

# Emergency Medical Services in Crisis: An Italian Case Study

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*This paper deals with the system of emergency medical services in Italy. More specifically, it is a case study of the organization and operation of this system in the region of Tuscany. Recent decentralization decrees have established regional governments with major responsibilities for health care, including emergency medical services. The effects of a long history of social and political cleavages on provision of these services at the regional level are presented and discussed. The paper concludes that prospects for rational reform of emergency care services are dim.*

## Introduction

Modern Italy, with its long and at times glorious history, has frequently been described as a paradoxical blend of the old and the new. The same may be said of the medical scene in that country. In some sectors the nation is very advanced, while in others development has been slow or sporadic or both. One area which may be included in the latter category is emergency health care services. In Italy these services have received little attention from government, scholars, and consumers. Even those who provide the services do not seem to have taken a great interest in their improvement. This article deals with the organization and operation of emergency health care services in Italy and more specifically with a case study of emergency medical assistance in one region<sup>1</sup> of that nation—Tuscany. This discussion is set in the broader Italian systemic and cultural context.

Italy has always experienced severe social problems, but health and other forms of social protection were developed quite late compared to other European nations. Given the predominance of a liberal and laissez-faire philosophy, the national government did not become involved with health care services until the turn of this century. Prior to that time, efforts in the health care sector were limited to private initiative. Circumstances favored the development of voluntary associations, called Mutual Aid Societies,

<sup>1</sup>Italy is divided into 20 regions akin to the American states.

which were the precursors of present-day organizations involved with the delivery of emergency medical services and which had the purpose of assisting members in cases of sickness, old age, and other infirmities.

It was not until the Fascist era that governmental health insurance schemes began to flourish. However, while the Fascist leaders attempted to make some inroads into the development of a health care delivery system, their accomplishments were minimal. As in so many instances in Mussolini's regime, policy goals and actual practice did not coincide and an already fragmented health care delivery system was further fragmented.

Following the fall of Fascism, it was hoped that the new republic would be a social as well as a political democracy. The health care sector was singled out as one in which progressive reformers anticipated great improvements. This enthusiasm for the future is evident in the 1948 Italian Republican Constitution which recognized the major interest of the total community in the health care delivery system, the right to health as fundamental for each citizen, and the responsibility of the national government in this field. Given the nature of the constitutional provisions pertaining to health, it was obvious that the entire delivery system had to be revamped. However, it is one thing to enunciate lofty goals and another to implement them.

In an attempt to reconstruct health care delivery arrangements, several official commissions undertook studies of the problem, and economic development plans recognized the relationship between social and health care services and long-range economic development. These documents, which envisioned profound reforms in the health care delivery system, including the creation of a National Health Service, were passed into law. However, it was impossible to realize their objectives because enabling legislation was not forthcoming, as a result of disagreement among the parliamentary political parites. Consequently, legislation pertaining to health care assistance was undertaken sector by sector in piecemeal fashion and often with diverse criteria. Legal instruments dealt with emergency medical services in an incidental manner because they were not viewed as a vital component of the total health care system.

In postwar Italy the nature and enormity of the tasks to be dealt with were such that any achievements and reforms ac-

complished were dwarfed by the existing problems. Also to be noted is the fact that Italians tend to view problems globally and thus search for global reforms, although they too infrequently achieve them. As a result, there is a tendency to assign to a circumscribed sector of a public policy field, such as emergency medical services, a limited significance.

One of the major reasons for the lack of reform in the health care delivery system is that the forces associated with the decision-making process reflect the deep divisions evident in the Italian political culture. These cleavages, which have a geographic, economic, class, religious, and ideological basis, cross-cut and tend to reinforce each other. They serve as a framework for the decision-making process and have helped to mold the nature of governmental institutions, the multiparty system, and their outputs in the form of public policy, all of which reflect the lack of consensus that pervades Italian society. This situation, plus the dispersion of authority in health matters among many executive agencies, has had an adverse effect on health policy making and administration.

Other societies have deemed emergency medical services as essential and critical components of the total health care system. Given the nature of these services, political cooperation has been achieved in nations with fragmented political cultures and which were deeply divided on other issues of public policy. However, the character of Italian political conflict, the nature of the political culture, and prevalent values have not encouraged this cooperation. Thus it has been asserted (Unità sanitaria, 1974:10):

. . . we now have a health care system which as far as the emergency service component is concerned, can be compared to that of countries, which . . . are labelled underdeveloped. . . . [Italy is] a nation which is underdeveloped not only because of the blatant insufficiency of its health care system . . . but also because of the inadequacy and backwardness of its communication system.

## Emergency Medical Services: The National Scene

Historically, Italian emergency medical services have functioned primarily within the confines of hospitals and, like these institutions, developed in a haphazard fashion with autonomous structures and total administrative independence which resisted prac-

tically any type of control. Until recently, Italian emergency health care was delivered under a hospital law passed in 1938 and, for the most part, by voluntary, newly graduated physicians. Usually duty encompassed a long period and the volunteer had patient assignment as a major task. If emergency services were delivered by the regular hospital staff, its members often concurrently served the emergency room as well as another division of the institution. Given such utilization of personnel both entities—emergency services and the other division—suffered in terms of the level and quality of care rendered.

