Modern Italy (2022), 1–17
doi:10.1017/mit.2022.50

CAMBRIDGE UNIVERSITY PRESS

RESEARCH ARTICLE

A history of Italy's health policy from the Republic to the new century

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(Received 3 June 2022; revised 18 October 2022; accepted 18 October 2022)

Abstract

This article analyses the development of Italian health policies in the post-Second World War period. Shortly after the setting up of the 'Beveridge model' and the creation of the British National Health Service, Italy also introduced a new approach to health, which became part of the Constitution. However, the implementation of the necessary reforms was delayed due to resistance from the country's institutions and government parties. The introduction of a radical health reform became possible only in 1978 through pressure generated from social conflicts, trade unions and left-wing parties. The implementation of the National Health Service encountered a number of obstacles due to the specific conditions of Italy, but also owing to changes at the international level. The neoliberal policies started in the 1980s introduced restrictions in health spending, the regionalisation and privatisation of services, and a new selective approach to health. In spite of these limitations and contradictions, the Italian healthcare system has been considerably successful, leading to strong improvements in health and to a life expectancy at birth among the longest in Europe. The recent developments – and the experience of the pandemic – confirm the important impact of a public, universal health service and, at the same time, the persistent policy efforts aimed at weakening its reach.

Keywords: Italy; health; politics; Welfare State; National Health Service

Introduction

The Covid-19 pandemic has brought back to the centre of public debate the right to health, in its physical and mental, individual and collective dimensions. In order to understand how the welfare system and healthcare policies have addressed these challenges, a wide-ranging historical analysis is required. This essay reconstructs the history of health policies introduced in Italy from the beginnings of the Republic to the end of the last century, identifying the problems that characterise the current health system.

The first question to ask is when and why did politics take on board the promotion and protection of individual health as a central objective. The *Beveridge Report (Social Insurance and Allied Services*, 1942), the official debut of the European Welfare State, is a crucial starting point. Since then, the concept of social security has been progressively taken over by the social policies of other countries and the National Health Service model implemented in 1948 in Great Britain has become one of the major instruments of intervention.

A second essential step in the international diffusion of this approach was the creation in 1946 of the World Health Organisation (WHO), whose definition of health remains

important today: health is considered as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'. At the international level, the right to health was the first to be institutionalised at the WHO, coming into force in April 1948 even before the proclamation of the *Universal Declaration of Human Rights* (the following December).

The establishment of a right to physical and mental, individual and collective health arose from requests for social, political and cultural change in the aftermath of the Second World War, in a new international context characterised by peace, demands for redistribution and the emergence of the Welfare State. In a number of countries, this concept of health influenced a new organisation of society and generated new relationships between citizens and institutions. In the following paragraphs, we shall see the importance of this vision in the development of health policies in Italy.

The responsibility of politics in matters pertaining to healthy living

The 'Beveridge model' represented an important step in the development of a universal right to a healthy life as an objective of new public policies. The well-known plan to reorganise the British social security system was presented to parliament in 1942 by a commission chaired by the Liberal William Beveridge. Shortly after, it was adopted as part of the social legislation of the Labour governments of 1945–1951. The war was seen by Beveridge as an opportunity from which a more just social order could emerge (Beveridge 1942, 171). The new British order would therefore develop through the sense of common sacrifice that was shared during the war, which had generated a general sense of solidarity. As after the First World War, people perceived that the social debt that accumulated during the war had to be honoured by institutionalising the concept of 'equality-redistribution' (Rosanvallon 2013, 201, 342).

War and the Welfare State had important connections (Obinger, Petersen and Starke 2018), both structurally, due to increased state intervention, and symbolically. The war reinforced feelings of national unity and strengthened the legitimacy of a government that could actively control the health and welfare of its citizens. It was possible to win the war if it appeared as an opportunity whereby the old world of injustice would be replaced by a new order that could guarantee 'freedom from want' (Costa 2001, 430).

The outstanding characteristic of the Beveridge Report was that it envisaged the provision of a social security system that could guarantee social protection for all citizens. This meant the organisation of an extensive healthcare system that would provide all citizens with a complete range of medical and hospital services, including dental and eye care. It foresaw extensive social insurance; a universal welfare system; and a minimum income to ensure the survival of individuals regardless of their employment status.

From an operational point of view, the change came in the form of the policies introduced by the Labour governments led by Clement Attlee, which were based on a universal and democratic Welfare State model. The United Kingdom managed to set up the National Health Service very quickly – the National Health Service Act of 1946 came into force on 5 July 1948 – thanks in part to the impetus of people such as the Health Minister, Aneurin Bevan. Of all the measures introduced, the establishment of the NHS represented the key reform of the time. In fact, while previously only a few million British citizens were entitled to free healthcare, the reform meant that the entire population was able to benefit from healthcare services (Rivett 1988; Cohen 2020). The NHS became a model for universal public health services in the rest of Western Europe. The success of the health reform was possible due to strong social consensus, especially among the working and middle classes, which was also promoted through a large mass media operation.

