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The partitocracy of health

Towards a new welfare politics in Italy?

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I. Healthcare, political logic and party government

Healthcare is undoubtedly one of the most delicate areas of state intervention: what governments do or do not do directly, and almost literally, affects the chances of life of their citizens. The very complex nature of the production and distribution of health services tends to give a primary role to players with a professional and technical background (doctors, researchers, administrators), in this area of policy: here, much more so than in other areas, knowledge (specific and general, medical and managerial) greatly influences the processes by which decisions are reached and their contents. The great visibility and high impact of these decisions, as well as a strong government involvement in regulating the most important aspects of healthcare (access, funding, organisation of services, etc.) nevertheless means that the specific preferences of political players - above all political parties - retain their own importance.

Despite the recent growth of a fruitful field of comparative research on healthcare policy, the relationship between the former and political parties still remains largely unexplored. [1] True, the literature has highlighted the links between ideological and programmatic positions of the various political families and the features of the healthcare systems which they have helped to build over time. But the direct link between political competition (especially party competition) and healthcare decisions has not been analysed systematically. Yet the hypothesis that this competition has had some impact, i.e. that there has been some "political exploitation" of healthcare by parties, with tangible effects on the content and results of public policy, appears to be highly plausible and, at least for political scientists, is certainly worth serious consideration.

Italy offers more than its fair share of material for the purposes of such research. The healthcare scandals of the early 1990s (the *malasanita* - or evil health care - as these scandal are known in Italy) have revealed practices of political manipulation of incredible levels of sophistication (and cynicism). Furthermore, these practices were just the climax of decades of use of the healthcare resource by Italian political parties for the purposes of obtaining consensus. Reconstructing this history would, therefore, appear to provide interesting material to enrich the comparative theory on the determinants of healthcare policy.

1 For a critical survey of these studies, see Immergut, 1992, chap. 1.

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Besides, such a reconstruction could probably also lead to equally interesting indications for the current debate regarding the crisis of the so-called 'partitocrazia' (partitocracy). The healthcare scandals not only testify to the existence of massive exploitation of this sector by the parties but also - and perhaps above all - its spectacular failure both in terms of results and as a way of gathering consensus. The metaphor of a "giant with a clay foot" has been recently proposed as promising interpretative tool for understanding the ascent and - especially - the demise of Italy's partitocratic government (Cotta and Isernia, 1996). This metaphor appears to be highly suited to interpreting the relationship between the political parties and the healthcare system in Italy from the post-war period to the present, and to assess to what extent the dynamics of the national healthcare system contributed to the fall of the partitocratic giant. In the paragraphs that follow I, therefore, propose a re-reading of the events within healthcare policy over the last forty years, emphasising the rise and decline of Italian-style party government in this sphere, and showing how the rise was intimately linked with the decline.

II. From insurance funds to a National Health Service

The political exploitation of healthcare began in the 1950s by the DC, was perfected by the governments of the centre-left during the 1960s and reached its climax in the 1970s and into the 1980s, with the involvement of the PCI and the extension of the spoils system from national level to sub-national level (regions and local health units). The healthcare system generated political resources for the parties mainly through four channels.

The first (in chronological terms, as well) was the selective extension of healthcare rights to the various social groups. At the end of the Second World War, only employees (manual workers and white collar workers) were entitled compulsory healthcare insurance. In the 1950s and 1960s the right to free treatment was gradually extended to new sections of the working population, sometimes even including quite small groups: journalists (1951), domestic workers (1952), managers, (1953), retired state employees (1953), owner-occupier farmers, sharecroppers and tenant farmers (only those in work 1954), general compulsory pensioners (i.e. former private employees 1955) working artisans (1956), home workers (1958), fishermen (1958) working shopkeepers (1960), retired artisans (1963), traders, retired owner-occupier farmers, sharecroppers and tenant farmers as well as the unemployed (1966) and social pensioners (1972). Very often, this led to new insurance funds, with their own regulations (both in terms of contributions and provisions) and their own administrative structure. In some cases (such as the extensions to various categories of pensioners, or to the unemployed), they were true financial gifts: services for the newly insured could be paid for through greater contributions from the working and employed categories. And needless to say each of these little inclusions into the citadel of the welfare system was intelligently exploited by government parties (particularly the DC and the PSI) to retain or attract into their own electoral orbit the beneficiary groups. The political and distributive use of healthcare eligibility nevertheless had a natural limit in the universalisation of cover, which was achieved de facto at the beginning of the 1970s and formally established in 1974 (for hospital care), and in a more complete form in 1978 with the establishment of the Servizio Sanitario Nazionale (SSN - National Health Service).