Few or no resources, or for that matter, attention were specifically devoted to the emergency component of the health care delivery system. Emergency medical services were characterized by fragmentation and a lack of coordination. Usually the patient was shuttled back and forth between various hospital services which did not manifest effective linkages with each other or exhibit a willingness for collaboration. It should be noted that Italian hospitals in general have been marked by a series of uncoordinated or barely coordinated elements. Consequently, they have not operated as total institutional structures, but rather as a series of subsystems governed by authoritarian hierarchies which served as a base for empire-building.

Physicians themselves, for the most part, remained unconcerned with emergency medical services, and there was no commitment or dedication on their part to this sector of medicine. Furthermore, among the doctors, as is true in most instances today, association with emergency medical care held little social or professional prestige. Those working in this sector viewed the emergency room as a stepping-stone to permanent assignment to other hospital services. As a result of this attitude, emergency health care could not benefit from the talents of the more mature, experienced, and capable physicians. In terms of staff, little continuity existed. Moreover, the training requisite to the proper use of newcomers and paramedical personnel was never given (Bencivelli, 1974:119).

In addition, there has been a lack of diagnostic and therapeutic equipment; resuscitation, radiology, and laboratory services; operating rooms open twenty-four hours a day; available specialists; and well-equipped ambulances. As a result, some commentators (Scala, 1973:966) have preferred to speak of emergency

medical disservice! Attempts to change this situation were fruitless, and within the hospital sector only created friction between the general and specialized hospitals as well as inside these institutions. The situation was further complicated by the resistance of organizations, some of a national character, involved in the delivery of emergency medical services. Official sources deemed it best to leave well enough alone.

It was not until the 1960s that emergency medical services or health care services in general received attention from official political sources. Within the last decade or so Italy has witnessed a notable rise in the number of medical emergencies. This phenomenon is associated with the many problems connected with a society experiencing rapid multifaceted development. Thus matters concerned with emergency medical care as well as the organization of the health care delivery system in general were recognized.

### *Efforts at Hospital Reform*

Given the failure to achieve national health reform, the importance of at least achieving sectional reform was acknowledged, and a hospital reform plan was passed into law in 1968. This legislation, commonly known as Law Number 132, and an ensuing decree issued by the President of the Republic on March 27, 1969, served as a basis for the reform of emergency medical services. These legal instruments were concerned in a limited fashion with emergency health care and theoretically transformed hospital emergency departments from mere centers for patient referral into centers for diagnosis and treatment. Moreover, the formal availability of emergency medical services was to be enlarged.

The objective of extending emergency medical arrangements is evident in the hospital reform legislation, which provides that all hospitals must have an emergency medical center with adequate means of transportation at its disposal. Other innovations are found in the Presidential Decree, which includes emergency medical services as an obligatory part of diagnostic and curative services for all Italian hospitals. Such a provision represents an important break with the past, since for the first time a legal document officially recognizes the importance of emergency services and, furthermore, places them on an equal basis with other diagnostic and treatment services.

The same decree expands on the provision concerned with obligatory emergency medical assistance contained in Law Number 132. It affirms that every hospital must assure the public full-time emergency health care and that such services must be coordinated with those of other local health centers by means of a regional health care plan. It is also asserted that each hospital must have at its disposal not only adequate means of transportation but adequately equipped ambulance and rescue service in addition to the necessary means for emergency diagnosis and treatment.

The hospital reform legislation developed a classification of general hospitals<sup>2</sup> according to the size of the population served and the number and type of specialized services offered. Thus a distinction is made between zone hospitals, which serve a population of 50,000, and provincial and regional institutions, which serve a population of one half million and one million persons, respectively. As far as emergency medical services are concerned, a distinction is made in the nature of the assistance to be offered, depending on the type of hospital involved.

The Presidential Decree stipulates that emergency health care in regional and provincial hospitals must be delivered by a permanent staff associated with this sector of the hospital. Moreover, Article Thirteen provides that emergency medical services must be organized in such a manner as to ensure “. . . efficiency, continuity, promptness and completeness of assistance.” This objective is to be accomplished through the establishment of a coordinated hospital structure. Unlike regional and provincial staff, zone-hospital emergency service staff need not be permanent and may consist of medical and surgical personnel from other divisions of the institution.

The legal provisions concerning the emergency medical staff of regional and provincial hospitals have caused differences of opinion. Some commentators argue that members of this staff must be specialists in the field of emergency medicine and emergency surgery. However, others do not agree because the article merely speaks of “permanent medical personnel” without mentioning further qualifications. Because of this lack of clarity, emergency care in regional and provincial hospitals has not been delivered by medical personnel with uniform professional backgrounds and

<sup>2</sup>General hospitals are defined as those which have departments of general medicine and general surgery as well as specialized divisions.

training. Further, it is argued that every hospital emergency treatment center must be an integral part of an emergency surgery division and associated with an intensive care unit and anaesthesia services. The intent here was to eliminate the *raison d'être* of the "deposit" in which emergency patients were held for observation if they could not be referred, or if they required hospitalization for only a few hours.<sup>3</sup>

It is to be noted that emergency centers perform different functions depending on the classification of the hospital involved. For example, in the case of zone hospitals, emergency medical services are more traditional and resemble those delivered prior to the 1968 legislation. Thus the work of the emergency medical staff is limited to the most urgent measures without further responsibility for care.

