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Like Surfers Waiting for the Big Wave:

Healthcare Politics in Italy

Federico Toth

Abstract

This article focuses on the main health reforms enacted in Italy over the past 100 years. Such reforms were all undertaken in conjunction with a severe political and institutional crisis. The 1943 reform was approved few weeks prior to the fall of the Fascist regime. The National Health Service established by Law no. 833 of 1978 and enacted during one of the most turbulent times in the history of the country, represented the apex of the brief experience of the «national solidarity» governments. Even the 1992-93 reform was put into effect in the midst of the Tangentopoli scandal, which marked the transition from the First Republic to the so-called «Second Republic». To attempt an analysis of the main turning points in Italian healthcare policies, the well-known Multiple Streams Approach is adopted.

One of the most debated issues in politological studies on healthcare systems focuses on how these systems evolve over time (Immergut 1992; Wilsford 1994; Maioni 1997; Hacker 1998; Tuohy 1999; Oliver and Mossialos 2005).

Healthcare policies have reportedly alternated long periods of stability with brief moments of profound transformation (Evans 2005; Wilsford 2010). Healthcare policies have indeed been shown to be characterized by marked elements of continuity and inertia. Once a given healthcare organizational model has been implemented, a change in direction to adopt a different model is rather difficult (Wilsford 1994; Maioni 1997; Hacker 1998). It is nonetheless also true that in the course of time several western countries have undergone radical health reforms, which have marked the shift from one organizational model to another (Tuohy 1999; Oliver and Mossialos 2005; Toth 2013). Therefore, moments of thorough change and break with the past do occur, albeit rarely (Wilsford 1994; 2010). The literature has forged expressions such as «critical junctures» (Collier and Collier 1991; Capoccia and Kelemen 2007; Hacker 1998) or «crucial points» (Tuohy 1999) to refer to these moments of break with the past.

But how do these breaks come about? Do great reforms mostly result from factors that are exogenous or endogenous to the healthcare sector? To what extent are health reforms engendered by premeditated strategies rather than fortuitous circumstances?

The Italian case analyzed in this article may contribute to the debate, providing an answer, albeit incomplete, to these queries.

Compared with other countries, the Italian case is of interest because the principal health reforms were all undertaken in conjunction with a severe political and institutional crisis. The 1943 reform was approved few weeks prior to the fall of the Fascist regime. The National Health Service was established in 1978, at the end of one of the most tragic years in the history of the Italian Republic. Finally, the 1992-93 reform was put into effect in the midst of the Tangentopoli («Bribesville») scandal, which marked the transition from the First Republic to the so-called “Second Republic” (Cotta and Verzichelli 2007).

To attempt an analysis of the main turning points in Italian healthcare policies, this article adopts the well-known multiple streams approach (Kingdon 1984; Zahariadis 2003).

The fundamental elements of the multiple streams approach are briefly discussed in the next section. The third section reconstructs the situation prior to 1943, when voluntary insurance was in effect in Italy. The fourth to sixth sections dwell on the 1943, 1978 and 1992-93 reforms, respectively. The analysis of each single reform episode is based on the same analytical grid, identifying: problems, solutions, politics, policy windows and the presence, if any, of policy entrepreneurs. Conclusions are drawn in the seventh and last section.

We should therefore point out that there is no biunique or deterministic relationship between a crisis of the more general political system and health reforms. In this article, we do not claim that in Italy every political crisis leads to reforms in the healthcare system, nor do we argue that the political-institutional crises of 1943, 1978 and 1992-93 have necessarily been the most acute in the history of the country. Here we are asserting that each reform that radically changes the healthcare system is determined by the concurrence of multiple factors (as also envisaged by the multiple

streams approach). In the following sections we will see how a period of strong political turbulence is just one, but not the only, driving force of health reforms.

The Multiple Streams Approach

Many different criteria have been proposed to classify healthcare systems. A traditional, but still widely adopted classification (OECD 1987; Freeman 2000; Blank and Burau, 2004; Rothgang et al. 2010), takes into account three different models¹: 1) voluntary insurance; 2) social health insurance; 3) the national health service.

Italy is among the countries that – over the decades – have experienced all three models: first, voluntary insurance (up to World War II), followed by social health insurance (from 1943 to 1978), and finally the national health service (from 1978 onwards). After coming into effect, each of these three models showed limitations and critical aspects requiring a radical reform.

The Italian health service has indeed evolved through three turning points: 1) in 1943, with the introduction of social health insurance; 2) in 1978, with the establishment of the National Health Service (NHS); and 3) in 1992-93, when the public health service was radically reformed, changing – at least on paper – from a largely «integrated» system to a «contractual» model (Mapelli 2012).

