The Old Roots of the Italian Health Legislation

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Abstract *Current Italian Health legislation is a paradigmatic example of a system based on the fundamental principles of the safeguard and right to individual health. This raises the question of its evolution and gradual shaping stemming from very old and deep roots. Such a long process started in the second half of the 19th century, when the newly reunified Kingdom of Italy, born in 1861, started to face the issue of a very obsolete health system. A number of laws sequentially provided the regulation of physician activities and health care for all people in need, regardless of their economic status and without any religious or political belief distinction, and culminate in the "Comprehensive Law on Health" enacted in 1934. These whole systems of laws have oriented the legislation on health care and organization, becoming a fundamental landmark until the promulgation of the Italian Constitution in 1948.*

Keywords: *Italian health legislation, the Kingdom of Italy, free medical assistance*

1. Introduction

On the eve of the 150th anniversary celebration of Italy Unification, a very relevant topic is represented by the issue of the origin and evolution of the health legislative system during the Kingdom of Italy. Indeed, this is a paradigmatic example of how a health system (e.g. the current Italian health system) has evolved and has been gradually shaped stemming from very old and deep roots. Although the normative path of the sanitary assistance and organization that started after the political unification could appear to us obsolete, a more deep analysis shows the innovative aspects of the Kingdom of Italy's health laws. In fact, some of the late XIX and early XX century health laws represented the necessary conditions for the future development of the whole Italian health legislation system.

Nowadays, the right to health is guaranteed in Italy by the articles 2, 3, 32, 38 and 117 of the Constitution[1], where it is conceived as a "fundamental right and interest of all the community". However, if this is true for the Italian Constitution established on 1948, how was this issue regulated in earlier years, during the Kingdom of Italy? Until the Unification of the peninsula[2], the health assistance for poor people was considered just a matter of charity. Since 1861, the

1. In the WHO Constitution's preamble there is very extended definition of health, conceived as:" […] state of complete physical, mental and social well-being and not merely the absence of disease and infirmity. The enjoyment of the highest attainable standard of health in one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition. The health of all peoples is fundamental to the attainment of peace and security and is depend upon the fullest co-operation of individuals and States. The achievement of any State in the promotion and protection of health is a value for all. […]".
Htpp://www.ordinepsicologilazio.it/binary/ordine_psicologi/normative/Costituzione_OMS.1272287163.pdf
2. The unification process will be completed in the 1866 with the liberation of Venice and Veneto as well as of Rome and Lazio in 1870.

Italian politicians rather aimed to define a national regulation and organization of this matter, thus representing a transition switch towards modern health systems.

2. The Hygienic and Health Conditions After the Unification Process of the Kingdom of Italy

Before analyzing the legislative path started in 1862 with the law dated 3 August n. 753 (the so called Legislation on the "Opere Pie"), it is useful to outline a brief description of the hygienic and health conditions of the country, right after the unification, in order to have a better understanding of a society that could appear today very far from ours. A key role, during the *Risorgimento* process and in the post Unitarian period, was represented by an important figure of physician, a doctor named "*Medico Condotto*". This physician was responsible for a town or district community's assistance and care services and he was financially dependent on the local municipality economic resources[3].

This historical figure is important at least for two reasons. Firstly the *medico condotto*'s job was not only related to the assistance and care of sick people but also to the sanitary and hygienic basic instructions to the community. These doctors in fact seeded the fundament of a social medicine conceived as common care and attention. The latter issue will represent one of the main purposes of the Italian health system even a long time later. Moreover the doctor efforts were concentrated in fighting the superstition and the popular beliefs and in some cases the ignorance of the basic sanitary and hygienic principles. One of the greatest challenges was in fact represented by the lack of a personal hygiene culture.

Secondly, *medico condotto*'s activity represent today a valuable input for the reconstruction of the socio-sanitary condition in the years following the Unification. This assumption was confirmed by the agriculture survey held in 1878, in which the decision to involve these doctors to get information and suggestions on the hygienic habits of some rural communities[4] played a remarkable role. Indeed, the hygienic and health conditions in most of the rural communities were really precarious especially regarding maternity and children status. Mortality during the first year of life was almost one-third higher than the national overall average (about 204 deaths per 1000 born alive). The principal cause of death, both for children and for the entire population, was represented by the spread of infectious diseases. Drinkable water and a waste system were not accessible to 40% and 50% of the population, respectively. Moreover the wet-nurse system contributed a lot to increase the diffusion of infectious diseases. In addition the second half of the 17th century and afterward were characterized by a large number of deaths due to typhus and fever of typhus origins (strictly connected to a bad or poor nutrition, extreme misery, migration movements and to a very bad hygienic habits), as well as smallpox, malaria and, later on, cholera. Differently from the previous centuries, these diseases were the so called social epidemics, tightly linked to the socio-economic conditions of social classes which were harshly disadvantaged. Indeed, the questionnaire undersigned by the government (108 questions in total), highlighted

3. The doctor was linked to one or more communities that usually signed a contract named *"di condotta"*. The subscription of the contract committed the doctor to assist continuously a certain community. In the pre-Unitarian period and in the years following the Unity, this kind of contract was signed for three years without any guarantee to be renewed. The wage was quite low while the assistance competences were constantly rising in terms of quantity and public health surveillance responsibilities. The law n. 5849 enacted on December 2nd, 1888, improved the contract duration aspect, establishing that the doctor and surgeons appointment done by the Municipality gained the stability after three years. After the triennium the Municipality could not fire them, except for a justified reason, after prefect's approval and Provincial Council affirmative consultancy.