However, in theory the situation is different in regional and provincial institutions in that the personnel delivering emergency health care are supposed to be responsible for treatment in the emergency room as well as in other divisions of the hospital. Thus, supposedly, the physician on emergency service is in a position to be directly involved with the emergency patient who enters the health care system for as long as he or she remains in the system. This means that the physician delivering the primary medical care is to collaborate with the *primario* (head physician) and the *aiuti* (helpers) of other divisions on a patient-by-patient basis.

It was generally believed that such collaboration would lead to change. As opposed to past practice, an interdisciplinary approach to diagnosis and treatment would be encouraged and there would be a stimulus to undertake interdisciplinary research. Furthermore, it was hoped that such cooperation would lead to the recognition and development of a field of emergency medicine and in turn to more qualified medical personnel in emergency medical care. The end result was to be a marked improvement in the quality of care rendered (Scala, 1973:967).

Directives from the Ministry of Health have given attention to issues related to emergency medical care. For example, pediatric emergency medical care (Alì, 1971:91) has been singled out, and there have been provisions for programs to supply requisite, specially trained personnel and to assume in-service training of existing staff. However, these goals have not been achieved.

<sup>3</sup>The image of this "deposit" is most abhorrent to the general public. These areas are frequently overcrowded and generally unpleasant in their effect.

*Transportation*

In terms of planning and development, the emergency health care system is generally viewed as encompassing on-site-service response by public-safety groups and ambulance and rescue service. It is significant that in Italy such response historically has not been viewed as an integral part of the system. In many nations where the importance of ambulance and rescue service has been recognized (Nicoletti et al., 1974:2) as “. . . one of the most important, most delicate and most dangerous moments in emergency health care systems”, a network of transportation facilities has been developed and legally regulated. Such is not the case in Italy.

The responsibility for patient transfer has been left to the Red Cross or other groups, several of which have their origins in the previously mentioned Mutual Aid Societies, reflecting the divisions within the Italian political culture. Many of these organizations, such as the Misericordia, Fratellanza Militare (Military Brotherhood), Croce Verde (Green Cross), Croce Bianca (White Cross), etc., developed under the voluntaristic and service spirit and in an autonomous manner they flourished. Hospitals preferred to leave responsibility for transportation in the hands of these associations because it was to their economic advantage. Also, in many cases, it was deemed wise not to interfere with the operations of many of the associations because they represented vested interests and wielded a great deal of political and social power.

The uneven geographical distribution of emergency medical transportation facilities as well as the lack of equipment within vehicles are characteristic of the transportation sector of the Italian emergency health care system. Moreover, it is noteworthy that in spite of the importance of the on-site-service response to emergency medical situations, there is no national inventory of staff or available emergency transportation facilities.

Historically, there have been no standards concerning the type of vehicles to be adopted or the personnel to be utilized in patient transportation. Post-World War II legislation concerned itself with the problem but only in a very limited way. The previously cited legal instruments merely mention the requirements of *adequate* means of transportation equipped *adequately* for the performance of emergency medical services. The notion of adequacy is not, nor has it been, defined. Furthermore, in view of the fact that in these legal documents emergency health care services are discussed



within the framework of the hospital, such requirements relate only to these institutions.

However, vehicles adopted for emergency patient transportation may no longer be mere "medical taxis," but must serve as centers for the administration of emergency medical care. This implies certain standards of transportation and equipment. An effort to develop some standards of ambulance service is evident in a document issued by the Minister of Health to the Presidents of the Regions on February 15, 1973. Ambulance units of three different types were established, differentiated according to the medical equipment available as well as the composition of the ambulance crews.<sup>4</sup> Furthermore, the document described in detail the general technical characteristics which were to be common to all three kinds of vehicles.

It was hoped that this document, which was not binding on the regions, would serve as a guideline for them in their health-planning efforts. It was also hoped that the regulations would not only aid in enhancing the quality of vehicles and personnel utilized but would encourage the growth of national standards.