This work focuses exactly on these three «crucial points» (Tuohy 1999), trying to understand what these three reforms have in common. Very useful for this purpose are the basic concepts of the multiple streams approach: problems, policy proposals, political stream, and policy windows (Kingdon 1984; Zahariadis 2003).

Problems. To retrace the great reforms that have marked Italian healthcare policies over the past 100 years, we start from the problems inherent to the different historical periods. Focusing on the problems is essential, as the lack of user satisfaction, and thus the need of a more or less radical reform, arise exactly from the dysfunctions of the system.

¹ Different authors point out that the boundaries between one model and the other are often blurred (Rothgang et al. 2005; Wendt et al. 2009), and that many healthcare systems are actually hybrid forms (Schmid et al. 2010; Tuohy 2012).

Policy proposals. Different reform hypotheses are usually elaborated in the attempt to solve problems perceived as more serious and urgent by the population and policy makers (Tuohy 1999; Zahariadis 2003). These policy proposals are often in contrast with one another and result in a debate between policy experts and the different political forces.

Political stream. This concept brings into play political consensus and what can be defined as «health politics». To be seriously taken into consideration by policy makers, a given policy proposal requires ample consensus, both by the population and, to an even greater extent, by the most influential stakeholders in the health sector. Each reform proposal is capable of dividing policy experts, political parties and stakeholders, and even more so if it is innovative and radical. More often than not, a reform proposal results in the formation of two coalitions: on the one side, the supporters of the reform, and on the other the defenders of the *status quo*. The relations of power between the coalitions – as well as any transfer from one group to the other – greatly influence the chances for a bill to pass.

Policy windows. Enjoying ample consensus may nevertheless not be sufficient. Legislative bodies often do not concur with policy experts and with the views of society in general. For a given bill to pass into law, favorable conditions are required (Wilsford 1994): the conditions that Kingdon (1984) calls policy windows. These windows of opportunity may open within the problem stream (in which case they are considered endogenous to the health sector), or they may open within the political stream, triggered by events outside the health scenario (Zahariadis 2003). The following sections discuss how the major health reforms in Italy were largely favored by external shocks (Sabatier and Weible 2007). We should also point out that policy windows are often short-lived: it is therefore necessary for them to be promptly used to good advantage by one or more *policy entrepreneurs* (Kingdon 1984) acting as facilitators of the process, and capable of pushing the policy proposal of their choice towards approval.

Based on the foregoing, we can now undertake the essential historical reconstruction of Italian health politics from the early 1900s till present.

Mutual Aid Societies

Until the late 1930s, Italy relied only on a typical system of voluntary insurance for protection against health risks. There was no obligation to have an insurance policy, and coverage of healthcare costs was possible in two different ways: joining a mutual aid society or registering in the municipal indigent registers.

Mutual aid societies were free, non-profit associations, whose main purpose was to protect workers in case of sickness or injury. Health fund societies, subscription to which was voluntary, collected contributions from their subscribers on a territorial or occupational basis. In turn, they reimbursed the healthcare expenses borne by their members.

There were different types of mutual aid societies: the health fund societies in Italy were territorial, occupational, corporate or mixed; some were large-sized, others small; some were of catholic inspiration, while others had a republican or socialist imprint, but most had no ideological connotation (Cherubini 1977). From the unification of Italy until the 1930s, subscriptions to health funds were constantly on the increase: in 1862, there were 443 health funds throughout the country, with approximately 121,000 subscribers. Forty years or so later, in 1904, there were more than 6,500 mutual aid societies and 926,000 subscribers, and in 1937 these societies counted more than 2.2 million subscribers, including members and their respective families (Cherubini 1977; Piperno 1986). In addition to mutual aid society subscribers, another category was entitled to protection against health risks: the indigents. Each municipality held a register where indigent people could ask to be listed. The town council was obliged to provide healthcare to those listed in the register. The indigents were entitled to free medical assistance by the “municipal doctors”², and free hospitalization. People who had not subscribed to a mutual aid society nor registered as indigent had to pay for medical care personally. This was the case for the vast majority of the population.

² Municipal doctors were paid by the town council to play a twofold role: on the one hand, they had to provide healthcare to the indigents at no charge, on the other, they also served as health officers, taking care of vaccinations and sending in periodical reports on the sanitary conditions on the territory within their competence.

The voluntary insurance system inherited from liberal Italy continued its course without any great changes even under the Fascist regime (1922-1943).

