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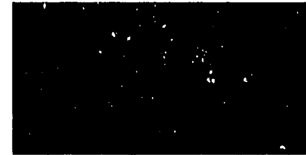
27 February 1979



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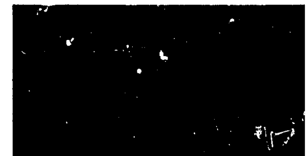

TRANSLATIONS ON WESTERN EUROPE

(FOUO 13/79)

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CONTENTS PAGE

INTERNATIONAL AFFAIRS

French-Dutch Negotiations on Aeronautical Cooperation (AIR & COSMOS, 25 Nov 78) 1

BELGIUM

Organizational Breakdown of Air Force Described (AIR & COSMOS, 11 Nov 78) 3

FRANCE

Pierret Explains Reason for Break With CERES (Christian Pierret Interview; LE NOUVEL OBSERVATEUR, 30 Dec 78) 6

ITALY

Causes of Spiraling Health Costs Detailed (Antonio Brehna; IL SOLE-24 ORE, various dates) 8

ENEL's Alternative Nuclear Plan Presented to CIPE (IL CORRIERE DELLA SERA, 14 Dec 78) 35

Canonica d'Adda Oil Deposit Find Hits Record Depth (Giuliano Albani; IL CORRIERE DELLA SERA, 20 Dec 78)... 37

SPAIN

PCE Leaders Discuss Postelection Program, Plans (CAMBIO 16, 28 Jan 79) 41

WEST GERMANY

Bonn Continues Heavy Subsidies to Airbus (Kurt Breme; STERN, 18 Jan 79) 46

APPROVED FOR RELEASE: 2007/02/08: CIA-RDP82-00850R000100020034-1

APPROVED FOR RELEASE: 2007/02/08: CIA-RDP82-00850R000100020034-1

INTERNATIONAL AFFAIRS

FRENCH-DUTCH NEGOTIATIONS ON AERONAUTICAL COOPERATION

Paris AIR & COSMOS in French 25 Nov 78 p 12

[Text] Last Monday, Yvon Bourges, minister of defense, and Joel Le Theule, minister of transportation, went to the Hague for a meeting with the secretary of state for defense, Van Eekelen and the secretary of state for the economy, Van Aardenne. They were there to discuss French-Dutch aeronautical cooperation.

The Netherlands plans to replace its royal navy's Neptune either with the Atlantic NG or with Lockheed's Orion. Thirteen Orions would cost some 300 florin less. As compensation for this difference, France is offering the Netherlands an opportunity to participate in the production of the Atlantic NG. France is also offering to buy 18 Fokker F 27's to be used on missions in the Pacific and to replace the DC-3's now used for training in the national navy.

However, the Dutch find that these compensations are not sufficient. In addition, they proposed a partnership in the production of a short-range courier aircraft F 28 Super. The total expenditure for this program is approximately one billion florin. The Dutch plan to assume about half the expenses and are proposing that the French assume one fourth. The Netherlands hopes to interest Germany in investing, perhaps through the payment of an indemnity for the German-initiated separation of VFW [United Aeronautical Works] from Fokker. The Bonn cabinet will discuss this transaction on 29 November.

Last Monday at the Hague, there did not appear to have been any discussion of the Netherland's participation in the Airbus industry. There is evidently a difference of opinion on this subject. France wants all new airliners, including the future F 28 Super, to be a part of the total production of Airbus. The Netherlands seems to want Fokker to remain commercially independent.

From the French point of view it might be noted that definitive plans for the F 28 Super (previously called the Super F 28, then the F 29) are far from being established and France cannot commit herself to signing a blank check.

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The Dutch state that they merely want France to sign a declaration of intention to participate in the program.

It seems unlikely that these differences can be resolved in the short amount of time France has been given by the Netherlands. The Dutch had hoped to have a more precise answer from Paris yesterday, in order that this transaction might be discussed at the 24 November meeting of the Dutch cabinet. If France were to offer any new, significant proposals, a report for 1 December has been authorized. The Hague has from now until 1 December to choose the aircraft which will replace the Neptune. After that, the Dutch parliament will have 2 weeks to discuss the choice which will become definitive in mid-December.

At this writing, the Hague does not seem likely to choose the European craft. The consequences would be serious for Fokker: not only will they lose an opportunity for compensation with the Atlantic NG, and a significant amount of orders for the F 27, they will also be unable to undertake the civilian project on their own.

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BELGIUM

ORGANIZATIONAL BREAKDOWN OF AIR FORCE DESCRIBED

Paris AIR & COSMOS in French 11 Nov 78 pp 40, 56

/Article: Alphajet in Service Soon in Belgian Air Force/

/Text/ The Belgian Air Force, which employs about 18,000 persons, comprises three main units:

The Tactical Air Force groups all the combat units assigned to NATO. It includes: an all-weather fighter wing and a fighter-bomber wing, both equipped with Lockheed F-104 G's; a fighter-bomber wing equipped with Mirage 5's; a wing composed of a fighter-bomber flight and a reconnaissance flight, both equipped with Mirage 5's; two NIKE ground-to-air missile wings; a wing composed of a tactical transport flight equipped with C-130 H Hercules planes and a liaison flight equipped with Boeing 727's, HS 746's, Falcon 20's, and Merlins; a Westland Sea King helicopter flight; two radar control and detection stations; a meteorological wing, a telecommunications wing, and various support units.

The Instruction and Training Group, responsible for training all personnel, comprises: the basic flight training school, equipped with Siai-Marchetti SF-260 M side-by-side two-seater planes; the advanced flight training school, equipped up to the present with Lockheed T-33's and Fouga Magisters, both of which will soon be gradually replaced by Alphajets; the military training school; the military training center; and a technical school.

Finally, the Air Force Base is responsible for all logistical support. It comprises four wings for aeronautical and electronic equipment, auxiliary equipment, munitions and explosives, as well as various support units.

The Belgian Air Force is presently preparing to receive and place in service the first Alphajets and the first F-16's which are going to be delivered to it.

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With Alphajet, All Instruction on Two Types of Airplane

The latest issue of the magazine ALPHAJET CONTACT, published jointly by Dassault and Dornier, contains the text of an interview with Air Force Lt Col A. Vanhecke, in charge of the Alphajet program for the general staff of the Belgian Air Force. We recapitulate below the most interesting passages from this interview.

The Belgian Air Force is made up of a single type of pilot: fighter pilots. Therefore there is only one training program. Until now, it has been carried on with the use of three types of airplane: the SF-260 (which had replaced the Stampe SV4), then the Fouga Magister, and finally the T-33. In 2 years, with the placing in service of the Alphajet and the gradual withdrawal of the Magisters and the T-33's, the complete program of instruction will be done on only two types of airplane: the SF-260 and the Alphajet. The entrance of the latter into service will make it possible to save a great many hours of flying time. Until now, the pilot's wings were awarded to the cadets of the FAB /Belgian Air Force/ only after 350 hours of flight. With the Alphajet, this time will be reduced to 275 hours. A saving of 75 hours per cadet--this is a lot for an Air Force which has to train some 40 pilots each year. These 275 hours will break down as follows: 125 hours in the SF-260 M and 150 hours in the Alphajet: that is, 90 hours in the advanced flight training school and 60 hours in the transitional flight training school. The four FAB instructors who last month took a changeover training course on the Alphajet at the Military Air Testing Center of Mont-de-Marsan will in turn conduct the changeover and instruction of the Alphajet coaches of the Belgian Air Force.

The pilot candidates who entered the Belgian Air Force last September with the prospect of a fighter-pilot career will be the first to benefit from the program with only two types of airplane. With these two types of high-performance airplane, the training should be improved and the results should be better.

The Belgian Air Force has always considered that the advanced training plane with which the pilot-training program is completed should have very high performance characteristics, for the professional quality of the pilots derives, in the last analysis, from these high performance characteristics. The FAB found in the Alphajet the principal performance characteristics which it desired: very short takeoff time and high rate of climb, to accustom the cadet; fast cruising speed so as to accustom the pilot to rapid reading of maps and interpretation of landscapes--two necessities for the ground attack missions taken on by Belgium within the framework of NATO; considerably long range, so that the mission can be sustained for at least an hour, and a comfortable range so that if the young pilot makes a navigation error, for example, he does not panic from obsession with fuel consumption; good operational training capacity and great simplicity of use; and finally, reasonable cost, both of purchase and of operations.

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The differences between the French Air Force's Alphajet and that of the Belgian Air Force are minimal and relate only to certain equipment and the ejection seats: the French Air Force has adopted the Martin Baker MK IV because it is built in France, and the FAB has preferred the MK 10, which offers zero-zero capacity, simplified maintenance, and greater comfort.

Questioned on the notion of safety, Lieutenant Colonel Vanhecke replied: "I think that Alphajet will be a very reliable airplane in use, because it is a twin-engine plane and because it is a very sound machine."

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FRANCE

PIERRET EXPLAINS REASON FOR BREAK WITH CERES

Paris LE NOUVEL OBSERVATEUR in French 30 Dec 78 p 29

[Interview with Christian Pierret by Franz-Olivier Giesbert]

[Text] [Question] The leadership of CERES [Center for (Socialist) Studies, Research and Education] received the support of 95 percent of the delegates to the Epinay conference last week. Thus, you represent almost nothing: the minorities within the minority.