From the foregoing discussion of legal documents related to emergency medical services it is evident that in Italy limited attention has been given to the subject matter. The few legal instruments in existence have viewed emergency health care within the framework of the hospital and have focused only on various fragments of a total emergency medical services system. As a result, comprehensive planning is lacking and rational delivery arrangements have not been forthcoming. Consequently, one Italian source, *Unità sanitaria*, (1974:9) has commented:

. . . today, as far as emergency medical services are concerned, we only have a folkloristic assortment of "white crosses," "red crosses," "green crosses" or "gold crosses." We only count on archbrotherhoods of the *misericordia* or voluntary aid societies. We

<sup>4</sup>The classification is as follows:

1. *Medical Transportation Vehicle*: A vehicle for transportation of patients whose conditions do not require treatment during travel.
2. *Type A*: Ambulances for the rescue, aid, and transport of the wounded, poisoned, and sick who require treatment at the scene of the emergency or during transit.
3. *Type B*: Ambulances for the aid and transport of patients who in transit require care which can only be delivered with equipment not found in Type A vehicles and by specially trained personnel.

have no emergency plan for calamities other than the interministerial plan, which has been in a phase of "advanced study" for the last ten years. . . .

## Emergency Medical Services: A Regional Case Study

One of the innovative features of the Italian Constitution of 1948 was the division of governmental power in a way that would prevent the recurrence of a dictatorship. Thus it was provided that devolution of power would be realized by dividing the nation into nineteen regions. However, these regional governments did not come into existence fully until 1972. The major areas of their responsibility are health, public works, forestry and agriculture, public transportation, and city planning. High priority is given to reform of the health care delivery system.

The transfer of state powers to the regions to make health care policy was based on decree-laws which gave the regions full competence in some matters, allowed the national government to have exclusive jurisdiction in others, and provided for some concurrent powers as well. The national government was given the responsibility of setting the guidelines for regional activities in the health care sector and coordinating them. The *legge-quadro*, the law which would establish these guidelines, has not been implemented because of the difficulties involved in achieving consensus on the foundations of a new health care delivery system.

The transfer of legislative and administrative functions to the new regional governments allows for the development of a health care delivery system which can be adapted to unique local or regional requirements. It has been argued that while a health care delivery system must be articulated on a national level it must also focus on intermediate levels of a certain size. Thus it is of value to examine emergency medical services within this framework. This section will be concerned with these services in the region of Tuscany.<sup>5</sup>

<sup>5</sup>Because of a lack of documentary evidence and literature on emergency medical services much information contained in this section is based on interviews with regional government leaders, personnel delivering emergency medical assistance, and consumers.

Emergency health care services involve a delivery system which may be analytically described as a temporal sequence of events. Viewed in such a manner the system would consist of four elements (Plaas, 1974:8):

1. The detection and communication of need
2. The resuscitation and maintenance of patient life or the prevention of patient deterioration
3. Transportation of the patient from the point of the emergency to the point of care (or of care to the point of emergency)
4. Rapid diagnosis and treatment of basic and urgent medical problems

The patient enters the emergency health care system at the site of the mishap through a reporting mechanism which, in turn, in many cases, enlists on-site response by public-safety groups and ambulance and rescue service. In Tuscany the latter service is provided by volunteer aid societies organized into *Pubbliche Assistenze* (Public Aid Associations) or by the Red Cross or the Misericordia.

The need for on-site response may be communicated through different channels. It may be transmitted to a central headquarters for all emergency situations by dialing "113," a national telephone number maintained by the Ministry of the Interior. In this case, the local emergency division of this ministry will evaluate the situation and provide the proper aid. Also, contact may be directly made with public-safety and/or with ambulance and rescue services all of which operate autonomously. Consequently, communications are a problem. In Italy, public-safety groups, such as the police and fire departments, are not responsible for administering basic emergency medical care. Their members are not trained for such services, which are considered the responsibility of the ambulance and rescue squads only.

In order to coordinate efforts, it has been deemed necessary to establish definite relationships between the fire department, the police, and other forces associated with emergency situations in general and specifically with on-site service. Most sources interviewed by this author suggested the establishment of an emergency communications network that would allow for rapid communication of need to a central regional headquarters with

possible provincial<sup>6</sup> and district branches functioning twenty-four hours a day, with a staff, consisting of at least one physician responsible for evaluating the emergency situation at hand and for enlisting and coordinating the necessary and proper aid. Other sources claimed that it would be opportune to work out an agreement with the aforementioned "113" communications system rather than to maintain duplicate services. Still others advocated a central communications network to be manned solely by police or one hospital in the region. These sources did not particularly seem to care how the communications problem was solved, but they were vehement about the critical nature of the matter, the fact that an immediate solution was necessary, and the need for a centralized regional communications system.

Responsibility for emergency care and transportation of the patient from the point of the emergency to the point of care is largely that of the aforementioned *Pubbliche Assistenze*. There are 56 of these in the region, as well as 171 *Misericordia* and various branches of the Red Cross. Within Tuscany, all of these associations have a history of autonomous development, reflecting cleavages evident in the Italian political culture. Furthermore, it should be noted that they are self-financing. They usually do not receive public funds.

In addition to their emergency services these agencies perform many duties similar to those of the previously cited Mutual Aid Societies. Other charitable duties involve health education, funeral activities, volunteer work in hospitals, and financial aid to the needy. Moreover, these organizations provide many services delivered in the United States by visiting nurse associations and routine medical assistance, free of charge or at a reduced rate for members and at lower fees for non-members in clinics they operate.

