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**“150 YEARS OF ITALIAN GOVERNMENT:
WHAT HAS BEEN ACHIEVED?”**

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1. Theoretical Framework

1.1. Solidarity: a positive and normative concept

The idea of solidarity has many facets, and several concepts, drawn from philosophy, sociology, economics, law and religion, can be invoked to explain it (Villa 1998): among these concepts are co-operation, loyalty, membership, mutuality, reciprocity, unity, brotherhood and so on. All these concepts relate to the social order and are aimed at improving social co-operation. Especially after the French Revolution, solidarity has been connected with two other principles of democratic societies, namely freedom and equality. In contemporary societies, the market economy relates to freedom (e.g., freedom of employers), while the representative democracy relates to equality (e.g., of citizenship). Social solidarity is, therefore, a very scarce resource and its meaning changes with historical periods, crossing other words of the political vocabulary, such as equality, freedom, justice, self-interest, altruism etc.

The concept of solidarity is not an heritage of the Enlightenment tradition nor of the liberal ideology; its origins, especially in its 'fraternity version', can be traced to the Christian-Catholic democratic ideology and to the socialist tradition (Martinelli 1989). These traditions have been determinant factors in some models of Welfare State, that have been created in many European countries after the Second World War. More recently, the debate on social justice in political and social theory, centred on the alternative accounts of liberalism and communitarianism, has had large implications with respect to solidarity as well.

In this section I will first try to set out the problems in the relationship between the individual and the society, particularly focusing on the problems of solidarity in modern societies. Besides, I will consider the problems of social citizenship within the Welfare State, in the light of the complexities of contemporary societies, in order to single out the main arguments justifying solidarity-based public policies, with particular reference to social policies. Finally, taking account of the present communitarian criticisms to the modern view of society, I will try to sketch a model of 'selective solidarity', able to integrate justice and solidarity, in order to confront the difficulties posed by the emergence of new social rights and of evolution of society.

While traditional societies exhibit a 'strong bond' between individuals, modern ones show a larger solidaristic feeling, that in some cases becomes a universalistic one. This feeling of modern solidarity is aimed to remove inequalities or disadvantages between social groups through the redistribution of social resources. Actual democratic regimes exemplify a model of 'contractual solidarity', built on the concept of the equality of citizenship, on which empirical and theoretical analyses of welfare systems have been developed. Modern solidarity functions between impersonal and non-related members, whose only common foundation is the sharing of the institution of citizenship. The meaning of solidarity thus parts from concepts such as altruism or gift relationship and becomes more similar to the idea of co-operation.

However, as a result of the transformation of contemporary societies, a different trend in sociological theory has emerged, which tends to carry back the concept of modern solidarity towards a communitarian and particularistic view. The economic difficulties faced by many welfare systems based on the equality of citizenship has led some to develop a different model of solidarity. They suggest to get over the private/public and the market/State dichotomies, and stress the voluntaristic dimension, in which the transactions between the members of society are mutual and involve families, relative networks, voluntary groups, mutual-help and self-help groups and so on. This is called the model of societary-citizenship, because it focuses on relations taking place in the civil society and it is based on activities of both primary (e.g. family) and secondary (voluntary groups) solidarity. The assumption is that, given the inadequacy of the State in managing the social services, it is necessary to stimulate the capacity of self-regulation and the resources of the civil society, which ground joint ventures of market and solidarity (the so-called 'social market').

The solidaristic model thus moves from a statutory solution, stressing the relationship between the State and the citizens, to a 'social-private' or 'social-communitarian' solution, based on voluntary actions, third sector activities, social co-operation and family networks (Zincone 1992, Donati 1993). This perspective proposes a new organisation of social policies and of the relationship between the private and the public. However, the rising rhetoric of the social market risks legitimising privatistic cultures and opportunistic behaviours in relation to public goods, thus weakening the social links and destabilising the entire society (de Leonardis 1998).

We can thus say that the concept of solidarity moves from a pre-modern or traditional society to the modern society, and then partly goes back by incorporating elements of communitarianism disregarded by liberal theories of citizenship. Now, in the light of the ongoing debate concerning the evolution of the

welfare systems in Western democracies, we propose to analyse the new challenges emerging from the peculiar area of social policies that is health care.

1.2. Towards a new social citizenship: problems and perspectives

Against the background of social complexity, our aim will be to understand the challenges posed by the plurality of demands of goods and services in the face of a social and economic situation that imposes a revision of the means of allocation and distribution of scarce resources.

Discussing the means inevitably involves reflecting on the ends of social policies, taking into account the qualitative, as well as the quantitative, dimensions of the goods delivered. In this situation, the concepts of right and need change their meaning, leading to a redefinition of the concept of citizenship (strictly tied to that of welfare)¹ which, while becoming ever larger (so as to give rise to a ‘universal citizenship’), risks to jeopardise the very basis of its enjoyment, as far as the civil, political and social rights are concerned.

Besides, multicultural and multiethnic societies pose the problem of pluralism, with respect to values (especially in a post-materialist vein²), of life-styles and of different conceptions of the good; this creates difficulties concerning the definition of the goods and services to which the citizens can make legitimate claims. For example, the provision of plastic surgery for aesthetic reasons and of therapeutic treatment for a tumour presumably caused by an unhealthy life-style may both claim the same right of citizenship and ask for unprejudiced consideration on the part of the public decision-makers allocating scarce resources.

The problem is whether the social sciences are able to give objective criteria (some common currency) to define which goods and services are included among the rights of citizenship and which are to be considered as mere individual preferences, not deserving public commitment for their satisfaction (Dworkin 1981a, 1981b, Granaglia 1988, 1999, Grillo 1998)³. This is particularly relevant for the question of the possibility to take into account both individual rights and collective purposes. Sometimes the two are compatible, while at other times the inconsistency of individual and collective purposes must be acknowledged. As far as social policies are concerned, this means that answering individual and collective needs through the regulation of access to goods with reference to which the individuals are in different condition, for the most part produces tensions not only between different individual ‘legitimate’ claims, but also between the same aggregate claims and other common objectives aimed at different purposes. Hence, it is inevitable for those in charge of the public institutions, to make a choice, notwithstanding the social conflicts that this may raise.

With reference to solidarity, several questions arise: while the distributive principles for allocating scarce resources in health care have been so far inspired by criteria of urgency and emergency, which reflected shared priorities with regard to who and what to cure, nowadays factors concerning both the medical sciences (i.e., technological innovations, scientific developments, increase in diagnostic abilities), and the structure of society (i.e., increase in the users’ expectations in all phases of the life cycle, variability of non aggregable life-styles) pose severe socio-political problems in defining the purpose of public health care policies, as well as of other social policies. Given the plausibility of the Marshall approach on the issue of the rights of citizenship, the contemporary systems of welfare must work out new answers to the ever more differentiated demands of the individuals.

The problem of social citizenship involves some central issues in the analysis of contemporary society. Among these are: the boundaries of a society; the definition of which groups are a part of it and which are excluded; the criteria to claim full citizenship; the requisites for the different members of the

¹ The very concept of citizenship is clearly the object of analysis both in empirical studies in sociology and the social policies, and in

more abstract analyses of social and political theory, and of political and moral philosophy as well. The focus will be on the concept of social citizenship, and particularly on the central issues regarding rights and duties typical of contemporary society (Bulmer-Rees 1996; Roche 1992).

² The post-materialistic dimensions of values and of life-styles has received particular attention in sociological theory since the pioneering work of Inglehart (1977). New dimensions of value have thus been considered, such as corporeity, subjectivity, personal identity and its needs, that are not always qualifiable as material needs.

³ For example, according to Dworkin, it is impossible to build a theory of equality on the basis of the welfare paradigm: individuals have different conceptions of welfare and they cannot deal ‘as equal’ about some dimension that all take into account in a different way. This point is very important for our analysis because this conception of equality makes it possible to understand the evolving model of social rights and citizenship.

society to have access to social benefits and services; the relationship between the actual and the ideal distribution of rights (Dahrendorf 1996).

The politico-cultural traditions which have characterised the public debate of the last two centuries are the liberal-democratic and the social-democratic. According to the first tradition, constitutional arrangements are the result of a voluntary agreement (the social contract) between individuals who choose freely how to live, according to their desires, needs and rights. This tradition is interested mainly in the protection of individual autonomy and of negative rights; it is critical that individuals should not be interfered with, nor be the object of arbitrary impositions (civil and then political rights). However, if limited to the protection of liberty rights, such a contract will not be able to guarantee the fundamental rights of all members of the society, for some, thanks to their superior natural and social endowments, will condition the contract to their advantage (Rawls 1971). The limits of the liberal-democratic tradition in solving the problems of civil life and public and social order are counterbalanced by the social-democratic tradition which, taking care of the collective outcomes in terms of welfare, endorses the priority of the principles of equal opportunity and social justice over the principle of freedom, and justifies the introduction of social rights.

It could be argued that the two traditions, being complementary, should be able to solve the problem of finding the moral and social principles that generate the *shared values* that make the stability and cohesion of a complex society⁴. However, to reconcile differently inspired and sometimes incompatible rights, or to solve the crisis of compatibility between the two major systems of regulation of public life (the State, through legitimate authority, and the market, through economic exchange), is a challenge for all those committed to redefining and transforming contemporary social systems (Grillo 1998). As a matter of fact, choice and conflict cannot be avoided, and, particularly in the field of health care, may create dilemmas.