The Beveridge Report introduced a new right, the right to live in good health. This right would be guaranteed by the state, which would take charge of the health of its members. The novelty lay in the fact that for the first time states became directly involved in the relationship between health and illness, 'not for themselves' (as had been the case, for example, in fascist regimes, for the purposes of imperial and national power), but for individuals. Compared to the past, the relationship was reversed: the concept of the state at the service of the healthy individual replaced the concept of the healthy individual at the service of the state and the question of health entered 'the realm of macroeconomics'. The universal guarantee of receiving medical treatment and healthcare became part of a policy to correct income inequalities. Health, illness and the body hence began 'to have their own basis of socialisation', while at the same time becoming 'an instrument for the socialisation of individuals' (Foucault 2021, 4–6).

Politics and health in Italy at the dawn of the Republic

The Italian road to the affirmation of the right to health and the adoption of innovative health policies has been long, complex and difficult. The central issue of state intervention to guarantee the essential conditions for a life in good health emerged as early as the years of the Resistance and the Constitutional Assembly. However, the characteristics of the political and institutional set-up of the country meant it was difficult to introduce the reforms quickly. In fact, it took about 30 years before the National Health Service (SSN) was created in December 1978.

In the Resistance, the foundations were laid for a new society together with a new legal and institutional order. A 'process of cultural maturation' was set up based on the links between environment and health, the active role of citizens, and on the decentralisation of health organisation (Berlinguer 1991, 191). In particular, the Veneto Health Council, an organ of the National Liberation Committee of the Veneto Region, drew up an initial *Project to reform the Italian health system*, which was signed by the hygienist Augusto Giovanardi (1945). The project contained the first formulation of a radical reform of the health and welfare system (Giorgi and Pavan 2021, 239 ff).

Shortly after came the important drafting of Article 32 of the Constitution, which provided a definition of the right to health that was extremely advanced in Western Europe. In the Constitution, health came to be considered as the only universal fundamental social right.[1] The Italian Constitution was the only one in postwar Western Europe that regarded the interests connected to citizens' health as 'a complete discipline' (Mortati 1961, 1). The right to health combined both *positive claims*, by providing individuals with the right to demand goods and services from the Republic that protect health, and *negative claims* of individuals regarding detrimental behaviour that may damage their psycho-physical integrity and individual treatments which are not required by the interests of the community. In this regard, the Constitution outlined another essential aspect of the right to health, namely the freedom of therapeutic choice, included in Article 32, which refers to the right to individual self-determination.

The physical and mental integrity of the human person, both from an individual and social point of view, was also considered a right according to the aforementioned definition provided by the WHO. Thus, two profiles emerged: the public commitment to the creation of health facilities of a universal nature and, at the same time, the message that the state and its institutions should be required to provide free healthcare to the poor, i.e. those considered to be particularly in need of protection due to their economic and social condition. This principle of substantial equality is outlined in Article 3 of the Constitution.

The right to healthcare came to be considered as a right to receive positive benefits from the public authorities, which encompassed the widest range of activities (preventive,

curative, rehabilitation, healthcare and hospital care) and outlined what was achieved through the late establishment of the SSN. Finally, another important aspect regarded the connection established, especially from the 1960s and 1970s onwards, between the constitutional protection of health and the environment. In fact, there was an increased awareness concerning the link between the health of individuals and the state of the environment.

Despite these advanced elaborations, until the late 1970s, Italy maintained the mutual-assistance system inherited from Fascism, which was characterised by a contributory and occupational system. In the field of healthcare, Fascist policies had been characterised by strong fragmentation and centralisation, with the erosion of the powers attributed to the municipalities in the liberal period (Taroni 2022, 109) and under the banner of the interclass collaboration proclaimed in the 1927 Labour Charter, of which the mutual sickness funds then created had been essential instruments. The latter developed chaotically and were characterised by a lack of homogeneity in terms of benefits and contributions and by a differentiation of interventions and treatments. The organisational paradigm of public health during the 20 years of the Fascist period maintained an anachronistic policy vision, which excluded the main hygienic-sanitary issues and the necessary structural interventions required concerning the social causes that were at the root of some very widespread diseases, such as tuberculosis (Preti 1987, 2002). In this field, as was the case in the rest of social policy, corporatist and repressive criteria prevailed. The regime's interventions in the field of health were characterised by an approach based on the insurance paradigm, which was decidedly different from the concept of rights and citizenship, and which meant there were major inadequacies and distortions in the health care system as a whole.

At the dawn of the Republic, the Italian health care system was characterised by large pension and mutual-assistance institutions designed to manage insurance against illness for various professional categories belonging to the public or private sector. Among these institutions, the most important was the INAM (the National Institute for Health Insurance). This name was adopted in 1947 and inherited from the regime, which in 1943 had founded the Fascist Mutuality Agency with the aim of merging the thousands of mutual insurance funds set up to provide health insurance for private sector workers. By the end of the 1950s, the INAM – which was run mainly by people close to the Christian Democrats and which was in difficulty due to poor financial management – assisted more than half the Italian population. It was flanked by mutual insurance funds for farmers, artisans and traders and numerous other sectoral funds. The mutual system prior to the SSN was particularly fragmented, lacked unitary guidance and coordination (Taroni 2011, 73), and provided only limited and unequal treatment. This set-up lasted for a long time, with improvements being made in the quantity and quality of healthcare, also thanks to progress in medical research (Berlinguer 1958, 40). In fact, from the early 1950s onwards, several measures, aimed to extend and improve health and welfare protection, were passed, which had been proposed by the various political parties and voted for by a large parliamentary majority. The main objectives of these laws ranged from the extension of compulsory insurance against illness to new categories of the population; to improvements in the field of occupational accidents and illnesses; to the extension of therapeutic and prophylactic measures to combat new social illnesses; to the creation of the Ministry of Health (1958). For some time, the setting up of the new ministry was considered to be of great importance because previously the Italians' health had been managed by eleven different ministries. With the new ministry, it became possible to break down the traditional authoritarian and chaotic structure of public health.