Christian Pierret: Strictly speaking, the CERES leaders should have gotten 100 percent, since they were the ones who named the delegates to the meeting! That is in fact what is called bureaucratic manipulation, worthy of the organization of the congresses of the SFIO [French Section of the Workers International (French Socialist Party)] under Guy Mollet. Enough to discredit the speeches by CERES officials on self-government.

In my opinion, we represent 35 percent of the CERES. But we intend from now on to address the party as a whole.

[Question] Why this sudden break with Jean-Pierre Chevenement? What was the reason for the split finally?

Christian Pierret: For the past 2 years the CEREA leadership has been embarked on a nationalist course. Everything began with that small affair of Chevenement's appeal to the Gaullists in 1976, which I rejected at the time. Those responsible for the trend have since become more and more bogged down in a very coherent reasoning: their anti-European, military ideas have brought them today to the defense of an autarkic line that in a way converges with that of Michel Debre. Now, as far as I am concerned, being a socialist means being an internatonalist! I also believe that one can be a European while still opposing the Europe of Giscard.

By dint of failing to look reality in the face, the CERES leadership shrouds itself in theological language. Its thinking is immobilized. Thus, its loss of meaning. Chevenement likes to think he is living in June 1940. He preached a "national leap." Let's drop this "Cochin-call" type of vocabulary; socialism would have everything to gain from it.

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[Question] Do you agree with people who accuse CERES of "tagging along" with the CP?

Christian Pierret: I find that after they gave up their pursuit of self-government several years ago, the CERES leaders stopped criticizing the communist countries. They even refuse to call the Soviet system imperialist!

[Question] Jean-Pierre Chevenement and his team predict a quick, open break with capitalism. Aren't you to the right of them on this issue?

Christian Pierret: What has not been done in the name of a break! Remember, Guy Mollet ruled the SFIO from 1946 to 1949 on a pure, hard line. In the government he came to terms with the colonialist right but, as soon as he got into the halls of congress, once there, he was on the side of a break. After that, the French socialists should be careful, it seems to me, not to pride themselves on words.

I am in favor of a break, obviously, but I believe it is more important to define it in technical and economic terms than to build a statue to it. A return to Molletist scholastics is not the way to mobilize the French nor the way one can satisfy their aspirations. Let's wake up! For the time being, the real debate--on social planning--is going on in the CFDT [French Democratic Confederation of Labor] and the GGT or the CP more than in the Socialist Party. It is time we got away from personal, liturgical quarrels.

[Question] The CERES leadership denounces the "American left," which, in its preachings of social experimentation, would play into the hands of capitalism. Do you agree with this?

Christian Pierret: That is a publicity formula of Servan-Schreiber. He has not come up with anything new since the 1950's. It should not be taken seriously. In their discussions, socialists should not use this type of excommunication. Rather, why not talk about a "Chiraquian left" to describe certain new types of nationalism?

[Question] What is your line?

Christian Pierret: We want to relaunch the union of the left and endow our party with real self-government.

[Question] In the final analysis, are you a Rocardian?

Christian Pierret: We disagree with Michel Rocard on the Union of the Left because we reject the hypothesis of leaving the CP on the sidelines, and also on the subject of nationalizations. As far as we are concerned the latter is one of the decisive factors in the building of socialism. But we believe, instead of placing a ban on him, Michel Rocard should be asked the real questions so that he will shed his ambiguousness and join the line of Epinay in earnest.

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ITALY

CAUSES OF SPIRALING HEALTH COSTS DETAILED

Milan IL SOLE-24 ORE in Italian 5, 10, 15, 29 Oct 78

[Seven Part article by Antonio Brehna]

[5 Oct 78 p 3]

[Text] Health: The Cost Burden

> As health reform moves toward its final scrutiny at Palazzo Madama, doubts are surfacing in several quarters as to whether or not the economy can sustain the burden of its cost. The debate, as often happens in Italy, is based not only on skimpy documentation, but also on scanty knowledge of the "economic groundrules" that govern the system. We believe therefore that we are performing a useful service by providing, in a series of articles by Antonio Brenna, director of the Institute for Economic Research in Health, some documentation on growing health costs and a few observations as to the structural -- as distinct from the institutional pose assumed by the health delivery system -- causes for our increased expenditures.

For a number of years now there has been increasingly insistent talk of crisis in the welfare state (incorrectly translatable as "state of well-being"). There are two apparently conflicting elements which characterize this crisis: one is the heavy burden of spending that must be borne to assure coverage of social demands which are viewed nowadays as fundamental (spending which, with its heavy and systematic impact on the budget deficit has wound up as one of the most widespread builtin causes of inflation); and, on the other, the apparently endless demand for social benefits from various population groups.

Free health services are one example typical of that contradiction. The marked increase in spending for health -- particularly

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public expenditure financed by mandatory contributions, taxes, or public debt -- which is usually accompanied by increasing public dissatisfaction with the services provided, has for at least 5 years been a phenomenon observed everywhere in the developed countries of the western world.

Recent empirical observations indicate the existence of a significant correlation beteen the incidence of health spending on the GDP and per capita incomes. The higher the latter (per capita income which, despite its lack of precision as an index, is unanimously considered, even today, a clue to the level of wealth or prosperity of a specific population), the higher the fraction of resources devoted to health care. This correlation holds up over time and space and, in this second instance, it can be seen at both the international and infranational levels.

Let's explain that a bit. The correlation holds up over time, in that the rate of increase of health spending is higher than that of the GDP. As the years go by per capita income -- except in periods of acute depression -- rises, but so does the impact of health costs on the GDP. If during the same year, further, we consider several countries -- or several regions within the same country -- we see that the impact of health care costs on the GDP is greatest precisely where per capita income is highest.

Within the EEC, that incidence has gone from 4.7 percent in 1970 to 5.6 percent in 1973, and to 6 percent just recently. A similar trend can be found in the larger international community of the OECD, which embraces, in addition to most West European nations, the United States, Canada, and Japan. As for Italy, the rise in the impact of [health] costs on the GDP has been extremely marked, particularly since 1969. From 3.8 percent in 1964 it has risen to 4.6 percent in 1969, and leaped to 6 percent in 1974. Conservative estimates for last year set it very close to 6.5 percent. It should be noted that the impact figures just quoted refer only to spending on health services, and hence do not cover expenditures on economic benefits (sick pay) or the financial costs (interest on indebtedness) for the health care system.

On the European Community level, the validity of the correlation is shown on the graph, which indicates, alongside the positions of each country (the arrowheads), what might be considered the combined normal positions (interpolating vertical). Unfortunately the data upon which this graph was construction refer to 1973. On the basis of more recent data now available, however, there seems to be no substantial change in the positions of the individual countries. Updating the graph would probably require no more than a shift in the vertical and in the points around it at the top. In 1973, as against an EEC per capita income of

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$3,930 and an impact of health spending on the GDP of 5.6 percent, we find, at one extreme point, Denmark (with a per capita income of more than $5,200 and an impact on GDP of 7.5 percent) and at the other Ireland (slightly less than $2,000 and a 4.2 percent impact). The richest countries are thus spending more on health care not only in higher absolute figures ($390 per capita in Denmark vs. around $85 in Ireland), but also in terms of the portion of resources which annually become available.

If we run the same pattern for the Italian regions, we come up with results that are altogether analogous. In Lombardy, for example, whose resident enjoy per capita incomes very markedly higher than those of the residents of Calabria, health spending per capita is more than half again as much as that in the southern region. And if we go on and look only at spending on hospitalization, the disparity becomes even greater.

These basic findings help us, for one thing, to dissipate a very widespread conviction -- one which is, in our view, as harmful as it is widespread -- that holds that health delivery services are, so to speak, basic necessities. On the contrary: all the data indicate clearly that a good proportion of the services actually available today goes to services which, if they cannot be defined as "luxuries" or "voluntary," in the strict sense of those terms, are nevertheless typical of affluent societies. This being the case, one of the first arguments to fall is the one justifying public financing for the health care delivery systems.

Two issues automatically emerge at this point. First: to what point will the rising trend in health costs be tolerable for the economies of individual countries? Second: where does Italy stand in this context on the international scene, and more particularly within the European Community? The answers are anything but pleasant. There are, however, a few considerations that may help dispel some of the fog. Although to establish limits, a priori, upon the limits of tolerance is completely arbitrary, we can confidently assert that perpetuation of the present trend is clearly impossible over the medium and long term. If we extrapolate the trends begun in the early Seventies, health costs in the EEC would swallow, on the average, more than 10 percent of available resources in 1985, and 5 years later, in 1990, more than 15 percent (around a sixth). Any "spontaneous" levelling off of the tendency toward increased expenditures looks highly unlikely from today's perspective: in the light of the expansionary factors already at work in health costs, that tendency is far more likely to be accentuated. Hence the whole gamut of cost containment measures already adopted, or under serious study, in other countries.

