens.

This configuration of the local health unit required the resolution of certain crucial issues. The first concerned the legal nature of the local health unit. In legal terms, the unit could be identified either as a technical body (within the structure of the municipality), or as a standalone entity along the lines of public agencies or municipal companies. Almost all supporters of the reform were against the second hypothesis[30]. They feared that the municipality would be weakened rather than strengthened, due to the negative experiences of traditional welfare and health organisations. They were also concerned about purely technocratic administrative criteria prevailing[31]. This does not indicate unconditional trust in the functionality of the municipalities,

29. Buiatti, Eva. Il «dopo-settantotto» sei anni inutili? Salute e Territorio. 1983; 33: 26-29.

30. Trevisan, Carlo. USL e riforma sanitaria: rispunta la «municipalizzata». Prospettive Sociali e Sanitarie. 1976; 8: 1-3.

31. Hanau, Carlo. Se l'USL diventa un'azienda municipalizzata. Salute e Territorio. 1983; 33: 6-8.

the limits and shortcomings of which were well known; rather, there was a great trust in the political possibility of achieving the new health goals.

A second crucial issue was the management office, which, far from being a bureaucratic and vertical structure, a source of circulars, directives, and controls, was to present itself as a collegial body in which the new functions of information and formation, programming, and technical assistance to operators would have found space. It was, however, the creation of the «Health Districts» that signalled the true innovation at the organisational level, which were presented as privileged «containers» of the principles and guidelines that the reform proposed. The idea of districts did not arise at the same time as the concept of local health units, but later, as a consequence of the overly large dimensions of the local health unit that would not allow the delivery of frequently used services to the citizen. This highlighted a need to consider smaller areas, which should not have been presented as simple administrative articulations of the local unit (the district branch) or as networks of marginal services (the district general health centre), or even as structures that distribute and organise the work of the operators within the territory (the service centre district). On the contrary, the district should have been configured as a «system of participated interventions», a privileged place in which to experiment and verify overall the renewed methods of health protection.

6.   Towards a modern hospital

In the 1960s, as mentioned above, an increasing institutional interest in the establishment of an NHS reflected the turmoil within civil society. In 1963, the CNEL presented a broad and controversial report on the need to rationalise the health insurance system. This was echoed by the parliamentary forces that, within the economic development plan for 1965-69 (Pieraccini Plan), approved a well-structured health reform framework. In this reform there was expected to be a territorial articulation of the services and their unity in terms of prevention, care, and rehabilitation. What fundamentally appeared to change, with respect to previous decades, was the general orientation towards the inclusion of social security within the economic-institutional framework of the country. In fact, for the first time, it was proposed to include the theme of health and social services within the economic development and planning framework, recognising the whole sector as a function of increased

consumption and collective well-being that could no longer be avoided. This not only opposed the exclusion of the social welfare system from the structural policies of the country, but opened the way to a reorganisation aimed at overcoming the insurance principle through the establishment of a national health service. The NHS would be a system financed by the citizens in proportion to their income and directed by the State through the Ministry of Health, the regions, the provinces, and the municipalities. The Pieraccini Plan and the economic development programme, therefore, officially proposed the establishment of a national health service for which instruments and resources would be provided, albeit fragmented and not without contradictions[32].

This was evidently a highly innovative but entirely preliminary action that would have required time and a strong will to achieve. There was much opposition, ultimately resulting in the project being shelved, and only the rules relating to the reform of hospitals were legislated. The Italian Republican Party (PRI), the Bank of Italy, and the CNEL itself, which focused on the financial aspects of the reform, identified a significant underestimation of the costs of the future health service and were the first to express their dissent. However, the Christian Democrats (CD) rejected the idea of a universalistic health system and to constitute, alternatively, a «national system for public hygiene» only. This was not, as Delogu recalls, «a subtle and curious play on words»[33], but a proposal aimed at recognising a further national body responsible for prevention and public hygiene tasks alongside a unified and renewed mutualistic structure. This therefore represents not the overcoming of mutualism, but its rationalisation and integration according to an incremental logic aimed at gradually modifying the current system. Nor did the health insurance institutions fail to oppose the strong resistance to the project, finding in the medical associations an unexpected ally. The latter feared the loss of prestige and authority over patients, and were anxious about becoming «public employees». As a result, the medical associations constituted a unique representative body which aimed to execute medical

32. Delogu, Severino. Sanità pubblica, sicurezza sociale e programmazione economica. Torino: Einaudi; 1967.
33. Delogu, n. 32, p. 106.

private practice within the NHS as well as ensuring the possibility of choosing between full and part-time work[34].

