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REFORMING THE REFORM
The Italian *Servizio Sanitario Nazionale* in the 1980s

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1. After the reform: from democratic universalism to well managed electivity

At the end of 1978 a sweeping reform shaped a new profile for the Italian health system, triggering a radical transformation which has very few precedents in comparative perspective (Ferrera, 1989; Piperno, 1985). Prior to this reform, Italian public health care was organized according to the traditional criteria of compulsory social insurance. In institutional terms, the main features of the pre-1978 system can be summarized as follows:

- Limitation and segmentation of coverage. The social insurance system was primarily (and originally) aimed at covering *workers* rather than *citizens.* It is true that, following a number of gradual extensions, the occupational coverage had reached a very high level in the mid-1970s (ca. 93% of the total population). Entitlement to care remained however subordinated to labour market participation (directly or indirectly, through the head of household), thus excluding a sizeable share of non-occupied citizens located at the margin or outside the "institutional" labour market. Moreover, there was a variation of entitlements across the various covered categories: in principle, for instance, self-employed workers had no established access to the lowest levels of care (i.e. general practice or medicines outside hospitals) (Ferrera, 1987).

- Organizational fragmentation. The system was based on a plethora of separate funds with different statutes and regulations. The most important fund was the *Istituto Nazionale per l'Assicurazione contro le Malattie* (INAM), insuring all private employees; public employees and the self-employed were covered by autonomous funds, in some cases with local differentiations.

- Normative and procedural disparities. Each fund established its own regulations and procedures for the respective category of insured. Some funds provided *direct* care (i.e. through their own ambulatories and with no financial disbursement on the side of patients), some provided *indirect* care (i.e. through contracts with private doctors and external facilities, with ex post reimbursement to the patients), some provided the option to choose.

- Compartmentalization of the various levels of care. As a corollary and largely as a consequence of organizational fragmentation and of normative disparities, the old insurance system had erected solid barriers between the various levels of care (general practice, specialists practice, hospital care) and their various phases (prevention, cure, rehabilitation etc.). The level of general practice (family doctors) had progressively deteriorated and was largely subordinated to that of specialistic care. General practitioners under contract with public funds had become quasi-employees, with little professional responsibilities and even less consciousness of their “economic” role as cost- inducers (Freddi, 1984; Paderni, 1981). Given their institutional autonomy, public hospitals operated in total disconnection with respect to the other levels of care, with many duplications of services and frequent conflicts with the funds on the “management” of their insured. Over-bureaucratization was the commonest criticism raised against this system of overlapping health “feuds,” which offered uneven treatments to consumers and did not allow them any possibility of voice or control.

The 1978 reform drastically changed this situation. Transforming health care from an entitlement of workers to an entitlement of citizens, it universalized insurance coverage to the entire population, thus filling the existing gaps. Suppressing the plethora of separate funds and establishing a new uniform structure for service provision, based on the regions and local health units, the reform paved the way -at least in principle- for a more efficient and rational use of resources. Furthermore, it brought about a massive normative standardization, offering uniform access and movement opportunities to all users within the public health system. Finally, the reform promoted a “horizontal re-organization” of services, aimed at suppressing the various barriers between levels of care and at re-integrating its various moments. A policy of “services flowing towards users,” of maximum opening to need and demand became the *leitmotif* of the whole process of rationalization (Ferrera, 1986).

The basic principle underlying this process can be labelled as *democratic-participatory universalism.* The fundamental idea - deeply rooted in the ideological humus of the Italian 1970s- was that the state ought to provide free and equal benefits to every citizen by means of a National *Service*, with absolutely no differentiation or discrimination based on occupational status (universalism) and no economic barriers at the points of use; and that the organization of this Service ought to allow for ample opportunities of popular “democratic” control and participation (Ardigó, 1979), which in the Italian setting meant (and still largely means) control on the side of political parties. The new Service was also to rely on the valorization of the role of doctors (especially family physicians), who ought to adopt a new “health maintenance” approach with their patients (Piperno and Renieri, 1982; Porcu, 1985).

The change of political climate (from “national solidarity” including the PCI to a more traditional center-left “pentaparty” government in 1979), the severe problems encountered in the implementation of the reform design and the alarming trends of some expenditure components (e.g. pharmaceutical expenditure and expenditure for specialists treatments) in the aftermath of the reform started to rapidly erode, however, the wide consensus on democratic universalism: the noble aims of this principle were in fact materializing a risky syndrome of “politicized over- consumption,” with no incentive for an efficient regulation of the demand for health care and for an efficient resource management (Brenna, 1984; CENSIS, 1983 and various years; CNEL, 1982).