The second channel that generated political resources was the distribution of economic and legal privileges to the providers of services. The most courted ca-

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tegory was undoubtedly the doctors, especially the *medici della mutua* (health insurance doctors), whose caricature in films (a mixture of incompetence and greed) is still seen today as a sort of cultural landmark of Italian society in the 1950s and 1960s. The centre and centre-left governments bought political and administrative support from these doctors by giving them large emoluments and various social guarantees (including paid leave for marriage) (Paderni, 1981). It should be noted that especially in Southern Italy, insurance doctors also acted as electoral advisors to patients (and in some cases as mediators in clientelistic voting). These clientelistic ties between parties and doctors ensured consensus, but also helped greatly to push professional standards down.

The third channel was the intense sub-governmental exploitation of the healthcare institutions. The proliferation and solidification of the insurance funds created new public (para-statal) sector jobs that the parties were able to distribute among their supporters and, most of all, to their peripheral lieutenants (with little attention to the requisites of technical expertise and, as a result, considerable negative effects on the operating efficiency of the funds) (Bonaccorsi, 1979). In the 1950s and the 1960s, the *Istituto Nazionale per l'Assicurazione contro le Malattie* (National Institute for Health Insurance or INAM) became a major stronghold of Christian Democrat sub-government (*sottogoverno*). The use of healthcare institutions as political spoils continued even after the dissolution of the funds and, indeed, intensified (as we shall see) after the 1978 reform.

Finally the construction of the *selva mutualistica* (a true forest of separate health insurance funds) created new opportunities to obtain secret funds. Culminating in 1993 with the indictment of Poggiolini (the head of the Health Ministry's pharmaceutical services, arrested on charges of corruption), the story surely began at the time of the insurance funds system - although, unfortunately, this will be difficult to document.

The clientelistic practices targeted to the various occupational categories and the shareout of posts produced a long "distributive cycle" in Italian healthcare politics, based on the proliferation of measures characterized by "concentrated benefits and diffuse costs". [2] As I mentioned above, these measures could easily be financed in a relatively painless way, due to the existence of quite generous "contributory dividends"; i.e. operating surpluses within the funds' budgets thanks to the expansion of working contributors, especially in the private employment sector. This syndrome was not exclusive to the state healthcare system. As a matter of fact it took on an even more acute form in the sector of transfer payments: entire generations of pensioners (e.g. within the self-employed) were blanketed in the new old age insurance schemes created in the 1950s and 1960s without paying any contribution at all. What, if anything, was unusual about the health insurance system, was the fact that financial difficulties came to a head much earlier than in other sectors: debt was already rising around the mid-1960s, especially in the case of hospitals. Various factors were responsible for the early onset of a financial crisis: changes in demographic and employment trends and the consequent imbalances in the actuarial equilibria of the insurance funds, rising levels of healthcare consumption by the insured population, ever rising costs of medical technology and its relative cost, particularly inefficient Italian healthcare bodies, the irrationality of some funding methods (Ferrera, 1993). There is obviously no link between some of these factors and the parties. Nevertheless, what

2 The concept of "distributive cycle" is dealt with in more detail in Ferrera, 1996a.

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is certain is that the dynamics of political exploitation of the insurance system, described above, did worsen the general situation, by generating waste and inefficiency and placing distributive interests before the requisites of good management. Typical of this was the hospital reform of 1968, which was approved shortly before the general election of that year; a vast shareout agreement between government parties, trade unions and the PCI introduced the funding of hospitals on the basis of *per diem* payments [3]: "The one minor drawback of this reform, noted Salvati (1978, p. 10) - was that hospital costs tripled in five years".

In short between the 1960s and the 1970s the healthcare sector witnessed an 'ante litteram' version of the "partitocratic giant with clay feet" syndrome. The distributive obsessions of politicians, on the one hand, and their planning and management incapabilities on the other, provoked a policy crisis of considerable proportions, especially with regard to funding. At the time of their dissolution (in 1977) the insurance funds had accumulated total debts of 6,151 billion lira (ca. 3.2% of that year's GDP): a shortfall which has rightly been considered as the main component of Italy's "original" public debt (Mapelli, 1984 and Panella, 1984). Italian-style party government was able, however, to come out of this crisis unscathed through a double operation: the extraordinary write-off of the insurance debt (which was transformed into public debt) and the approval of the health reform of 1978.