The necessity to adjust collective choices and individual interest (Arrow 1951), is accepted by that part of the social and political theory based on various interpretations of individualism (as opposed to holistic approaches), in order to find some convergence between individual rights, interests and actions and public goods and social actions (Olson 1971). The problem is to interpret the various social arrangements and their stability in the light of the fundamental individual rights (individual autonomy and negative freedom) and the social consequences of their exercise.

New rights have been added to those characteristic of the political Western tradition, that have been progressively extended from civil and political rights to social citizenship. These rights are both the old ones as revisited in the light of the complexity of contemporary societies, and the 'rights' attributed to non human entities (such as animals' or nature's rights), and also the rights of non living objects (such as monuments, works of art, etc.). When confronted with this lot of old and new rights, often in tension between themselves, the problem of justifying priorities in choosing different social policies becomes fundamental. The need for an ordering comes from the fact that public decisions between different desires, needs and interests do not rate such preferences as bearing the same value. To prioritise some over others means to conceive of some claims as more important and 'urgent', in the light of the shared values of the society.

The protection of social stability implies reconciling the implementation of individual rights of autonomy with the fair treatment of all citizens; but the increased individual differentiation makes it difficult to obtain general consensus while effectively answering individual demands. Moreover, the relation between individual behaviour and its social consequences has remarkable effects also in view of the severe economic restrictions imposed by the Governments in Western democracies. The actual systems of welfare seem to be involved in a sort of paradox: on the one side, the technological means for health care are constantly being innovated, on the other hand they are not able to follow a demand ever larger and more various.

1.2.1. *Solidarity in an evolving model of citizenship*

The Welfare State was developed in Northern European countries, particularly in Sweden and the United Kingdom (Ferrera 1998), along the lines of the famous 1942 Beveridge Report on social security (*Social Insurance and Allied Services*), in a universalistic logic: minimal standards of life and social security have been acknowledged to all citizens, independently of their position in the market of labour or of their contributive position (Flora, Heidenheimer 1983; Ferrera 1984). The evolution of the system involves the

⁴ For a critical analysis of this approach, called *lib-lab*, and a proposal to solve the questions posed by the crisis of political, social and economic systems of regulation based on the state-market complementarity in terms of societal citizenship, see Donati 1993.

progressive enlargement of the *rights of citizenship* through the universalization of *civil* rights (necessary to individual liberties) during the 18th century, of *political* rights (guaranteeing participation in the exercise of political power) in the 19th century, and of *social* rights (concerned with economic welfare) in the 20th century (Marshall 1970). The protection of individual rights was the philosophical presupposition of the liberal State that, during the 20th century, has become democratic, through formal democracy (i.e., universal suffrage, representative system, majority principle) and then through substantial democracy (i.e., compulsory education, national health service, State social insurance, progressive taxation on income and on succession). Historians of political theories see liberalism as the political theory that privileges the value of freedom, and democracy as the political theory that privileges the value of equality; finally, socialism as the political theory that centres on social justice as an extension of equality (Bobbio 1984, 1985, 1991).

By enforcing the social rights, the State grants to citizens the minimum availability of primary goods and services that allow to lead a decent life. Though the aim of social rights is to counter the most significant economic and social inequalities generated by capitalist societies centred on market economies, and though such economies use the differentiation of individual income as an economic incentive against idleness and parasitism, social rights theories do not aim at an equality of results, or endpoints (which is the end of Marxism); rather they aim at a less stricter equality in which every person, independently of her social position, is given the same opportunities to fully express her individuality, that is, a minimal endowment of material and cultural goods to realise her life plan. This challenge is still ongoing, and the success of the ‘modern project’ puts into play the capacity of democracies to solve these conflicts better than other political regimes, in order to realise the compatibility between democracy and capitalism (Martinelli, Salvati, Veca 1989).

While the right parties consider the welfare system responsible for the actual economic crisis in that it hinders the functioning of the market, social-democratic left parties consider it an innocent victim to which improper functions have been attributed: it ought not to be considered the remedy for all structural limits of capitalism, but only a shock-absorber of secondary tensions; it does not aim to eliminating all inequalities, but to making them socially acceptable (Gallino 1993). Since the universalistic principle is at the root of the Welfare State, it is generally accepted that universalism and redistribution should increase proportionally. Here we face a paradox: since the medium-high classes do not accept to pay the costs of welfare to protect the worst off, while not receiving proportionate benefits, it seems that the welfare system ought not to be limited to providing primary needs, but also other needs, characteristic of those medium classes; however, enlarging the area of satisfied needs makes the welfare system less redistributive (Hirsch 1977). Moreover, in this situation high standards of need satisfaction are requested, with a consequent increase in the costs, while on the other side there is a need for the containment of social expenditure with a consequent increase in the demand for private services. On the basis of such considerations, it is clear why the burden of the welfare institutions is very high, while the output is decreasing (Ferrera 1984, 1995, 1998).

Is there any way out of this *impasse*? Systems of welfare are now trying to reframe the institutions in charge of public choices, in order to make the system more rational and consistent, efficient and fair, by putting an end to the privileges and blackmails of certain categories, though this involves paying the price of unpopularity. The leading principle for the reformation of the Welfare State in order to grant efficiency as well as fairness, must be found in the adoption of positively selective strategies, which imply a restrictive definition of the right to the services, favouring particularly disadvantaged groups. Such new selective logic does not question the principle of social justice, but tries to give incentives to individuals, once a fair equality of opportunities is granted (Rawls 1971); it aims at putting everyone in the condition of enjoying fully one’s life by disallowing private benefits purchased with the contribution of all and through the waste of public resources.

1.2.2. *Can we speak of a ‘selective’ solidarity?*

The ever more differentiated and individualised demands in the field of social services and public goods lead to question whether traditional social rights should not be understood in an evolutive sense, so as to view them as rights of a “cultural and artificial nature”, which are the outcome of the modernisation process of contemporary societies (Moran 1991; Turner 1993).

Expanding the boundaries of citizenship leads to redefining the social rights in an expanded sense: on the one side, the fundamental rights to the resources necessary for existence, on the other side the cultural or ‘second-order social rights’ that are claimed as proper to personal identity and individual enhancement. In a certain sense, these second-order rights call into cause the civil rights of citizenship, that are the expression

of negative liberties. Schematically, the process of citizenship, starting from civil rights, is progressively extended to political and social rights, and, mediated by the new rights, goes back to the civil ones.

Satisfying social rights thus involves redefining citizenship in a heterogeneous sense, not only because social services are concerned with various sectors (education, health care, labour, social security, etc.), but also because such demands become ever more detailed (Rees 1996); standardised responses give way to more specific public services supplying more differentiated goods. The problem is that the supply of such services is unable, on the basis of the traditional social citizenship, to grant publicly claimed specific and individualised goods and services: unconditional universality is unable to answer particular social demands, both of individuals and of groups. This leads to the proposals of welfare systems based on criteria of selectivity. The difficulty lies in the compatibility between the demand of universality, that many would be willing to give up but at the same time are not willing to pay, and particular demands, such as social rights, for which the public intervention is required.

As noted by Dahrendorf, “the modern society of the citizens has created new social problems” (Dahrendorf 1988), that are not referable to the typical problems of subordinate classes, since they concern everybody with reference to individual preferences. Such demands in fact do not relate to the substantial goods protected by traditional social rights, but to the qualitative dimensions of life and to particular life-styles. This creates severe difficulties in aggregating all the differences in one basket of public goods.

Ironically, it is the very satisfaction of social rights that creates the conditions for them to generate further social inequalities and new cultural and artificial poverties (Runciman 1996; Hewett 1996). In fact, “the institutions of welfare that Marshall was concerned to develop referred to an historical phase in which most social life-styles were much more stable than today, and life itself was lived as a fate” (Giddens 1996:79). Giddens notes that “people are more autonomous than before with respect to their life-style and behaviour and this is why sociology speaks of a post-traditional society. Nowadays, life can no more be lived according to old habits or to the pattern of some fate given once for all. What happens depends in a much larger measure on ourselves, also quite independently of our economic standard. We live in a world of artificially created insecurity, a world in which we choose between several life-styles and personal identities and social groups are in continuous evolution” (Giddens 1997:8).

Certainly, when Marshall wrote his fundamental work, he did not have in mind issues now so widely discussed, such as future generations, or new bearers of rights, but adapting his framework in an enlarged version for an evolving society may be suitable in order to answer the question of what full citizenship means.

We are now moving towards a concept of citizenship that questions the traditional solidaristic principles on which social policies were based and promotes new frameworks for public choice. Within this framework, new social rights are affirmed not on the paternalistic basis of a definition by the State taking into account interpersonal confrontations with respect to the opportunity to have access to the good *X* or *Y*, but through an autonomous definition of the good claimed on the basis of individual life-projects and associated life-styles (Culpit 1992). Thus, due to the individualistic definition of the goods necessary for different life plans, the universalistic conception of welfare does not have a correspondence in the satisfaction of rights.

In traditional welfare systems citizens were treated impersonally, having little autonomy in choosing the goods they received; the new welfare implies more participation by the users, who have access to those goods selectively, by an individual choice. Since this process is at the very beginning, it is not yet possible to verify empirically the costs of this transformation of the social citizenship for the collectivity. We can presume that, while the demand for selective goods may lead to saving resources in that such goods are provided on a carefully individualised basis, the large demand for differentiated goods by ever more demanding citizens will significantly expand the functions of the State, leading to an increase in the public expenditure.