Thus the 1980s have witnessed a process of gradual but substantial revision of the original approach of the reform. In retrospective, this revision can be seen as a shift from democratic universalism to *well-managed selectivity.* This latter principle stresses both the need to differentiate access to care according to some criterion for purposes of demand regulation and the necessity of an efficient use of scarce resources through an adequate valorization of managerial skills and hierarchical controls as well as a greater collaboration on the side of medical professionals to control both the quality and the cost of care. The shift from “full” universalism to a new selectivity started relatively early in this decade and is now well advanced; the shift from democratic (party) control to efficient management is a more recent phenomenon, as is the attempt at involving more directly the medical profession in the formulation and implementation of policy objectives.

2. The new policy of "ticketing"

Table 1 lists in chronological order the main provisions introduced since 1978 with the aim of controlling the demand for health care. As may be seen, the most important instrument of this policy has been the so-called "ticket," i.e. a fee to be paid by patients at the moment of use of certain benefits and services.

The first ticket was introduced as early as in 1978 (actually, even a few months prior to the reform): this first ticket was very modest in its amount and remained circumscribed to medicines not included in the so-called "Therapeutical Catalogue" *(Prontuario Terapeutico Nationale),* i.e. a lists of approved pharmaceuticals which doctors were allowed to prescribe free of charge (this list was at the time very comprehensive). Despite these limitations, the economic effect of the new ticket was quite remarkable, as net pharmaceutical expenditure witnessed a real decline of 10% in the subsequent year (CENSIS, 1987). Throughout the 1980s, the policy of "ticketing" followed four basic lines.

The first line was an increase in the amount of the ticket. This took place already in 1981, but the real turning point was 1983, which witnessed the shift from a flat rate to a price related charge of 15%, up to a certain maximum. Again, the economic impact was remarkable, with net expenditure falling by 6.8% in real terms in 1984. The rate was elevated to 25% at the beginning of 1986: however, at the end of the same year, under heavy pressure from the trade unions the government decided to lower it again to 15%. Worried for the alarming increase of (net public) pharmaceutical expenditure which took place in the following year (about 14% in real terms, CENSIS Report, 1988), the rate of the ticket was raised again in 1988 and 1989, with a current range of 30%-40%.

The second line of action was the gradual extension of the scope of the ticket to affect other types and levels of service. Already in 1982 instrumental and laboratory tests were subjected to a charge of 15%, increased to 20% in the following year (up to a maximum). The new increase of 1986 (25%) was so violently opposed by the trade unions that the government decided to suppress this ticket altogether, only to re-introduce it again in 1989, with a higher rate (30%). In 1983 a proposal was made to introduce a fee on each GP consultation: the doctors' refusal to become "tax-collectors" shifted the new charge on actual prescription sheets rather than on consultations, the rationale being that a charge was appropriate only if the consultation originated a further cost in terms of medicines (the charge on prescription sheets is collected by pharmacies). As the table shows, this ticket was increased several times in the subsequent years and currently amounts to Lit. 3,000 per sheet. Specialistic ambulatory treatments were in turn subjected to the ticket in 1986 (25%): this ticket witnessed the same destiny of initial suppression after a few months and subsequent re-instatement in 1989. The great novelty of this latter year was however the much controversial introduction of a new ticket on hospital stays, i.e. the very "core" of the public health system. This provision provoked a real explosion of protest, culminated in a general strike: the government was compelled first to modify the provision (setting upper ceilings to the ticket and granting broad exemptions) and eventually to abandon altogether the idea.

The third line of this policy of ticketing was an extension/modulation of the "taxable pharmaceutical basis," i.e. the number of products to be charged with the ticket. Again, the turning point in this respect was 1983. In that year a substantial revision of the Therapeutical Catalogue took place, which subdivided all registered medicines in four groups: "life-saving" medicines, antibiotics and chemotherapy, other medicines chargeable to the SSN and a residual category. This differentiation was then taken as a basis for the determination of cost-sharing: the first group was left without ticket, the second was subjected only to the ticket on prescription sheets, the third was subjected to the price related ticket and the fourth was excluded from public financing. The goal underlying this revision of the Catalogue was to soften the impact of the ticket on the basis of the “risks” incurred by patients. In 1988 a new substantial revision of the Catalogue has taken place. The group of medicines provided free of charge has been restricted and in order to qualify for exemption these medicines must be provided by hospitals or public ambulatories. A new, large group of “auto-medication” products has been identified and subjected to a higher ticket of 40%. The basic principle of “exemption according to risk” still underlies, however, this recent reclassification of the Catalogue.