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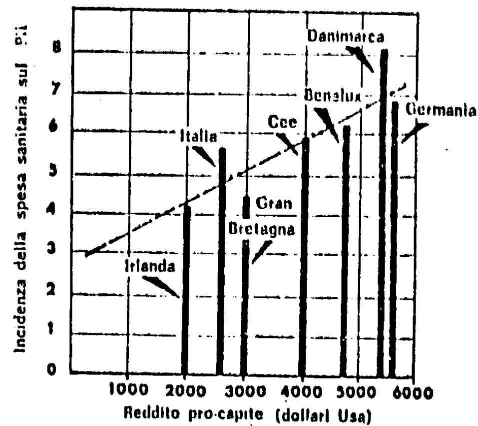
KEY TO TABLE
Ordinates: Impact of health costs on GDP
Abscissa: Per capita income (in U.S. dollars)
Countries, left to right:
Ireland
Italy
Great Britain
EEC generally
Benelux countries
Denmark
Germany

Source: Institute for Health Economic Research, using EEC and United Nations data.

HEALTH COSTS AND PER CAPITA INCOME



What about Italy? True, in this country health costs have not yet reached the impact on GDP, much less the amount in absolute terms, that prevail in Germany, Denmark, or France. Even so, there are three considerations that must caution us to extreme prudence in forming our opinions: first, the impact of such costs is greater in Italy than one would rightly expect on the basis of the mean European situation, if we consider the very modest level of our per capita income (the point indicating Italy falls above the interpolation line); second, the public deficit, for which health costs bear a goodly share of the responsibility, constitutes a far more serious problem here than it does to our European partners; and third, it must not be forgotten that, partly because of the jerrybuilt health care delivery system we rely on, the imminent reforms to that system have already aroused some very high expectations both among the people in general and among those in the system and, as recent experience has taught use yet again, those expectations will have the net effect of boosting costs still higher.

[10 Oct 78, p 3]

[Text] Why People Are Spending More on Health

The health cost explosion constitutes a very widespread phenomenon, involving, albeit at varying levels of intensity, every developed nation in the Western world. At its root, logically, in addition to aleatory factors affecting particular situations, there ought to be causes universal in scope. What are those causes? Are there solid grounds for the belief that

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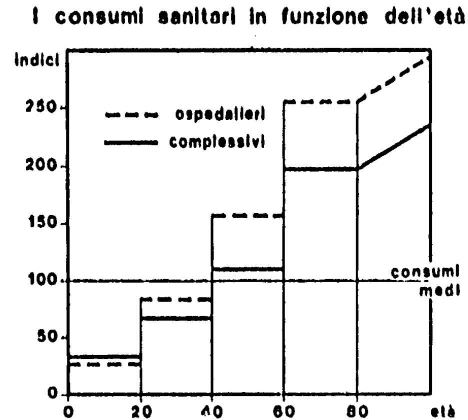
HEALTH CARE CONSUMPTION AS A FUNCTION OF AGE

(Key to Table)
Ordinates: Indices
Abscissa: Age
----- Hospitalization
▬▬▬ Total care
——— Average consumption of all kinds of health care.

Source: Institute for Health Economic Research (data from official Swedish publications)



the common factors behind rising costs in the recent past will spontaneously start losing their effect in the years ahead?

Health costs are nothing more than the product of the quantity of services utilized times their unit prices. It therefore becomes easier to single out the causes for their increase if we draw a distinction between the factors which swell demand and those which affect the prices of services. Well, the demand for health services has been rising steadily almost everywhere since the early Seventies, both by reason of phenomena involved in the economic development process, and because of the evolution in social legislation.

Improved living conditions, higher levels of education, and increasing urbanization, all of them phenomena which go hand in hand with industrialization, bring with them a rising demand for health services and for social services in general. This occurs partly because of the voluntary nature of a good portion of health service consumption (a kind of consumption which grows as living standards rise); partly because of heightened awareness of the state of one's own health, typical of a culturally advanced population; and, finally, because of the deterioration in the living and working environment which is the inevitable accompaniment of industrial development (and which has given rise to new kinds of pathology all but unknown among rural societies). Although there are no empirical data on the basis of which we

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might quantify the impact of these phenomena on health expenditures, recent research in Great Britain, France, and the United States agree in their finding that the demand for health services is greatest among the more affluent classes and, given equal income, those with more education, and among urban populations.

As for Italy, one significant piece of information in this connection comes from INAM (National Health Insurance Institute); the cost of health care for an industrial worker living in a capital city is, on the average, almost twice that of a farm worker living in a small country town. Note, though, that this applies only if both workers have the same health insurance.

Another extremely common phenomenon in industrialized societies, and one which exerts tremendous influence on health spending, is the ageing of the population. Individual demand for health care is also a function of physical age. While it is low in the early years of life, it begins to rise sharply at around 30, and reaches the mean level at around 40 to 45. From that age on, the upward trend grows steadily steeper until death occurs. The graph, which shows the consumption curves for health care services as a whole, and separately for hospitalization, with increasing age in Sweden, confirms what we have just said. Note that psychiatric treatment is not included: if we figure that in, the deviation from the mean is accentuated (one need only reflect, for example, that in the United States the demand for psychiatric beds among the population over 65 is almost five times the average). In Italy we have no detailed research data on this count. However, the -- very scanty -- information available would point to a very similar situation. A retiree on an INAM pension, for example, consumes about 95 percent more than the mean in days of hospitalization for acute illness.

Population ageing is an extremely disquieting phenomenon, in that, on the one hand, it involves in just about equal measure all of the developed countries and, on the other, it appears destined to continue far into the future. In the last quarter-century (1950 to 1975) the over-65 population in the EEC countries rose from 8.5 percent to almost 13.5 percent of the total. It Italy, that same population, which amounted to 8.2 percent in 1951, had reached 12.1 percent by 1976 and, according to reliable predictions, should hit 12.8 percent by 1981.

The expansion of social security systems, with the introduction of wholly or partially free services, is the other factor in the expanding demand for health care services we mentioned at the beginning. Here again, we are dealing with an extremely widespread phenomenon, and one which is probably not through growing. Insofar as Italy is concerned, health insurance which in 1955 covered less than 70 percent of the population now covers

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around 97 percent of us. With the advent of National Health Service, coverage should, within the space of a few years, extend to the entire population.

If we are to explain the explosion in health spending, we must look at the rise in unit costs of health services. Well, those costs are going up for at least three reasons. The first is to be found in the slight or non-existent rise in labor productivity in the system, and in the particularly marked upward push in wages, salaries, and fees. The first of these phenomena is easy to explain. Health services are, in the main, personal services. Scientific progress and technological innovation, as we shall see more clearly later on, rather than replacing the man with a machine, tend to attach that machine to a man, and thus to broaden the reach of medicine. The fact is that not only has the number of people employed in the delivery of health services been rising steadily just about everywhere; so has the level of qualification (roughly measured in terms of years spent in medical or specialist schooling) for the average medical employee. Hence you have increasingly numerous and increasingly expensive staffs. On top of this, you have an increase in physicians' earnings -- and by association in those of other categories of people in the system -- which is measurably faster than the average. Here again we have a phenomenon to be found everywhere in Europe, with the sole exception of Great Britain.

The second factor in rising costs is to be found in the fact that many of the more complex health care institutions (hospitals) are represented by public agencies or charitable institutions which, as such, are not overly sensitive to the reed for frugality in management.

And finally we have what has come to be commonly referred to as the "paradox of medicine." Advances in health -- unlike what happens in other sectors -- very frequently gives rise to new need and hence to new and more costly services. The reduction of prenatal mortality, for example, brings with it an increase in the number of handicapped. The lengthening of the average lifespan feeds the demand for services, hospitalization and other, among the elderly. And so it goes. Every medical advance feeds the hopes of new classes of patients, whose survival presumes systematic reliance on and utilization of health services which are often extremely expensive: organ transplants and hemodialysis are the most typical examples, though by no means the only ones, of this sort of thing.

This paradox constitutes a fundamental problem for the health care systems of the future, often facing the planner with awesome decisions (how, for example, can one justify spending huge sums to prolong the already precarious existence of one person,

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when you haven't the money to provide acceptable hygienic conditions for great masses of people?). This is not the place to get into the merits of this set of problems. One thing, though, we can say as of now. Merely knowing about the possibilities opened up by medical progress and being aware of the practical utilization of those possibilities presupposes the commitment of tremendous resources must spur those responsible to intervene with the utmost rigor in cutting back on the vast amount of waste that goes on, as well as on all expenditures which go to supply consumption whose efficacity is, to say the least, dubious.

[15 Oct 78 p 3]

[Text] Health Spending Peaked? Not Likely

Just how big has health spending grown in Italy? How fas has it grown? What changes have occurred in the ratios between spending and the more significant macroeconomic indicators? These are questions we shall try to answer, taking as our context a period long enough to embrace all the major trends.

So as to avoid misunderstandings, always possible when it comes to figures, we might best define, first of all, the real state of affairs to which the expenditures we are concerned with refer. Economically and financially speaking, the Italian health care system is a mixed one: alongside a public sector, which includes health services financed by local agencies and whose cost burden rests on the collectivity as a whole, there are also an insurance sector, kept going mainly by work-related contributions, and a private sector. Whereas the public sector provides, in addition to psychiatric services, mainly preventive prophylactic and hygienic services, the insurance sector has to finance almost all diagnostic and therapeutic services.