Problems. The main limitation of voluntary mutual aid societies was they did not gain a strong hold on the population: in the mid-Thirties, barely more than 5% of Italians had subscribed to a mutual aid society. Moreover, many physicians started to complain about the payment methods adopted by the societies, and among subscribers there was a widespread dissatisfaction towards the healthcare provided to them (Cosmacini 2005).

Policy proposals. The conviction grew that the voluntary system was inadequate and that some sort of mandatory insurance had to be introduced, following the example of measures already implemented in other countries. A first proposal in this direction had been brought to the Chamber of Deputies as early back as 1902. Over the following decades, the proposal of a mandatory health insurance, at least for subordinate employees, gained growing consensus (Cherubini 1977). Over the Twenties and Thirties, this proposal was not only supported by many politicians and reformist intellectuals, but also by the main trade unions, the federation of the mutual aid societies, and part of the medical world (Cherubini 1977). The major opponents were employers, concerned about a possible increase in the cost of labor (Piperno 1986).

The intention to shift towards a mandatory health insurance system was formally acknowledged in 1927 in the Charter of Labor (Cherubini 1977; Cosmacini 2005). This charter provided that each new collective labor contract had to envisage measures for worker's protection in case of illness. However, the Charter of Labor was not binding by law: the provision was therefore a mere declaration of intent (Piperno 1986); the government chose not to take any direct action, and thus referred the expansion of the health fund system to negotiations between employers and employees (Cherubini 1977; Chiappelli 1964). The numerous cases of non-compliance were also caused by the opposition of the entrepreneurial world (Piperno 1986).

The need to extend the population's healthcare coverage through mandatory insurance remained a topic of debate also in the second half of the Thirties. Some of the proposals discussed envisaged the

creation of healthcare funds based on the profession of the subscribers; alternative solutions hypothesized the implementation of territorial, and thus inter-occupational, funds. In the end, none of these proposals proved successful. The main reason for hindering the overall reform of the healthcare system was the lack of adequate public resources (Luzzi 2004). The project of a social health insurance was thus put off time and again (Chiappelli 1964).

A further attempt was made in 1939. The national collective labor contract of industry workers executed that year provided for an inter-occupational fund to be established in every province, with mandatory registration of all industrial and artisanal company workers. The funds had to guarantee their subscribers a sickness allowance and coverage of medical and pharmaceutical expenses. Perhaps also due to the war, this provision was only partly implemented, and many workers did not register with the provincial funds (Vicarelli 1997).

The Social Health Insurance System (1943-1978)

The policy window. The reform was put on hold until 1943. Law no. 138, approved in January 1943, established the INAM (National Institute for Healthcare Insurance), with mandatory registration of all subordinate employees in the agriculture, industry, commerce and credit and insurance sectors. The pre-existing social aid societies were absorbed by the new Institute. Insurance coverage included the subordinate employees and their dependent family members. Public employees and railroad workers did not have to pay their contributions to the INAM but to the ENPAS (National Social Security and Healthcare Body for Public Employees). As registration with these bodies (INAM and ENPAS) was no longer voluntary but mandatory, the 1943 reform proved to be an important turning point for the Italian healthcare system: from a voluntary insurance system the country embraced a social health insurance system. The reform project «*was drafted hurriedly, patched up as one best could*» (Chiappelli 1964).

The approval of the reform was not given great emphasis, by neither the government nor the press. In the past, Mussolini had expressed himself in favor of a general healthcare insurance (Cosmacini

2005), but in the first months of 1943 he had other matters to occupy his mind. We should recall that the law pursuant to which the INAM was established was discussed and approved during the most critical phase of the war (Chiappelli 1964). This was one of the last, significant measures implemented by the Fascist regime (Luzzi 2004). It is noteworthy that Law no. 138 was promulgated in January, but the Royal Decree allowing entrance into force of the law was signed in May 1943; Mussolini was removed from power and placed under arrest just two months later, on 26th July.

Policy entrepreneur. Tullio Cianetti, who first served as Vice-Minister and later as Minister of the Corporations (up to July 1943) was most active in his efforts to have the reform approved. At the time, the Ministry of the Corporations was one of the most important offices, whose competence included social security issues and labor policies. Cianetti, a former trade-unionist who enjoyed Mussolini's trust, was convinced that it would have been expedient for Italy to adopt a healthcare insurance system based on the Bismarck model (Cianetti 1983).