What was achieved during the five-year period 1953–1958, had important effects on the national health situation and on the inclusion of new occupational groups in health

insurance. However, many gaps and problems continued to persist in the country. These included an insurance-type approach managed by mutual-assurance institutions in serious economic difficulty; differentiation between occupational sectors; a general concept of 'uncertainty regarding the right of access to healthcare'; and the lack of an organic health reform project (Berlinguer 1958, 115). Furthermore, there was also a problem regarding the incomplete healthcare coverage for the entire population (about a quarter had no protection at all); the difficulties in eradicating a social disease such as tuberculosis; the large spread of poliomyelitis (not until 1966 and with various difficulties did this disease become the subject of compulsory vaccination). There were also high infant mortality rates, which made Italy one of the most backward countries in Western Europe,[2] and delays in dealing with the socio-behavioural causes of the new 'modern diseases', including above all cardiovascular diseases (Luzzi 2004, 55 ff). Regarding these latter diseases, together with cancer, the delays in developing a culture of prevention strongly impacted the entire course of the country's health history.

The quantitative expansion of treatments should in fact have been accompanied by a qualitative leap in healthcare intervention, which meant introducing a new way of considering the relationship between the psycho-physical health of individuals and their environment, based on a diagnosis that was not only personal but above all social, on greater public accountability, on a universal and global paradigm of health promotion, and on a new organisational form. In other words, a *health service*.

The drivers of change

The 1960s marked an important turning point in several areas and on a number of occasions the health debate opened up to new horizons. These new ideas took hold despite the resistance of centrist governments at first and the limitations of centre-left planning later, with a lack of vision of most political and health authorities. On the occasion of the general elections in the spring of 1963, the main left-wing parties (PCI and PSI) called for the establishment of a National Health Service, making it one of the key points of their election programmes. Soon afterwards, the project for an organic health reform became part of economic planning documents, an important test for the centre left. It was above all part of the *Project for an economic development programme for the five-year period, 1965–69* (the 'Giolitti Plan') and it specifically proposed the establishment of a National Health Service, which would be financed by citizens in proportion to their incomes, and managed by the state through the Ministry of Health, the regions and the local municipalities. It referred to a framework law that would regulate the entire sector, to be based on a concept of the unity and global nature of health intervention, the unification of competences and their democratic decentralisation.[3] For the health sector, the communist Giovanni Berlinguer became involved in the Giolitti Plan, and showed constant commitment to health and health policies. As early as 1963, Berlinguer drew up an initial *Outline of the National Health Plan (1964–1978)* and shortly afterwards he helped formulate an important bill presented by the PCI to the Senate in November 1965 which, although rejected, was a precursor to the health reform of 1978.[4]

In this new panorama, of equal importance were the proposals of the CGIL trade union, which as early as 1958 had called for the establishment of a national health service, in an aim to remedy the lack of 'an effective social policy and, in particular, of a modern health policy'. Faced with the prevalence of insurance principles, fragmentary measures and deep inequalities in protection between categories of workers and between different areas of the country, the establishment of a new health service became a central part of the trade union initiative (CGIL 1958, 101 ff). In the years that followed, the CGIL continued working on a new approach to health, also promoting various trade union and

scientific-cultural initiatives. The core elements of this commitment centred around the demand for a reorganisation of Italian health structures, which would satisfy the principles of social security, involve the local authorities, emphasise the connection between environmental health and work organisation, and extend health protection from the factory to society, linking prevention to participation (CGIL 1958; Quaderni di Rassegna sindacale 1971; Atti della Conferenza nazionale CGIL, CISL, UIL 1972).

Of the trade unions, the communist and socialist proposals converged in demanding a public health system that universally guaranteed free health services, and which was decentralised. Of particular importance in their programmes was the valorisation of prevention, the fight against environmental damage and harm in factories, and the establishment of a new relationship between personal conditions and socio-environmental conditions (Giorgi and Pavan 2021, 410).

Also during the 1960s, a number of investigations were organised to study health and safety conditions in the workplace, which included the work of those who refused to monetise risk and were committed to promoting the workers' right to psycho-physical integrity (hence the famous slogan 'Health cannot be sold').[5] These investigations led to a long season of activities that generated a renewed awareness of health issues, through the construction of an entirely new language that was able to combine workers' advocacy and knowledge of working conditions with that of the medical scientific community.

This increase in political and scientific initiatives dedicated to health issues in the workplace and in various territories strengthened the paradigm already present in the Constitution, reinforcing the social and political interpretation of health, *social in its genesis and political in its resolution*. Healthcare reform and the abandonment of the mutual-insurance system became a high-stake challenge, sparking strong conflicts between political forces and trade unions, doctors' associations, mutual-insurance institutions, health ministers and governments of the time. The demands for the renewal of the healthcare system involved a large part of society, with a variety of struggles carried out by progressive social movements.