The criteria of selectivity involving relevant consequences for the actual solidaristic arrangements go in two opposite directions: on one side, positive selectivity, which selects in order to give more resources, on the other hand negative selectivity, which selects in order to subtract resources. As noted by Ferrera, “we now speak of *‘targeting’*, that is, of the adoption of a more selective approach in the provision of social services. This option is at the centre of the debate on the reform of welfare in all countries, but it is interpreted differently in each (or in each family of countries), and finds different obstacles, according to the kind of arrangement now in force” (Ferrera 1998:79-80).

2. Concept of solidarity in the Italian health-care system

The aim of the II section is to analyse the following themes:

- a) the evolution of health and social care policies in Italy, within the framework of the solidarity model present in our welfare state system. These policies are also analysed with reference to the type of provision of health and social care services offered by the public sector, by the private sector and by the so called third sector of voluntary intervention;
- b) both policies have been analysed through the evolution of our welfare system beginning from the introduction of the Constitution of the Italian Republic;
- c) the public debate on main proposals to reform health and social care policies in Italy.

2.1. Principles and values

2.1.1. Charity versus solidarity

In Italy the welfare state is based on the *solidarity model*⁵ and we have different traditions as regards the concept of solidarity in the health-care system.

With the Republican Constitution the main object of the democratic state is the defence of the individual. And, even if in the solidarity model the notion of ‘freedom of person’ is given priority, State intervention is necessary in order to support it⁶. Three articles of our Constitution provide an idea of the principle of solidarity in Italy: article 32 on the right to health, article 38 on the social assistance for people “not in the conditions to self-maintain and not able to work” and article 53, which states that the fiscal system must be based upon a principle of progressivity. With regard to right to health, article 32 of the Republican Constitution (that came into force in 1948) adopted a solidarity model based on the conception of health and the right to health care: this article states that “the Republic protects health as a fundamental *right of the individual and an interest of the collectivity*, and guarantees free care to the needy”. At the end of the first part of article 32 of the Constitution we read that the Republic “(...) guarantees free care to the needy”. During the debate in which the article was approved, many members of the Parliament maintained that this sentence is in contrast with the first part of the article. This controversy on ‘indigence’ reflects two different ways of conceiving social security and the health care system. The first conceives of solidarity as charity to the poor and needy; the second goes in the opposite direction, requesting (expecting) State intervention in order to support citizens’ social rights, according to a universalistic approach (Poletti 1979:13). The Parliamentary debate during the Constituent Assembly in 1947 is paradigmatic of this dichotomy *charity-solidarity* in the field of health care and social care services.

Substantially, one tradition accepts the existence of the needy and believes that the State has a duty to help by guaranteeing them some resources, while the other simply cannot admit the existence of the condition of neediness. This second tradition believes that, in order to bring about an authentic social solidarity, a modern state should remove personal conditions of need, otherwise the people will have to resort to paternalistic and confessional forms of charity. As Merighi, a member of the Parliament at that time, put it: “There is no more charity, now we have social solidarity”.

In Italy a National Health Service was set up only in 1978. After the enactment of Act 833 in 1978, health protection has been organised in an organic social service, losing every feature of an individualistic, charitable and benevolent enterprise. In fact, before this law, citizens had to provide for their own health care according to their individual resources; contributions were provided only with funds coming from private charity and donations of beneficence coming from the State⁷.

⁵ The *solidarity model* is typical of democratic institutions, in that it acknowledges that every individual has equal dignity and the same rights of citizenship. State intervention has the aim of guaranteeing citizens the implementation of the principles of equality and freedom. The main reason justifying the solidarity model is the existence of large differences in the economic and social situations of the citizens. Only through the welfare services (with the principles of social justice and solidarity) can the State guarantee the social rights of the entire population in a universalistic approach.

⁶ After the Fascist authoritarian Government, in which the State was interested in citizens’ health as a function of the health of the whole society and even of the human race, the main principles of our Republican Constitution intended to turn upside down the central tenet of fascist doctrine, which subordinated the individuals’ rights and freedom to the interests of the nation. For this doctrine individual health is only one aspect of an individual’s social efficiency.

⁷ Later, in 1968, Acts n. 132 and n. 431 deprived the hospitals of the legal status of public institutions of assistance and beneficence, ascribing them the status of public bodies or Local Health Authorities. According to Colombo (1977), the origin of the name hospital comes from ‘hospitalis’ and ‘hospitium’, a place where the poor, the passenger, the stranger etc. were received; the transition from

2.1.1.1. Public solidarity versus private social solidarity

Today's debate about social solidarity and the relationship between principles and social policies reflects two different ways of thinking. To simplify, we have principles favouring the welfare state (public solidarity) and principles favouring the welfare community and welfare society (private solidarity); in the studies of social policies, we thus distinguish two different approaches about the public policies of social citizenship:

- 1) statutory solution (based on the Marshall citizenship model through civil, political and social rights);
- 2) social-private solution (based on voluntary action, third sector, social co-operation and family networks).

According to Villa (1998:278) "the duties of solidarity can be carried out both through voluntary and free initiatives and through the responsibility of the State and its institutions. In sociological terms we have a public solidarity and a private or free social solidarity". The first one relates to universalistic models in the field of social and health policies; the second to new approaches in the field of social co-operation, voluntary sector, non profit foundations. We deal with the first point, in relation to the public structure and the functioning of the care system in health care and social care services. Here we concentrate on the practice of solidarity in its more or less organised and informal forms.

Private institutions work mostly in the field of assistance and social services, but also in health sector. The role of private social enterprise initiative is in an associative solidarity area, where relationships of informal solidarity have a public value (voluntary action, social co-operation, mutual aid). Donati, in attacking the theory of modernity and the statutory solution about solidarity gives a useful definition of the private social initiatives: "organised systems of actions on the basis of motivations, rules, aims and means of social solidarity, which have the maximum inner managerial autonomy, and can also be structured in the shape of enterprise, whilst being publicly accountable towards the political-administrative system in the general framework of citizenship rights" (Donati 1993:101).

With regard to voluntary action (Ascoli 1987; Lazzarini 1998), at present there is a difficult passage from a stage of 'charitable aid' to a new form of organisation capable of creative answers to emerging needs and to new social rights. Within the complexity of the voluntary action phenomenon, some studies and research carried out during the 80s show that there is a substantial difference between voluntary action as an activity in the field of assistance and health care, typical of the period from the end of the Second War to the '70s and the mid-'80s (especially in the Catholic area), and voluntary action as a specific and organised activity performed in a social structure. This difference represents the passage from informal groups to legally recognised, non-profit organisations (foundations, social co-operatives etc.). Moreover, according to Ascoli (1987) the general culture of solidarity is made of voluntary reality and organised self-help, and both are a 'crucial resource' for the modern welfare system. In addition to the strategy of targeting welfare in a 'soft' state towards policies founded on selectivity (Ferrera 1998), another proposal to solve the crisis of the traditional welfare state model and to reform it, is characterised "by the principles of reciprocity and subsidiarity, in which the public sector reorganises its managerial intervention, offering new space for the third sector" (Lazzarini 1998:100).

With regard to social co-operation, the third sector and the social co-operative in Italy are widespread on the territory, so that in the second National Report on Social Co-operation (1997) the firms that work in the production of services of assistance, health, education and other "economic activities for helping disadvantaged people enter the working and social field" (Rei 1998:129) have risen to almost 4.000 with about 80.000 paid employees. In 1991 Act n. 381 gave a legal form and more legitimacy to the whole sector of social co-operation; in 1997 Act n. 460 (on «Reforming the taxation system for non business enterprises and for non profit organisations of social utility») provided these firms with important tax benefits.

With regard to the field of the family network, many scholars even talk of a 'fourth sector'. Saraceno (1998), while maintaining that the Italian family is moving towards an individualistic model, notes that it still has important social functions of solidarity and assistance which should be typical of a welfare system and which, moreover, are not supported by the State. In the health field, the structure of the Italian family is important in the promotion of personal and collective well-being (psycho-physical-social health), and in care, rehabilitation and assistance (Di Nicola, Rossi 1998:69)

the 'house of the poor' of that time to the 'hospital for everybody' of today reflects the move towards a universalistic concept of social solidarity.

In conclusion of this paragraph, we can say that at the beginning of the century and millennium, current differences peculiar to Italy, in the interpretation of the concept of solidarity and of its implications for social policies and practices refer to the historical debate that was the background of the division within the solidarity model sixty years ago and before.

2.2. Evolution of social welfare policy after World War II

The path taken by the Italian welfare state is partly atypical⁸. In the light of the examples of services offered elsewhere and of typology offered by comparative literature, the Italian model of the welfare state appears to be a sort of “favouritistic specimen” of the “particularistic-meritocratic” model of welfare state, characteristic of Continental European countries (Ferrera 1984; Paci 1992). Italy inherited two features from Fascism: a) corporativism (by which public institutions guarantee the private interests of certain professional and social categories); b) the patronage system (by which the supply of assistance programmes has the aim of granting social consensus to the political class) (Paci 1992:205).

In this perspective, we can better understand the phenomenon of the proliferation of State and State-controlled departments, which are the expression of particularistic needs, and therefore, the expansion of the public sector through the incorporation of “portions of the private sector” (Paci 1992:206).