How the social insurance funds worked. At the end of World War II, only public workers and private subordinate workers (both manual and clerical workers) had the obligation of taking out a health insurance. This obligation was later extended to many other occupational groups. The first to be included were the workers of local boards (1946) and public bodies (1947), followed by reporters (1951) and executives (1953); in 1954, it was the turn of independent farmers, in 1956 of craftsmen, in 1958 of fishermen, and in 1960 of tradesmen. The 1960s saw the establishment of health insurance funds for self-employed workers: pharmacists, physicians, veterinarians, engineers, architects, lawyers. Naturally, as more and more occupational groups became subject to the obligation of taking out an insurance policy, a larger percentage of the population came to be registered with a social insurance fund: in 1950, healthcare funds provided coverage to approximately 38% of Italians; in 1974, coverage reached 93% of the population (Taroni 2011).

Each occupational group had its own health insurance management, separate from the others. Therefore, in Italy there was a large number of health insurance bodies. In the mid-Seventies, when the National Health Service was established and all health insurance bodies were wound up, more

than 300 national institutes and municipal, provincial and corporate funds were counted (Mapelli 2012).

Problems. Starting from the Fifties, the health insurance system showed a number of problems, first among which its organizational fragmentation (Cherubini 1977; Ferrera 1995). The other great weakness of the system was the difference in coverage and services offered (Brown 1984). Each health insurance fund had its own charter of incorporation and by-laws. Mandatory contributions payable by the workers were calculated as a fixed percentage withheld from the salary. In this respect, it was possible to find substantial differences between one health insurance fund and the other. Differences in services were also evident insofar as the benefits offered were concerned: indeed, some health insurance funds were more generous than others. In the mid-Seventies, at the peak of their expansion, the different health insurance funds achieved an overall coverage of 93% of the population. This means that over three million Italians were left without health insurance.

Starting from the Sixties, these limitations – somehow innate to the social health insurance model – were complemented by financial difficulties. Many health insurance funds reported recurrent liabilities, which the State had to settle on several occasions (France and Taroni 2005). To top it all, health insurance bodies were the object of party patronage. The executives of these bodies were indeed politically appointed, and it was easy for the majority parties (above all, the Christian Democratic and Socialist Parties) to take advantage of this opportunity for patronage purposes and to gain voters from among the beneficiaries within each occupational group (Ferrera 1996).

The 1968 Hospital Reform. Around the mid-Sixties, the problems linked with the health insurance system, and in particular those of a financial nature, all came to surface. Owing to the constant increase in hospital expenses, health insurance funds accrued heavy losses (Taroni 2011). The weak point of the entire system was identified within the hospital system, which was reorganized pursuant to Law no. 132 of 1968 (also called the *Mariotti Law*, after the then Minister of Health). The Mariotti Law provided for relevant measures for the rationalization of the hospital system and opened the way

for the subsequent establishment of the National Health Service. This notwithstanding, it brought about only a partial reform of the healthcare system (Ferrera 1984; Luzzi 2004).

First and foremost, the 1968 reform extended the right to receive hospital care to all citizens, and not only to those registered with health insurance funds (this right came into effect in 1974). The debts of the hospitals were taken over by the State, while hospital planning was to be entrusted to the regional administrations, once established. The 1968 reform resulted in a standardization of the hospital network, subjecting all facilities to the same obligations and controls.

In any event, the hospital reform did not manage to mitigate the economic difficulties of the health insurance funds (McCarthy 1992): following the reform, hospital expenses not only did not decrease, but even tripled over a period of only five years (Ferrera 1989). The financial disruption of the health insurance funds thus became increasingly worrisome. As a consequence, an overall reform of the healthcare system became an urgent issue.

The Establishment of the National Health Service (1978)

Policy proposals. The proposal to establish in Italy a public service based on the British *National Health Service* model was not the only option under consideration (Taroni 2011). In the early Sixties, two opposing line-ups took shape: the «reformists» on the one side, and the «health fund» front on the other (Ferrera 1984). The reformist line-up, mainly represented by trade unions and left-wing parties, favored the implementation of a national health service. The contrary opinion was upheld by large segments of the Christian Democratic Party, a good part of the medical class and the personnel of the mutual aid societies, who supported the reorganization of the existing system, merging the hundreds of health insurance funds operative in the country in few, large bodies operating at national level (Brown 1984; Ferrera 1989). Hospital care could also have been separated from outpatient care, financing the former through direct taxation and the latter with the contributions paid to the health insurance funds. The National Health Service was clearly not the only solution envisaged, and probably it would never have been established if a favorable opportunity would not have occurred.

The policy window. The propitious conjuncture occurred in 1978. In that year, Italy, which had not yet recovered economically from the 1973 petrol shock, had to face a deep institutional crisis and an unprecedented terrorist escalation. It was indeed in May 1978 that the Red Brigades terrorist group kidnapped and killed Aldo Moro, Secretary of the Christian Democratic Party. Shortly after, following the Lockheed bribery scandal³, Giovanni Leone resigned as President of the Republic.