Although the first strategy ridded the party-system of the "small nuisance" of previous financial difficulties, the reform of 1978 in many ways crowned and gave new life to a long cycle of political exploitation of the healthcare system. It would be unfair to look at the establishment of the SSN as just another of the usual large shareout deals. Many players who helped to see the reform through (even from the parties) were really inspired by concerns of efficiency, justice and (to a lesser extent) of effectiveness. These goals were, however, unable to take precedence in the decision-making process and ended up being practically suffocated by the stranglehold of ideological pressures, on the one hand, and self-interest, on the other. At a political level, the reform was the result of a double compromise. A compromise of high politics, above all, preceded by an intense ideological competition, centred on general principles and normative references: State vs. Market, Public vs. Private, Democratic vs. Professional Control, Planning, Universalism, etc. (the political and cultural climate of the second half of the 1970s should be borne in mind). The emphasis on principles prevented serious debate on the methods and ways - in law no. 833/1978 - of rationally organising the infrastructure. The second compromise was purely based on a shareout deal. The parties (including the PCI) agreed to broaden the health care *party governmentness*, by creating additional important instruments of distributive government in the newly formed *Servizio Sanitario Nazionale* (National Health Service or SSN). [4] The main way was through the Management Committees, the controlling organs of the *Unita' sanitarie locali* (local health units or USL), which were politically appointed and in which the reform had concentrated all powers. It is a well-known fact that such organs were allotted immediately: and their *lottizzazione* was of-

3 The daily bill for a hospital stay invoiced by hospitals was calculated by dividing the annual operational costs by the number of stay days - a mechanism which provides no incentive to curb costs.

4 For a political and comparative analysis of the Italian healthcare reform see Freddi, 1984 and the articles by Freddi and Ferrera in Freddi, 1989.

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ten based on regional legislation which specified the percentages of members government and opposition could appoint in each single Management Committee. Research carried out on the composition of these committees gives a rather desolate picture regarding the technical expertise of the staff recruited during the first legislature (1980-1985); the majority did not even possess a higher education degree (Ferrera, 1986). It should be noted that the parties themselves had difficulties in filling all the positions allocated to them. These totalled about 11,000 posts ranging from Presidents, Vice-Presidents and ordinary members. In many cases not only did the committees contain members without any technical competence, but also persons who had poor political credentials such as candidates who had lost in administrative elections (Berlinguer, 1994). Also the trade unions supplied their own "manpower" to fill the new posts: it is important in this regard to note that throughout the 1980s the trade unions have been prominent participants of the distributive games played within the health care arena.

There has been a barrage of word written about the damage done by the spoils system for the USLs in terms of results in the last fifteen years. That experienced at the beginning of the 1980s was the last "feast" of the healthcare partitocracy - at least in terms of visible politics at national level. A few years after the write-off of the insurance debt, the issue of debts was, once again, on the agenda with growing urgency and the clay began to crumble more quickly under the heavy weight of the spoils system.

III. The 1980s and the new financial government of the healthcare sector

In the 1980s endogenous and exogenous problems surrounding the healthcare service led to a renewed worsening of the problem of (rising) costs and (falling) yields. Healthcare gradually changed from an easy spending resource into a "hot potato" for the parties, especially those in the centre. As it became impossible to pass an effective reform of the reform (which had actually been first mooted in the middle of the decade), the sector came under the "axe of the three Cs" (copayments, ceilings and cuts) (Vicarelli, 1995), wielded by the Treasury with the parties forced to go along. The reform of the reform was only passed in the autumn of 1992 by the Amato government, in the wake of an alarming currency crisis. Making costs explicit through the "three Cs" and through the new reform of 1992, nevertheless, slowly eroded the old consensus based on distributive deals and induced a polarisation of interests (social and political) which manifested itself for the first time clearly during the elections of 1994.