Beginning in 1975, when public hospitals were transferred to the regions, a new financial institute known as FNAO (National Hospital Care Fund) has been operating with work-related contributions and transfers of funds from the Treasury. The Fund is unique within the Italian financial structure, in that on the one hand, as we just said, it gets a very large share of its money from worker contributions, which constitute an extremely and very inequitable burden on that one segment of society; and on the other hand it pays for uniform and extensive services not only to workers with health insurance, but to the indigent as well as to "voluntary contributors." This means that as of early 1974, we have had a new economic sector in the health field in the form of the hospitals.

It is worth noting that the financial system we now have for hospital care will, with the establishment of the National Health Service (which calls for unification of the public, insurance,

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Consistent with the configuration our health system has been moving toward, then, starting in 1975, hospitalization spending is shown separately under the FNAO heading. Gross health expenditures (insured plus public) at current prices, as shown on the table, has risen from around 1,520 billion lire in 1964 to 2,690 in 1969, to 7,125 billion in 1974 and finally to last year's 11,520 billion.

The sums are smaller when gross health expenditures are purged of economic health payments (services which obviously are not direct health services, but rather money transferred to families in partial compensation for income lost as a result of illness); of the administrative costs of such ancillary services, and of the debt service costs which weigh so heavily upon the entire health sector. This last item has grown increasingly weighty over the span of years, thanks to the steady rise of indebtedness in the health sector as a whole (particularly among the insurance carriers) by comparison with the rest of the economy.

One need only think, in this connection, of the fact that at the end of 1974 the insurance carriers' debt and that of the communes to the hospitals -- and consequently that of the hospitals to the banks and to their suppliers -- together came to more than 4,100 billion lire. Considering that net overall spending for health in 1974 came to 6,050 billion, this one sector's deficit that year accounted for 68 percent of all spending for the fiscal year.

Health expenditures purged of the cited burdens (compensatory pay for illness, administrative costs for the compensation program, and debt service), meaning the money that actually went to pay for health services, came to the amounts shown in the last column of the table (from around 1,300 billion in 1964 to 9,850 billion in 1977).

The data shown here lend themselves to three kinds of remarks. First, the kind of spending that has grown in a way that can only be described as pathological is insurance fund spending. Over the 1964-1974 decade, in fact, while public spending on health services was roughly tripling, only a little faster than the GDP, insurance fund spending practically quintupled. Over the next three years, the gap widened perceptibly. The phenomenon is anything but insignificant.

The expenditures referred to here as public, which more than anything else show very moderate rises over recent years, are in fact the money that goes to finance hygienic and sanitary services, prevention and rehabilitation -- hence precisely the kinds pf health care delivery the reform is expected to increase. Diagnostic and therapeutic services, which in most people's opinion are riddled with abuses and consumerism, and which as such

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HEALTH CARE SPENDING IN ITALY - 1964-1977 (billions of 1978 lire)

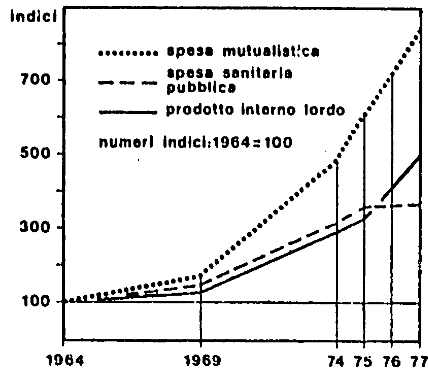
	1964	1969	1974	1975	1976	1977
Public spending	267	414	852	965*	971*	1.067*
Insurance spending	1,255	2,274	6,273	4,354	5,417*	5,936*
FNAO	---	---	---	3,300	3,750	4,515
Total Gross	1,522	2,688	7,125	8,619	10,138*	11,518*
Total Net	1,309	2,374	6,053	7,228*	8,480*	9,850

* Preliminary data
Source: Institute for Health Economics Research, using data from official publications.

HEALTH SPENDING AND GDP

(Key)

Abscissa: years
Ordinates: Indices
Source: cfr. Table above
.... Insurance spending
---- Public health spending
—— GDP
Index numbers:
1964 = 100



hospital sectors on territorial lines) be expanded to cover the entire health delivery system, thus emerging as an instance of improper financing.

The private sector of medicine, relying on the personal income of the users of its various services, completes the circle.

Although this sector's dimensions are in actuality far larger than one might think (it includes not only those who do not have health insurance, but also to a considerable degree those who do in fact have it), we shall confine our considerations here to public and insurance spending on health services. The difficulties involved in arriving at an estimate of private health spending are such as to prohibit our providing reliable data on that score.

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ought to be redimensioned, have on the contrary attracted constantly increasing amounts of money.

The second observation has to do with the different pattern that has governed overall health spending during the three periods into which we theoretically divide the 13 years covered by our data. Over the 5 years from 1964 to 1969 that kind of spending rose by an annual average of 12 percent. The real leap comes in the following 5-year period (which coincides with the last period of full insurance carrier management), the 5 years over which the mean annual rate of increase rose to 21.5 percent.

Beginning in 1975, the increases consistently begin to taper off (21 percent in 1975, 17.6 percent in 1976, and 13.6 percent in 1977). This levelling trend takes on greater significance when we remember that the inflation rate was rising during those same years. The data on expenditures for the last 3 years, however, should be taken with more than a grain of salt, for reasons which will be made clear later on. The graph shows the two observations just made (note that on it FNAO is included under insurance).

In the wake of that spurt of increase -- and this is the third observation -- the impact of gross health-connected expenditures on all the major economic indicators (GDP,private consumption, total consumption, etc.) has been growing even faster. Taking GDP as a reference term, the impact of gross health-connected expenditures (including such expenses as sickpay and other costs already discussed) has risen from a modest 4.5 percent or so in 1964 to 7 percent in 1974, and again to 7.5 in 1975. As of that year, our data show that the trend is turning around. In 1976, in fact, the impact of spending on the GDP came to 7 percent, and last year it was down to 6.6 percent.

Have we really peaked? That conclusion is not what one would call self-evident. At least two considerations come forcefully to mind in this connection. First, the data shown on the table for insurance fund spending and public spending over the past 2 years are preliminary, and there is every reason to assume that they will be revised upward. Second, the data referring to hospital care over the past 3 years do not reflect that expenditure, but merely FNAO payments, and we all know that those payments have shown themselves to be altogether inadequate to cover the actual expenditures by the regions for hospital care.

We must therefore be extremely cautious in drawing optimistic conclusions. The impression we get, above and beyond the data, is that the share of available resources swallowed up each year in the maw of the Italian health care system is going to increase still further.

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29 Oct 78 p 3]

[Text] The Grabby Hospitals: How They Got That Way

The hospital is the eye of the storm of contradictions swirling around modern health care delivery systems. On the one hand, and for years, there has been a growing urgency in demands that we cut down the space this institution occupies in the health organization; and on the other we must admit that there is steady growth in the share of blame the hospital must shoulder, although the blame pie is growing, too, if we look at the amount of money we spend on protecting our health.

On the one hand, there are those who insist that teaching and research activities be taken out of the hospitals and put into other health structures, and on the other hand we must admit that the hospital -- particularly the large hospital with clinical facilities -- is in practice the only place where students can get training, at the university and professional level, in the so-called healing arts.

On the one hand some say that the giant general hospital is increasingly hard to justify, given its particularly high costs and the difficulties encountered in its administration; and on the other we see people still planning general hospitals with more than 2,000 beds. We could, of course, go on with such conflicting examples indefinitely.

The fact remains that the hospital represents a concentration of power, a coagulation of interests, a chance for a job, and, more generally, a factor in local development whose weight few others can match in everyday terms.

These contradictions stand out more sharply in Italy than elsewhere. For at least two decades now there have been widespread calls for "de-hospitalization," for more emphasis on basic services, for "territorializing" services (enclosing terms of questionable taste in quotation marks is the requisite pinch of pepper in any discussion of health policy).

A posteriori, however,we cannot fail to see that while the hospital system has been undergoing spectacular expansion, at least in quantitative terms, the basic health organizations, including the fundamental public health services, have been steadily edged into poverty. Furthermore, the much-talked-of health reform program has thus far failed to come up with any measures other than those centering on the hospital sector. The major legislation from the institutional aspect to appear in the last decade is all to be found under the heading of "Hospital Reform" (PL 132 of 12 February 1968) and ancillary decrees, and in the act transferring hospital

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functions to the regions (PL 386, 17 August 1974). Finally, it is fairly pointless to recall -- especially in the wake of the pell-mell expansion of the sector -- that our hospitals, particularly the largest of them -- have in recent years become the focus of massive protest, where the period explosion of frustrated expectations acts as a potent agent for social instability.

The pervasiveness of the Italian hospital in its financial aspects is shown on the accompanying table, where the cost of hospital care is set against the cost of health care as a whole (this means hospital and health costs borne either by local agencies or by the insurance carriers, not including sickpay and benefits, interest on health system indebtedness, or administrative costs).

A Complex Problem

As you can see, the impact of hospital spending on health costs in general has risen from around 40 percent in 1964 to 44 percent in 1969, to around half (48.6 percent) in 1974. Since 1975, owing to the transfer of hospital care responsibilities to the regions, the problem has grown more complex. The table shows, along with the amounts actually spent by the refions to provide hospital care, the appropriations approved by Parliament for hospital care under the FNAO Health Fund.