In that over-troubled year, the weight of leading the country was borne by the Andreotti IV government: a one-party, Christian Democratic, «*national solidarity*» government, so called because it counted on the external support of the Socialist (PSI), Social Democratic (PSDI), Republican (PRI) and Communist (PCI) Parties. The involvement of the Communist Party in government represented a historical turning point in the history of the First Republic and proved to be a decisive factor for the approval of the health reform (McCarthy 1992): the Communist Party gave its support to the government on condition that it implement the National Health Service (NHS).

The proposal to implement a national healthcare service had already been presented before: as early back as the 1950s the CGIL (Italian General Confederation of Labour), Italy's largest trade union, favored the creation of a public health service based on the model of the British NHS; also, the first bill presented to parliament in this respect by the Communist Party is dated 1965 (Ferrera 1989). In addition to the trade unions and the left-wing parties, the reform was also largely supported by catholic associationism, Confindustria (Confederation of Italian Industries) and health professionals considered as «auxiliary» or «emerging», such as nurses, psychologists, and social workers (Luzzi 2004).

Against the reform, in addition to the parties of the opposition (the Liberal Party and the MSI Post-Fascist Party), there were a segment of the Christian Democratic Party, the subordinate employees of the health insurance funds and the medical associations, evidently unwilling to become «nationalized» (Ferrera 1989). In truth, the attitude of a large number of medical professionals was ambivalent. Practitioners feared not only to lose their professional autonomy, but also their income

³ The President of the Republic Giovanni Leone was accused of accepting bribes from the U.S. company Lockheed to favour the sale of transport aircraft to the Ministry of Defence. The allegations brought against Leone were never proved.

opportunities. The original reform scheme in fact did not allow public practitioners to practice privately. The federation of the medical associations expressed harsh criticism of this provision and went as far as threatening not to adhere to the newly forming NHS. Physicians gave their agreement only when it became clear that the reform law would pose no obstacles to private practice.

After numerous deferrals, the law for the implementation of the National Health Service was finally approved in December 1978. During the debate in the Chamber of Deputies, the Christian Democratic Party, the Communist Party (PCI), the Socialist Party and the Social Democratic Party were in favor of the reform, whereas the Italian Social Movement (MSI) and the Liberal Party, which were in the opposition, were against it.

Policy entrepreneur. The bill managed to overcome all the bottlenecks and traps of the parliamentary procedure owing to the initiative and perseverance of some politicians who showed a special interest in the success of the reform, including the Minister of Health, Tina Anselmi. She was an exponent of the progressive wing of the Christian Democratic Party and held the office of Minister of Health from March 1978 to August 1979. Tina Anselmi played a crucial role in seeking dialogue with the left-wing forces, and adopted a particularly combative approach (Luzzi 2004) in negotiating the contents of the reform with some influential communist members of parliament, such as the medical hygienist Giovanni Berlinguer (Cosmacini 2005).

The contents of the reform. Law no. 833 of 1978 for the implementation of the National Health Service was mostly aimed at promoting an important organizational integration process, both in terms of financing and provision of healthcare. With respect to financing, the reform replaced (and wound up) all the pre-existing health insurance funds with a single national insurance for the entire population: healthcare was no longer a workers' health protection program but a right of all citizens. The National Health Service was to be financed through general taxation. Insofar as healthcare provision was concerned, all public hospitals and outpatient clinics became operational facilities of the NHS. Most of the personnel also became subordinate employees of the public service. The different branches of healthcare would no longer operate separately, as they were all brought under

the same organization. The NHS indeed spanned primary care, highly specialized procedures, prevention, rehabilitation, public hygiene and veterinary services.

Special measures – resulting from difficult and delicate compromises at parliamentary level – were applied to private facilities and the medical staff. Unlike public facilities, private hospitals and outpatient clinics were not merged into the NHS but were entitled to enter into agreements with the public service. Not all physicians became public employees. Family doctors and some specialist physicians maintained their status of private practitioners but had access to a special agreement with the NHS. Conversely, hospital physicians who became employees of the NHS were given the opportunity of practicing privately outside their normal working hours.