The healthcare issue reflected the more general transformations that affected Italian welfare. Above all, the decade of the 1970s was important due to the approval of the largest number of reforms in the history of the Republic (Moro 2007), the design of numerous institutions and social services, and for an increasingly universal concept of welfare. The quality of conflict and planning in this decade influenced the overall organisation of society and the relations between citizens, needs, institutions and collective services. Many institutions were affected by this profound change, following 'a broad and differentiated collective mobilisation' that was characterised by different subjects and signs (Crainz 2003, 322). The trade union and workers' initiatives were a central part of the social struggles, which regarded wages and work and, in parallel, living conditions, especially health and basic services. The social movements that developed during these years also played a role. The mobilisations of the 'greatest season of collective action in the history of the Republic' (Ginsborg 1989, 404) were able to combine the construction of a broad social consensus concerning the urgent need for profound reforms in the country, a hegemonic vision of a new model of a more open, democratic and pluralist society, and the launching of new models and practices in the provision of services and social relations.

In several areas of welfare, experiments were carried out based on forms of co-production of services, which aimed to question the separation between providers and recipients, and were different from the usual bureaucratic, familistic, corporative logic. In particular, some highly original initiatives were set up in healthcare, which were very unusual in the traditional national scenario. In several contexts – in workplaces, universities, in various cultural networks, in protest movements – there was considerable

reflection on the links between science and power, with the aim of considering health in its collective dimension, and of experimenting with new and expansive social-health services. Italy was particularly active in this field due to the instances of transformation of the health paradigm aimed at changing the social relations of production and reproduction, the institutional set-up and the nodes of democratic citizenship.

Among the most qualifying initiatives in this field, it is worth mentioning the birth of 'Medicina democratica, movimento di lotta per la salute' (1976) of which Giulio A. Maccacaro was the main protagonist. In fact, he was responsible for innovating the links between medicine, science and politics, and a new approach to medicine which was open to social concerns, and he also showed a constant commitment to the issues of participation and the development of forms of direct democracy in the social and health fields.

The initiatives of that time concerning the urgent need to reformulate the relationship between health, politics and society regarded health in a collective dimension, as a condition of the individual, and made it one of the core issues of new political practices, which could involve the entire sphere of production, going beyond the factory floor to encompass every social sphere. The health field thus became a testing ground for processes of subjectivation linked with the mechanisms of social control present in the statute of medicine itself and with the resistance that was taking shape in this field.

Central to this was the critique of a medicalisation of social malaise that came from the attempts at control aimed at 'reducing a relational, i.e. structural, problem to the illness of the individual', preventing the emergence of a (class) consciousness of the problem and bringing it back to the terrain of personalised medicalisation (Maccacaro 1979, 461 ff). The position was the same one suggested in the same period by Michel Foucault: 'today, medicine is endowed with authoritarian power', which centred on normalising functions that went far beyond the existence of illnesses and the needs of the patient (Foucault 2021, 17). The demands of the health movements of the 1970s centred on a number of key objectives. They aimed not to separate social and health issues; they pursued a radical change in the training of health personnel; they put prevention first, giving priority to basic and community medicine. The strategy was to localise services and encourage shared health education, at the service of the population. The struggles for the reappropriation of health aspired to forms of direct democracy in the social-health field, to combating the concept of health as a form of profit, and to achieving de-hospitalisation, including the closure of psychiatric hospitals (Maccacaro 1979, 461 ff). They valorised a concept of the self-management of health, which meant the reaffirmation of different subjectivities and the recognition of what had been taught by the workers' movement and the struggles of the feminist movements, whose contribution including in terms of contraceptive practices played a fundamental role. Without falling into a sterile contraposition between medicine and anti-medicine, they rejected the repressive use of medicine, the interpretation of social hardship as deviance to be marginalised, any conditioning of women's freedom in terms of their health and life choices, and their self-determination.

The ideas of *Medicina democratica* had many things in common with other initiatives of the time, especially those concerning *Psichiatria democratica* (1973),[6] and Franco Basaglia and Franca Ongaro. These included new lines of research and a renewed political and social interpretation of health and healthcare.

Health, considered as an aspect of life and the care for people, of an approach to care that took on the peculiar meaning of *taking care* as opposed to the therapeutic medicalisation of society, became the terrain of new alliances and mobilisations. It became the terrain of a new culture of public services for people. The contribution made by women was fundamental in this process, as they played a leading role in the development

of these services and in 'defining services as a right' (Saraceno 1998, 221). The women's movement was essential to the growing awareness in the field of health and in social reproduction. Of particular importance was the law, No. 405 of 1975, which foresaw the setting up of family planning centres – defined as 'family and maternity assistance services' – which were entrusted to the regions and shortly afterwards integrated into the SSN. The compromise underlying this law, evident in the name itself that betrayed a family-oriented approach, did not change its universalist approach, as a free service for the general wellbeing of people, and as an institution capable of responding to the most advanced demands of women in those years. This law institutionalised a series of activities from within the feminist movement, including instances of freedom and self-determination, which had already been adopted by the organisational models of some regions.

The numerous publishing initiatives of these years were also significant. These included the series *Medicina e potere* published for Feltrinelli and edited by Maccacaro, the new series he inaugurated of the journal *Sapere*, and the launch of the journal *Epidemiologia e Prevenzione.*[7] In a synergy of initiatives, the country, after various vicissitudes, political clashes and institutional stalemates, eventually approved Law No. 833/1978, which established the SSN.