Let us consider the various stages of the sequence sketched out, starting with the financial problems. After the reform, Italian style party government found itself having to run a sector of vast and complex proportions, and one which was growing in economic terms, but whose ramifications as well as technical and management implications were still widely unknown. The law enacting the SSN had a system of administration based on a multi-step programming, (national economic programme, national health plan, regional plans etc.) based on "need" considerations rather than available resources. This system never got off the ground (Granaglia, 1990). The first five-party governments shifted the emphasis from needs to resources and appointed a liberal politician with a business background as head of the Health Ministry (Mr. Altissimo), in the illusion that it would be easy to curb expansionist tendencies in the sector - at least in macro-financial terms. Let us remember that at the same time inflation, debt and the deficit were spir-

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alling up, while the external constriction of Italy's membership to the European Monetary System began to have an effect. In the first two years of the SSN (which entered in full operation in 1980) there were nevertheless some worrying turbulence. In 1980 on top of a planned expenditure of 15,594 billion lira (4.6% of GDP) the government was forced to allocate another 2,000 billion in October and another 400 at year end (public health expenditure thus amounting in 1980 to 5.3% of GDP). In 1981, the gap between budgeted and actual was once again nearly 2,500 billion. The heated discussions on the *lottizzazione* of the USLs and on the confused organisation generated by the reform at the peripheral level in turn created pressures to return the management of the SSN under some form of control from the centre. The government (especially the Treasury Ministry) took cover and launched a new phase of financial administration of the sector, aimed, on the one hand, at curbing the demand for services by making users pay in part for services and secondly by making the regions and USLs accountable through the imposition of a number of aggregated ceilings of expenditure.

Copayments have been without doubt the most visible (and most unpopular) instrument of government action in the healthcare sector in the last fifteen years. Significantly, the year of change was 1983. Alarmed at the worrying excessive growth in healthcare costs (especially for medicines) in the previous two years, that year the government decided to change the copayment from a (modest) fixed fee to a percentage, making consumers pay 15% of the cost of drugs. This percentage was then raised on several occasions in later years (1986, 1988, 1989 and 1992) reaching 50% in 1995 (limited to the so-called class B set of drugs) - one of the highest copayment rates in Europe (Ferrera, 1995). The policy of copayments was not, however, limited just to the introduction of tougher measures, but also accompanied by action on three other fronts.

The first was the modulation of the taxable pharmaceutical basis, through ever more restrictive revisions of the Therapeutical Catalogue aimed at reducing the number of drugs that could be prescribed at the expense of the state. This process culminated in the reclassification of drugs into three groups: a verly limited class A of "life-saving" drugs (available with just a fixed prescription copayment); a class B of drugs obtainable with a percentage charge and a residual class C (payment of full price by the consumer).

The second line of action was the extension of the use of the copayment system first to diagnostic tests (1982) and later to specialist consultations (1986). Finally, the third line of action was the introduction of more detailed legislation on exemptions, based on therapeutic criteria (exemptions due to illness), income, family situation, and age. The copayment policy was heavily criticised for a long time as an ineffective way of bringing down prescription consumption, as having unfair distribution effects, etc. (Censis, 1988). From the point of view of governments which have pursued this policy, however, it generally achieved its aims, which were mostly financial. Pharmaceutical spending has, in fact, stabilised, copayments now represent 30% of this expenditure (compared to 10% in 1980) and the use of prescribed drugs has actually fallen (Ferrera, 1995).

The second major line of government action regarding the SSN, as mentioned before, was the introduction of ceilings on expenditure. Once the intended multi-step planning fell through, from 1983 onward the five-party governments (once again) tried to keep expansionist pressures in the sector under control by placing budgetary limits. The budget bill becomes the instrument par excellence to run the healthcare system from the centre: it is this bill that sets the global allocation for the National Health Fund (NHF) on the basis of available public funds,

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to be shared out among the regions; and it is again the budget bill that determines both the copayments and the cuts (the third C: reduction of facilities, staff, investments etc.) deemed necessary to remain in line with the ceilings. Generally under the sway of the Treasury Ministry at the centre, the policy of ceilings (and cuts) was mainly implemented by the regions. As these had little say in the fixing of ceilings, and were not bound by any fiscal accountability, they had little interest in keeping spending down, and objectively did not possess powers of control over the USLs or, above all, over the main "demand-inducers", i.e general practitioners. The regions in turn engaged in a tug of war with central government (Pistelli, 1995 and Veronesi, 1994). Throughout the decade 1984-1993 the typical sequence of events in each financial year with regard to the health service was the following: fixing of expenditure ceilings, of copayments and cuts in the autumn/winter budget; spring adjustment of the previous year's deficit; alarm in the summer due to the insufficiency of the funds allocated to the regions, consequent delays in USL payments to suppliers (such as pharmacies) and threats of insolvency, lockins etc.; agreement in September between central government and regions on further allocations; new ceilings and more severe copayments and cuts in the next budget. There has been a gradual escalation over time in this sequence of events. On the one hand, the government, under increasing pressure of budgetary restrictions (internal and external), has begun to set ceilings that are quite unrealistic; on the other hand, local health units have made very little effort to curb spending. To give but just one example, very few regions (and USLs) have introduced the systems of effective monitoring of medical prescriptions recommended by the government and clearly set out in the national agreements with doctors. This escalation of the financial stakes between centre and periphery is borne out by the growing gap between the funds budgeted ex ante for the regions and actual ex post expenditure. In percentage terms, this gap rose from 4.5% of ex ante expenditure in 1983 to 20.3% in 1990 (Veronesi, 1994).