2.2.1. *The health policy from the post war period to the 90s: the reform process*

During the Constitution Assembly in 1947, there was an attempt to universalise the provision of assistance, backed by the coalition between the Catholic and the Socialist–Communist parties; this attempt was, however, thwarted by the economic and cultural conditions of the country, and by the fact that the medical class was very much involved in the creation of the health insurance scheme. (Vicarelli 1994:13). From the point of view of both vertical and horizontal solidarity, this was a missed opportunity, as it provided for the extension of health insurance to all workers and the extension of health care to the family of the insured and to pensioners.

In the ‘50s, there was an increase in the number of free health care services and of the people benefiting from them: national health assistance progressively opened up to ever larger categories. All the same, health policy continued to be based on pure health insurance criteria, not responding to the needs of an active safeguard of health (Cosmacini 1994:113-119). Not even the establishment of the Ministry of Health, in 1958, which was meant to impose a unique and articulated direction on health care policies, was able to substantially modify a situation characterised by large disparities of treatment among patients and by territorial differences between the North and the South, the city and the countryside, and among the Regions (Cosmacini 1994:124-5). Ferrera (1995) describes the 50s as a decade of deep political exploitation of Health by political parties on the basis of ‘distributive policies’.

The ‘60s and the ‘70s are characterised by a long drive towards the health care reform. The political and social atmosphere of the country seemed to change when civil society was shaken by new collective movements that aimed at the transformation of health care policies in a more active way, with the principal objective of creating a system of welfare for the safeguard of health (Vicarelli 1994:10). This long struggle led to the NHS Act (n. 833 of 1978) aimed at an authentic democratic management and at giving priority to preventive medicine, after a process of progressive inclusion of health care services in the public system through the dissolution of the health insurance scheme in 1977 (Act 386, 1974), the attribution to the Regions (created in 1970) of the political functions related to health care subjects and the hospital Act of 1968. The principles on which the NHS is based are universality, equal access to all citizens in matters relating to health needs and the uniformity of treatment available throughout the country, planning the resources and expenditure. In the NHS Act, the Republic guarantees health as a fundamental right and interest of the collectivity through the NHS, in the respect of the dignity and freedom of the individual. The main aims of the NHS are health education of citizens and the community, the prevention of illness and accidents in every area of life and work. These dynamics led to the creation of the NHS by the realisation of non occupational, but universalistic health care policies. However, the NHS also provided the political parties with an opportunity to exploit health care to obtain political consensus, through a long distributive

⁸ Suffice it to say that, in spite of Article 32 of the Constitution, the right to health was practically unattended in its clear universal import, till the law that created the NHS in 1978.

cycle that involved State, regional and local power through patronage and the party-dominated management of Local Health Centres (Ferrera, 1995).

A situation of fragmented health care policies progressively emerged, favoured by a blocked political system whose normal democratic functioning was limited by a sort of “partnership” between the Government and the Opposition, and by a consolidated tendency to distributive and non redistributive policy making.

The ‘80s and the ‘90s were decades of financial emergency and economic restraints. Talk about ‘reforming the reform’ started in the mid ‘80s, and was stimulated by a wide acceptance of liberal principles, by an anti-reform ideology (fuelled, in most countries of the western world, by the victory of the Reagan–Thatcher political line) and by the urgent need to stop the uncontrolled dispersion of public expenditure. These tendencies were favoured by the crisis of the Trade Unions and of the Communist Party, and by the ever growing conditions of widespread prosperity that supported meritocratic and individualistic models of action. During the ‘80s a process of revision of the welfare state in a neo-liberal sense started, aiming at more selective and meritocratic models in health policies. As noted by Ferrera (1995), the Government and particularly the Treasury initiated a new phase of financial management concerning the health sector, with the double aim of limiting requests of performances by introducing the co-participation of users in expenditure and by increasing the responsibilities of the Regions and of the Local Health Authorities: “from 1984 to 1993 the budgets (financial laws) introduced a progressive escalation of the three ‘Words’ “Ticket, Ceilings, Cuts”. However, in the absence of a strong redistributive line from the legislator, the growing expense of specialist test charges and the extension of their application, resulted in generating new inequalities (pushing honest supporters the system towards evasion) (Ferrera, 1995).

In 1992 the Government introduced the ‘reform of the reform’ through the Legislative Decree 502/92; this decree shifted responsibilities from political to administrative bodies and put the responsibility for the financial stability of the NHS directly in the hands of the Regions. Some principles are fixed concerning the participation and protection of citizens’ rights: quality standards of services, also the humanisation care, and attention to voluntary service structures. New criteria in the management of hospital structures (e.g., the introduction of the general manager, the DRG system of reimbursement, the citizens’ health charter and so on) were also introduced.

In 1993 with the Legislative Decree 517/93 a more selective orientation on health policies was introduced, even though the general approach respects the usual ‘solidarity’ of the Italian NHS. This Decree stressed the right to minimum uniform levels of assistance that the State intends to assure to all citizens, regardless their residence. In this way formal equity is assured by transferring to the Regions a share of resources calculated in proportion to the resident population; in order to assure substantial equity this share should be adjusted by age, type of pathology etc. Every region has a wide margin of autonomous decision-making in matters of organisation, assistance and management of the services. In actual fact, the production and the distribution of assistance is attributed to specific figures (accredited private institutions deemed to be up to standard, new public realities, some big hospitals etc.), which take the responsibility for guaranteeing assistance levels in competition. There is a principle of separation between figures who produce and deliver care and assistance, and those who pay for them (see Section III).

2.2.2. Social care services: a residual part of the Italian welfare state

Public provision of social care services has traditionally been quite scarce in Italy. The amount of public resources devoted to care of the elderly, the disabled and children has always been low, leaving this responsibility mostly in the family’s hands. The main reason for scarce provision of social care services in Italy concerns the role of the family in the culture and society of this country. In order to understand the limited provision of these services, one has in fact to consider that there is in Italy “a widespread culture that considers care as an issue to remain private” (Taccani 1994:249); this culture has strong historical origins and is deeply rooted in society.

Developments of the last thirty years have not seriously undermined that assumption. Till the ‘60s social care services were not an issue in public policy debate, but that decade was characterised by an increasing attention towards them. The debate grew and in the ‘70s a huge demand for reforming and increasing social care services emerged throughout the country. It was part of a bigger demand for developing public policies and the role of the state in sustaining citizens, that in 1978 led to the introduction of the National Health Service. As for social care - despite several attempts – a national framework of legislation was not introduced. Social care provision grew but by far less than expected and in the ‘80s these

services still had an utterly residual role in the Italian welfare state. Besides being scarce, social care provision was – and still is – substantially fragmented. There is first of all a significant difference between the North and the South of the country, because in the former we see a bigger and more articulated provision of services than in the latter. It must be stressed that in the South public policies have traditionally played a less significant role than in the North, while the family has instead always had a bigger one. Differences in social care provision do not actually lie only in the North/South divide. In the absence of any national legislation setting rules and standards for the whole country, marked differences exist also within those areas. It means that both the quantity and the quality of the provision of the same service can be extremely different between two Municipalities situated next to each other. In this context of differentiation, one feature is shared by most of the countries and is a trademark of Italian social care: the services' target. In Mediterranean country, social care services are provided only to people with significant care needs and a family income inadequate to meet them privately. In order to receive public social care services in Italy, a person has thus to meet these two criteria: care need and a limited family income.

2.3. Towards which welfare?

The main debate, in Italy as in other European countries, concerns the rethinking of the traditional forms of universalistic access to welfare services to *selectivity and targeting solutions*, in order to fight the crisis of the welfare system. But, since on this issue social consensus is substantially lacking, the challenge faced is very hard.

As we have seen before, with the introduction of a universalistic right to access to health services, Italy has formally moved nearer to other European welfare systems, though in social awareness there were many difficulties to consider in the new rules about the right to health care. Moreover, our universalistic welfare state, that has been called a 'particularistic-patronage system' (Ascoli 1984; Ferrera 1984; Paci 1994), has in fact implemented very fragmented social policies and has generated a strategy of 'distributive policy', that has been favoured by the stalemate of the political system. After 1992, the whole area of health policy and other social policies have entered a new phase; attention to the economic aspects and the constraints of public finances has become more important than the aims for which the NHS was created at the end of the '70s.

Nowadays, the Italian model of welfare state is characterised by a mix of particularistic-occupational criteria in the pensions sector and of universalistic criteria in the health sector. "Income maintenance benefits are provided by occupationally fragmented social insurance funds, while health care is provided by a universal national health service. A variegated, largely decentralised system of social assistance provides cash benefits and basic social services to various categories of needy people, such as the poor, the elderly or the disabled. In contrast with most other EU countries, there is no 'last resort' national minimum income guarantee" (Ferrera, 1998: 56).

Generally speaking, however, the Italian welfare system is no more expensive than the European average. Apart from the main problem of our social security system (i.e., old age pension costs), all other items are considerably below the European average. The political debate is focused on old age pension reform, so as to shift some resources towards other sectors covered by public expenditure, which have been underdeveloped.

Today, it's important to reform of the welfare state, which remains a priority of government policy in the last five legislatures. Though it is extremely difficult for the Government to implement acts aimed at modifying the old welfare system, the aim of policy makers is to make proposals for the rationalisation and containment of the social expenditure. The principal problem facing whoever proposes a radical reform of the Welfare State is how to bring traditional areas of consensus into the debate.