In the complex design of healthcare reform (see Giorgi and Pavan 2021, 439 ff), the salient features included the conceptualisation of health as a social and political issue; the centrality of prevention; the preference for a peripheral, decentralised and territorial organisation; the initiation of participatory management; and the new relationship between patient and doctor and more generally between health worker and citizen.

The birth of the National Health Service

On 23 December 1978, during the fourth Andreotti government, which was characterised by a DC coalition with the external support of the PCI, the law establishing the National Health Service was approved. It was voted for by a very large majority, with the Italian Republican Party (PRI) abstaining and the Italian Liberal Party (PLI) and Italian Social Movement (MSI) voting against. This was a dramatic year for Italy, as it was the precursor of three fundamental reforms in the field of health: the health reform, the psychiatric assistance reform (Law No. 180), and the voluntary interruption of pregnancy (Law No. 194).[8]

The development of the SSN represented the expression of wide-ranging transformative aspirations of the social fabric and institutions, of an unprecedented pressure from below, of new political and participatory practices, and of a far-reaching intellectual ferment (Vicarelli 1997; Taroni 2011; Luzzi 2004). These, therefore, were the peculiar 'political' origins of the universal, public and decentralised structure of the national health service, which responded to a unitary vision of the physical, mental, individual and collective nature of health. It was characterised by an integrated approach to health and social intervention, by the centrality of the epidemiological approach, by territorial organisation, and by an approach able to address issues related to working conditions and environmental protection.

The vicissitudes that led to the health reform were the result of a particular synergy created between the political proposals of reform, workers' and trade unions' successes in the factories, the requests expressed by the various mobilisations of the time (students, workers and feminist movements), and the health policy experimentation in some regions made possible by the institution of regional authorities[9].

The conception and birth of the SSN was characterised by a particular combined action resulting from pressure coming from society, from an unprecedented policy of alliances, from the renewal of the institutional system, and from the position of the trade union

movement and left-wing parties. The very concept of a territorial social service that emerged at that time was evident in the manifestation of a demand for collective services, which was decentralised and offered equally to all, as opposed to the particularistic and monetary logic that had been in force until then.

The realisation of the National Health Service, like other *welfare* institutions in the 1970s, can be traced back to the historical moment regarding the introduction of many of the reforms that contributed to the implementation of certain constitutional principles that had long remained frozen. It is in this light that it is possible to understand a specific characteristic of the Italian situation – in other words, the fact that an expansive reform of healthcare was achieved when, at the international level, this very area had become the target of policies to contain public and social spending.

But it is precisely this sort of mismatch of national realities that confirms the importance of the Italian experience of the 1960s and in particular the 1970s and the political and cultural convergence that took place in this historical period around the project to reformulate the healthcare system in universal terms (Vicarelli 1997, 584). Law No. 833 contained 83 articles, of which we will recall the most significant ones. Article 1 referred to Article 32 of the Constitution and stated that the SSN was the

> set up of functions, structures, services and activities, whose activities would promote, maintain and recuperate the physical and mental health of the entire population with no form of distinction between individual or social conditions and in a manner that would ensure the equality of citizens with respect to the service.

The state, regional and local authorities were the subjects of reference for the implementation of the SSN, while guaranteeing citizens' participation. Article 2 outlined the objectives of the new service, including overcoming territorial imbalances; job security; the protection of mental health; and the elimination of the causes of air, water and soil pollution.

The law also set out the functions and structures of the National Health Service, assigning to the state the direction of health policy through the National Health Plan; to the regions the tasks of integration, planning and coordination of health, hospital and territorial interventions in matters pertaining to public health, including through legislation; and to the municipalities the direct responsibility for the management of the USLs (Local Health Units). These were responsible for the unitary management of health, across the entire national territory, and they represented the main organ of democratic and popular participation. The SSN was to be financed by the National Health Fund, with a sum established each year when the state budget was drawn up, which was to be distributed among the regions taking into account the indications laid out in the national and regional health plans, and on the basis of indices and standards that were intended to guarantee uniform levels of health services throughout the entire country.

An important point of the reform concerned a form of planning conceived on two levels: the National Health Plan and the various Regional Health Plans, with the former directing the latter on a three-year basis and the latter acting as a constraint on the municipal management of the USLs. A connection, therefore, was foreseen between regional planning and a National Health Plan, which aimed to guarantee equal and uniform services throughout the territory. With the SSN, mutualist fragmentation was overcome, the principle of universality and equality of citizens in access to services was affirmed, and the democratic character of the new system was established.

In short, the inspiration leading to the setting up of the health service was: universality, comprehensiveness of healthcare and homogeneity of coverage, equity of access, territorial uniformity, and unity of the system. Its main points included the global nature of

interventions; their planning in connection with economic and territorial plans, linked to social healthcare; the centrality of the role of the state; the territorial decentralisation of the new service; the guarantee of a uniform right to health throughout the nation; financing through general taxation; the democratic participation of social forces, operators, and users in the determination and management of services.

At the international level, 1978 also marked a defining phase in the new approach to health. Global health policies were in fact defined innovatively at the Alma Ata International Conference, which was promoted in September 1978 by the WHO and Unicef. Here the guidelines for health promotion and health policies in all countries were specified, with *Primary Health Care* being the pivotal concept. The essential tool to achieve the goal adopted the previous year by the WHO, 'Health for All by the Year 2000', was identified in the dissemination of primary healthcare, according to the priorities of universalism, equity, community participation and prevention. This event marked 'a radical turning point in the international strategy of the fight for health', affirming the unity of all interventions for the defence and promotion of health and not only for the treatment of ongoing diseases (Seppilli 1989, 172). For the first time, the health problems of the poorest countries were also systematically addressed, reaffirming the constituent principles of the WHO on a global scale.