In the second half of the 1980s, the issue of fiscal unaccountability of the regions and of the USLs became a *leitmotiv* of the debate on the reform of the reform (Balassone and Franco, 1995). The budget for 1992 attempted to modify this situation for the first time, by officially mooting the transfer of direct responsibility for the financing of health services to the regions. The actual transfer from the centre to the regions of the responsibility for balanced budgets in the SSN was decided by the Amato government only in the autumn of 1992 (even though, as we shall see, it is still to be actually implemented).

Although less visible to the eyes of the general public, the policy of ceilings (and cuts) has also come in for a good deal of criticism for both technical and political reasons: it is said to have had generally negative effects on the technical efficiency of the sector as well as the non-clinical quality of services (France, 1995). Once again, from the point of view of the successive governments applying the policy, however, it has resulted in some quite remarkable changes. It is true that budget allocations to the SSN have constantly risen (social contributions now cover just 50% of the expenditure), and that the gap between budgeted and actual costs has grown. Nevertheless, in percentage terms of GDP, public expenditure on healthcare did not rise much between 1980 and 1992 (from 5.3 to 6.5%) and remains at values that are fully in line with (if not lower than) those of other European countries (OECD 1994).

It should, however, be noted that there is a big mortgage to be paid for this apparent success: the huge hidden accumulated debt of the USLs towards their creditors over time, as a result of operations "off the books" (Veronesi, 1994). Tolerated (and sometimes even directly encouraged) by the regions and already

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partly written off by lenient governments, this debt has been the hidden cost of the policy of ceilings and cuts. Estimated at twenty billion lire in 1995 (ca. 1.2% of GDP), this debt is a real Sword of Damocles hanging over the still precarious conditions of Italy's public finance system - a new "hot potato" which the First Republic is sadly about to bequeath to the Second Republic.

IV. The reactions of parties at national, sub-national, visible and invisible levels

The institutional re-organisation brought about by the reform and cost containment pressures at the macro level re-structured party interests in the health-care sector during the 1980s. This re-structuration has been somewhat complex. To fully understand its various forms it is useful to distinguish between national and sub-national levels, on the one hand, and between visible and invisible politics, on the other.

At the national level, the opportunities to exploit the SSN directly became increasingly scarce. The only measures that made sense were the "3 Cs", i.e. those which placed sacrifices on users, producers/suppliers, on regional and local politicians and local administrators. The initiative to work out and introduce such measures was willingly left to "technical" Ministers and to the Cabinet which acted in union with senior levels of the civil service (Court of Accounts, Bank of Italy, Central Service for Health Planning etc.). The parties have kept their distance from cabinet actions: events in the health care system confirm that the functional needs of policy management (in a restrictive sense), which came to the fore in the 1980s, contributed to the institutionalisation of the executive and its independence from the party system. This withdrawal of the parties from the executive sphere has nevertheless been accompanied by the their mobilisation - at national level - in two directions. Firstly, in blame avoidance so as to prevent erosion of support from the categories that were hit by government measures. Secondly, in cross-vetoing all proposals aimed at structural change.

Avoiding blame (and consequently punishment from the electorate) is a primary objective of all political players in general. However, it becomes the primary objective when politics turns into a negative sum game, where only losses are being distributed. The comparative literature has identified many possible strategies of blame avoidance (Weaver, 1986; Pierson and Weaver, 1993). Italian parties in the 1980s adopted, above all, two strategies: "passing the buck" and "finding a scapegoat". As noted above, the introduction of unpopular measures was left to the cabinet, while the parties played off the political responsibility for them against each other, often assigning the "blame" to the regions or the European Community and its pressures for austerity. In some cases, this gave rise to a sort of "jumping on the bandwagon", but in reverse - with parties outbidding each other in proposing attenuations of the "3 Cs".