A brief examination of three aid societies within the region—the *Misericordia*, *Fratellanza Militare*, and *Humanitas*—will illustrate the nature of these organizations as well as their different traditions and political orientations. In terms of age, the Archbrotherhood of the *Misericordia* is the oldest, having originated in the thirteenth century. In Tuscany, this confraternity

<sup>6</sup>The province is a unit of local government which serves as an intermediary between the commune, the basic unit, and the region. The nation is divided into 92 provinces. In the American context this entity is similar to the county.

has enjoyed a unique tradition due partially to its age. In interviews it was consistently identified as the most important organization associated with the second and third elements of an emergency health care system.

The Misericordia is also one of the wealthiest aid societies in the region. Traditionally it has been identified with professional persons who as a result of their occupations rank high on the socioeconomic scale, or with members of old, wealthy families. These people, possessing a social conscience, served as volunteers in the charitable services of the association. They are also responsible for significant financial support as well as gifts in the form of land, estates, business enterprises, etc. These resources are combined with the annual dues required of all members. Historically the Misericordia has enjoyed social prestige, and this, coupled with its great financial resources, has earned it political power as well.

On the other hand, other associations, such as the *Fratellanza Militare* and *Humanitas*, with a different social basis, are forced to rely on modest membership dues for their financial resources. It should be noted that in most of these societies only a part of the membership performs charitable services; the rest merely pay dues in order to receive medical care.

These associations also have different membership requirements. For example, in the case of the Misericordia, prerequisites for membership include practice of the Roman Catholic religion, suitable physical fitness, a spotless reputation, and outstanding social position. There are also age limits in certain membership categories. In one interview, this author was told that a certificate of baptism had to be included with a request for admission to the society. In general, the Misericordia is regarded as politically conservative and allied with like forces in the Christian Democratic or Liberal<sup>7</sup> parties.

On the other hand, the spirit of the *Fratellanza Militare* and of *Humanitas* is quite different. It is generally acknowledged that these societies came into being in reaction to the Misericordia. The *Fratellanza Militare* has a military tradition dating back to the last century, which still characterizes the operation of the society. Its volunteers are assigned ranks corresponding to those of the Italian military. In contrast to the Misericordia, the literature of these as-

<sup>7</sup>In spite of its name this political party is in the conservative camp.

sociations mentions a dedication to the notion of the brotherhood of all political and religious faiths and all social classes, in addition to commitment to community service. However, in spite of official declarations, these societies have definite orientations.<sup>8</sup> Fratellanza Militare is generally characterized as anti-clerical, Masonic, and social democratic in nature, whereas Humanitas, which is also anti-clerical, is linked with forces further to the left of the political spectrum. All of the many aid societies in the region show particular social, political, and religious orientations.

On-site emergency services and patient transportation are carried out by the volunteers of the various associations. But emergency teams vary in number and training. For the most part, each association offers its own training program and requires its volunteers to participate in it. Although a lack of uniformity is evident, no regional public controls have been established. It is generally acknowledged that personnel of the ambulance squads are not adequate and that training leaves a great deal to be desired. Interviews revealed that each association prides itself on its own particular efforts in this sector and repudiates those of others. Training of volunteers, the capabilities of the ambulance teams, and the level of care they deliver also serve as a basis for division between the various societies.

Service requirements differ as well. Some agencies have fixed requirements, while others do not. In the case of the Misericordia, those in their first year of membership work when they desire and for as long as they choose. After this initial period, weekly service is obligatory and volunteers establish the day in which they will serve as well as for how long. On the other hand, the Fratellanza Militare has no fixed service requirement, and volunteers participate when free. One member of the Fratellanza Militare asserted to the author: "After all, we're different from the Misericordia. Our guys have to work for a living." In most cases, it was found that these associations have their night operations covered by permanent staff.

This large-scale reliance on voluntary staff presents many problems, but one of particular importance experienced by several

<sup>8</sup>Evidently persons with military backgrounds or with anti-clerical attitudes or with special ties with Fratellanza Militare would request one of its ambulances in an emergency. Similarly, it is likely that a conservative Roman Catholic with a knowledge of the Misericordia would ask that this society be contacted.

societies pertains to absenteeism in general and specifically at critical times. A few sources interviewed by this author also reported avoidance of duty by members of socially prestigious organizations. It seems that membership is sometimes desired for social prestige but not as a basis for the performance of regular volunteer services.

Hospitals in the region have a minimal number of ambulances at their disposal, but they are not utilized for on-site emergency service. The types of vehicles utilized by the Pubbliche Assistenze, the Misericordia, and the Red Cross and the degree of sophistication of their equipment vary with the financial resources of the society and the training of their volunteers. Rural Tuscany suffers from inadequate transportation facilities and equipment. As McNerney and Riedel (1962:161-162) write in reference to the American scene:

. . . Each rural . . . community faces a basic decision during a given phase in its growth, i.e., to lie back passively and seek major services from the nearest "large" city or to assert itself actively in at least a few significant areas. . . . The speed with which a community can be rallied to protect its autonomy suggests the majority tendency lies in this direction . . .