Problems. The NHS soon became the object of negative criticism of different nature. During the Eighties it was accused of providing low quality healthcare, of being bound by too much bureaucracy, and of tolerating frequent wastes and episodes of corruption (Freddi 1984; Ferrera 1995). The Local Health Units (USL – Unità Sanitarie Locali) were governed by a joint committee, the board of management, whose members (from 7 to 13) were appointed by the town councilors of the municipalities within the territory of each USL. The objective of Law no. 833 to place the management of the USL under democratic control produced some undesirable effects: right from the start, the boards of management became fertile ground for party patronage, and ended up using the resources destined to healthcare for reasons linked to political favoritism (Ferrera 1995). The boards of management thus started recruiting members who were often lacking in expertise and motivation, selected on the basis of political affiliation rather than merit (Ferrera 1989). These problems contributed to a widespread dissatisfaction towards the management and the services provided by the NHS, to the point that several sides started pressing for a «reform of the reform».

The 1992-93 Reform

Policy proposals. Experts started debating the issue and identified the two most appealing solutions. Both aimed at removing healthcare management from the control of political parties, giving the

system a “managerial imprint” (Ferrera 1995; Taroni 2011). The first solution drew inspiration from the 1990 reform by the Thatcher government: it intended to promote greater competition in the provision of healthcare services, making a clearer distinction between buyers and providers. The second solution – supported mostly by the Radical Party and some exponents of the Liberal Party – envisaged a national health service based on voluntary registration: individual citizens could have chosen between public healthcare or private insurance coverage (preferably non-profit); in the latter case, patients would have had to pay the mandatory contributions directly to the private insurance company and not to the public system.

The policy window. The opportunity to undertake a reform arose in the 1992-93 biennium. Like the 1978 reform and the 1943 reform before that, the reform of the early Nineties was approved in extremely exceptional conditions, both in terms of economy and politics (Ferrera 1996; France and Taroni 2005). As regards the economic situation, in 1992 Italy had to tackle one of the worse crises of the post-war period: the economic conjuncture, in itself negative, was further magnified by a speculative wave against the Italian lira, which forced the government to exit the European monetary system. The Italian government’s capacity to achieve the convergence criteria of the Maastricht treaty signed few months before (February 1992) was inevitably at risk. To deal with the currency crisis and fulfill the obligations required by the European integration process, the «technical» government led by Giuliano Amato was forced to put in place stringent policies based on new taxes and heavy cuts to public spending.

The economic crisis was complemented by the political-institutional crisis, attributable not only to mafia massacres (the bomb attacks against anti-mafia magistrates Falcone and Borsellino occurred in 1992), but also to the «Tangentopoli» scandal (February 1992). In the following months, both the executive branch and the Parliament were in an upheaval as a result of the investigations by the magistrates on systemic episodes of corruption and illegal political party financing: one third of the Members of Parliament fell under investigation, including as many as seven Ministers of the Amato government, who were thus forced to resign. The «Mani Pulite» (Clean Hands) judicial investigation

resulted in a delegitimation of the entire political class and weakened the Parliament, which ended up giving *carte blanche* to the executive branch until the following elections, which were to take place in 1994. It is not surprising that the key message in such a political climate was to «depoliticize healthcare» (Taroni 2011).

In October 1992, the Parliament chose to delegate to the government the reform of a number of sectors (including healthcare and pensions) considered to play a strategic role in paying off the government debt. The reorganization of the National Health Service was rapidly dealt with by the Amato government, which understood to have – at that precise historical conjuncture – an extraordinary opportunity for political initiative. The urgency reasons provided a fast track route to the decree (Cosmacini 2005); legislative decree no. 502 of 1992 was thus approved in less than two months, despite the contrary opinion of the Chamber of Deputies and Senate commissions (Maino 2001).

Policy entrepreneur. Minister of Health De Lorenzo⁴ played a major role in drafting the text of the reform (Cosmacini 2005; Taroni 2011). The Minister was in favor of a reform of the NHS that would exclude political parties from the management of the USL, and promote “fair” competition between public and private providers (Cosmacini 2005). A bill geared to these principles had already been presented by De Lorenzo in 1989: this bill was approved by the Chamber of Deputies (in 1990), but the process came to a halt in the Senate. The bill, once revised and amended, served as basis for drafting the final version of the 1992-93 reform.