The strategy of avoidance was particularly cautious when it came to co-payments, the most visible and unpopular measure in the eyes of the mass electorate. Here the syndrome of blame avoidance worked more or less as follows. The government proposed the introduction, extension, and/or higher levels of co-payment (and perhaps passed a decree to this effect). The opposition parties and trade unions protested strongly and, in some cases, took their protests to the streets. The five parties of the majority thus began a sort of 'reverse auction', proposing concessions, new exemptions etc. in parliament. In 1986, for example, charges on medicines were raised from 15% to 25% and then brought back down

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to 15%. In some cases, the 'reverse auction' (sparked off also by Communist intransigence and social protest) even led to the abrogation of the measure. Once again, in 1986, the attempt to increase the copayment on diagnostic tests to 25% raised such protests that in the end the five-party government decided to eliminate it completely. The same thing happened to the attempt to introduce a copayment of ten thousand lire a day (ca. five ECUs) on hospital stays, proposed by the government in 1989 (and practised in many other countries). The left-wing opposition organised a general strike, the government parties initially proposed a series of ceilings and exemptions and then gave up the idea. In the case of the "doctor tax" introduced in 1992 (eighty-five thousand lire a year - ca. 42 ECUs - to retain free access to general practicioner consultations), the parties agreed to the introduction of the measure, but later withdrew support from government and from administrative attempts to verify payment, following an almost mass evasion.

The second direction that mobilisation took was the issue of the reform of the reform. Discredited by the furore at the unfettered division of the USLs spoils at the beginning of the 1980s, the parties realised that they had to loosen their control over health (at least at the visible level): as noted previously, the debate on the de-politicisation of the USLs and the professionalizaton of medical staff and managerial competence had already begun in the mid-1980s. In actual fact, however, the parties vetoed the reform of the reform (especially on the revised USLs) and it appeared that approval would be postponed sine die. It was only the financial crisis of 1992 (and the beginning of 'Tangentopoli') which finally opened a window of political opportunity so that the Amato government was able to finally get the bills through parliament (law no. 421, and later, delegated decree no. 502).

In short, the political exploitation of the healthcare system was scaled down considerably in the 1980s at national and visible level. For government parties, at least, the balance in terms of support and resources was negative; the only electoral strategy possible was the transfer of blame onto other parties; within the spoils system, competition was only defensive, taking the form of a veto on those proposals that directly threatened single shares of power.

At the national, invisible level, however, the party system continued to make full use of the health sector as a source of illegal and secret funding. A fourth C (corruption), through a very refined clientelistic network, was piloted by the Ministry of Health with large bribes flowing through the *Commissione Unica del Farmaco* (CUF or Single Drug Committie, approving new drugs and their classification within the Therapeutical Catalogue) and the *Comitato Interministeriale Prezzi* (CIP or Inter-ministerial Committee on prices): the *malasanità*. The Court of Accounts has estimated that the kickbacks alone which were paid to politicians by pharmaceutical companies between 1983 and 1993 amounted to a total of 15,000 milliard lira (0.9% of the 1995 GDP) and added, on average, 3,000 milliard a year (ca. 0.3 percentage points) to the public finance bill (due to artificially higher prices) (Il Sole-24 Ore, 19/7/1994).

The sub-national level allowed even more opportunities for political exploitation of healthcare than from the centre, even at a visible level, throughout the 1980s. The political administrators of the region and the USLs are, as I mentioned before, not institutionally bound to financial accountability. At this level, therefore, there are no political incentives to distinguish between administrative government and party interests. The local, political and administrative decision makers (especially in the USLs) are, in addition, imbued with a 'debt culture',

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that has developed with many years of practice and learning, perhaps in the administration of public hospitals or insurance funds. [5] To a large extent, the local partitocracy can continue its own distributive games unhindered, claiming credit for the appropriation of resources from the centre and in sharing them out locally or for its own accounting creativity. Being by far the most important sector of decentralised government, healthcare has allowed and promoted the development of a peripheral party government, distinct from (and perhaps in some ways rivalling) the national one, undoubtedly with its own dynamics which are still widely unknown. This local partitocracy suffered a serious blow with the appointment of external administrators to run the USLs (1990) firstly, and with the managerialistion later, introduced by the reform of the reform. The "giant" seems, nevertheless, to be more resistant at this level, at least with regard to the regions. And in the sphere of invisible behaviour its appetite appears to be just as voracious as at ministerial level. As research is beginning to show (Della Porta and Vannucci, 1994), individual USLs were the scene of large-scale corruption, especially with regard to external contracts and commissions.