Once the psychological balance is tipped in favor of "standing up to be counted" then the question arises as to how the community should act. The development and support of community institutions is one obvious course. What better symbols of wholeness and viability can be found than schools, churches, libraries, and hospitals.

And in reference to the case under discussion, one might add ambulance and rescue squads. It should be pointed out that the Italian citizen is more oriented toward regional or local institutions and structures that have not been fully integrated into the political system. Thus, given the strength or entrenchment of subcultures in Italy and the phenomenon of *campanilismo*,<sup>9</sup> these efforts on the part of rural communities become most significant and understandable. However, techniques and facilities adopted in these areas are often quite outmoded.

The decision concerning the point of patient delivery or the

<sup>9</sup>The *campanile* is the bell tower, a symbol of this association with a local town or city.

selection of a particular hospital emergency center is usually made by the most experienced member of the ambulance squad. Officially, for most societies the site selected for patient delivery is supposed to be that closest to the scene of the emergency. Or, in the case of some societies, if it is evident that a specialized hospital is needed this site may be selected even if it involves traveling a greater distance. However, interviews revealed that there are informal factors which influence the decision, and there exists a tendency for ambulance squads to favor one hospital over another. Evidently political and social loyalties can affect the situation. It was disclosed that in some instances ambulance squads will not deliver a patient to a particular hospital whose politics differs from that of the association involved in the case.

Thus it was reported that patients requiring emergency services of a specialized institution have often been delivered to general hospitals because of divergent politics. It was also reported that gifts to the ambulance squads, such as wine at Christmas, have created a situation in which service associations favor one hospital over another. Consequently, certain service agencies have consistently avoided specific emergency medical centers.

In an evaluation of this phase of an emergency health care system, one must point to the multiplicity of organizations performing services; the lack of coordination among them; the lack of uniformity and standards concerning available means of transportation; and the type and level of care delivered. However, it is interesting to note that most volunteers did not raise these matters in response to interview questions concerned with evaluation of their agencies' services. For the most part, they took pride in the sector and claimed that Tuscany is an atypical region in that its on-site service is efficient and adequate. Furthermore, communications were judged "good." It was felt that no significant problem areas exist.

Coordination of volunteer efforts will be a most difficult undertaking in Tuscany, given the differences between the associations, their divergent politics, the influence of campanilismo, and Tuscan pride as it relates to the organizations. By statute, these volunteer agencies may not be abolished. With regard to the issue of coordination, interviews revealed that there would most likely be a division among these agencies as well as among the political parties in the region. Two basic positions emerged.



It was generally believed that the Misericordia and perhaps some of the Pubbliche Assistenze would oppose a change in the position of these associations, and would advocate a preservation of the status quo. It was argued by some that the regional Christian Democratic party would, for the most part, support such a position because of its sympathy for the Misericordia. On the other hand, other forces asserted that such volunteer efforts must continue as a basis for general on-site service but that they must be improved. Also, they must be coordinated by a precise plan and publicly controlled by the *unità sanitaria locale* (local health unit) which is to be the basic element of a National Health Service. It may be stated that generally the *Dipartimento sicurezza sociale*<sup>10</sup> of the region supports this position and thus it is assumed that the political parties of the majority would follow suit. However, the divisions are not so clear-cut, and interviews revealed as many nuances of opinion among the voluntary aid societies as there are among the political parties.

From the foregoing discussion one sees that these voluntary affiliations perform a primary role in the delivery of emergency medical care in Tuscany. Equally significant is the fact that within the region there exists no official census of the total resources available through these organizations. In an effort to remedy this state of affairs the Dipartimento sicurezza sociale has recently established a commission to examine the matter. The commission is charged with preparing a detailed report on the total operation of these entities with relation to health care generally and specifically to emergency medical care. In order to ensure the cooperation of the Pubbliche Assistenze, the Misericordia, and the Red Cross, it has placed a representative from each of these agencies on the commission. This is an important undertaking because official statistics are being compiled for the first time and also, because of the manner in which the survey is being carried out, it could serve as a prelude to the growth of cooperation and coordinated efforts among these various societies.

Since there are no mandated intermediate aid stations in the Italian emergency medical services system, diagnosis and treat-

<sup>10</sup>The Dipartimento sicurezza sociale (Social Security Department), a component of the executive branch of the Tuscan regional government, is responsible for health planning in the region.

ment are carried out within the framework of the hospital.<sup>11</sup> As elsewhere in Italy, hospital emergency medical centers were established throughout Tuscany in a haphazard, unpremeditated fashion. Their distribution does not follow a rational pattern, nor does it respond to the needs of the area. For the most part, they are associated with urban areas, so that rural and other areas suffer from a lack of service. Of recent import is a significant increase in leisure-time accidents and in non-urban tourism which create special needs. The Tuscan emergency medical services system is not geared to these developments. Another problem revealed in interviews is the need for more centers which can handle specific emergencies—i.e., burns and cardiac cases. Consequently, one of the most urgent regional problems concerns the appropriate distribution and coordination of emergency medical services.