The problems involved in implementing health reform

In the last two decades of the century, there was a change in the political and economic conditions that had underpinned the implementation of previous welfare reforms.[10] The room needed to continue and complete the welfare system gradually reduced, so ending the long cycle of expansion that had led to a growth in public spending levels in Italy that were comparable to other European countries (in 1981 it reached about 45 per cent of GDP, which was similar to Germany and France). The combination of activities introduced in the previous two decades, which had been fundamental in initiating the most important era of social policies, was weakening. The ability to introduce far-reaching changes was replaced by a policy of limited interventions, spending constraints became increasingly stringent, and particularistic logics prevailed once again, which weakened the more innovative measures of the 1970s and blocked the reform processes that had been started. From the 1980s onwards, public spending deficits had to be financed by issuing new public debt, which increased the national debt to 12 per cent of GDP in 1993, thus reducing any possible room for growth in social spending.

Regarding healthcare policies specifically, the implementation of the 1978 reform immediately came up against major obstacles, which were attributable to a number of factors specific to the Italian healthcare scenario (Berlinguer 1982), but also to a change in the international order. Influencing factors included the imposition of models that were contrary to the universalist principles that had led to the establishment of the SSN; a changed political order and new governments that no longer reflected the reforming majority present at the time Law no. 833 was passed; and the new push towards public expenditure containment, which led to the introduction of user co-participation in the costs of healthcare services, especially through the introduction of the payment of fees for specific services. At the same time, from the citizens' point of view, new forms of behaviour began to take shape which centred on individual lifestyles as the main way to improve well-being and health.

Therefore, in the space of only a few years, a change took place compared to the previous decade. The integrated approach to health was substituted by a prevalence of market models; the centrality of political action in the health sphere was replaced by an individualisation of the responses provided; the valorisation of prevention and the

focus on the social and environmental determinants of health were superseded by a selective and biomedical paradigm of health, centred on an individual approach to illness.

There were a number of other obstacles during the implementation of the healthcare reform. These included, in particular, the very late approval of the National Health Plan scheduled for 1979 and which finally took place in 1994, with the consequent lack of coordination between national policy and regional interventions; a serious delay in the total financing of the SSN through general taxation and the persistence of contributory mechanisms; and the start of a managerial approach in healthcare organisation. It was in this context that new political ideas aimed at 'counter-reforming' the healthcare system developed. The setting up of private activities was accompanied by the intolerance by those at a social level (the 'middle and upper middle classes') and at a governmental level – the new *Pentapartito* (five-party coalition governments between 1981 and 1991) – who hoped for a downsizing of the public service (Vicarelli 2011, 83).

During the 1980s, there were some attempts to revise the National Health Service, but no significant results were achieved and the Treasury's choices regarding funding played a decisive role. The role of politics weakened and there was an inability to identify strategies and priorities, with the parties exercising an improper influence on the functioning of the system and cases of illicit behaviour and corruption became more widespread (Ferrera 1996, Maino 2001).[11]

During the economic crisis of 1992, Health Minister Francesco De Lorenzo decided to change the 1978 reform. This took place as part of the overall financial manoeuvre launched by the Amato government following the devaluation of the lira (September 1992), which aimed to adopt a series of exceptional measures amounting to 93,000 billion lire (approximately 6 per cent of GDP).

Public health expenditure dropped sharply, the cuts made in the 1993 budget amounting to 7,000 billion lire. In this way, the upward trend registered between 1981 and 1992, with a growth from 5.3 per cent to over 6 per cent of GDP, came to an end. The Legislative Decree No. 502 of 30 December 1992 introduced major changes in the principles, structure and functioning of the SSN, inthree directions: corporatisation, regionalisation of the service, and privatisation of activities.

Corporatisation transformed USLs from organisations run by municipalities into public companies controlled by regions (ASLs), run according to managerial principles. This approach followed in the wake of the international diffusion of the models of the *New Public Management*, and could count on a legitimisation deriving from the generalised discontent with unfair and widespread local healthcare mismanagement. It also paved the way for the separation between purchasers and producers of health services; the *purchaser provider split* was introduced in the same period in the British health service through the policies of Margaret Thatcher.

The *regionalisation* of the system was justified according to the principles of federalism, but the effect was to tighten the budgetary constraints of the regions in matters pertaining to healthcare spending. While the regions had broader competences over the organisation and operation of services, they were burdened with the responsibility for coping with any excess spending that went beyond the budget established by the state. And through *privatisation,* the regions could arrange the voluntary exit of part of their citizens from the SSN to 'professional, company, voluntary mutual or private insurance companies' (Taroni 2011a, 252).

While the danger regarding the privatisation of financing was largely averted by the measures introduced by the new health minister Maria Pia Garavaglia (who succeeded De Lorenzo, who was caught up in 'Tangentopoli', 1993), it remained, however, an ever re-emerging temptation. It was above all the regionalisation of the system, the corporatisation of its management and the context of financial restriction of this decade that led

to the introduction of significant changes compared to the health service devised in the 1970s. Nevertheless, the last health reform of the century, launched by Rosy Bindi (Legislative Decree No. 229/1999), marked a discontinuity with the 1992 legislation and attempted to return to some of the qualifying elements of the SSN at the time of its conception.