With reference to health, the "reform of the reform" of the NHS started with the legislative decree n.502/1992. In recent years there has been wide public debate on possible different strategies for health care both in Parliament, in the society at large and among health professionals. In the spring of 1999 the Parliament passed a new Act containing Directives for rationalising the NHS (legislative decree n. 229/99). This reform provides a greater emphasis on public structures versus the accredited and *tout-court* private ones (in this way shifting from an open market logic towards that of balanced planning), and attributes the leading role to districts and local levels.

As for implications of solidarity, the reform just approved (aka 'ter') should introduce some elements to define what have to be the "essential" services, which have to be supplied by the NHS, and as well as are the principles of integrated funding in the NHS.

Public debate focuses on how to consider the reform itself with reference to the aims of public finances (control over public expenditure) and to fiscal federalism (with the financial responsibility of the Regions and of health industries), in addition to a much wished process of innovation of Public Administration (its de-bureaucratisation and customer-orientation). There are some differences from site to site, e.g. the richer regions of the North criticise the central Government for the excessive contributions given to the South, where there is a negative balance on the issue of patients' extra-regional mobility, in stark contrast to the positive balance which characterises the Northern regions pattern (Mapelli 1999: 83). Following the implementation of IRAP in 1998, regions have a certain level of freedom in any decision to "provide assistance levels which supersede national funding – with a consequent increase in fiscal pressure – or otherwise not to increase the tax burden, by maintaining limited quality, and variety in the health services provided" (Mapelli 1999: 84). The debate centres on the issue of different welfare levels in different regions, starting from a fiscal federalism model: this fact, theoretically, could lead to the destruction of the fundamental principle of the national solidarity model, which is the expression of co-operation and distribution towards the less advantaged areas.

Besides the question of territorial solidarity, great attention is given to the argument of who effectively pays for the health services provided. Basically, in the NHS demand criteria are not correlated to contributive capacity, a fact which burdens the community (in its totality or, in a particular way, with some of its members) with some forms of taxation for health needs without considering individual responsibility for those needs. In a comparative interpretation, and in relation to the various forms of "targeting", a tendency emerges pointing to the selective provision of money, in the sense that, though some costs will be necessarily paid by society as a whole, all the others should be provided by single individuals, in proportion to their specific needs.

3. Market thinking and Italian culture: the case study of National Health Service⁹

3.1. Introduction

In Italy current problems concerning the relationship between medicine and the market are encapsulated in the debate, both in the past and in the last legislatures of the government and parliament, on both health policy and the redefinition of health rights in the light of the new role some would give the Italian National Health Service (INHS).

The purpose of this section takes into consideration indicators of health policy at national level, the main strategies with regard to the principles of NHS as well as analysis of the new equilibrium between the State and the market in health. It concerns the role of government and the private sector, their aims of providing better ways of health care, in order to address the issues of the effect of market thinking and its impact on equitable access to health care, system efficiency, outcome for both individual and population, and on the doctor-patient relationship.

First, in this section I analyse a brief recent history and description of the Italian health care system and the key role of regions in health policy.

Second, I examine the INHS principles and the changes in National Health Planning in recent years; what we would like to do here is consider whether they are market-oriented or not.

Third, after the analysis of the essential levels of health care as basic health needs within an universalistic model, I look at some empirical evidence concerning services like primary health care, specialist treatments, hospital care etc., and focus on the opinions expressed by Italian people on their satisfaction with the Italian National Health Service. This has implications not just on health financing, but also on preference for a public or a private system. In this way, I try to examine the impact of market thinking and its practice in Italy on the equity and efficiency of the INHS.

3.2. Are the INHS principles market-oriented?

The short answer is no.

Health is, according to the Italian Constitution, a fundamental right of each individual in the interest of society (article 32 of the Constitution). The Italian National Health Service basic principles are within a *universal system* of care and comprise (www.ministerosalute.it; Italian Ministry of Health (2003)):

- *Human dignity* according to which every individual must be treated with due dignity and have equal rights irrespective of their personal characteristics and role in society;
- *Protection* according to which the health of the individual must be protected before it is threatened;
- *Need* according to which those in need have a right to health care, and available resources must, as a priority, be allocated to the promotion of activities aimed at meeting the primary health care needs of the population and overall public health;
- *Solidarity*, especially towards the more vulnerable: resources must be allocated primarily to the support of groups of people, individuals and for certain diseases that are socially, clinically and epidemiologically sensitive;
- *Effectiveness and appropriateness of interventions* to which resources must be channelled for services whose effectiveness is scientifically based and for individuals who can benefit the most from them;
- *Cost-effectiveness* which stresses that when choosing between different supply patterns and types of activity, priority should be given to solutions which offer optimal effectiveness rather than cost;
- *Equity* which guarantees that no geographical and economic barriers should prevent any individual from accessing the health care system, and that any lack of information or any behavioural differences should be overcome to avoid health discrimination between individuals and groups of people; equal access and availability of health care must be guaranteed in the light of equal needs⁹.

⁹ This section is a part of the article *The Impact of Market Thinking and Italian Culture on National Health Service*, by Luciano Fasano and Nicola Pasini, in "Notizie di Politeia, Rivista di Etica e Scelte Pubbliche", Anno XXIII – N.88 -2007, pp.77-94; the article was a new version of the report (2003-4) on *Italian National Health Service and the Market Ideology* commissioned for the book *Medicine and the Market. Equity v. Choice*, by Daniel Callahan and Angela A. Wasunna, The John Hopkins University Press, Baltimore, 2006.

With regard to equity, a propos the health of immigrants in Italy, we note that it has passed beyond the initial emergency legal and medical phase and is now at the stage of consolidation in terms of promotion and recognition. This also reflects the crucial issue of access and use of public health services and concern not just dependence on the right to health as a function of the existing legislation, but also the capacity of the health services themselves to provide appropriate responses to the health and welfare needs of new patients, whose cultural background is different from those of Western patients.

In Italy in the 90s and at the beginning of the millennium, as part of the process of implementation of the measures for the reorganization of the NHS, the role of the regions is taking on increasing importance. This is in line with the importance that had already been identified in the institutional structure outlined by law 833/78 of the health reform, endowing it with new functions such as planning the regional health or social and health system and the management as well as distribution of the Regional Health Fund. We have, therefore, witnessed the creation of regional health services, quite individual different from each other, but in harmony with the idea of health federalism or neo-regionalism. This autonomy granted to the regions relative to determining the creation of the social and health system has led to the establishment of different regional models; this differentiation is inevitable, in view of the considerable differences regarding the dimension of territorial, economic and socio-cultural nature between the regions which lead to the presence of health policies and levels of service which are very particular and different. The process of reorganization of the NHS which began in 1992 - and which has continued with different rules of implementation during this decade - has not however led to the complete and uniform adoption of the reform, especially within the regional health services. This delay can be attributed both to the regions and to national governments, which have followed on since the start of the wave of reforms.

However, especially since 1999 health policy has attempted to guarantee greater protection of people's health, aiming to improve quality and efficiency of health care on the one hand and, on the other - with the introduction of fiscal federalism - to attribute a new role to the regions in the management of care services and programming of resources allocated to them.

Currently, the NHS in Italy is conceived as a system where the supply of health care services moved from central to regional governments, under the monitoring of the regions, and the kind of services delivered are divided by means of the Essential Levels of Health Care (ELHC), distinguishing between free charge services (for which people don't pay anything) and co-payment services (for which people pay for a ticket). The national and regional governments must agree on health objectives to be achieved within a period of time, as indicated in the National Health Plan, and it's the regional responsibility to establish the best practices needed in order to realise those objectives. Control over the actual realisation of the contents of the National Health Plan as a whole remains in the hands of central-national government.

3.3. Is national health planning changing?

In accordance with the principles, the fundamental objectives of prevention, treatment and rehabilitation and the general outline of the INHS are contained in the main planning act of National Government exemplified by the National Health Planes on a 3-year scale. The National Plan attributed particular importance to the people's general health needs and not only to the delivery of health care. This attitude is in line with the indications of the World Health Organization and in particular with their "Health for All Strategy". The plan makes a strong plea to create a real nationwide "solidarity health pact". The institutions include responsible for the safeguard of health operators, institutions, voluntary workers, profit and non profit producers of health related goods and services, media and the national and international society. However, this plan also defined some strategies in order to change health care.

As the institutional system in Italy is in a transitional phase rapidly moving towards federalism, the health plan takes on a new significance as it also define the basic outlines of health policy as unifying elements of the health system in Italy.

Nevertheless the federal policy requirements have not modified the basic principles of the INHS still remain fundamental points of reference. These principles, noted above, are the right to health, dignity and inclusion of "all people" (including immigrants), equity within the system, quality of services, attributing responsibilities to the relevant bodies, social-health integration, development of knowledge and research and safety for the people. Furthermore, efficacy and quality of health care indicators have been identified in agreement with the Regions and defined in the Ministerial Decree. Indicators have been divided into several groups: some indicators have been identified for the levels of collective health care in life and work environments; other of them for district health care levels and for hospital health care.

In the light of this, the Ministry of Health develop the draft of the national health plan which has been preliminarily approved by the National Governments (the centre-right or centre-left wing) and is presently being evaluated by the Regions (as part of Permanent Conference for Relations between the State, the Regions and the Self-governed Provinces).