### *Hospital-Service Response to Emergency Medical Situations*

Interviews with hospital personnel involved in the delivery of emergency medical care revealed several areas of concern. One of the most pressing problems noted is the fact that in Tuscany there is no intercommunication between mobile units and emergency medical centers in the hospitals. Several groups of medical personnel have noted deficiencies concerning communications in one form or another (Nicoletti et al., 1974:3, 20–21), but to date no official action has been taken. Sentiments manifested in several interviews indicate that forces involved in the decision-making process recognize the inadequacies of the present communication system and acknowledge them. But it was also believed that the influence of divided loyalties and ideologies would inhibit remedial action.

In general, medical and paraprofessional personnel criticized the services performed by the aid societies. This attack centered on

<sup>11</sup>As in the United States, Italian hospital emergency centers have been over-utilized particularly at critical times—i.e., holidays, weekends etc. In an effort to relieve these centers of some pressure a new service—*il servizio di guardia medica*—was recently instituted in some areas of Tuscany and then copied by a few other regions. By calling an emergency telephone number at off-hours, patients may reach a physician available for house calls. But most of these physicians are recent graduates, a disadvantage despite their enthusiasm, given the theoretical orientation of Italian medical schools and the resulting lack of practical experience.

the training of the volunteers as well as the quality of care delivered. It was asserted that these volunteers are not adequately prepared for the role they perform in the emergency health care system and that, for the most part, they are unable to operate basic equipment and fail to carry out vital care procedures. Most felt that non-professionals could not be included in a modern health care delivery system. But they recognized that given the political, social, and economic resources of many of the aid societies, the elimination of these volunteers would be difficult. Furthermore, it was generally felt that in any efforts for reform the battle lines would be drawn between the hospitals and the aid societies, complicated by the divisions among the various volunteer groups.

Standardization in terms of training volunteers was deemed a necessity. Sources interviewed described various methods for training, but all involved the assignment of this responsibility to schools of nursing or to hospitals in the region.

Another problem raised by hospital personnel was the composition of ambulance teams. It was recognized that diagnosis and treatment of the patient must begin as soon as possible. Thus a question was raised concerning the presence of a physician aboard the rescue vehicle. Interviews revealed no fixed sentiment on this matter. Some sources argued in the affirmative, but they did not agree on the type of physician, while others felt that the inclusion of medical personnel represented a waste of time, money, and effort. The latter group believed that sufficient treatment could be delivered in transit by adequately trained volunteers. In an attempt to link the hospital-emergency service to the on-site service and to relieve problems of inadequate training, one doctor argued that emergency-room physicians should divide their time between hospital and ambulance duty.

### *Staff*

In terms of staff, the major problems revealed in interviews concern qualifications of medical and paramedical personnel as well as the shortage of all types of workers. Emphasis was placed on the fact that training is not adequate in general but especially for paramedical staff. Physicians were united in their criticisms. They felt that they could deliver excellent care with fewer paramedical personnel if they were correctly trained. It was suggested that all

staff be required to participate annually in continuing-education courses. Also urged was the establishment of required courses dealing with emergency health care in medical and nursing schools. Further, obligatory work in these services by interns for a specific period of time was advocated.

All hospital staff interviewed commented on the shortage of available personnel for emergency medical services. In part this deficiency results from the fact that nurses and paraprofessionals can find work with fixed hours and the same pay without expending effort for advanced training. Thus, hospitals often have the necessary equipment but not the personnel to operate it.

### *Lack of Coordination*

Emergency sectors of Tuscan hospitals, according to their medical staff, still focus on patient referral. Failure to achieve the desired transitions results from lack of cooperation among the various hospital elements. Interviews with emergency care physicians revealed that supplies as well as services were not forthcoming from other sectors which in theory are an integral part of emergency health care within the hospital framework. This was found to be particularly true in the case of general as opposed to specialized hospitals.

Physicians have made proposals to alleviate this problem. For the most part, these have entailed the creation of emergency departments—i.e., a multidisciplinary structure within the hospital—but they have not been favorably received by the entire hospital community. In general, the medical hierarchy associated with each hospital division has remained wed to its autonomous position and its concomitant benefits and has resisted efforts for change in organizational structure.

Many physicians delivering emergency medical services criticized the length of time necessary for diagnoses. Given the lack of staff as well as these circumstances, the Tuscan situation may be characterized as one in which emergency medical services are not assured, nor can they be assured, on the round-the-clock basis called for by law.

This lack of cooperation among the various hospital divisions has an impact on the utilization of hospital beds. In interviews, physicians, for the most part not those with specialized institu-

tions, noted that they were forced to hospitalize many patients, who, if services had been available, could have been immediately released with diagnosis and primary treatment completed. According to one study (Nicoletti et al., 1974:8), the fragmentation of services results in a hospitalization rate of 50 percent for emergency patients in general hospitals, while it is only 2 percent in specialized hospitals.