Faced with the difficulty of launching the health reform, both the CNEL and some of the governing parties saw the need to bring forward the hospital reform that was most urgent, simplest to realise, and cheapest to implement, an argument supported by the CISL and, unexpectedly, by the PCI[35]. In reality, many of the actors hoped to gain immediate benefits from the renovation of hospitals: the health insurance institutions hoped to be better able to cope with the increasing deficit caused by hospital costs; the doctors saw in the reform a means to overcome their still precarious employment position; and the CD themselves aimed to continue their patronage policy within the new public hospitals[36]. More generally, the growing interest in specialist and technological medicine required an adaptation of the hospitals, which were not only still managed as a charity, but were often completely inadequate and often malfunctioned. Furthermore, a series of inquiries launched by newspapers in Italy (e.g. the *Avanti*, *Tempo Settimanale* and *Paese Sera*) and abroad (such as *The Times* and *The Economist*), were collected in 1965 in a *Libro Bianco*[White Paper] published by the Minister of Health, and drew public awareness to the situation within hospitals, and more generally to healthcare and *Mutue*, which had already become synonymous with inefficiency and ineffective healthcare[37].

As Ferrera points out, the electoral deadline created an urgency, and in February 1968 the hospital reform was launched[38]. The law passed was the result of numerous compromises and balances, although it still introduced elements of great innovation in a sector that for centuries had been anchored to the charitable sector, which had only marginally changed since Law N. 6972 of July 17, 1890 *Norme sulle istituzioni pubbliche di assistenza e beneficenza* [Rules on public assistance and charitable institutions] and the *Regio Decreto*

---

34. *Secco, Antonella*. La corporazione medica in età repubblicana. In: Malatesta, Maria, ed. I professionisti. Annali 10. *Storia* d'Italia. Torino: Einaudi; 1996, p. 191-221.

35. Delogu, n. 32.

36. Ferrera, Maurizio. Il welfare state in Italia. Sviluppo e crisi in prospettiva comparata. Bologna: Il Mulino; 1984.

'37. Taroni, Francesco. Politiche sanitarie in Italia: il futuro del Servizio sanitario Nazionale in una prospettiva storica. Roma: Il pensiero scientifico; 2011; Giannelli, Giorgio; Raponi, Vito (eds.). Libro Bianco sulla riforma ospedaliera. Roma: Ministero della Sanità; 1965.

38. Law n.º 132, 12 Feb 1968 with the related delegated decrees of 27 March 1969, n.º 128, 129 and 130.

[Royal Decree] n.º 163 of September 30, 1938. With the establishment of public hospitals, every citizen was afforded the right to admission to a facility with its own administrative autonomy and organically linked to its own territory. Furthermore, the members of the board of directors at each hospital were almost exclusively elected by local authorities (regions, provinces, and municipalities). According to the hospital reform, the regional and national planning would have marked the lines of development of the sector, in which physicians saw themselves as having been given a clear legal status, and the Ministry of Health a direct power. Furthermore, the reform proved to be consistent with the interests of the many actors that supported it. Medical staff, for example, obtained the opportunity to work part-time by law (art. 43 Law 132/68). Aside from this victory, which introduced a more flexible working life, many doctors were able to enter the new public service, with universal admission criteria and with more than adequate remuneration. The governing parties, on the other hand, postponed any instrument of planning and control; in this way, they bent the hospital structures to fit their own interests, either through the excessive localism of the interventions (for example, by indiscriminately strengthening the services or by duplicating them), or through the political nature of the members of the Hospital Board of Directors[39].

Moreover, the reform, presented as the first step towards the realisation of the NHS, emphasised the centrality of the hospital structures and specialised medicine, but not of territorial health services. From then onward, the hospital-territory duality was even stronger. The concept of prevention itself, the cornerstone of the Italian National Health Service, would come into conflict in the near future, with hospital services, which are strongly focused on cure (rather than on care), as well as with specialised services. In other words, medical science and its representatives gained a further benefit: the institutional consecration of a general, specialised, and reductionist health approach rather than an anthropological and holistic one[40].

39. Rugge, Fabio. Il disegno amministrativo: evoluzioni e persistenze. In: Storia dell'Italia repubblicana, II, 2: La trasformazione dell'Italia: sviluppo e squilibri. Torino: Einaudi; 1995, p. 213-295.

40. Cosmacini, Giogio. Storia della medicina e della sanità nell'Italia contemporanea, Bari: Laterza; 1994.

7. The approval of Law 833

The establishment of a broad consensus on health reform was not a sufficient condition for its implementation, given the political and economic interests that were associated with the old mutual aid system. In the first half of the 1970s, however, facts and circumstances that accelerated and made the establishment of the national health system possible were emerging. This can be ascribed to the following: the very serious financial crisis faced by social security institutions and hospitals; the most critical phases of Italian electoral history; and the new institutional role played by the actors of the reform, in particular the PCI and the trade unions, by the middle of the decade.