4. The percentage of the attending doctors was about 50%. This number is quite high considering that there was not payment neither a State incentive for participation.

the socio-economic conditions, the social habits, the instruction and the education: all categories related to the backwardness of the socio-economic situation of these areas and therefore linked, for a future development, to a coordinate activity of the government. Similar data were observed in the entire peninsula. The general mortality was more than 30% of the population and the children's mortality was around 25% of the born alive in the first year of life (it is also important to underline that the birth-rate was exceeding 37-38% of the inhabitants). The shortage of drinking water, the lack of an efficient sewer system, the scarce urban cleaning system, the bad paved streets and the rare school buildings completed a picture that strongly suggested the necessity of an effective and coordinate intervention of the government authority (Molfese 2008)

3. The Key Aspects of the Health Legislation in the Kingdom of Italy

The data provided by the "*medici condotti*" together with their professional considerations and suggestions (solicited by the government members), affected in a very positive way the formulation of the law n. 5849 of 1888, that represented a turning point for the definition of the Italian health policy through the institution of the General health direction. However it is necessary to proceed gradually to recall how this law has been reached.

For the very first time, the new-born State took care of this field through the law of August 3rd 1862 n. 753. Until that date in fact the poor people medical assistance was meant to be simply a charity matter, or an activity provided especially by the Catholic Church and by the related institutions, in the fulfillment of their charity mission. It wasn't therefore, the right to assistance and care neither the right to health. The Church competence was extended to the organization and administrative aspects of the medical assistance. In this way the new State, once reached the maturity, understood the necessity of the regulation in this field, for two reasons: i) to regulate, such an important matter which would impact deeply onto the entire national territory, through a legislative function and, ii) at the same time, to define the sphere of competence and the ambit of action of the State and the Church. The law n. 753 of 1862 founded the "Opere Pie", Charity Organizations that represented the first institutions devoted to the public assistance of needy people. However this law was restricted to the regulation of the "*Opere Pie"* and to establish the freedom of each Institute to manage itself autonomously. It has been necessary to wait until the law n. 2248, Annex C, March 20th, 1865 to have an accurate intervention of the State in order to regulate the public health. This law represented the landmark for the future legislation in the field considering that, until that moment, health assistance was conceived as a private, religious and charity question. The Ministry of the Interior was supported by a Superior Health Council while local prefects and vice-prefects were helped in the development of their functions by Health Provincial Councils and by Health District Councils, according to a decentralization logic. Article 15 (in the section entitled "on the assignment of the health councils in general") established that the Health Councils were in charge of the preservation vigilance of the public health and of the respect of the above-mentioned law. These Councils could also suggest to the government actions to be undertaken. The following articles specified that the Council vigilance power was extended to the hospitals, places of imprisonment, public education institutes and health plan that didn't depend on the Military Health Councils. Article 17 established that the councils should control that doctors, surgeons, midwifes, veterinarians and pharmacists would respect the law. Finally, the Ministry of the Interior, the prefects and the vice-prefects could call for consultations or even obtaining information, everyone they considered necessary to hear. The General Health Direction was established with the law n. 5849 approved on December 22nd, 1888. This law (replacing the previous one dated 1865), was very important in public health field, since established the specificity of health and the need of an appropriate regulation within the Kingdom of Italy. Article 2 of n. 5849 law established the institution of an High Health Council within the Ministry of the Interior. Furthermore, every province had a Health Provincial Council and each municipality needed to have a health official doctor, corresponding in nature with the

appointment of the "*medico condotto*". The health service freely accessible to poor people was a municipality competence and it concerned the medical, the surgical and the obstetrical assistance as well as veterinary assistance, but only in situations and places where necessity would have been ascertained. Hygienic vigilance of the territory was another important municipality duty. After a detailed description of the High Health Council and Health Provincial Council composition and competences[5], the law established that in the municipality where there wouldn't reside voluntary doctors or midwifes, health assistance would be carried out by a resident *"medico condotto"* surgeon and midwife paid by the municipality. However it is very important to underline that the State had not already an exclusive competence on this field. In fact in the hypothetical situation of the existence of *"Opere pie"* or other institutions dedicated to the poor people health and care assistance, the article 14, last paragraph, established that the municipality would be exonerated or only obliged to complete their work. Finally it is worth mentioning the pecuniary penalty for people who would practice illegally the medical profession[6].