These appropriations should have acted as a brake on hospital costs themselves, but that is not the way it turned out. Given FNAO appropriations of 3,300 billion in 1975 and 3,750 billion for 1976, the regions spend 3,513 billion in 1975 and 4,061 billion in 1976 (the data for last year are the combined preliminary budgets for all the regions except Calabria, for which an estimate was made). Anyhow, even if we take into consideration actual expenditures for hospital care, the impact on health spending for 1975 begins to flatten out: from 48.6 percent during the first year after the regional takeover to 47.9 percent in 1976.

The real spending explosion thus occurred in the 5 years immediately following the 1968 "reform" (from 1969 to 1974 the annual average increase in hospital spending was more than 24.5 percent). Why should that be? Can any remedy really help at this point?

This is not the proper place to go into the merits of the 1968 Hospital Act. Citing it, however, is anything but idle, since it is the symbol and epitome of a reform which, having failed to spot the most obvious economic implications of its provisions, has had disastrous effects. It is an example deserving of serious reflection (not to mention avoidance) right here and now, as we put the finishing touches to another reform, that of the health system, far greater in scope and dimension.

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Spesa sanitaria e spesa ospedaliera - Anni 1964-1977

	1964		1969		1974		1975		1976		1977	
	Val. assol. (mil.di)	Incr. medio annuo	Val. assol. (mil.di)	Incr. medio annuo	Val. assol. (mil.di)	Incr. medio annuo	Val. assol. (mil.di)	Incr. medio annuo	Val. assol. (mil.di)	Incr. medio annuo	Val. assol. (mil.di)	Incr. medio annuo
Spesa sanit. complessiva netta	1.309	—	2.374	12,6 %	6.053	20,6 %	* 7.228	19,4 %	* 8.480	17,3 %	* 9.850	16,2 %
Spesa ospedaliera	534	—	1.054	14,6 %	3.170	24,0 %	** 3.[illegible]	10,8 %	* 4.061	15,6 %	n.d.	n.d.
FNAO							3.300	—	3.750	13,6 %	4.515	20,4 %

* Dati provvisori.
** Dato provvisorio, in esso è inclusa non la spesa ospedaliera a consuntivo ma lo stanziamento nel FNAO.
Fonte: Elaborazione dell'Istituto per la Ricerca di Economia Sanitaria su dati estratti da pubblicazioni ufficiali.

TOTAL HEALTH SPENDING vs HOSPITAL SPENDING (billions of lire)

KEY TO TABLE

Reference column entries:

Total net health expenditures
Hospital expenditures
FNAO

Headings for six double columns:

Year		Year		Year	
Actual amount	Mean annual increase	Actual amount	Mean annual increase	Actual amount	Mean annual increase

.....

* Preliminary data

** Preliminary data, not including final hospital expenditures but including payments into the FNAO

Source: Institute for Health Economics Research, using data from official publications.

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HOSPITAL SPENDING vs TOTAL HEALTH SPENDING IN ITALY

(Key)

Ordinates: Index

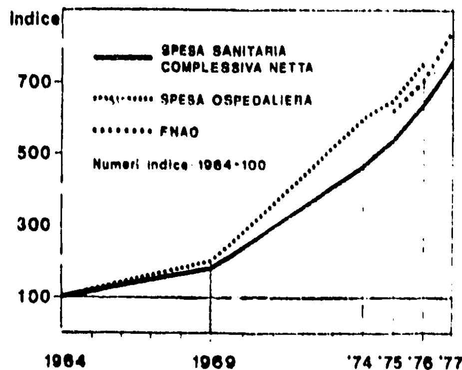
Abscissa: Years

———— Total net health expenditures

. . . . Hospital expenditures

oooooooo FNAO

Base year for index levels: 1964 = 100



With the 1968 Hospital Act, what happened substantially was the introduction of four innovations (I am referring to the greatest innovations with reference to what we are talking about here): first, we endowed the hospitals (operated theretofore mainly by "public welfare and charity institutions," the "Corporal Works" of blessed memory -- with complete autonomy, turning them into functional public agencies; second, we liberalized access to them, making it quite impossible for them to turn anybody away for any reason, sound or otherwise; third, we set up regulations covering staff, at the very least from the point of view of standards; and fourth, we took care, through a device as ingenious as its consequences were catastrophic, of covering the costs of the hospital agencies.

That last point is particularly important. Therefore we had best begin with it. With the reform of public hospitals it became possible to finance the services they rendered through what was called the "hospitalization fee" (the cost per day of staying in a hospital); that fee is reckoned simply as the ratio between the predicted overall cost and the number of days hospitalization expected for that particular admission.

No Controls

There is no control worthy of the name over the sum of costs: that function -- assigned to the regional auditing boards -- amounts in practice to merely ascertaining the legitimacy of the various

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items of expenditure. The insurance carriers--the principal "purchasers" of hospital services--are thus stripped of any contractual power, and their role is thus reduced to merely paying the bills the hospital sends them, based on nothing but the number of days the insured spent in a hospital bed.

The public hospitals, therefore, have found themselves in the position of a monopoly holder, with one additional advantage: while the monopoly lets its holder set prices, provided he is willing to settle for whatever demand there is at that price, when a hospital sets a high per diem rate (high enough to cover all costs, however incurred) it does not thereby lower demand, since the demand is guaranteed by the insurance systems and--albeit in far lesser measure--by local agencies.

Further: the public hospital agency, thanks to the full autonomy it now enjoys, is suddenly operating like any private business, but without having to stay within any budget: maximizing profits, which may be considered to constitute the dominant aim in private hospitals, is replaced in the public hospitals with maximizing the satisfaction--in terms of opportunities for backstage maneuvering for prestige and power--of local administrators and bigwigs. The elimination of all barriers to entry, the establishment of minimum levels of staff together with official recognition of their status, not to mention the declining efficiency of the basic services, ever ready to palm off onto the hospitals any case involving the slightest difficulty, have largely contributed to the disorderly growth of the hospital system and to the consequent inflation of costs.

To this we must add that the only two provisions contained in the 1968 Act designed to improve efficiency have never been put into effect. There is reference to the powers delegated to the government to issue standards covering hospital administration and accounting practices, and to the planning function assigned to the regions (and, pending their institution, to ad hoc committees, the regional committees for hospital planning). Well, the government has let those delegated powers lapse. With the result that even now hospital administration and accounting practices are still governed by regulations dating back to the 19th century. As for the planning authority, it is enlightening to reflect on the fact that as of the end of 1974 only one single region, Lombardy, had adopted a plan and passed the enabling legislation.

This, in brief, is the history of all the things that have helped to beget the truly precarious situation inherited by the regions in 1975. The ability of the regions to apply the timeliest (and most feasible) remedies is matter for another inquiry.

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[9 Nov 78, p 3]

[Text] Without health reform and pending a specific programmatic plan, Italy's hospitals are adrift.

High costs, endemic chaos, and crises arising with maddening regularity are the traits characteristic of the hospital scene in Italy, and have been for at least a decade. Why? The answer is anything but simple. Even so, we do not feel it would be far wide of the mark to say that, underlying the whole situation, is the failure of the so-called hospital reform of 1968.

That reform was based on a wager: that we could turn our hospitals from charitable-welfare institutions, relying largely on volunteers, on low levels of skill and remuneration to staff, into modern health delivery structures of high efficiency, with well paid and well trained staff capable of providing medical care at a high level, as well as of performing educational, teaching, and research functions. The increased costs of the operation -- it was thought at the time -- would be partially offset by the people's using the hospitals less frequently. The modern hospital for acute cases is different from the old charity institutions in several ways, including its prerogative of picking and choosing its admissions, and the relative brevity of the average patient stay.

What was missing in this plan? First of all, any provision for controlling the demand for hospital services. The demand for admissions is measured in days of hospitalization. And hospital days are nothing more than the number of citizens admitted each year times the number of days each patient stayed, on the average, in the hospital. Well, the number of days spent in every sort of hospital by the average Italian shows no sign of declining, and the time spend only in the public general hospitals (the ones for acute cases, which notoriously have higher unit costs) is increasing, although not by much, in spite of the fact that the original datum was -- quite correctly -- felt to be excessively high.

More specifically, by comparison with a modest decline in the average length of hospital stays from 13.83 days in 1969 to 13.34 in 1974 and again to 12.49 in 1976, there has been a marked rise in the frequency of hospital admission: in 1969, 118 of 1,000 citizens were admitted to public general hospitals; in 1974, there were 133 per 1,000, and in 1976 there were 142. This means that there is a steady upward trend in the number of patients admitted per year, while the decline in the length of stay is slight and hence not substantial enough to offset the admissions rise. Consequently the number of days the average Italian

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spends in the hospital rises from 1.63 in 1969 to 1.78 in 1974, and hits an all-time high (1.82) in 1975. The graph shows very clearly the trend from 1964 to 1976, the latest year for which data are available.

A good portion of the failure we referred to at the beginning lies in these very figures. The transformation of our hospitals, as a vast body of experience abroad teaches us, must come about through a massive reduction of admissions. If you do not achieve that goal, you might as well forget about the other one.