The correction of the ticket impact on the various categories of users on the basis of equity criteria has been more explicitly pursued via a system of exemptions from cost-sharing targeted to specific groups: and this represents the fourth basic line of action of the policy of “ticketing.” The first provisions in this direction were introduced already in 1981; in the subsequent years, regulations have become so complex that it is rather difficult to outline the general picture. Initially, the basic criterion of selection was the annual personal taxable income: all those beneath a certain threshold qualified for exemption and could apply for it. This threshold was repeatedly increased overtime and was also “tuned” in order to take account of non taxable assets, family size, age and occupation. Since 1986, exemption regulations have been gradually made more restrictive (e.g. in terms of controls), in order to discourage abuses. As of 1989, the categories exempted from cost-sharing on the basis of income are: citizens in “state of poverty” certified by the local authorities; recipients of social pensions; recipients of minimum pensions with an annual taxable income of Lit. 10 million (15 if with spouse, with an additional million of Lit. for other dependents).

Besides income, another element has gained overtime an increasingly important role for the determination of exemptions: the type of health risk incurred by patients. The 1981 provision already excluded all the categories of disabled. In 1984 a list of illnesses “of particular social relevance or of peculiar interest for the protection of public health” was compiled, and patients affected by these syndromes were declared exempt from cost-sharing, regardless of income, as were pregnant women. The criterion of risk has remained important also in the subsequent years and a number of proposals have been made in order to refine the catalogue of illnesses, comprehending all neo-natal and pediatric diseases.

As can be seen, the policy of ticketing has profoundly changed the relationship between users and the SSN. The universalistic approach of the reform (equal and free benefits and services on the simple basis of citizenship) has gradually yielded to increasing doses of selectivity: benefits and services with co- payment to all citizens, with no charge only for those users in conditions of economic disadvantage or exposed to individually burdensome and/or socially relevant risks. Some have labelled this new selectivity as "positive selectivity," because it is superimposed to a background of equal entitlements to access into the public system, although with different cost-shares. As a matter of fact, this type of selectivity appears as clearly distinct from that which prevailed in the past, when only the official "poor" (i.e. those registered in special "poor lists" compiled by local offices for public assistance) "deserved" free hospital care in case of need: a care otherwise reserved to those covered by occupational insurance funds. The reference to both income and risk as criteria for exemption and the easy access to the status of "exempt" (via self-certification as regards income and physician certification as regards risk) have completely destigmatized the entitlement to free care; the existence of universal coverage and standardized (equal) services for all avoid, in principle, the emergence of a dual system of class-based differentiations in the health system. The latest emphasis on tighter income controls, the re-emergence of the very notion of "state of poverty" together with the proposals of (self) exclusion of some categories from public coverage may however lead to a return to a more traditional understanding of the principle of selectivity.

On the economic effects of the ticket there can be little doubt: all the available evidence suggests a tangible "moderating" influence on demand, in both aggregate volume and cost (CENSIS, various years). Starting from a situation of almost completely "free meal," Italian patients now find themselves to pay comparatively high prices for comparatively low services. This has greatly increased in recent years the political visibility of the SSN, as witnessed by the real wave of protest encountered by the 1989 attempt at “ticketing” public hospitals. In the short to medium run, further success in demand containment by means of financial barriers to users seems unlikely. It is not surprising then that the government has been recently re-orienting its policy towards a more effective regulation of doctors’ behaviors.

3. The regulation of doctors

Doctors -and especially the so-called family physicians providing basic care- were to be the fundamental pillars of the new SSN according to the 1978 reform and its supporters (Ardigó and Barbano, 1981; Piperno and Renieri, 1982). They had to cure, but also guide their patients, educating them into preventive practices of health maintenance; they had to select the most appropriate means and levels of care, with an eye to therapeutical success and another to cost-effectiveness. Implanted on the background inherited by the previous system, these ambitious goals of the reform soon proved to be mere wishful thinking. Their attainment implied a degree of cultural and political consensus and of active collaboration far higher than Italian doctors were ready to concede; it also implied organizational and information resources which went lost during the reform process. Thus after the reform physicians just continued to do what they were used to: prescribing a lot of medicines and tests to their patients and referring them to the higher levels of care as often and as soon as possible.