4. The State Becomes Directly Responsible for the Public Health Care With the Crispi's and Giolitti's Laws

We can properly speak of a first State intervention in the field of the health assistance only after the approval of the so called *Crispi's law* in 1890 (n. 6972/1890). This law, enacted by the Prime Minister Francesco Crispi, established that the *Opere pie* and other moral institutions would be subjected to that law if their final or partial mission were: i) free health care to poor people; ii) education, instruction and professional training in an art or profession, or in every other way related to moral and economic improvement. This law was also an emblematic example, for entitled public institutions of charity, of the progressive secularization of the State through i) the introduction of the public appointment of the administrative councils, ii) the obligatory prevision of the preventive and consultative inspection of the public charity institution's balance and iii) the imposition to invest their patrimony in bond state and in real estate. This law confirmed that the surveillance on the Public Charities was a duty of the Ministry of the Interior, which guaranteed that these institutions would provide charity assistance toward all people in need, without any religious or political belief distinction. This law did not apply to the Institution that, according to their statute, were taking care of people professing a specific religion, with the exception of emergency cases. Finally, *Crispi's law* established Charity and Assistance Institutions ("*Enti di Carità e Assistenza", ECA*).

We have also to recall *Giolitti's law*, enacted by the succeeding Prime Minister Giovanni Giolitti in February 14th, 1904 (followed by the executive regulation, law n. 615, 1909), regulating the institution of provincial Asylum for the care and cure of insane patients. Although the purpose of this law was more related with the regulation of compulsory admission in psychiatric hospitals rather than with a real medical and social rehabilitation of the insane patients, it was inspired by a regulation and decentralization logic and by the will to assign to the provinces a key role in the assistance and care of patients affected by mental diseases. In particular, the institution of public psychiatric hospitals in each province was oriented by the necessity of keeping sick people close to their relatives. Canosa (1999) defined that law as innovative and progressive, when compared to the political-administrative conception of that particular historical period. Then the Law n. 36 of 1904 established three different situations for the compulsory admission to a psychiatric hospitals: i) when the sick person could be dangerous; ii) in case of public scandal and iii) when a medical verification stated that the insane patient

5. For other details see articles 6,7,8 e 9 of the mentioned law.

6. Other penalties were for violation of rules on ground and food hygiene (title III), beverage and food hygiene (title IV), infectious diseases (title IV), and lastly funeral policy (title V). For the first time, rules were established for juridical requirements for livable houses.

couldn't be assisted and kept in safe in other places but the psychiatric hospital[7]. Compulsory admission at a psychiatric hospital required a medical certificate and, while the temporary admission was directed by the decision of a magistrate, the definitive admission followed a Court's judgment based on the instance of a public prosecuting attorney and consequent to a report by the psychiatric hospital director[8]. Finally, it is worth mentioning the fact that, because of this law, all provinces had to establish public and private psychiatric hospitals and to provide the maintenance of poor insane patients. The Ministry of the Interior had the responsibility for public vigilance over the public and private psychiatric hospitals and insane patients. This law was followed by law n. 455 of 1910 establishing, in every province, professional Boards of doctors, surgeons, veterinarians and pharmacists that allow the legality of the professions of enrolled people. Law n. 468 enacted in 1913 stated the rules for authorizing the establishment and working of pharmacies. Competence issues and decentralization process in the health field were further regulated by the legislative decree of December 3rd, 1923 and, finally, by a "Comprehensive Law on Health" ("*Testo unico*") enacted by the royal decree n.1265 of July 27th, 1934 (including around 400 articles). These whole systems of laws will orient the future legislation on health care and organization in Italy, becoming a fundamental landmark until the promulgation of the Italian Constitution in 1948.

5. Conclusions

This work has been focusing at drawing the fundamental aspects of health legislation path in the Kingdom of Italy, tracing a reading key alternative to the closing viewpoint between the health legislation in the Kingdom of Italy and in the Italian Republic. The fundamental concepts of Italian health system and universalistic culture (i.e. health care freely accessible to poor people, decentralization of health competences and the transition from a charity concept to the right to health), found their legislative premises in the post Unitarian legislation. In fact at the time of the Kingdom of Italy period, a big secularization process started, with regard not only to economic and administrative issues, but also to the contents of the discipline itself. The 1890 "*Crispi's law*" established the equality of access to the urgent treatments without any politic or religious discrimination, even for that religious institutions created for the benefits of people believing in a specific worship. Therefore, the legislative process starting from the second half of the 19th century, represents the necessary, though limited, premise for the development of the future health care. Italy identity can be defined only by rebuilding his past and looking at 150 years ago when Italian state and organization structures were shaping. The Kingdom of Italy structured as a complex organization, has gradually regulated the public health following a path that provided an increasing participation of the State in terms of surveillance, regulations and organization.

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7. The article 1 of the law n. 36/1904 established that assistance in a private house could also be demanded, after the authorization of the Court and on the basis of a royal prosecutor's request. In this case the person that received the insane people and the doctor in charge were subjected to juridical obligations. The madhouse director could authorize the insane admission in private house on his own responsibility but he had to immediately let know the royal prosecutor and at the public security authority.
8. The release of cured insane people was authorized by a Court President's decree after a request made by the madhouse director, by those people mentioned in the first part of the article or by the Provincial Deputation. In the last two hypothesis it was mandatory to hear before the Director's opinion (art. 3)

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