Changes introduced by the reform. Legislative Decree no. 502 of 1992 soon became the target of harsh criticism by the regional administrations and part of the medical professionals (Luzzi 2004, Taroni 2011). This criticism focused mainly on the provisions pertaining to voluntary health insurance. Section 9 of the decree granted citizens the possibility of exiting from the public health

⁴ At the time, Francesco De Lorenzo was a leading exponent of the Liberal Party. A medical doctor, with important scientific publications in the field of molecular biology, between the late Eighties and early Nineties he was a very influential figure in the healthcare and other sectors. He was Minister of Health in two successive governments from 1989 to 1993. Prior to that, he had held the office of Vice-Minister of Health (from 1983 to 1986), and then of Minister of the Environment.

service, transferring their individual share of health expenses to voluntary insurance funds. In this manner, the latter would have been in competition with the new local health agencies and could have acquired the services of both public and private providers on behalf of their healthcare recipients. The provision actually produced no results, also due to the fact that it was soon abolished by the Ciampi government, which took over the Amato government in the spring of 1993. The new government issued a corrective decree (Legislative Decree no. 517 of 1993), which established that voluntary insurance funds could only cover medical procedures that were not guaranteed by the National Health Service. Therefore, the health insurance funds were not to be considered an alternative, but rather a complement to the public service. Besides the contested Section 9 and some new provisions pertaining to the accreditation of healthcare facilities, the decree passed by the Ciampi government contained no substantial innovations as compared with the previous decree. Decrees no. 502 and 517, approved in 1992 and 1993, respectively, can therefore be considered a single reform intervention, destined to redesign the National Health Service according to the following guidelines: 1) corporatization; 2) split between purchasers and providers; and 3) regionalization.

The first relevant change introduced by the 1992-93 reform involved the transformation of the USL and of the more important hospitals into public corporations. This was meant to favor the autonomy of public healthcare facilities and the adoption of management tools borrowed from the private sector. The USL were thus transformed into Local Health Agencies (ASL - Aziende Sanitarie Locali), i.e., public entities with extensive managerial autonomy. The main hospitals were separated from their respective ASL and transformed into hospital agencies (AO - Aziende Ospedaliere). The management of the new health agencies was entrusted to public managers appointed by the regional council with the intent to «managerialize» the public health facilities, replacing the boards of management with monocratic general managers responsible for the results achieved.

The second major change brought about by the 1992-93 reform was the split between territorial agencies (the ASL), which were to act as purchasers of services, and hospital agencies (AO), responsible for the provision of specialist healthcare. To mark out the different nature of the territorial

and hospital agencies, it was established that the former were to be financed based on the number of healthcare recipients residing in their respective territory, while the latter were to be financed depending on the number of procedures actually performed. The reform bill envisaged that the potential providers would be in competition amongst them. To this end, it was decided to equalize private and public providers, on condition that the former would accept the prices and quality checks imposed at regional level. Citizens would thus have been able to choose among all accredited, public and private providers without the need to obtain authorization by the competent ASL. This, at least, was the design of the reform: the model of quasi-markets was only partially implemented and almost all regions preferred to keep most of the hospitals within the territorial agencies. The only region which separated almost all hospitals from the respective ASL was Lombardy (Mapelli 2012).

The third significant change introduced by the reform of the early Nineties was the greater empowerment at regional level. This increased empowerment was achieved by transferring powers from the national government, and taking the management of the USL away from the municipal councils, which thus took on a marginal role insofar as healthcare planning was concerned. Conversely, regional administrations were given great discretionary powers for planning, organizing and financing healthcare services throughout their respective territories.

The 1990s and the 2000s. In the years immediately following its enactment, the 1992-93 reform was accused of being incomplete and presenting some ambiguities (Maino 2001; Taroni 2011). Some subsequent interventions became necessary to settle pending issues, and elucidate or amend the most controversial points. The major corrective intervention is represented by Legislative Decree no. 229 of 1999, drafted by the Minister of Health Rosy Bindi (first D'Alema government). It is nonetheless noteworthy that Decree no. 229 did not manage to achieve the logical completion of the 1992-93 reform (Maino 2001); it rather marked a sign of discontinuity with respect to the early Nineties' reform, reaffirming some of the inspiring principles of the National Health System (France and Taroni 2005). Legislative Decree no. 229 took a softer approach in terms of competition and market, while focusing on public planning and integration of public and private entities.

Great Reforms and Times of Crisis

Having considered the great reforms of the Italian health system, we can now draw some conclusions. The Multiple Streams Approach has already been used to interpret health reforms in different countries (Blankenau 2001; Leiber et al. 2010; Oborn et al. 2011; Kusi-Ampofo et al. 2014; Agartan 2015). Let us try to understand which particular aspects emerge from the reforms discussed in the foregoing, and which lessons can be learned from the Italian case.

Over the past decades, Italy has experienced the three main models of healthcare organization: up to the 1930s, there was a voluntary insurance system; in 1943, the system implemented was based on social health insurance and, in 1978, the National Health Service was finally established.