The plan contains proposals on the main operational measures for carrying out these priority objectives. The central level's role is to guarantee equity of the health system (*Lep= Livelli essenziali di prestazioni*), while the regional level's role is to organize and provide health services. The objectives, to guarantee an equitable access to health care in a universal fashion, are defined in line with EU health policies and those of the other international organizations such as WHO and the Council of Europe. There is another means to access health care: the health care private sector not under contract with NHS, but, of course, available only to the upper-middle classes who can exit from the INHS because of their capability to pay for accessing to the market system(see later);

3.3.1. *Essential levels of health care as basic health needs within an universal model*

The Essential Levels of Health Care (ELHC) are services that the *INHS is expected to deliver to people, free of charge at the point of access or upon payment of a small pro capita charge*. The ELHC costs are covered by public resources that are collected from general taxation yield. The ELHC can be divided into three large groups (www.ministrosalute.it):

- “collective health care in day to day life and working environments, including all the prevention activities related to the population and to individuals, including protection from the effects of pollution and industrial-accident risks, veterinary public health, consumer protection, prophylaxis for communicable diseases, vaccination and early diagnosis programmes, forensic medicine;
- district health care, including the health and social care services distributed throughout the country; from primary care to pharmaceutical assistance; from specialised and diagnostic out-patient units to supplying the disabled with prostheses; from home care services for the elderly and chronically ill people to local consulting services;
- hospital care, in emergency wards, ordinary hospitalisation, day hospitals and day surgery, structures for long-term hospitalisation, for rehabilitation and so on”.

At the same time, there are services and activities that are not provided by the INHS (not included in the ELHC) because they are not directly intended to safeguard people's health, their efficacy has not been sufficiently proven from a scientific point of view or the results achieved compared to the costs do not prove to be convincing. This exclusion from the ELHC, for most health services listed (e.g. unconventional treatments, cosmetic surgery and facultative vaccinations), existed prior to the implementation of the decree 29 November 2001, people requesting such services had to cover the expense on their own. The main reason for this exclusion is that some types of services are frequently subject to "hyper-prescription" compared to the patient's essential clinical needs and, therefore, the balance between INHS costs and patient's benefits is generally considered unfavourable. In any case, the possibility exists also for some health care presently excluded from the ELCH to be reinstated to the list upon a decision of the Region providing specific clinical justification.

A third group of services to be supplied to people *only on condition* that the principle of clinical and organizational appropriateness applies; the requirements are that conditions of the patients are such that the specific services are deemed to be beneficial (clinical appropriateness); and the delivery system for the service (e.g. ordinary hospitalisation, day hospital and day surgery) guarantees the most efficient use of the resources in relation to the nature of the treatment and patient's condition. In these cases, particular conditions and individual cases should be subsequently identified by the Ministry of Health and/or the Region. The INHS will continue to guarantee certain services (it is the case for certain pharmaceuticals that can be delivered at no cost only to patients, affected by certain types of disease).

3.4. Some empirical evidences

3.4.1. *Services and the public opinion: the verdict on INHS*

The services provided by the INHS include:

- community health and hygiene;
- primary health care;

- specialist treatment; hospital care;
- care and rehabilitation of non self-sufficient people.

Regarding the dichotomy of public/private sector, we now focus on primary health care, specialist treatment and hospital care.

In Italy, *primary health care* includes diagnosis, treatment and first level rehabilitation together with prevention, health promotion and education activities and, in particular family doctors and paediatricians, pharmacies and home carers. Primary health care is mainly provided by General Practitioners (GPs) included in an ad hoc list. The main activities of GPs are the provision of medical care, prescribing medicine, ordering diagnostic tests and hospitalising patients. Patients are registered with a GP who acts as a conduit to specialist services. The relationship between patient and GP can be terminated by either party at any time if it is not considered satisfactory. The services of GPs are free at the point of use. GPs have contracts with the INHS managed by the relevant Region, and are paid on a capitation basis, depending on the number of patients enrolled in their lists up to a maximum of 1500 per GP. Patients are registered with the doctor and not the practice and the GP/patient relationship is close. Children under 12 years are looked after by paediatricians (they have the same contracts as GPs but are limited to a maximum list of 1000). There are important geographical variations in the size of GP lists and the availability of their services, and some Regions have smaller physician/patients relationship.

In case of emergency, patients can go directly to the hospital emergency departments. Patients who turn to hospital emergency may have to pay a small amount (so called “ticket”). Public health nurses have the specific function of safeguarding the health of individuals and the community through preventive and health education activities. They establish direct relationships with people in their daily lives and work, families and the community.

Pharmacies have the monopoly of medicine sales but are subject to numerous regulations. A pharmacy can be privately owned (and have a contract with the relevant Local Health Unit) or belong to a municipality or a hospital, in which case the pharmacists are paid a salary. Given the limited number of public resources available for the pharmaceutical budget, evidence-based medicine and benefits/costs are the main criteria for providing drug treatments within the NHS in Italy. Prescribed essential medicines for chronic diseases are free of charge at the pharmacy (List A) if no more than reference price fixed agreed for medicines belonging to a particular class/therapy, specific dosages and therapeutic indication. Medicine belonging to a given class therapy more expensive than the reference price is not covered by the NHS. Most medicine prescribed under the INHS can have a regional prescription charge (ticket) according to the financial policy of each Regions (i.e. Lombardia). However, exemptions are made on the basis of income, particular medical conditions or special status (e.g. disable persons). The remaining medicines, also known as “comfort medicines” belong to List C and are fully charged patients.

Regarding *specialist treatments*, these include clinics and laboratories (public and private under contract with the INHS), family planning clinics, drug services for addiction, prevention and rehabilitation, departments for mental health, rehabilitation centres. In our country, there are more private than public outpatient clinics, although this depends on the region. The Public clinics are mainly located in hospitals and other structures.

A propos *hospital care*, the INHS guarantees hospital admission for conditions that cannot be treated on a home or outpatient basis, as well as for interventions in day hospital structures. Most general hospitals include at least four basic services: general medicine, surgery, paediatrics, gynaecology and obstetrics. Depending on referral by a GP, care is provided free of charge in public hospitals or in private facilities under contract with the INHS. Patient choice (see below about the free choice of citizens) is respected and as a result there are important cross-border flows between Regions, even though all have at least one general hospital. Hospital services are mainly free of charge at the point of use.

Available data indicates the numbers of beds in different Regions of Italy show that the total number of hospital beds has fallen significantly in recent years. Reasons behind for this trend are containment policies, change in technology, different methods of treatment, reasons that reflect a combination of cost-issues of primary health care and social care.

Furthermore in Italy, as in most countries, with the introduction of the system of the Diagnosis Related Groups (DRGs), there has been an increase in admission rates together with a reduction in the average length of stay (is this an impact of the new market ideology?). The latter trend has accompanied changes in the management of patients, improvements in clinical techniques such as minimally invasive surgery, and incentives to reduce length of stay and ensure that patients who no longer need acute care are discharged to other facilities. In recent times, the progressive ageing of the population and decreasing birth rate has led to a

reduction in the number of beds in medical-surgical and maternity-children's wards, as well as an increase in the number of beds in the rehabilitations and long-term care.

In the year 2000, the World Health Organization (WHO) carried out the first worldwide analysis of the performance of NHS of 191 Member States. It concluded that the performance of the INHS, as assessed in terms of "life expectancy corrected by disability", is the third highest among 191 different countries, whereas, in terms of global performance, Italy is second only to France.

Despite this data, public opinion in Italy remains to some degree dissatisfied with both poor service, and accidents in health related areas, often caused by the lack of a global system guaranteeing standards of quality: the public notes medical errors, long waiting lists, duplication of tasks and services, lack of trained staff and training programmes, the absence of set procedures, bureaucracy and obvious waste etc.

Much research on national and international scales indicates, and as we have already noted, Italian health policy from the beginning of the 90s is in a process of considerable transformation: the objective of this changes is to introduce elements of competition within a system which will remain predominantly public, and that this approach will guarantee a quality service for everyone entitled to it. In any case there are any numbers of different interpretations of how the system will actually work. There are even more variables to be taken into consideration in the analysis of the levels of satisfaction as indicated by the general public with relation to the National Health Service in Italy. Different levels of satisfaction within the public exist in different sectors and clinical specialities (for example basic medicine, testing, examinations, home services and hospitals themselves, surgeries, accident and emergency, reception), the biggest problems include poor service, long waiting lists, queuing for appointments, and a clarity in information on diagnosis and treatment.

Concerning the organisational method (public or private) surveys in recent years indicate that there are contradictions in the choice between public and private health services, in the sense that they do exist side by side and the users' views seem somewhat incoherent in the way they use the services and the way they evaluate them. Not only the upper class take advantage of the existence of private services in the absolute market sense. In fact in Italy in the last ten years about 35% have been using the totally private sector. Justifying such a choice by circumventing the public sector, especially with regard to the waiting list problem (32%) and lack of confidence (22.8%). Looking to the future, almost 50% of the public are potentially ready to opt for private services. At the same time the actual use of services remains prevalently public (see later). People demand a comprehensive health system and are on the whole respond positive when asked of their satisfaction levels. This apparent contradiction in the service overlap, offered both public and private is interpreted by the users as a further resource which on current legislation offers a freedom to choose, and therefore more personal freedom (more than 80%). The level of satisfaction is nevertheless in line with the geographical response. The situation in the south of Italy is heavily critical.