As a result of the hospital reform law, between 1969 and 1974, hospital spending tripled, with average annual increases of 24.6%. This brought about a vast increase in the debt owed by the health insurance institutions to the hospitals which, as of 31 December 1973, stood at 3,000 billion lire (compared to 300 in 1969). The consequence was that mutual institutions collapsed, due to their over-exposure to banking institutions and suppliers[41]. The State provided significant contributions in an attempt to restore the management of mutual institutions, but this was of no use, as the crisis, although not attributable to the hospital reform alone, was certainly exacerbated by it. The belief that the mutualistic system had led to a disastrous dissipation of resources seemed indisputable. Indeed, in the period 1960-1974, for example, the INAM (National Institute for Health Insurance, the largest Italian insurance institution) saw an increase in the number of insured persons of 28.1% (from 23,748,000 to 30,399,000), and identified significant increases in morbidity, hospital assistance, and health services. The morbidity ratio, for example, increased from 9.8 to 17.1, hospital admission by 156.7%, hospital days by 167.2%, general and specialist services by 92.9%, and, finally, pharmaceutical prescriptions by 219.1%[42].

The elections of 1975 and 1976 thus become an opportunity for all parties to renew their commitment to the implementation of the NHS, which became one of the focal points of a particularly heated electoral debate. The period from the referendum on divorce on May 1, 1974 to the political elections of June 20, 1976, including the regional elections of June 15, 1975, was a phase

41. Bernabei, Paolo; Cirinei, Giuseppe; Zolo, Paolo. L'Unità Sanitaria Locale. Roma: La Nuova Italia Scientifica; 1980.

42. Fausto, Domenicantonio. Il sistema italiano di sicurezza sociale. Bologna: Mulino; 1978.

of great democratic expansion, comparable perhaps to that of 1946-48, even if the political outcome was reversed [43]. The electoral data from this time reveals the effects of the intense social mobilisation of the preceding years, favouring the PCI and clearly penalising the CD that emerged shaken, even if not defeated, as had been feared. The Christian Democrats, during the period of the secretariat of Amilcare Fanfani (1973-75), had attempted to redefine themselves and their role in Italian society by focusing on anti-communism and on the fundamentalist and repressive response to the demands and tensions in the country[44]. The failure of the referendum on divorce, in which the anti-divorce side received 40.7% of the votes, was the first defeat of this policy. This was shortly followed by the outcome of the regional and administrative elections of June 16, in which the CD received a 35.3% vote share (the lowest achieved since 1946), a negative result that appeared worse given the great advance of the PCI. Following the elections of June 15, the Communist Party was in charge of a large number of local administrations, was present in six regional councils, in all the municipal administrations of the cities with more than 200,000 inhabitants in the centre-north (with the exception of Milan), and in the related provincial administrations. If the Communist Party, in the mid-1970s, found itself able to establish its new power, the same can also be said of the trade union confederations. The latter, in 1975, through the agreements on contingency and unemployment insurance, saw their contribution to the formation and management of the country's economic and social policy recognised for the first time. This is a role that developed in the second half of the 1970s, when attempts were made to create a consultation structure similar to that used in the northern European countries[45]. Overall, by the first half of the 1970s, the great social mobilisations of the previous years (the working class, feminist, and anti-psychiatric movements) had exhausted their strength, but a political cycle had been triggered that was particularly favourable to those who supported the reform, which saw the realisation of the institutional, economic, and cultural conditions for its implementation.

Nevertheless, in the second half of the 1970s, the Italian scenario changed significantly. On the one hand there was increasing concern about

43. Pasquino, Gianfranco. Il Partito Comunista nel sistema politico italiano. In: Pasquino, Gianfranco ed. Il Sistema politico italiano. Bari: Laterza; 1985, p. 128-168.

44. Caciagli, Mario. Il resistibile declino della Democrazia Cristiana. In: Pasquino ed., n. 43, p. 101-127.

45. Regalia; Regini, n. 26.

the stability of the State, due to the escalation of terrorist actions after 1977; on the other hand, the Italian economy experienced a long period of crisis, marked by a rising inflation rate. The worsening of the economic situation, in particular, led to a shift in priorities, so much so that economic problems were discussed in Parliament to a greater extent than social problems[46]. Accordingly, the PCI and the trade unions, initiated a practice of austerity and reduced contractual demands (for example the labour cost agreements of 1977). This, in turn, affected (and reduced) their ability to represent and realise the NHS.