Problems. Once set up, each one of these three systems showed its limitations: problems which – depending on the model – pertained to the insurance coverage for the population, fair treatment and financial sustainability. Some of these limitations were overcome, even if only partly, by changing from one model to the next. Other problems – like the inability to control spending, or the use of healthcare resources for political purposes – are common to all models: it would seem that they are endemic in the Italian healthcare system.

Policy proposals. From time to time, reform bills were presented with the aim of solving these problems. It is noteworthy that the three reforms analyzed in the foregoing were at the centre of the debate, long before their final approval.

An interesting aspect of the three cases analyzed here is that the content of the reforms is largely inspired by foreign experiences. This may seem a peculiar trait of “Italian-style” healthcare reformism. Perhaps, the domestic debate focuses on systems already tested in other countries to lend greater legitimacy to the proposed solutions (Marmor et al. 2005). This is a typical case of policy *emulation* (Rose 1991). Usually, the countries that are emulated are those which are considered forerunners, and those governed by ideologically kindred political forces (Robertson 1991; Rose 1991; Dolowitz and Marsh 1996). Indeed, this is what happened in 1943, when the Fascist regime

took as model the German system of social health insurance. In the reforms that were to follow, the reference model was, instead, the United Kingdom: it was so both for the 1978 reform (with the implementation of a public service similar to the British NHS), and for the 1992-93 reform (the contents of which refer to some important aspects of the 1990 Thatcher reform).

Policy entrepreneurs. When a policy window opens, there are several options one can select from (Capoccia and Kelemen 2007). The advocates of the different solutions must have the skill to submit their proposals in a timely fashion. In this context, John Kingdon's comparison between policy makers and surfers seems rather apt (Kingdon 1984, 173): like surfers, who cling to their board, ready to surf the perfect wave, policy entrepreneurs cling to a given reform bill, awaiting the favorable conditions that will make it pass into law.

In the three reforms analyzed in the previous sections, the role of policy entrepreneurs was played mostly by the minister responsible for the healthcare sector⁵. This is a further peculiarity of Italian healthcare reforms. The major facilitator of the 1943 reform was Tullio Cianetti, Minister of the Corporations of the Fascist government. The 1978 reform resulted from the compromise between the left-wing parties and Minister Tina Anselmi, exponent of the progressive wing of the Christian Democratic Party. In 1992, the major supporter of the reform was Minister De Lorenzo, a medical doctor and leading figure of the Liberal Party. As important as it may be, the role of ministers as policy entrepreneurs should not be overestimated. The policy entrepreneur merely takes advantage of favorable opportunities, whenever they arise. However – if we consider the major Italian healthcare reforms – it is not the policy entrepreneur (i.e., the minister in office) who defines the issue; the minister only partly elaborates original solutions, and it certainly is not the Minister of Health who brings about the opening of a policy window. After all, surfers – to stay within the imagery chosen by Kingdon – do not produce waves, they just ride them.

Policy windows and external shocks. As discussed in the foregoing, the main Italian health reforms seem to follow a regular trend: they have all benefitted from dramatic moments of political,

⁵ In 1943, the Ministry of Health had not yet been set up. Back then, healthcare issues were dealt with by the Ministry of Corporations.

institutional and often also economic crisis. In other words, the great reforms coincided with exceptional – often unexpected – windows of opportunity, which have opened the way to radical changes in direction with respect to the past. In the three cases under study, these policy windows were opened by shocks outside the health sector, which undermined the entire political and institutional system. The 1943 reform passed when a regime crisis was imminent. Law no. 833 of 1978, enacted during one of the most turbulent times in the history of the country, represented the apex of the brief experience of the «national solidarity» governments. Even the 1992-93 reform was favored by a system crisis brought about not only by stringent budget limitations, but also by the Mani Pulite investigation and the consequent crumbling of the First Republic.

Health politics. The interpretation seems to come on its own, confirming different prior studies on the subject of health politics (Hacker 1998; Tuohy 1999; Evans 2005): the health sector is an intricate bundle of interests and values rooted in the social and productive fabric. In “normal” conditions, it is rather difficult to unravel the bundle, overcoming the resistance and the crossed vetoes of the various stakeholders. Radical changes that overturn the most deep-rooted convictions and challenge consolidated relations of power are thus possible only in exceptional conditions of systemic crisis (Wilsford 1994; Sabatier and Weible 2007).

As already stated in our opening remarks, a crisis of the political system does not automatically bring about a reform in the healthcare sector. The political-institutional crisis may contribute to the opening of a policy window, but once this occurs it is up to the policy entrepreneurs to grasp the opportunity and make problems, solutions and political consensus converge in their favor.

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