The main issue in the public debate of the last decade regards the role of the market and of freedom of choice in health care. There is a widespread perception that the introduction of competition in health care can be an important tool in order to regenerate the whole system. When asked about the possibility to have freedom of choice in selecting between public and private providers, 81% of Italians judge it positively because the individual is allowed to follow their own preference and just 11% state that it is negative because it can produce waste and duplication in the delivery of health care. It should be stressed that the 90s' reforms have introduced competition between private and public providers, but the degree of users' freedom of choice varies substantially from Region to Region. While there is an overwhelming majority of people supporting more users' freedom of choice, attitudes towards health expenditure are more controversial. Italian public health expenditure is – as will be stressed later - below the EU average: this is the consequence of the tight cost-containment policies implemented during the '90s.

3.4.1.1. "No to public health in the hands of the private sector": the verdict of the electorate

Public opinion indicates for the most part a preference for public health sector. In two different ITANES (*Italian National Electoral Studies*) surveys, in 2001 and 2006, almost 40% of a representative sample Italian people interviewed in 2001 and 60% of the same sample in 2006, were totally against any private health policy, while only almost 60% in 2001 and 40% in 2006 were in agreement with it. In 2001, many of those who disagreed were found to vote for centre-left parties (83.3%), whilst people who claimed to be in the centre politically numbered (66.7%), and even those who supported the centre right numbered (56.1%). The percentage difference between centre-left and centre-right electorates in 2001 was 24%, while in 2006 it was 22%. Inside the two coalitions, in 2001 there weren't found any appreciate differences among centre-left parties, with left parties, Democratici di Sinistra (DS) and Margherita DL (DL) respectively on 18, 16 and 17

per cent in agreement with private health policy, whilst in centre-right coalition, people voting Lega Nord (LN) who were in agreement with the same issue was 49 per cent, slightly more than Forza Italia (FI) (43%) and Alleanza Nazionale (AN) (41%) electorates. In 2006, the percentage of people voting centre-left parties who were in agreement with private health policy globally decreased, with DL electorate on 12%, more than people voting Left parties (they include Partito della Rifondazione Comunista - PRC, Partito dei Comunisti Italiani - PdCI and Verdi) and DS, respectively on 8 and 6 per cent. Inside centre-right coalition, from 2001 to 2006, Unione di Centro (UDC) electorate in agreement with private health increased 2 per cent, whilst people voting FI, AN and LN decreased respectively of 18, 4 and 6 per cent.¹⁰

Tab. 1. Electorate Agree with Private Management of Health Policy (percentage on overall electorate)

	Center-left coalition	Center-right coalition	Differences
Survey 2001	18	42	24
Survey 2006	8	30	22

ITANES 2001 and 2006. From ITANES (2006)

Tab. 2. Electorate Agree with Private Management of Health Policy (percentage on singular party only)

	Left parties*	DS	DL	UDC	FI	AN	LN
Survey 2001	18	16	17	24	43	41	49
Survey 2006	8	6	12	26	25	37	43

ITANES 2001 and 2006. Source: ITANES (2006)

Tab. 3. Health Care should be in private hands

Percent	N	
8.7	280	Agree completely
20.2	647	Agree fairly
22.8	732	Agree a little
41.1	1,318	Disagree completely
7.0	226	Doesn't know
0.2	6	No ansie
100.0	3,209	Total

ITANES 2001

Tab. 4. Health Care should be in private hands for Self-placement (Centre-left; Centre; Centre-right)

	Self-placement			Total
	Centre-left	Centre	Centre-right	
"Don't agree"	781	466	502	1749
	83,3%	66,7%	56,1%	69,1%
"Agree"	157	233	393	783
	16,7%	33,3%	43,9%	30,9%
Total	938	699	895	2532
	100%	100%	100%	100%

ITANES 2001

¹⁰ The following question was put to interviewees: "Now I am going to read some opinions people often hold on politics and economics. Please tell me how much you agree with each of them. Health care should be in private hands". It was measured by a Likert scale in 2001 and by an ordinal scale from 1 to 7 in 2006.

Tab. 5. Health Care should be in private hands for Professions

	Professions				Total
	teachers	workers	Employer class Self-employed professional	Tradesman Skilled operatives	
“Don’t agree”	73 82%	277 68,9%	57 48,7%	122 57%	529 64,4%
“Agree”	16 18%	125 31,1%	60 51,3%	92 43%	293 35,6%
Total	89 100%	402 100%	117 100%	214 100%	822 100%

ITANES 2001

With respect to the professional classes, teachers are the sector with the highest percentage who voiced opposition to a private health system (82%). Followed by the general workers (68.9%), tradesman and skilled operatives (57%). Only the employer class and self-employed professionals offered almost an equal diversity of view 51.3% for the private and 48.7% for the public.

Overall therefore the *majority of Italians are against a market system in the health argument*. The data cuts right across political persuasion and professional class. The suggestion is that there is widespread fear that a move towards a private health system in the future will not guarantee a health service for all, independent of ability to pay.

3.4.1.2. Differing attitudes of the people towards the public and private sector

The Italian population, with regard to hospital in-patient treatment, on the whole use the public sector. The most recent survey on the family, of the Italian Institution of Statistics (ISTAT 2003) demonstrates: 88% of the population when in need, uses the public sector, 10.8% use private institutions under contract with the INHS, and only 1.2% opt for a totally private hospital.

The centre and the north of the country, taken together, take advantage of public institutions (around 90%) whilst further south and in the islands is only a little less (86%) and if they do use the private system more, it is under contract to the INHS.

Tab. 6. People treated in hospital, identified by sex and geographical region

Geographical Distribution	Public Structures			Structures under Convention			Private Structures		
	Male	female	Tot.	male	female	Tot.	male	female	Tot.
Nord West	89,4	86,4	87,8	9,2	12,3	10,9	1,3	1,4	1,3
Nord East	90	90	90	8,6	9	8,9	1,3	1	1,1
Middle	90,9	89,6	90,2	8,2	8,8	8,5	0,9	1,7	1,3
South	86,1	85,7	85,9	13,3	13	13,2	0,5	1,3	0,9
Islands	85,9	87,1	86,5	12,7	11,3	11,9	1,5	1,7	1,6
Italy	88,5	87,5	88	10,4	11,1	10,8	1,1	1,3	1,2

Source: ISTAT (2003)

As we consider, people of a high level of education, which overall relates to a healthier socio-economic position, the percentage using the public sector levels off a little (83.4% for graduates and high school achievers) and this is mirrored in the increase in hospital stay in the private system but under contract with the INHS (13.3%) and in completely private treatment (3.3%).

The majority of those treated who have actually paid can be divided into: those who have directly contributed (78.2%), those who have the benefit of private health insurance (16.9%), and finally those who have both directly contributed and taken advantage of health insurance (4.9%).

It is the ageing population who are on the whole the ones who pay directly for their treatment (90.2%) and only 6.8% of the elderly has health insurance.

There is also a correlation between the economic conditions of those less well-off and their need for increased hospital services, particularly for the elderly.

Tab. 7. People treated in hospital identified by their contribution to the expense of their hospital treatment, and broken down into class, age, and geographical region

		Percentage Expenditures				Percentage Contributions		
		Partial Contrib.	Health Expend.	Other Expend.	Total Expend.	Direct Contrib.	Private Assuran.	Mix Dir.+Ass.
AGE CLASSES								
under 64		6	55,1	18,2	29,9	72	22,1	5,9
65 and beyond		6,3	55,1	26	19,8	90,2	6,8	3
Total		6,1	55,1	20,9	26,4	78,2	16,9	4,9
GEOGRAPICAL DISTRIBUTION								
Nord West		6,3	61,2	14,8	20,4	73,4	25	1,6
Nord East		4,4	66,4	18,5	22,1	81,3	11,2	7,5
Middle		7,5	56,3	14,4	35,2	66,7	23,9	9,4
South		5,8	46,1	29,3	25,1	87,2	9,9	2,9
Islands		6,5	45,9	30,8	23,2	87,6	7,1	5,3
Total		6,1	55,1	20,9	26,4	78,2	16,9	4,9

ISTAT (2003)

3.4.2. DRG: Implications on the efficiency and equity of health structures

The implementation of the system of DRG has had a drastic effect on the Health service in Italy. The principle, imported from the United States had been tried for a period of three years up until the end of 1997 when it was adopted comprehensively. In Italy, as in many other countries throughout the world, this implementation brought with it considerable innovation, incorporating radical change in the relationship between the people and health institutions, and particularly in the system of financing health care. So what exactly was the overall effect of DRG implementation? From 1994 when the experiment started in-patient treatment turnover increased significantly. Looking at the in-patient situation in routine practice, number of diagnosis again increased as well as the number of operations. An overview indicates an increase in diagnosis and in operations on an even grander scale in private as opposed to public health institutions. Taking into consideration the implications of the implementation of the new financial health arrangements brought about by DRG, if not overseen by some form of watchdog it could be subject to manipulation and at the same time favour a type of opportunism, the cost of which would be borne by the Italian public.

In order to illustrate this scenario let us consider some examples from Lombardia (one of the most important regions in Italy). We are taking into consideration here the length of stay in hospital for all categories of diagnosis in both public and private institution. Within public hospitals the average stay decreased only minimally (from around 10.4 to 9.2 days) without radical variations with respect to the period prior to DRG implementation. Whilst within private hospitals the statistics show an increase in the average stay (10 days, but with a significant drop from 1994 (14.1 days) which represents a cut of 31%, exemplifying an optimum adaptation to the financing system. This may well be positive from the point of view of efficiency, but carries a serious risk of too-early release, when the patient is simply not ready, and often leads to re-admission, and post-operative mortalities etc., classic examples emanating from an opportunistic approach.