V. A new political demand in healthcare: prospects for the future

From 1993 onwards the healthcare partitocracy was caught up in the whirlwind of 'Tangentopoli' (Bribesville). The wrongdoings of various health Ministers, bureaucratic chiefs of Ministry, members of the CUF and the drugs CIP have perhaps dealt the final blow against Italian-style party government. Speculation "on people's lives" has, in fact, had a particularly marked impact on public opinion. The reform of the reform - finally passed in 1992, as already mentioned - has erected institutional barriers to the presence of parties in the management of the sector and in the continuation of the distributive games at the sub-national level. Following the disbanding of the management committees, the USLs are now run by General Managers who, at least on paper, must possess verifiable technical expertise. The USLs (and large hospitals) are, in addition, becoming public companies, with increased powers of independent management and a duty to balance budgets. The regions, for their part, must make good any financial debts through their own resources. The new institutional model is slowly taking off while old habits die hard: in the spring of 1995 the Italian press reported on continuing attempts by regional councils (i.e. parties) to shareout posts. The regions, for their part, have engaged in a battle against central government through legal appeals, in order to reduce their fiscal accountability: they argue (and they are not totally unjustified) that they do not have effective powers to monitor local spending. The institutional system of healthcare is nevertheless restructuring and its level of party governmentness is gradually diminishing, albeit with great difficulty.

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5 It has been noted that one of the main causes of regional irresponsibility was "the operational culture of the USLs, heirs of other institutional bodies (hospitals and funds) that were generally run with a shortage of resources to meet objectives (necessary or unnecessary). As a result, incurring debts without the means to pay them off became an accepted state of affairs, and skill was used to obtain more credit from suppliers of goods and services" (Veronesi, 1994, p. 180). These observations provide the basis for developing an interesting theory as to how the healthcare debt grew (and perhaps the public debt, in general), based on a cognitive - cultural and policy learning perspective (Gualmini, 1995).

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The account I have just given suggests that this restructuring is to a large extent the result of the failure of party governmentness: its shareout excesses, its corrupt practices, and its ineffectiveness at the planning and management levels. The "financial" government of the SSN by technical Ministers has prevented the declining standards from developing into a complete breakdown of the system. But it has not been able to protect the old parties from the long term political consequences of their behaviour and the progressive erosion of those resources that have traditionally been obtained through these behaviours. Indeed, the financial government of the healthcare system has, in itself, ended up accelerating the break-up of the partitocratic system, generating an ever greater political demand for change. This is a very important point and requires greater development.

During the 1980s, not only did the parties run the SSN at the macro level badly, halting the dynamics of organisational and institutional innovation at the meso and micro levels: they also failed to make choices of a purely political nature regarding the distribution of costs of healthcare services among social groups. It has been said that the reform of 1978 was, on the one hand, a compromise of high politics on principles and, on the other, a compromise on the sharing out of power. Besides ignoring the "middle ground" of managerial and organizational considerations, the reform also failed to be accompanied by clear redistributive decisions (who receives what and, above all, who pays what) - the very healthcare choices which in other developed countries are normally made by the parties themselves (at least in the sense of parties-in-government). These choices, in fact, constitute the "wherefore" of party action in the various policy domains (the *partyness of government*, if you wish). The "financial government" of the SSN could not do much on this aspect: it has imposed sacrifices where it has been able to do so (technically as well as socially), while the parties have tried to manipulate the social distribution of these sacrifices so as to protect their own share of the electorate from copayments and cuts. To illustrate this point, we could mention the failure to shift from conributory to tax financing of the SSN, the retention of contribution differences between categories, the selective concession of exemptions (for example various types of disabled) as well as the tolerance of widespread fraud in this sector, and inaction against large pockets of evasion (contributions from self-employed workers, health tax and, finally, the above mentioned doctor tax). Applied against such a background, the copayment policy has only generated further inequalities (honest tax payers versus evaders). The policy of ceilings has for its part indirectly contributed, as has been said, to a fall in standards, at least at a non-clinical level.

In the long term, all theses dynamics have generated widespread ill-feeling among the consumers of the SSN and have created a constellation of potentially favourable interests for change. This constellation, it should be noted, is tendentially anti-universalist and anti-state, exasperated by the excessive taxes (although ready to avoid them where possible), by operational inefficiencies, by the wrongdoings of politicians, etc. The comparative literature has shown that it is difficult to create and mobilise anti-universalist coalitions in the health sector due to the typical model of service utilization in this sector: everyone needs health services sooner or later and, therefore, everyone is interested in retaining the right of access (Moran, 1991). The case of Italy shows that - under certain conditions - such a coalition can be formed even in a mature welfare state, lending itself to be mobilised at a political level.