At the end of the 1970s Italian doctors presented themselves in a state of professional degrade, organizational confusion and political weakness. Still formally “free professionals,” general practitioners had developed a relationship of bureaucratic subordination to the insurance funds; they retained the right to independent practice and clinical autonomy, but had to comply with a lot of formal rules regarding the terms of practice (e.g. the maximum number of customers, the scheduling of visits etc.) and with detailed procedures regarding how (and often what) to prescribe. In exchange for bureaucratic compliance, they had acquired a semi-tenured status (sickness leaves, seniority advancements etc.) and their remuneration was based on a number of fixed, salary-like components (Paderni, 1981). Their social reputation had markedly declined and the very label of *medico della mutua* (insurance fund doctor), following the caricature of a famous film of the 1960s, tended to evoke incompetence and greed.

Hospital doctors were in no better shape. With the “democratization” of hospitals after a reform in 1968 (Ferrera, 1989; Freddi, 1984), the old hierarchical style of recruitment and practice centered around top “primary clinicians” was replaced by a system of unionized egalitarianism, with political criteria increasingly displacing professional ones. The traditional organizational particularism of Italian medicine degenerated during the 1970s to the point of confusion and the massive output of new graduates on the side of a relaxed system of higher education was increasing the political vulnerability of the whole category: the number of medical graduates per year grew from about 5,000 in the early 1970s to 12,700 in 1977 and 14,200 in 1980. Unionized hospital doctors and of course younger graduates in search of work favoured the reform, from which they expected career/employment opportunities; but the bulk of “the profession” and especially general practitioners fiercely opposed it. During the debate on the reform, the idea of offering exclusive salaried employment as the sole form of medical practice within the SSN (thus “nationalizing” doctors) was repeatedly launched by radicals of the Left. The threat was not very serious: even the PCI and the big workers’ unions never adopted the idea officially and in the end the right to independent practice within the SSN was guaranteed, not only at the level of general practice, but also in public hospitals (as part time addition to salaried employment). But in the hospital sector doctors were lumped with the paramedical staff in a single contractual category; more generally, medical professionals were not given any right to participate in the overall management of the health service, and the idea was to subject them to close “democratic control” via the political committees which were going to govern the Service at the local level. Thus, most of “the profession” entered the reform era with feelings of hostility and fear, and with few objective resources of self- assertion. This situation was not the most appropriate in order to promote that “revalorization of the medical role” wished by the reform ideologues: but certainly the “state” appeared to be in a very strong position vis-a-vis the doctors, commanding a high potential of bureaucratic and political control over their behavior.

This was however only the appearance. In the organizational chaos originated by the reform process, the central government lost a resource which was indeed crucial for the control of doctors and, more generally, of the whole sector of public health: information. The point is important and deserves some elucidation.

Thanks to the above-mentioned bureaucratic constraints imposed on physicians, the old *mutue* (and especially INAM) were capable of closely monitoring their behavior: in fact they possessed detailed information on the amount of prescriptions (medicines, various tests, referrals to specialistic and hospital treatments etc.) originating from each single practitioner and had also established varied rules on admissible practices. When the funds learned that they were going to be liquidated, they just terminated their activity of information collectors and no other institution (of the many which could have: the regions, the Ministry, the Central Committee for the Liquidation of the *Mutue* etc.) set out to perform this important task. Thus between 1975 and 1978 the basic premise for any “steering” of doctors (indeed, for any planning for health) went lost and the new contract negotiated with the doctors in 1978 “freed” them from the obligation to provide direct information to the SSN about their prescriptions and diagnoses. The reason offered to justify this change was “administrative simplification.” It is indeed possible that none of the actors involved in the negotiations was fully aware of the implications of this informative black-out: the technical impossibility of any public regulation of medical practitioners and a corresponding sudden “bureaucratization” of the latter, after at least two decades of increasing subjection.