To conclude, the philosophy behind DRG is almost directly akin to market thinking and indeed practice, having examined the before and after scenarios of implementation, the major effects on the working of the health system in Italy are:

- an increase in standard in-patient treatment;
- an increase in constancy of day-hospital practice
- a reduction in the length of actual stay

3.4.3. Health financing: consequences of competition in the INHS

Since 2002, with the introduction of Essential Level of Health Care (ELHC), the State guarantee that the health care services delivered by each regions are monitored. Furthermore, regions with their own additional resources can provide their citizens with more health care services than those guaranteed by the NHS. Within this general framework, it's clear that the public sector still has considerable power. Only 16% of the population has private insurance and only around 16% of all hospital beds are provided by private. Today, in Italy, the private sector alone takes just a small role in health care services, exclusively three areas:

- a) integration with public sector through contracts in basic individual provision, which are completely free of charge (related with the);
- b) the provision of health care services that are not available under the NHS, which are to pay for;
- c) the relief of pressure on the public sector concerning long waiting lists. The overall incidence of the private sector in Italy varies between regions. For example, in Lazio private hospitals show a much higher proportion of public beds, whereas Umbria seems to have very few. Only 1,6% of all patients admitted to hospital care are completely covered by private health insurance, while private hospitals follow a bed-day basis logic, showing a longer length-of-stay and higher occupancy ratios than public hospitals.

The core problem of the INHS concerns neither effectiveness nor costs. The main deficiency rests in the health service's inability to be people-oriented, in its bureaucratisation; it has turned out to be a supply-led service suffering from a number of organisational problems.

To solve this problem, a key policy theme in the '90s was the introduction of elements of competition in the INHS. Under the 1992/93 reforms a "quasi-market" was established, where public and private providers accredited by the NHS compete, on an equal basis, to deliver services, though since the reforms of 1999 partially modified the "quasi-market" the INHS is slowly moving towards a more integrated system (Mapelli 1999).

The 80s and 90s have been characterised by a continuous growth in the types and dimensions of co-payments of health care. They are now deeply embedded in the INHS and their level is among the highest in the European Union. A significant part of the population is nevertheless entitled to partial or total exemption from co-payments: this was the case for 21 million Italian people in 1996, some 37% of the population. Co-payments have played an important role in the cost-containment policies of the nineties, which have been characterised, by a strict policy of public expenditure cuts aimed at decreasing the public debt. Health care has been deeply involved in this policy, and its public expenditure has been substantially restrained. Another common feature - shared by health services as well - regards the problems in finding out the real economic situation of applicants and their relatives: in a country characterised by widespread fiscal evasion, it is really difficult to understand whether or not someone (or their relatives) has the possibility to contribute the service they are receiving.

3.4.4. The new scenario: exit and moving towards market in health care?

Now, which are the new options for health policy? In the health care debate and practice of the '90s the role of exit and market has been crucial. The 1992 legislation provided citizens with the possibility to opt out of the NHS and opt for a private social insurance, but this option was denied after one year. But the 1992/93 reforms also introduced elements of competition in health care. Both the kind of competition and the degree of choice open to the users have been extremely variable from one Region to another.

Italian health policy is characterised by a complex interaction between different ways of financing and delivering services. The NHS aims at providing citizens with all the services they need. The only private health expenditure should therefore - in theory - consist of that requested by the National Health Service for the co-payments or that due to the purchase of "unnecessary" items not provided by the NHS; the reality however, is quite different. Why? In Italy there is a huge level of private health expenditure, now amounting to 42,9% on the Total Expenditure. More than 50% of private expenditure is actually used by Italian citizens in the purchase of services already provided by the NHS itself, but that - for several reasons - people choose to obtain privately.

What we are saying therefore is that Italians could get these services from the NHS, either for free or with co-payments, but choose to buy them from providers not linked to the NHS (paying the whole cost). The private purchase of services one could get from the NHS has been in recent years a major cause of the private health expenditure's continuous growth.

The high level of expenditure on private services that the NHS itself provides is explained by the presence of (often long) waiting-lists, the perceived low quality of services and - for services such as diagnostic tests and specialist consultations – of a really high level of co-payments. A crucial issue worthy of more investigation is whether or not the fact that those who can afford private services often use them, decreases the quality of the public ones. It is in fact likely that in a situation where the middle-class utilises its “voice” option to “exit” (in Hirschman’s terminology) for at least some services, this can have negative consequences on their quality. But this is an “exit” *sui generis*, because upper-middle class people who use private services are in any case obliged to finance (through their contributions and taxes) the NHS. The introduction of a “real” chance to exit the service, waiving the duty to finance it for people who would insure themselves with private insurance, was widely debated over the 2001 AND 2006 campaigns for the general elections. This idea is still debated and some parties (i.e. Forza Italia and overall Lega Nord) in the centre-right coalition flirt with it, but, as we noted in ITANES survey (2001 and 2006), the majority of the people were not impressed by the argument.

The “exit” option has probably been the most passionately debated health policy issue of the ‘90s and at the up to the present along with the role of the market. Local Health Authorities are not in direct charge delivering services to citizens living in their areas any more: public and private providers accredited by the NHS compete - on an equal basis - to provide services to citizens. Regions now have really wide powers in setting their own health care legislation; after the national reforms of the '90s and 2001, each Region has thus enacted its own reform in order to conform to national legislation relative to its own context. The differences between Regions have concerned several issues, including the kind of competition among providers and the role of users’ choice. For the former, the actual degree of competition and the form of contracts used are extremely variable; for the latter, while in some Regions users can directly choose the provider they want, in others they have to use the one their Local Health Authority chooses on their behalf.

How to continue to control public health expenditure in the next years is an issue that worries several commentators, while others argue that expenditure should be increased. Italians share the views of their fellow Europeans concerning which level of public expenditure is most appropriate: some half of the population thinks public health care spending should be increased. When asked how extra-resources for health care should be raised, the supporters of this policy answer overwhelmingly (91,5%) “by spending less on other things” - while the EU average on this answer is 79,7% - and only 2,5% of them say “by raising taxes or health insurance contributions” (EU average 11%). The message is therefore that half of the population would like more public resources to be directed to health care but almost none of them is prepared to pay more money for them.

3.5. Conclusions

It would seem clear, in Italy, as in other countries throughout the world, that the market will play some role in the future of health care provision.

This inevitability however is absolutely full of *contradictions*. The above Section (I) has tried to highlight some of these. Contradictions in what people say, and what they choose to do, contradictions in the way the various political parties see market-thinking influencing policy within the health service and not for example in let us say education.

Contradictions in the way that people's expectations change too. The general public want freedom of choice, and at the same time they are loathe to miss out on the security that 'mother' National Health Service has and continues to offer. The classic example here will show upper classes happy to join the private sector, they are either insured for health or they pay directly in the free market; the middle class would prefer to choose the private sector - especially in the north - but they continue to use the public services, whilst resenting being asked to pay more in taxation to maintain standards of care therein.

Having said that the market influence is inevitable, we should nevertheless ask why in the first place did Italy in particular enter the world of private/public provision?

More contradictions are here perhaps. The INHS introduced the market system in order to tackle the many problems of efficiency and effectiveness in the existing services (waiting lists, bureaucracy, poor relationship between patient and doctor etc). The market therefore was very much a means but not the end.

Variables on the impact of market thinking on the services provided are many but we note on a general level that the INHS remains an equitable system wherein the populace, including those in disadvantaged socio-economic positions, have the full range of service provision and which remains of a generally high standard. However considerations about the future capability of continuing to provide equitable and overall

cover brings us to a more serious question of not only the INHS which must take its place in the larger whole of funding for society itself.

In practice if we look at GNP, the percentage allocated for health purposes is poor; in fact it rests below the European average. It is a problem that is not going to go away with time. Hence we return to the inevitability question. Health has to take its place in the public expenditure round, and it's clear that other areas, take a larger 'slice of the cake' than the social service field.

And of the future? From the point of view of efficacy and guarantees of standards within health provision, if the share of public expenditure falls to an even lower level, we are faced with another inevitability. At the moment the burden of taxation on individual families is high but not unduly excessive. However, despite the fact that the INHS functions adequately and its umbrella is all-encompassing, there are weak points like care for the elderly who continue to be disadvantaged and in some situations must pay for their treatment.

And if we are saying that the INHS does function adequately why then the haste for individuals to join the private practise? The middle classes in particular hurry towards the market system (the majority however under contract to the public service) because for them it's trade-off between cost of treatment (or visit) and the alternative - a long waiting list.

Given that state provision of health care remains of a high standard, the only differences that the private sector brings is a) a more customer-related approach, immediacy of treatment; b) outside of treatment the rest is more cosmetic (comfortable surroundings, better rooms and food, flowers, television etc).

The fundamental provision of health care in Italy remains one which believes firmly in accessibility, free at the point of delivery, and an equitable approach to health care provision.

Italy is a country notwithstanding its many contradictions, with a positive cultural and social make-up, and would find it extremely difficult to take on board totally any idea of a health system top-heavy with the influence of the market.

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