Furthermore, it has been argued that these rates could be decreased by disregarding traditional concepts of the organization of health care personnel and by using a broad team approach to the delivery of emergency health care services within the hospital framework. One proposal (Nicoletti et al., 1974:4, 18-19) provides for an *équipe*, or team, which would consist of multiple specialties including social-service personnel. Consequently, all of these talents would be available within the emergency service network and would reduce the need for hospitalization in many cases. The social worker is on the team to deal with cases in which hospitalization might be necessary for social but not medical reasons. It is argued that the social worker, who is in contact with agencies beyond the hospital, can aid in avoiding hospitalization or at least in reducing the length of stay.

## Summary and Conclusions

It is evident that there are many problems associated with the delivery of emergency medical services within the framework of the hospital and external to it. Furthermore, a general pessimism prevails among those most directly involved with the delivery of emergency medical care concerning the achievement of viable solutions to these multiple problems in the near future.

Health systems must not only be related to available resources, but, above all, they must be accepted by the people involved and related to their way of life and basic values. Social and cultural attitudes toward the type of care provided are just as important as the way in which care is organized. Solutions to contemporary health care problems require a critical analysis of the existing delivery arrangements; knowledge of the expectations of the residents of the area; and knowledge of response capabilities of the health sector, in this case, emergency medical care. To date in Italy

the consumer has had no formal input in the determination of emergency health care delivery arrangements.

It would seem that the region is best suited in Italy to serve as an arena for the achievement of solutions to problems related to emergency medical care. However, interviews revealed that in Tuscany there is no public awareness of the emergency medical services system and its problems. It was generally believed that even the most rational delivery arrangements for emergency medical services would lose some of their efficacy if they were not accompanied by extensive consumer-education programs. This lack of awareness on the part of consumers suggests that they cannot be counted on for the initiation of changes in the operation of emergency health care services. Nor does it seem that the consumer will have a significant role in the development of reform which might be initiated by other forces.

While national political parties and their regional counterparts have an interest in general health care reform, there is no similar concern for emergency medical care. Spokesmen for political parties in the region argued that more urgent problems required their attention. Here again one may cite the Italian propensity for global solutions to policy matters. The political-party representatives felt that problems associated with the delivery of emergency health care services would be resolved within the framework of a general health reform. This attitude results from a lack of pressure by consumers, interest groups, and other social forces for reform. Italian political parties do not seem to relate the problem of emergency medical services to either the quest for votes or the ideologies of welfarism, social democracy, or egalitarianism.

It is generally believed that initiative for reform will not be forthcoming from other institutions involved in the delivery of emergency health care. For example, incentive for change will not emanate from the volunteer aid societies which have a significant role in the delivery of emergency medical services. Given the divisions among these organizations, the vested interests which many of them represent, as well as their apparent satisfaction with the current delivery arrangements, they are not likely to serve as innovative forces.

In reference to the American scene it has been asserted (Burns, 1973:31) that “. . . the hospital is at once one of the most

important elements in the delivery system and also the one that is large and powerful enough to take the initiative in improving the present delivery system." However, in the case of Italy, change in reference to emergency medical services will not be initiated by the hospital. It has been noted that proposals for reform by the providers of these services have generally not been accepted by the entire hospital community. Interviews with members of this community revealed that often these projects were defeated or disregarded for other than scientific reasons. The current delivery arrangements appear to be organized more for the convenience of the influential members of the hospital community than for the primary providers of emergency medical services and the consumer.

Interviews with physicians delivering emergency medical assistance indicated that they did not feel they could generate a transformation in the emergency health care system for the simple reason they generally do not enjoy any prestige within the medical profession. Furthermore, there was a prevailing opinion that those who delivered emergency medical care did so because they were really dedicated to this type of medicine or else because they had no other available position. The latter reason was viewed as central to the decision to become involved with emergency health care. These physicians felt that another reason for their lack of prestige in the medical profession was that with their contacts limited to the emergency room, they had little chance to develop conventional practice careers. Most of the doctors interviewed felt that emergency medical care was held in such low regard because the concept of emergency medicine remains undeveloped, as is evident by its omission from the curricula of Italian medical schools.

It was felt that any hope for reform in the current delivery arrangements lies with the physicians on medical school faculties. In Italy these professors have such high status that many believe they could spark the necessary innovation in this sector of public policy.

The Italian emergency health care system does not operate in the best interests of the consumer, is wasteful of resources, and functions with little regard for efficiency and economy. Moreover, the system is not viable, rational, managed, or coordinated. As its various components developed, effective coordination between the constituent parts was not created, and no concern was directed toward the system in its entirety. National legislation and other legal instruments concerned with emergency medical assistance

are few in number and have had little impact on the delivery of such assistance.

Admittedly, some improvements have been made by a few of the regional governments. Others have undertaken or are about to undertake studies concerned with emergency medical assistance. However, these are only isolated instances, and much remains to be done. Given the attitudes of consumers, providers, professional groups, official forces involved in the decision-making process, and the general political climate, prospects for a reform in the current emergency medical services system seem quite dim.

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The author is indebted to Dr. Edward C. Hughes for his useful comments on the first draft of the manuscript.

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