When the organizational “smoke” caused by the reform process had withered, the government tried to regain the lost ground and started to re-bargain with doctors on the issue of information. The new contract of 1981, for example, granted very generous economic concessions in exchange for the commitment to provide again detailed, computer-readable data on prescriptions (in the widest sense). But at this point doctors had learnt the lesson of the past and despite repeated formalized promises they made it very hard for the government to acquire these data. The setting up of the *Sistema Informativo Sanitario* (health information system) was one of the most complex and controversial operations of the 1980s and -not surprisingly- the major problem was the resistance of doctors. Issues such as the compilation of "patient cards" (on the side of general practitioners, but also hospital staff), the introduction of standardized computer-readable prescription forms etc. have been the object of hot disputes, with doctors literally distilling first their readiness to comply and then actual compliance (Boni, 1988; Pagni, 1989). Mainly centered around the issues of information provision and prescription controls, the relationship between the government and physicians under public contract witnessed during the 1980s a slow move from bureaucratic confrontation towards quasi-corporatist institutional concertation. This move rested on the intermediation of local governments and on a partial re-structuring of medical unionism and organization.

Disappointed with the actual results of the 1981 agreement, the government adopted a number of unilateral provisions aimed at setting "external" bureaucratic constraints on physicians. This reflected increasing preoccupations regarding expenditure trends, in the light of the worsened macro-economic conditions of the early 1980s. Between 1977 and 1982 the public health bill passed from 4.5% to 5.5% of GDP: physician-induced expenditure on pharmaceuticals and tests was identified as priority target for measures of containment, as it was considered to be burdened by consumerist (and even fraudulent) abuses. Thus in 1982 and 1983 (and later again in 1988) a number of substantive and quantitative limitations were posed to clinical decisions (see table 1), such as the ceiling on the number of medicines per prescription sheet, the enforcement of "protocols" for standard treatments and diagnostic procedures, the prohibition to general practitioners to prescribe certain costly examinations or the obligation to prepare detailed reports in case of referrals to the higher levels of care. The above illustrated modulation of the Therapeutical Catalogue can also be understood as a quasi- unilateral restriction of clinical autonomy. All these measures were introduced "by decree" (in almost literal sense), were valid *erga omnes* and did not imply pre-existing information on individual behaviors. Their enforcement was relatively straightforward: it sufficed to instruct pharmacies to reject irregular prescriptions or hospital wards to refuse patients without personal reports etc. Quite obviously, the doctors' protest against this policy of bureaucratic regulation was extremely vocal and harsh political confrontation remained the prevailing mode of relationship between the central government and the medical unions up to the late 1980s.

But at the local level things began to move in a different direction, at least starting from the mid 1980s. In 1982 and 1983 the regions and ultimately the various *Unita Sanitarie Locali* found themselves entrusted with the unpleasant task of organizing experimental controls on the prescriptive behavior of individual practitioners. Most of the *Mezzogiorno* regions did nothing, due to technical obstacles, political resistance or sheer inefficiency (the media even reported mafia threats). Center and Northern regions (most notably "red" Piedmont, Tuscany and Emilia-Romagna) were more active. Partly distancing themselves from the central government as "forced victims" of its policy and resorting to gentle persuasion, a number of USL in these regions succeeded in setting up efficient data-collection systems. This was achieved by establishing mixed "working parties" and "technical committees" with the participation of local administrators and representatives of pharmacists and the various categories of doctors, and granting broad assurances about the purely "informative" goals of the initiatives (Salute e Territorio, 1987). These experiences of micro-corporatist concertation served to ease the tensions generated by national confrontation and to build a new collaborative fabric between doctors and the SSN.

Another development worked in a similar direction: the increasing aggregation of medical associations and unions and their growing interest in acquiring a more relevant role in the making of health policy and in the management of the Service. A number of factors promoted this development, which constituted a significant departure from a long standing tradition of organizational particularism: the suppression of the funds and the unification/centralization of the public "counterpart;" the homogenization of the figure of general practitioner *(medico di base)* in the new SSN, as against the various figures of the previous system *(medico della mutua, medico condotto* etc.); the very "aggression" of bureaucratic regulations of the early 1980s, the wish to counteract the control of the political committees of the USL etc. (Vicarelli, 1986). The process of associational aggregation took place in various subsequent steps: the establishment of a new professional association in 1982, the *Societa' Italiana di Medicina Generale* (SIMG), with the institutional aim of promoting the "valorization of general practitioners within the SSN" and the political goal of networking more closely these practitioners; the establishment of organizational links among the various autonomous unions, thus overcoming old ideological distinctions; the strengthening of the *Federazione Nazionale degli Ordini dei Medici* (FNOM), the traditional association of the whole profession, which became very active as a mediator between the central government and the various medical unions and as the most vocal claimant of greater medical representation within the organs of the SSN. It must be mentioned that these developments of associational aggregation within general practice have been paralleled by similar developments within the other sectors of Italian medicine, most notably with the hospital sector.