Hence the hospital, if it is to be judged on the basis of the volume of services it delivers, is still functioning as a non-discriminating place of shelter, and, viewed in that light, it is not much different from the welfare and charity institutions it was supposed to replace. The picture, though, changes when we take a look at costs. The hospitalization fee (per diem cost) for the "average insured patient" rises from around 5,000 lire in 1969 to almost 25,000 in 1974, thus practically quintupling in the space of 5 years.

The reason for this soaring spiral can be explained with a few data. The number of hospital beds is increasing, although at a fairly moderate pace (in the ordinary public hospitals the increase over that 5-year period is 15 percent) without bringing any noticeable reduction in the existing territorial imbalances. But what is increasing faster than anything is staff. It has risen, as the table shows, from 194,000 in 1969 to 335,000 a mere 5 years later. The staff increases involve primarily skilled medical personnel (trained nurses, ward supervisors, Ob nurses, and paramedics).

Two considerations are needed in this connection, though: first, the number of professional nurses is still very low, and in any case well below any reasonable requirement; second, there are still legitimate doubts as to the level of training of that staff. A good many of those now on the roster as professionally trained nurses have become such after taking crash courses designed to turn practical nurses into trained nurses (see PL 124 of 25 February 1971).

Properly cited along with this shortage is the truly exorbitant number of those ISTAT defines as "technicians, attendants, and other staff," thus lumping the bioengineer along with the doorman, the security guard, and the cleaning crews. Although no breakdown data are available, it may be assumed that most of this catchall category consists of people with a very low level not only of specific skills, but also of schooling. It is noteworthy that, if we add to this last category the administrative staff, we come to the astonishing conclusion that about half of all hospital employees are not doing any kind of patient-related work at all, but are performing what might be called support functions.

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PER CAPITA ADMISSION DEMAND AT PUBLIC GENERAL HOSPITALS: Base Year 1964 = 100.

▬▬▬▬ Frequency of admission

^^^^^^^ Per capita length of hospital stay

●●●●●●● Mean length of stay

Source: Institute for Health Economics Research, using data from ISTAT.

REGULAR PUBLIC HOSPITAL STAFF from 1969 to 1974

	1969	1974	Increase
Physicians	31,836	46,612	46.4%
Professional medical staff	16,046	40,126	150.1%
Trained aides	42,071	81,486	93.7%
Technicians, attendants, and other staff	88,957	141,003	58.5%
Total staff	194,029	335,839	73.1%
Religious staff	9,249	7,244	- 21.7%

Source: Institute for Health Economics Research, using ISTAT data.

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The increase in staff, as we said, was accompanied by an increase in wage and salary levels. The annual labor cost per staff member rose by around 80 percent from 1969 to 1974, up from 2.9 million to 5.2. That average, though, hides some huge disparities; in 1974 it ranges from an annual salary of more than 18 million for a head physician working full time (and equivalent grades) at the peak of his career to 1.5 million for the skilled worker in his first job, a pay level which rises to a little over 2 million for a trained nurse, also on her first assignment.

According to a recent study by the National Federation of Regional Hospital Associations (FIARO), the average 1975 earnings for medical personnel, either full time or on regular hours, was 10.7 million (of which 9.4 was base pay, and the balance for additional services including overtime), while for non-medical staff it was 3.4 million (of which a little over 3 million was base pay). It should be noted that among these non-medical personnel there are people who draw relatively high pay, such as administrative directors (secretaries) and administrative personnel in general. It should also be borne in mind that the data shown here are averages, which mask situations differing from one hospital to another: there are in fact many cases of "corporate" contracts tied in with the national contract.

This latter consideration leads us to what is perhaps the single most worrisome aspect of the present hospital picture. The institutional and regulatory uniformity introduced with the 1968 reform masks situations that are extremely heterogeneous insofar as efficiency and economical management are concerned. It takes only a superficial look at individual hospitals to see extremely diverse situations, both from the point of view of costs and from that of the quality of care. Differentials in unit costs (for example, the cost of staff per bed, the cost of medications per day of hospitalization, the cost per meal, etc.) of as much as 100 percent from one hospital to another apparently just like it are common. On top of findings like these, we are aghast to discover what might be called the normal tenor of hospital activities. Apart from such periods of crisis as we are going through now in connection with hospitals that are, in the final analysis, simply "hanging on" -- these are mainly modest-size hospitals in provincial cities -- there are a great many of our hospitals where people live in a state of chronic emergency, where high absentee rates, tardiness, insubordination, the lack of controls and the backwardness of the administration are everyday constants.

In a situation like this is it hard even to attempt to wrap up a neat summary, without resorting to banalities. Two observations, though, may confidently be ventured. The first has to do with the illusory nature of any reform that affects only one part of the health delivery system -- the hospital. The macroscopic lack

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of first-echelon services (we are alluding specifically to medical attention in general) inevitably dumps a volume of demand on the hospital which is incompatible with the costs of the present day hospital. The second has to do with the attempt to make any substantial change in the hospital situation in the absence of a clearly spelled-out and articulated plan.

What we have seen as a consequence is an expansion in hospital beds and staff stemming from fragmented decisions which were wholly uncoordinated and therefore took no account of the real needs expressed in the country. They tried to reform the hospitals by putting a premium on quantity, forgetting that health services depend substantially on the quality of those who deliver them. And those who deliver them are not all doctors and nurses: they include planners, organizers, administrators, and managers.

The regions which, as we know, took over full responsibility for operating the hospitals 3 years ago, have become aware of these shortcomings. Although it would be greatly premature to venture an opinion as to how they are doing, one gets the impression that, apart from a few exceptions, as of right now the ability to achieve and maintain real control over the situation still belongs in the realm of good intentions.

[12 Nov 78 p 3]

[Text] Striking a trial balance while the debate over health reform goes on: lots of shadows and a few gleams of light in the rapport between the regions and the hospitals.

The Health Reform bill now before the Senate contemplates, among other changes, vesting full authority over and responsibility for all health services in the regions. The regions will not be called upon to manage the services directly, but rather to regulate their management, which will be transferred to local agencies, anu to finance them, using funds from the central government.

In other words, with the institution of the National Health Service, the authority the regions assumed for the hospitals as of the beginning of 1975 will be expanded to take in the whole range of health services. In fact, ever since the passage of PL 386 in 1974, the regions are responsible for providing hospital care through the public hospitals and, should those prove insufficient, through privately operated hospitals. The regions must finance their hospitals out of funds they receive for the purpose from the central government. On the other side of the coin, the regions have considerable authority to intervene in the management of their hospitals, since they wield final authority over their major decisions, which are those regarding investments and staff.

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A Mixed Picture

From the economic and management viewpoints, there is no artificial simplification of reality in asserting that the present relationship between the regions and the hospital agencies will find a parallel in the future relationships between the regions and local health service delivery units. The only major difference from this angle being the greater complexity and scope of the operations the new relationship will have to embrace: today it is only hospital services, but tomorrow it will be the entire range of health services, once the reform takes effect.

The performance of the hospitals in the last few years can thus be viewed as some indication of the regions' aptitude for coping with health matters in general.

What criteria ought we to use in proceding with such an assessment? The first one -- in our view -- cannot be any but the demonstrated ability of the regions to take over from the point of view of knowledgability in the field, which in turn presupposes gathering the more significant data available on hospital management. Information -- regular, reliable, screened, and timely -- is the one requisite basis for making any rational choice.

Well, by this first criterion the picture is a spotty one indeed. Along with those regions which have practically final data for 1977, we find a great many others which still don't know exactly how much their outlay was 3 years ago. True enough, the state of affairs they inherited in 1975 was not the most orderly ever (the administrative and accounting procedures now in use by the hospitals date back to the 19th century, and hence were never designed to yield the data most essential to the management of contemporary hospitals); but it is just as true that the regions as yet do not have -- since they are, after all, still very newhatched entities -- solidly established administrative-burocratic apparatus; and finally, it is true that there is a lack of people with the specific background and training needed to do the work of health planning and management (disciplines like health economics, management of health services, which have long been offered at the undergraduate and postgraduate levels in other countries, some of them our near neighbors, attract few scholars in Italy, and offer even fewer opportunities for teachers); however, one might quite properly have expected a greater commitment in this direction.

Specifically we find (always barring the exceptions, as rare as they are remarkable) unbelievable slowness in setting up stable organizational structures on the part of local health commissioners, who have specific specific responsibilities toward the hospital sector.

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Again, at least as of now, very few regions have managed to set up data handling systems that embody any advances over those in use; if we exclude Lombardy -- which, by law, has acquired a new hospital accounting system -- most of the regions have merely imposed standardized bookkeeping practices on their hospitals. The task of gathering and sifting the data on the various vital aspects of hospital activities is often left to the commissioners -- and even more frequently to their assistants -- who are parti cularly sensitive to such requirements. However, these few initiatives are by no means general, and often sporadic, quite outside of any institutional obligations.

Still another important element has to do with the relative heterogeneity of the level and kind of data gathered in the various regions. In this connection, however, it should be emphasized that there has been a lack of direction and coordination on the part of the central government. It is a fact that the volume, the reliability, and the timeliness of the available data is diminished on the way from the hospitals to the regions, and even more on the journey from the regions into the various ministries concerned (most particularly the Ministry of Health).