Therefore, the health reform, which was approved in December 1978, in fact partly owed its realisation to the years of great democratic growth of the country, when, through the projects presented in Parliament and some explicit legislative interventions, its implementation was anticipated and defined. In 1974, for example, the decree prepared to aid the financial recovery of hospital facilities (later converted into Law N. 386 of 7 August), brought about the dissolution of the boards of directors of the mutualistic bodies and the appointment of extraordinary commissioners by July 1, 1975. At the end of a two-year period commencing from that date, the mutualistic regime was dissolved, and its functions taken over by the State, regions, and local authorities. This was a real pre-reform mechanism that led, in the same month of August 1974, to the first presentation of a government bill aimed at the establishment of the NHS: *Disegno Di Legge* (DDL) N. 3207 of 12 August. The discussion in Parliament, where proposals had already been filed by the PSI, the PCI, the CD, and lastly by the PLI, led to the approval of 26 articles with the consensus of all the largest political forces, even though the early elections then interrupted the parliamentary process. Nevertheless, in 1975, Law N. 382 was approved, which concerned the regionalization of the public administration. This led to the Decree of the President of the Republic N. 616 (of July 1977), which can be considered a further and decisive step on the long road towards the realisation of the health reform. This decree obliged all the regions to develop territorial frameworks suitable for the management of social and health services, promoting forms of cooperation between municipalities and, if necessary, promoting mandatory forms of association between them. Furthermore, in April 1976 the decentralisation

---

46. Golden, Miriam. Neo-corporativismo ed esclusione della forza lavoro dalla rappresentanza politica. In: Pasquino ed., n. 43, p. 208- 231.

and participation of citizens in the municipal administration began with the implementation of neighbourhoods and districts (Law N. 278). In 1977, parliamentary discussion of the health reform resumed on the basis of four proposals (presented by the PCI, the PSI, the PLI, and by CD respectively), and a bill from the Minister of Health (DDL N. 1252 of 16/3/1977). At the same time, Law 349, which was compliant with the deadline of Law 386 (relating to the dissolution of mutual institutions) set out transitional rules for the transfer of health functions to the regions and for the stipulation of a national employment contract that needed to be renewed in light of the health reform still under discussion.

The parliamentary proceedings continued in the Chamber of Deputies until June 1978, and in the Senate from July to December of the same year, when Law 833, establishing the National Health Service, was finally passed. The year of 1978 proved to be crucial for social reforms, as the law on voluntary termination of pregnancy and the new legislation on psychiatric hospitals were also passed, in May and June respectively. Italy, however, seemed not to be aware of this, being preoccupied with other great events that saw, a change of government; a referendum on public order and party financing; the murder of Aldo Moro (one of the most important representatives of the CD) at the hands of the Red Brigades; the resignation of the President of the Republic; the election of a new president (for the first time from the Socialist Party); and the deaths of two Popes, and the election of a new one.

8. Conclusions

To conclude this study, we will try to answer the three questions we raised at the beginning.

1) In relation to the identification of the actors, it is possible to highlight the relatively weak role played by governments and institutional subjects in designing and instituting the transition to the mutualistic system. For the most part, this was because the majority party, the Christian Democracy, did not support a reform that would have reduced the power and the sphere of influence of clerical institutions, which had endured (although not continuously) over a long period in the healthcare sector. Instead, a dominant role was played by some cultural élites (especially hygienist doctors) and social movements (of young people, women, opponents of asylums/

mental institutions), which, during the 50s and especially the 60s, shaped the model of the future NHS. Trade unions and some professional groups (general practitioners, psychologists, social workers, engineers, architects) contributed to formulating ideas and proposals for the NHS. Opposition political parties (PCI e PSI) supported these reform proposals, but did not take the lead.

2) Taking into consideration dominant cultural orientations, it is important to shed light on how healthcare reform, firstly resulting from the need for reorganizing the supply of local services and with an emphasis on prevention, became a political issue. In the reform process, what prevailed was the intent to realize a democratic-participatory system aimed at providing fulfilment of citizens' health needs in life and work environments. It is necessary to read these dominant orientations within the context of the social and political excitement in the aftermath of 1968, which is a feature of the early 1970s in Italy[47].

3) Focusing on conditions explaining the effective enactment under Law 833, which created the NHS, it is important to remember the impact of institutional and economic factors. These related to the deficit of the *Mutue* as well as the electoral victory of left-wing parties in the mid-sixties and the creation of the Regions, which then played a leading role in the healthcare sector. The climate itself, which was one of financial and institutional crisis in 1978, explains why the law was approved without parliamentary debate along with the finance Law in December of that year.

This seems to prove the need to overcome dichotomous understandings when analyzing the origin of welfare systems. In fact, it is also worth adopting more complex interpretations, which underline the role of social actors and their calls for change, in line (or not) with the actions of economic and political actors who are normally its focus. ▮

---

47. Berlinguer, n. 27; Ergas, n. 21.