To a great extent thanks to the intermediation of local government and to this process of associational aggregation, the second half of the 1980s witnessed a gradual attenuation of bureaucratic confrontation between the central governments and physicians and the attempt at extending concertation initiatives from the local to the regional and national levels. Proposals were made to invite representatives of the medical profession to join the National Health Council, an organ entrusted with wide competences of health planning; at the regional level and within each hospital the establishment of Consultative Commissions of doctors was suggested, with the task of advising on a wide range of technical and organizational matters. A further valorization of the role of medical professionals in these matters is foreseen in the various proposals of general re-organization of the SSN which a re currently debated. What is being attempted is a sort of political exchange whereby Italian doctors accept to collaborate to restrain demand-pushed expenditure growth while the government accepts to recognize their role and power as partners in policy making and management, at the expenses especially of local party committees. If the government seems ready to curb the power of the latter, its latest plan however aims at bestowing greater authority on managers rather than on doctors, thus undermining the conditions for a compromise with this crucial category.

4. A new model of administration

As mentioned, the 1978 reform aimed at replacing the fragmented and over-bureaucratized administrative structure of the previous system with a new model based on extensive decentralization and democratic control/participation. The basic pillar of this model was to be the so-called *Unita' Sanitaria Locale* (USL), responsible for the organization and provision of all services in areas comprising 50,000-200,000 inhabitants. These units were in turn to be run by Managing Committees elected by General Assemblies expressed by local authority councils.

The activity of the USL started in 1980, after a year of transition from the old to the new system. Managing Committees were elected towards the end of the year, following the round of regional and local elections in the Spring of 1980. Given the emphasis placed by the 1978 law and by the regions themselves on the "participative" and "democratic" character of these Committees, it must be no surprise that these organs were formed primarily on the basis of party recruitment and political considerations. As a matter of fact, the USL immediately transformed themselves into relevant arenas of party competition and much appreciated spoils in the old Italian practices of *lottizzazione* (Ferrera, 1987).

A research on the educational and occupational backgrounds of the components of these Committees for the period 1980-1985 has shown that most of them were school teachers, pensioners and public employees, with non-technical diplomas (Ferrera and

Zincone, 1986). Having to fill more than 6,000 new posts (if only part time), political parties did what was just natural to them: they looked for loyal delegates with some spare time. Educational qualifications, professional experience, managerial skills were only secondary criteria of choice: and it could not be otherwise, since not even a country with seven "relevant" parties can produce in a few months more than 6,000 clever health administrators with certified party loyalties. The thing is that without clever administrators administration did not work. The performance of these ill-designed Committees proved in fact increasingly disappointing: slow and incompetent decisions, growing contrasts with technical and medical professionals (especially within hospitals), even widespread frauds (CENSIS, various years).

Already in 1982 the government intervened with a minor, but important modification of the institutional profile of the Managing Committees, creating a College of Auditors as a new organ of the USL. Starting from the mid 1980s, however, a process of substantial re-definition of the overall structure of these units has begun, which has been gradually wiping away the "democratic" style of administration and replacing it with a system of incentives for efficient resources management.

In 1986, following the electoral renewal of local councils, the general assembly of the USL was suppressed as an organ, the size of the Managing Committees was reduced and the role of the College of Auditors was strengthened. Meanwhile, under pressure from a public debate originated by the media on the "over-politicization of the SSN," the parties themselves started to prepare various proposals of broad institutional reorganization.

In early 1989, the government tried to introduce by decree a number of new important innovations: the transformation of Managing Committees into bodies with only general planning and orientation tasks; the concentration of administrative powers into the hands of the President and of the newly introduced Director General of the USL; the uncoupling of larger hospitals from the USL and their administrative autonomization, together with the possibility for the regions to partially privatize some of them. The governmental crisis of the Spring of 1989 and the change of the Minister of Health (from a Christian Democrat to a Liberal) in the new government temporarily halted the process of institutional reform: in fact the decree was not converted into law.