We have dwelt thus at length on this point because we believe that a public health system financed by the central government and controlled through a system of budget restrictions imposed on the lower echelons of government by those higher up (from the state to the regions and from the regions to the hospitals now and to local health units in the very near future), cannot work without regular flows of information from bottom to top and vice versa, and consequently without administrative and burocratic apparatus that can activate and manage such flows.

Information Flows

The lack of up-to-date information covering the entire country prevents our drawing any specific conclusions as to the regions' capacity to supervise and control the hospitals. However, in the light of available data (which is all but complete for 1976 and altogether preliminary for last year), the following trends seem to be emerging as the regions gain experience. First of all, we have a decline in the nationwide average rate of increase in hospital care spending, as compared with the preceding 5-year period (the rate has dropped from 22 percent annually to around 16 or 17 percent); and that is an even more creditable achievement when you consider the higher rate of inflation of more recent years. In the second place, the trend toward increasing the numbers of hospital beds is tapering off. In 1976 we find an actual drop from 1975 in the number of beds in public hospitals (down 0.4 percent nationwide).

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That bit of information, encouraging in itself, takes on greater significance if we consider the fact that along with a considerable reduction in those regions with excess hospital beds we see an increase in their numbers in those regions which even now have not enough. A third datum is the increase in occupancy, with a particularly significant rise in some regions. Unfortunately we do not have data as to the distribution of new staff according to skills or professional levels, but from the available information most of it apparently concerns general personnel. One decidedly unfortunate tendency is that of increased resort to private hospitals: from 1975 to 1976, while costs in public hospitals rose by around 14 percent, the cost of a stay in a private hospital rose by over 25 percent (while costs in Church-run hospitals rose by 30 percent).

The discrepancy increases if you consider, in addition to costs, the number of days per stay. One may well wonder, finally, whether or not the goal of restoring equilibrium among the regions, to which PL 386 of 1974 attached so much importance, has ever been pursued, and if so to what degree. But in this connection we also find, along with the increase in numbers of hospital beds and in rate of occupancy (and consequently of expenditures) in the southern regions that are decidedly starting well behind the rest, two more phenomena, to wit: a markedly lower occupancy rate for hospital beds precisely in those less favored regions, and a demand for admission on the part of people whose homes are in the south to hospitals located in the central and northern regions that is steadily rising. This would certainly indicate that the structures for providing care are not adequate: the quality of those structures is crucial.

Taking it all together, then, despite the woeful lack of planning and management tools available to the regions, we must admit that there has been some improvement in the state of the sector on a national average, at least if we stop to look at the raw economic data. Two considerations arise forcefully at this point: first, along with the resources the system soaks up, we must assess the benefits it offers the population (though this is a question the available data do not allow us to deal with) and, second, we must not forget that the national averages tend to cloak situations that are extremely disparate at the regional level.

[28 Nov 78 p 3]

G.P.s Make Most Health Spending Decisions

[Text] The huge and growing size of the hospital plant and the expenses connected with it present a real risk of neglecting the rest of the health-care delivery system. We are alluding here to the medical practitioners patients see first, what we call rank-and file medicine, whose importance turns out to be decisive not

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so much because of its direct cost to the collectivity as because of its pervasive effect on the efficiency of the whole system.

The general practitioner -- otherwise known none too flatteringly as the "insurance company's doctor" -- is the first and biggest link in a chain that has been lengthening out of all conscience over the past decade. It is from him, for example, that we must take our clues in explaining the phenomenon that goes by the vague but significant appellation of medical consumerism.

The reason for these assertions will emerge clearly if we stop and remember that in the health field it is not the consumer who expresses a demand for services, but the physician, in most cases the general practitioner. The individual's role is confined to presenting himself as a candidate-patient; from then on, he must rely on the judgment of the physician as the interpreter par excellence of his "medical needs." It is he who decides whether, and to what extent, to convert the expressed need into a demand for services.

The specialized literature clearly shows how the behavior of the GP is influenced by a set of factors which have very little to do with the state of health of the patient (or would-be patient). They include such matters as the physician's level of education and of professional experience; whether or not he is a member of this or that (sometimes "fashionable") school; the availability of specialized services; the doctor's status in the system he is part of (private practice, under contract, full-time employee), who pays his fee and -- to include only the commonest -- how many other physicians there are (the ratio of physicians to population): all seem to exert considerable influence on the channels by which the patient's expressed need is converted into demand for services.

It has been statistically proved, for example, that the number of referrals to specialists (including the radiologist and the laboratory expert) increases as the number of specialized out-patient clinics. The same applies to hospital services: the per capita length of stay increases as the number of hospital beds.

Again: the number of office calls and of medical prescriptions rises along with the numbers of physicians: as the ratio of doctors to population rises, so does the number of office calls. And finally, it is general knowledge that, in the case of physicians under contract, calls and prescriptions regularly run higher when the doctor is paid under the "notula" system (so much a call) than when he is paid a "quota capitaria" system (so much a year per insured).

It is precisely the most obvious correlation that has yet to find statistical corroboration: the correlation between the health of

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the population and recourse to available medical facilities. The behavior of the GP, in addition to affecting the volume of demand accumulating downstream from him, so to speak, with obvious impact on costs, also has an effect on another social phenomenon having very great economic impact: the phenomenon of absenteeism, particularly brief but frequent absenteeism due to illness.

From the foregoing we can divine the importance of front-line medicine and hence the need for well-trained physicians who are aware of the implications -- including the economic implications -- of what they do, and for placing them in a context that will give them an incentive to behave responsibly.

We need only go back to the most recent history of our insurance system to see that this sector has, on the contrary, been totally neglected. No specific preparation is required of the physician for a contract with the insurance company (which ipso facto makes him a GP). The spread of completely free medical services (direct attendance is in fact rapidly replacing attendance for a fee); the increase in the number of physicians; massive resort to the "notula" form of compensation, coupled with the complete and utter lack of supervision over professional practices, even in contract situations -- all are factors which have not only contributed to the increase in the number of calls: they have provided an inducement for the physician to refer his patients ever more frequently to the more complex health services.

Competition among doctors for patients has aggravated the situation, since that competition is based not so much upon the physician's professional competence -- which the patient is in no position to judge -- as upon his readiness to "satisfy" even the most groundless of his patients' demands. The insurance doctor has thus increasingly come to play the role of a builder of demand for medical services. His professional services have been downgraded to merely writing prescriptions, issuing certificates to explain absences from work, and referring patients to radiologists, laboratory experts, specialists, and hospitals. Demand generated in this way has helped to swell the volume of more complex services, with obvious implications for the overall cost of medical care.

As a consequence of all this, while the cost burden of GP or family doctor medical care on overall medical costs has been declining over time (partly because of the low fees paid for calls paid for by the insurance companies), the cost of services properly rendered by front-line medicine, but shunted off onto the rest of the system has mounted enormously.

The table, which shows the trend over time in the commonest services offered by INAM, is the most tangible demonstration of what we have just been talking about. From 1964 to 1978, pharmaceutical prescriptions per patient have increased by 75 percent,

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INCIDENCE (number of services per insured) OF SOME MEDICAL SERVICES PROVIDED BY INAM

	1964	1969	1974	1975
Calls (*) House calls	2.3	2.6	2.3	2.4
Out-patients	5.9	7.6	8.4	9.0
TOTAL	8.2	10.2	10.7	11.4
Pharmaceutical prescriptions	10.5	13.4	16.3	18.4
X-ray examinations (**)	8.6	10.1	12.4	12.0
Laboratory examinations (**)	16.4	30.1	64.0	71.2
Consultations with specialists (**)	4.7	8.9	13.4	15.0
Hospitalization (***)	1.2	1.8	2.3	——

(*) under the "notula" payment system
(**) per 100 insured
(***) length of stay per insured in acute-case care hospitals.

X-ray examinations by 40 percent, and laboratory examinations have actually more than quadrupled. Recourse to the specialist and to the hospital -- although other factors have affected this latter case -- show quite similar patterns.

From the financial point of view, as we were saying, the cost load of front-line medical services is declining; for all the carriers it has gone from 158 billion lire, equal to 17 percent of total expenditures for medical care in 1964, to 758 billion, equal to 11 percent in 1975. The real problem though, we repeat, lies not so much in holding down the costs of front-line medicine as in increasing the benefits, including the economic benefits, it would provide if it were properly delivered.

What is the outlook in this connection for the impending health care reform law? The recent contract between the front-line physicians and the insurance carriers seems to offer some breathing-space. Not only is the "quota capitaria" to be applied across the board; so are some qualitative aspects, such for example as continuing professional education, the possible introduction of group practices, etc.,which will be taken into serious consideration.

That, however, still leaves us with two nagging uncertainties. The first has to do with the constant growth in the numbers of medical school graduates, accompanied by a decline in their level of preparation. The second directly involves the regions. The task of implementing the contracts is theirs and -- insofar as we know -- there are not many local governments that have started on the long list of actions required for prompt and complete application of the new regulations.

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ITALY

ENEL'S ALTERNATIVE NUCLEAR PLAN PRESENTED TO CIPE

Milan IL CORRIERE DELLA SERA in Italian 14 Dec 78 p 11

[Article by "Dr. F."]