During the 1990s, when the levels of healthcare were changing from rights to objectives depending on financial availability and budgetary constraints (Taroni 2011b, 61), the relations between the state, the regions and health agencies became a problem, aggravating the already evident territorial disparities in the organisation and functioning of the regional health services and accentuating the problems linked to the progressive dissociation between national and regional policies. The problem was linked to a number of factors: the 'discrepancy' already present in Law No. 833 regarding the centralisation of revenue and the decentralisation of expenditure (Dirindin 1996, 55); the emergence of a gap between the expansion undertaken early on by the regions and the rigid policies of public and social spending containment that had taken over; the progressive loss of a proactive function on the part of the regions, which had in the 1970s been laboratories of innovative and democratic models; and the late approval of the National Health Plan, with the consequent lack of national guidelines. Moreover in this decade the municipalities saw their role reduced under the pressure of regional neo-centralism and the power of larger ASLs (Taroni and Giorgi 2020, 63).

Health during neo-liberalism

Also on the international front, from the 1980s onwards, there were major changes in the configuration assumed by the Welfare State of the 'Beveridge model'. After the national and international economic crisis of the 1970s, capitalism started to be characterised by neo-liberal reorganisation through the expansion of finance, a reduction in the social intervention of the state, a reconfiguration with respect to the market, and the initiation of privatisation processes.

Margaret Thatcher's victory in the UK general election of 1979, followed shortly afterwards by Ronald Reagan in the US in 1980, opened up a new phase: welfare was reduced and redefined, with social rights being less protected and the concept of financial profit being introduced into public services. The agenda of social reform was altered, processes of welfare reformulation emerged and there was an increase in the role of private organisations and market actors, decidedly different from the universalist and public paradigm that prevailed during the 1960s and 1970s. This represented a reversal of the trend that had developed in the 30 years following the Second World War. The welfare systems of Western countries began to experience the problem of scarcer resources, to suffer the constraints of compatibility of public accounts, and a consensus grew around the economic unsustainability of welfare policies. From that moment on, activities such as healthcare, and assistance for the most vulnerable, were increasingly provided in the form of goods purchased on the market rather than rights guaranteed by the Welfare State, and so the 'great reversal' of equality principles and practices took place (Rosanvallon 2013, 244).

In this scenario and for the whole of the following decade, the health sector represented a privileged field of application of new welfare policies adopted by several Western governments, whose aim was downsizing or recalibration.[12] Under the impetus of a growing concern regarding the impact of expenditure on the GDP (caused above all by the ageing of the population and increases in social needs), several countries planned or adopted measures which aimed to increase the influence 'of market mechanisms in the sphere of public interventions of production, financing and regulation of the

health sector' (Balassone and Franco 1995, 117). As regards the organisation of the health services, the paradigm that had presided over the construction of the postwar healthcare system was questioned and new models of administration and governance were introduced. The state-administered health organisations in particular were blamed not only for overspending, but also for being highly bureaucratic and inefficient (Maciocco 1998, 209). A selective approach was adopted, which centred on the privatisation of health services, on the *outsourcing* of public services, on the promotion of insurance systems, and on the strengthening of market logic, which was becoming increasingly more widespread in healthcare activities.[13]

The objective of ensuring access to health services for ever larger sections of the population shifted towards the idea of controlling excesses in social consumption and public spending. In many countries, strict budgetary policies were imposed, which included measures to control the supply and cost of services. In several countries, these developments provoked an increase in inequalities in healthcare, a reduction in public health expenditure (with serious consequences for the number and working conditions of health personnel), an increase in forms of co-participation by citizens regarding the cost of services (*out-of-pocket* expenditure), and a loss of capacity in the planning of social and health services.

At the international level, the WHO's policies also suffered more setbacks. The very role of the WHO was scaled down due to the emerging prominence in the health sphere of the World Bank, the International Monetary Fund and the World Trade Organisation, which gave more importance to economic considerations and market logic, so paving the way for the influence on health policies of private actors such as large pharmaceutical companies and international foundations (Dentico and Missoni 2021).

The poorest countries, in particular, saw the imposition of a single-disease-focused model of intervention dictated by the agendas of financiers, which differed greatly from the previous global and universal approach and from the comprehensive Primary Health Care established in the 1970s.

What was removed was an approach to health that coordinated the health sector with other social aspects considered essential for human well-being. In parallel, the market and competition became 'the dominant thinking behind health policy' (Dirindin and Caruso 2019, 106). In important areas of global health policies – including those concerning drugs and vaccines – global public-private partnerships (PPPs) took on a decisive role in the funding and implementation of interventions, following principles of profit.

Although these represent the main forms of transformation of health policies – national and international – under the banner of neo-liberalism, there have, however, been important specific changes in individual countries worthy of mention. In Italy, while on the one hand the importance of the SSN and the public approach has remained, on the other, there has been an increasing extension of private healthcare, fragmentation at regional level and an increase in inequalities in service levels (Giorgi 2022a, 2022b).