On September 30th, 1989 the government presented a new draft bill on the "re-ordering" of the SSN, which is currently (June 1989) under examination by Parliament. With respect to the provisions introduced by decree (and then abandoned) by the previous government, the current bill stresses to an even greater extent the need for efficient management and for larger responsibilities in the control of expenditure on the side of all actors involved in the supply of services. Thus the regions must set up a special body for the allocation of financial grants to the various local units and for the supervision of their activities: if regional expenditures exceed for some reason the planned budget covered with central government funds, the regions themselves must find additional resources or cut services. The USL are transformed into "public agencies for the provision of services," with ample organizational and administrative autonomy and responsibility: they are run by a Single Manager, selected by the regions on the basis of professional qualifications and with a private contract, renewable every five years on the basis of performance records. The Single Manager will be assisted by an Orientation Committee (the old Managing Committee), with only broad planning and supervision competences. Larger hospitals are uncoupled from the USL and transformed into "public hospital agencies," with autonomous organization and administration (parallel to that of the USLs). Regions, USL, hospitals are encouraged to experiment the "contracting out" of certain services and the shift to "indirect care," i.e. the possibility for patients to purchase certain services in non-public facilities and then claim public reimbursement at some fixed rates. The introduction of performance and service quality indicators as well as of a system of medical review is also foreseen, resting on the active collaboration of medical associations. The government is actually bargaining with the national federation of the medical orders (the above mentioned FNOM) the establishment of regional sections which should work with the regional orientation committees in order to set up efficient review systems. Even though during the parliamentary *iter* of the bill some modifications are likely to be introduced in order to accommodate the interests of all affected parties, the reasonable guess is that a "re-ordering" of the SSN, following *grosso modo* the lines of the present draft will eventually come about during the year 1990. No major opposition to it has manifested itself so far in the political discussion.

With the approval of the bill, the "reform of the reform" will be completed on the organizational level. The old administrative model characterized by "high partyness" is expected to give way to a new model characterized by a good degree of "stateness," i.e. a firmer grip on the side of the central government over the SSN via a system of effective incentives and accountable managers. With this transition, the Italian SSN is also expected to align itself more closely to the other European health systems (especially the post-Review British NHS).

Despite these good intentions and high expectations, a number of doubts and perplexities on the actual success of the "re-ordering" have been raised by many observers. Will parties actually withdraw? Will the single managers be able to effectively govern the USL, having to cope with a highly unionized administrative personnel whose hyper-protected status will remain unchanged? Will the doctors collaborate? Regarding the latter, their worries (and hostility) for the forthcoming change are mounting. The control of managers may prove more suffocating and constraining than that of political parties: managerial definitions of efficiency and effectiveness and proximity of control do not promise well for the preservation of (what remains of) professional autonomy and thus threaten to undermine the attempted move towards semi-corporatist concertation witnessed in the latest years. In the Spring of 1990 the Minister of Health tried to buy off doctors' opposition by granting them very generous pay and fee increases: but opposition has not subsided.

Thus, the games seem still quite open for the Italian health scenario of the 1990s. And the administrative profile of the SSN (with its internal power balance among actors) is not the sole uncertain element of this scenario. The larger public debate has in fact recently started to address a new theme: the revision of the very principle of compulsory public universal insurance.

5. An end to universal coverage?

The general argument increasingly raised against compulsory universal coverage is that this principle - a central tenet of the 1978 reform, as already illustrated -generates some perverse redistributive effects in combination with the current mechanisms of financing, favouring some occupational categories while penalizing some others. Moreover, it tends to "lock" the entire population into a public system which often operates with very poor standards of performance, especially regarding the organizational context of care.

In order to fully understand these indictments against the SSN, some information on its financing side is needed. The original aim of the reform was to parallel the universalization of services with a shift from ear-marked contributions to general revenues as the main (hopefully, sole) source of financing. In this way, the vertical redistributive flows of progressive taxation would have financed the horizontal redistribution of resources between the healthy and the ill. In practice, however, the mechanisms of financing have never been reformed and ear-marked contributions still represent the major source of revenue for the public health budget (Censis, 1988). Given the structure of these contributions, the burden of financing is unequally shared by the various occupational groups: more precisely, employees (especially higher income private employees) contribute a much higher share than the self-employed. Within this latter group, moreover, there is a much higher rate of tax evasion, which means even lower financial participation to health financing (lower rates applied to unrealistically low taxable incomes). The policy of ticketing, with its income-related exemptions, has further exacerbated these disparities: a number of tax and contribution evading self-employed qualified in fact for exemptions. Since the mid 1980s the increase of contribution rates for the self- employed, the stricter controls on exemption applications and the adoption of tighter criteria have partially redressed the balance: but the distribution of burdens still remains partly (and is certainly perceived as very) inequitable. Hence the accusations towards the good-intended framework of universal coverage *cum* positive selectivity on the side of many political actors, especially of the spokesmen of higher income strata of the private sector.