As a result of the inability of the old parties (given the well-known macro-political and institutional constraints of the First Republic) to break of the distri-

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butive cycle and make bold redistributive choices, the process just described has contributed - and I wish to emphasise this - to the break up of the partitocratic system as a whole. The anti-universalist and anti-state interests in some major social groups have, in fact, been mobilised by the new parties: initially the Lega Nord and later Forza Italia. It is worth remembering that the Lega supported a referendum (rejected by the Constitutional Court) on the abrogation of compulsory membership of the SSN. Forza Italia's electoral manifesto in the elections of 1994 included plans for the dismantlement of the public service and its replacement with a system of vouchers reserved for the most needy (the most radical proposal ever officially put forward by any European party). In other words (and to conclude): the healthcare system shows how the inadequacy of the partitocratic system to produce a policy of redistribution has created fertile ground for the emergence of a new political demand and new political entrepreneurs. The elections of 1994 signalled a re-orientation of the political system in this direction: at least in their manifestos the parties formulated quite detailed proposals. In the coming years, the pendulum of healthcare reforms might well swing (for the first time in Italy) towards greater partyness in the running of healthcare, together with the dismantling of the spoils system. The margins of choice will not be great. Comparative experience shows that the "extremist" options (all public or all private, all state or all market) are technically and politically very dangerous in this sector. The adoption of a mixture of various instruments appears to be the most promising strategy to achieve good results in terms of efficiency, effectiveness and fairness (France, 1994). A serious debate between left and right on the kind of state healthcare towards which to aim (a debate which is pragmatic but also based on value options), open to "non-partisan" voices, but promoted by parties, and subjected to the electoral test, would nevertheless be an important sign that the *malasanità* is truly a thing of the past.

VI. Towards a new model of welfare

A development in a similar direction would be extremely positive not only for the health care sector, but also for other social policies as well. As mentioned in passing throughout this article, the whole welfare state has been the object in Italy of a systematic and pervasive exploitation by the First Republic's partitocracy. In certain sectors (e.g. invalidity pensions or unemployment subsidies) parties (and trade unions) have been able to set up extremely elaborated patronage machines for the individualized delivery of benefits to their voters. The Italian academic debate of the 1980s has coined the label of a "paricularistic-clientelistic welfare model" to characterize the Italian case vis-à-vis the other Continental welfare states belonging to the same "Bismarckian" family. [6] Whether the emerging Second Republic will be able to effectively reform this model and break with the legacy of partisan patronage, without however dispensing with the idea of a national welfare state is a crucial, but still uncertain question.

The debates and proposals made during the 1996 electoral competition have sent some promising signs - but they have also switched on an alarm bell. The positive signs are the programs of welfare reform presented by the two opposing

6 See for instance Ascoli, 1984 and Ferrera, 1984. For an update on the particularistic-clientelistic model (with references also to the other Southern European countries) see Ferrera, 1996b.

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coalitions. These programs are clearly differentiated on the basis of typical left-right principles: but the relevant thing is that they are both serious, pragmatic and realistic documents, devoid of the ideological clichés and simplifications of the past. The PDS has for instance abandoned its traditional, intransigent "etatisme", while Forza Italia no longer questions in its turn the maintenance of a public and compulsory social insurance. The alarm bell is represented by the Lega Nord. This party advocates a dismemberment of the national welfare state and its radical regionalization: regional health services and even regional pension systems, with only a moderate amount of inter-regional redistribution. It will not be easy either to accomodate the demands of the Lega: but it could be very risky to ignore them. Amongst the many challenges confronting the new "Olive tree" government (and, more broadly, the new Parliament), welfare reform is certainly a very compelling one - and possibly even the most important of all.

Abstract

This article illustrates the relationships between political parties and the healthcare sector in Italy since the 1950s. The several ways though which parties have "exploited" health policies are explored, ranging from the selective extension of care entitlements to the various occupational categories to the clientelistic ties with doctors, from the placement of party personnell in the various administrative posts to illegal financing. The author argues that the partitocratic exploitation of the health care sector has greatly contributed to the failure of the 1978 reform establishing a National Health Service. This failure has in its turn backlashed against the partitocratic government, accellerating its demise in the early 1990s. The article concludes with some considerations on the future of Italy's health policy and, more generally, welfare state policy.