Conclusion

The responsibility of politics for a healthy life for citizens represents a key issue when we place the history of Italian healthcare in its international context. Following the end of the Second World War, the country's political and institutional set-up met serious difficulties in introducing a radical health reform, which was made possible instead by the social mobilisation of the 1960s and 1970s. The delayed introduction of the reform in 1978 led to an overlap between the difficulties in its implementation and the newly emerged context of neoliberal policies that brought limitations on healthcare spending and privatisation of services, calling into question the principles that had originally inspired the creation of the SSN.

This persistent contradiction became visible also when the Covid-19 pandemic hit the country, earlier than other European countries. On the one hand, the effects of the pandemic were aggravated by the downsizing of public healthcare, the weakening of territorial medicine and of epidemiological prevention services, staff cuts, the expansion of private healthcare, and the territorial and social inequalities in access to services[14] (Ufficio Parlamentare di Bilancio [Parliamentary Budget Office] 2019). On the other hand, the pandemic has highlighted the importance of the national health service, which has been a fundamental means available to the community to cope with the emergency and to protect the right to health (Geddes da Filicaia 2020, 2022). The result is that Italy's health is characterised by an excellent position in terms of mortality and life expectancy at birth (in 2018, 83 years compared to an EU average of 80.9) while, at the same time, it has a level of healthcare spending, both per capita and as a percentage of GDP, that is markedly lower than in the major European countries with a similar life expectancy.[15]

In this context we have to stress the continuing importance of the fundamental principles of the SSN, considering health and healthcare 'first and foremost a political fact', viewing health not as a mere absence of disease in individuals, in a clinical and therapeutic perspective, but as the primary object of public health policies, with their social, environmental and cultural contexts (Cosmacini 2005, 561; Marmot 2019).

The lesson to be learnt from the past is that the resilience and improvement of public health services depend above all on the political choices that will be made at national, European and international level; on the planning of services and their territorial decentralisation; on the refinancing of health and social spending; and on the integration between health, social care and broader welfare policies (Vineis and Dirindin 2004; Dirindin 2018, 2022).

Translated by Michael Gerard Kenyon

Acknowledgments. The author wishes to thank the editors and referees for their interest and comments.

Competing interests. the author declares none.

Notes

1. For legal-constitutional information, see Luciani 1980; Pezzini 1983; Tripodina 2008.
2. See Berlinguer and Terranova 1972.
3. 'Economic development programme for the five-year period 1965–69'. Regarding the Giolitti Plan and social security issues see Giorgi and Pavan 2021, 336 ff.
4. The PCI's bill was entitled *Implementation of Article 32 of the Constitution and Establishment of the National Health Service*. See Berlinguer 1964.
5. See Giorgi and Pavan 2021, 407 ff; Righi 1992; Berlinguer 1969.
6. On this subject, see Foot 2018; Valeriano 2022.
7. Regarding Maccacaro, see Clementi 1997; Ferrara 2010; Ribatti 2021.
8. For an overview, see Rufo 2020.
9. For an in-depth analysis of regional protagonism in the field of healthcare, see Taroni 2015.
10. For a historical overview see Ginsborg 1989; Gentiloni Silveri 2019; Colarizi, Giovagnoli and Pombeni 2014.
11. Regarding the 'allotment' and 'partitioning' of USLs, which have been very frequent in recent years, see Ferrera and Zincone 1986; Lanaro 1992; Cosmacini 2005.
12. For more details, see Pierson 2001; Saraceno 2019.
13. For details regarding the effects of neoliberal policies on health and healthcare, see Dentico and Missoni 2021; Rajan 2017; Maciocco 2009: for the British case Pollock 2005.
14. Regarding the more recent persistence of interregional gaps, see Pavolini 2012, and more generally, in relation to social inequalities, Costa, Spadea and Cardano 2004; Viesti 2021.
15. Istat 2020.

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Italian summary

Questo articolo analizza la traiettoria italiana delle politiche per la salute del secondo dopoguerra. Poco dopo l'affermazione del 'modello Beveridge' e la creazione del National Health Service britannico, anche in Italia si posero le basi per un nuovo approccio alla salute che trovò fondamento nella Costituzione. Tuttavia le resistenze degli assetti politici e istituzionali del paese tardarono la realizzazione delle riforme necessarie. L'introduzione di una radicale riforma sanitaria avvenuta nel 1978 fu resa possibile grazie alla pressione dei conflitti sociali e a quelle del movimento sindacale e dei partiti della sinistra negli anni Sessanta e soprattutto Settanta. La realizzazione del Servizio Sanitario Nazionale ha incontrato numerosi ostacoli riconducibili alla specifica realtà italiana, ma anche legati a un mutato assetto internazionale. Le politiche neoliberali affermatesi a partire dagli anni Ottanta hanno introdotto limitazioni alla spesa sanitaria, privatizzazione dei servizi, un nuovo approccio selettivo alla salute. Nonostante i limiti e le contraddizioni, la sanità italiana ha registrato un importante successo, con un'alta speranza di vita alla nascita, tra le più lunghe in Europa. Il recente dibattito – e l'esperienza della pandemia – suggeriscono l'attualità di un servizio sanitario pubblico, universale ed egualitario, frutto dell'impegno politico volto a tutelare e promuovere la salute.

Cite this article: Giorgi C (2022). A history of Italy's health policy from the Republic to the new century. *Modern Italy* 1–17. https://doi.org/10.1017/mit.2022.50