The irritation of these strata is also growing because of the low standard of services, which stimulates their frequent de facto “exit” from the public into the private arena of service provision. Private insurance plans, offering additional coverage or substituting entirely for public coverage have witnessed a massive expansion of their market within these strata in recent years (Censis, 1988). Thus a real interest has developed in these categories (and of course in private insurance companies) for a “loosening” of their link with the SSN, especially in financial terms. What is asked is the possibility of “opting out” of the public system, at least partially.

This new constellation of interests has already started to originate some practical proposals, such as for instance the exclusion of the self-employed from the SSN: this idea was unofficially launched in the debate by the former Minister of Health, Carlo Donat Cattin (DC). The most articulated plan formally submitted to Parliament so far is that of the Liberal party (currently a coalition partner holding the Ministry of Health). This plan envisages the shift from the present system of compulsory insurance within a single uniform scheme to a new system offering three distinct insurance options:

- all inclusive public insurance (same as now);
- partially inclusive public insurance: only hospital care as free entitlement; 40% reduction of contribution rates;
- compulsory private insurance, with possibility of access to public services upon payment; 60% reduction of contribution rates.

The proposal of the Liberals appears as very “radical” with respect to the orientations expressed so far in the debate on the reform of the SSN. Even though the activism of the Liberal Minister may gain some consensus around his party's plan, in a general context of growing re-valorization of the role of competition, privatization and the market, a real break with the tradition of public universalism is not likely to occur in the short run. How to respond to the claims of financially overburdened and quality-conscious higher income consumers will be however one of the greatest dilemmas, in sociological terms, of the Italian SSN during the new decade.

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TABLE 1

Main Provisions aimed at controlling the demand for health: 1978-1989

1978

Introduction of a pharmaceutical ticket (min. Lit. 200, max. Lit. 1,000)

1981

Increase of the pharmaceutical ticket (min. Lit. 300, max. Lit. 3,000); income-based exemptions.

1982

Introduction of a ticket on instrumental and laboratory tests (15% of price up to a max of Lit. 40,000).

Introduction of "protocols" regarding instrumental testing and standard therapies.

Introduction of limits on the number of medicines to be prescribed on each prescription sheet.

Introduction of experimental controls on the prescriptive behavior of family physicians.

Full cost of dental, optical and aural services/treatment to be born by patients.

1983

Restrictive revision of the Therapeutical Catalogue.

Increase of the pharmaceutical ticket (15% of price).

Increase of the ticket on instrumental and laboratory tests (20% of price up to a max of Lit. 50,000).

Introduction of a ticket on all physicians' prescriptions(Lit. 1,000).

Tighter controls on exemption applications.

Experimental controls on the prescriptive behavior of family physicians and technical improvements on data collection on the use of medicines.

1984

Broader risk-based exemptions.

Increase of the ticket on physicians' prescriptions (Lit. 1,300).

1986

Increase of the pharmaceutical ticket (25% of price). Later lowered again (15% of price up to a max of Lit. 25,000).

Increase of the ticket on physicians’ prescriptions (Lit. 2,000 up to a max of Lit. 30,000). Later lowered again (Lit. 1,000).

Increase of the ticket on instrumental and laboratory tests (25% or price up to a max of Lit. 60,000). Later: abolition of this ticket.

Introduction of a ticket on specialistic consultations (25% of price). Later: abolition of this ticket.

Further restriction of the number of pieces to be prescribed by family physicians per single prescription sheet (6 pieces for antibiotics, 2 for other products).

Revision of criteria for exemptions.

1988

Restrictive revision of the Therapeutical Catalogue.

Increase of the ticket on physicians’ prescription sheets (Lit. 2,000).

Increase of the pharmaceutical ticket (re-introduction of a cost- share of 20% of price: 40% of price for some products).

Tighter controls on the price and on the quantity of pharmaceuticals on sale.

Tighter controls on the provision of specialistic care and on physicians’ behaviors.

1989

Increase of the pharmaceutical ticket (30%-40%).

Increase of the ticket on physicians’ prescription sheets (Lit. 3,000).

Re-introduction of the ticket on instrumental and laboratory tests (30% of standard prices fixed by the Ministry).

Re-introduction of the ticket on specialistic consultations (flat rate charges according to branches).

Introduction of a ticket on hospital inpatient treatments (Lit. 10,000 per day for the first 10 days only, with a maximum of Lit. 200,000 per year). Later: abolition of this ticket.