[Text] The ever-lengthening delay in the nuclear power-plant building program in our country has moved ENEL to work out an emergency plan calling for construction of 65 conventional power plants by 1987, thus enabling it to cope with future energy demand.

The agency's plans to build both nuclear and conventional power plants call for enormous investments: the expenditures slated for that plan by 1987 come to more than 23 trillion lire at 1978 prices. These are some of the data contained in a voluminous document on ENEL's programs which has been sent to the Interministerial Committee for Economic Planning (CIPE).

The ENEL document is based on electric power consumption forecasts for the next few years, on the basis of data from 1977: 160.4 billion kilowatt hours, which was an increase of 3.7 percent over the previous year. On the basis of predicted growth of the gross internal product, ENEL has extrapolated energy demand from now until 1987.

Demand in 1980 is expected to be 193 billion kwh, with an installed capacity of 36.4 million kilowatts. By 1987, demand will have grown to 330 billion kwh, with an installed capacity of 62.5 million kilowatts.

The government and Parliament have made the nuclear choice for the future. The new necessities, ENEL explains, were going to be met with nuclear power plants.

The program, however, has been slow to get off the ground. The problems still to be solved are many, not the least of them those

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connected with the environment. For this reason it is feared that within the next 10 years we can count only on those nuclear power plants which have already been given the green light, which would mean a total of 12,000 megawatts. The demand for electric power, however, will be considerably greater than that. Hence the need to get started on a supplementary operating program.

ENEL has constructed two scenarios: one more optimistic, which calls, in addition to bringing the already approved nuclear plants on line, for starts on other plants of this kind. The more pessimistic scenario, which starts with the assumption that when 1987 rolls around we shall be sure of having only those nuclear plants already approved, means putting the supplementary plan into effect, and that, ENEL warns, will certainly have an impact on production costs.

Under the first hypothesis (the optimistic one), ENEL talks of power shortfalls beginning in 1984, which by 1987 would run as high as 7.2 megawatts. To meet the needs of the years just ahead, ENEL says it will need 640 megawatts in conventional generating capacity.

The investment forecasts are, as we said, disconcerting, and the peak burden should fall on the years from 1982 to 1985. In 1984, for example, it calls for investments of 4.22 trillion lire at the lowest, and 4.92 trillion at the highest. Overall investments (some of which will carry over beyond 1987) come to 25.5 trillion lire under the low hypothesis, and 26.9 trillion under the highest. From these figures, another 2 trillion lire must be subtracted, since they will be spent during the current year.

Under the lowest hypothesis, ENEL says that more than 13 trillion lire must be invested in nuclear plants. Given the higher one, the investments projected for the nuclear sector come to 17 trillion lire.

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ITALY

CANONICA D'ADDA OIL DEPOSIT FIND HITS RECORD DEPTH

Milan IL CORRIERE DELLA SERA in Italian 20 Dec 78 p 20

[Article by Giuliano Albani]

[Text] The map of the Lombardy oil fields is growing. AGIP plans to sink another 35 billion into the Po Valley oil hunt. The chances of finding new fields are running around 50-50 today. The latest well sunk at Canonica d'Adda has broken all European records by hitting a depth of 7,110 meters. Already depleted underground gas pockets have been pressed into service as storage for incoming gas imports.

It would seem that Malossa -- the richest of Italy's hydrocarbon deposits -- has found its twin sister at Canonica d'Adda. One well that has already set a European record -- 7,110 meters -- beat out East Germany by only 10 meters. The previous Italian record was set at Chiari, in the province of Brescia, with better than 6,800 meters, while the Malossa bits had bored down 6,475 meters. That is a fine record, of course, achieved with the latest and most sophisticated technology for research, which makes it possible to reach depths unthinkable only yesterday, and to do it at relatively low cost.

Canonica like Malossa. Why? Even though as of now there are only "indications," the odds are about even that the new well will yield oil too.

The map showing the Lombardy wells is growing more and more crowded. AGIP has announced its 5-year (1979-1983) plan, which calls for 30 to 35 billion lire in investments for exploration in Lombardy. The plan is tied to a "fourth cycle" of research. The first cycle covers the years 1944-1957, the second runs from 1955 to 1964, and the third dates back to 1973.

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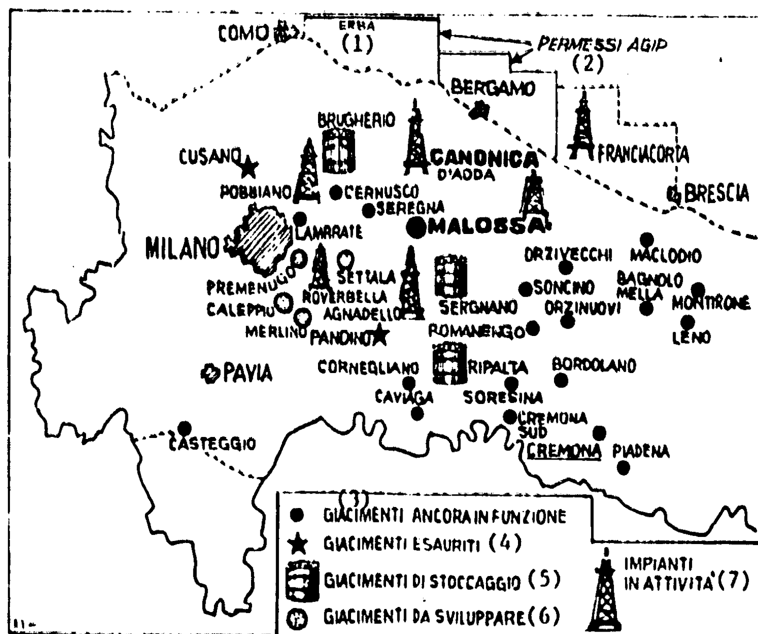

KEY: (1) ERBA (2) AGIP concessions (3) Fields still producing (4) Depleted fields (5) Storage fields (6) Undeveloped fields (7) Active pumping installations.

These four research chapters have to do with obsolescence and replacement of exploration techniques, and hence with the depth at which the sought-for pools may lie. For example, to reach the Caviaga "trap" (trap being understood as a natural reservoir) they drilled only a scant 1,500 to 2,000 meters. About the middle of the Fifties the emergence of the first geophysical technology made it possible to strike oil with less work and in less time: this technology hit no fewer than 14 producing fields at the lower depths.

In 1973 the big strike came, the one at Malossa, when the hole went down to around 6,500 meters. And now we are hearing about the record Canonica d'Adda hole, whose "trap" was ferretted out with geophysical soundings and very advanced geological surveys.

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This fourth cycle also embraces the finds at Settala, Merlino, Caleppio, Premenugo, and Agnadello, plus the exploratory wells at Franciacorta, Burago, and Roverbella.

AGIP holds an exclusive prospecting concession to almost the whole of the Po Valley. Those who want to look for oil in other provinces such as Bergamo, Brescia, Varese, and Como, which are not covered by AGIP's exclusive concession, must first get prospecting permits and then, should they find oil, "cultivation" permits. And then there are sometimes bitter quarrels with local governments. Both the quarrels and the foulups are pointless, according to Dr Oreste D'Agostino, director general for exploration. "It's a psychological thing. The fear felt by private individuals and communities is unreasonable. We are not hurting the ecology. All we do is probe into the earth, just a small rectangle of it, for a few months at a time. Then, if we do hit a pool, all you see on the surface is a big faucet, the so-called Christmas tree, a couple of meters high, which doesn't even take up much room."

Engineer Giancarlo Ristori, in charge of Italian production, gave us a peek into the secrets of underground Lombardy.

Over the past 10 years AGIP has drilled 50 wells, 13 of which were dry, 25 are producing (cultivation wells), and 12 were made over storage wells. The oldest well, as we pointed out earlier, is the Cavagia well (1944), and after a good 30 years that field is still producing 300,000 cubic meters of gas a day, the equivalent of 46 million cubic meters every year.

To get a better grip on these figures, let's look at the records for 1976. Lombardy consumed 6.5 billion cubic meters of gas, which amounts to 25 percent of total Italian natural gas consumption, and 23 percent of the region's total energy consumption. Local production came to 300 million cubic meters of gas (the equivalent of 300,000 tons of crude oil). When the latest strikes come into regular production Lombardy can count on a fuel equivalent of 2.5 to 3 million tons of crude oil a year, of 15 percent of all energy consumption in the region.

Lombardy, where the biggest Italian reserves have been found, also has another record: storage. AGIP has transformed depleted holes into enormous reservoirs into which, every summer, millions of cubic meters of imported methane gas are pumped, for safekeeping in the depleted wells at Ripalta, Sergnano, and Brugherio.

But let's get back to that "fourth cycle" of research that has barely begun, yet seems to have been born under a lucky star.

Statistics show that in 1977 and 1978, four of the wells drilled in Lombardy were brought in, and four were not. Again, the same

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odds that apply to the Canonica d'Adda well: there will be oil in half of them, and none in the other half.

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SPAIN

PCE LEADERS DISCUSS POSTELECTION PROGRAM, PLANS

Madrid CAMBIO 16 in Spanish 28 Jan 79 pp 23-25 LD

[Report: "If the Communists Win"]

[Excerpts] If the PCE won the 1 March election, let nobody think of the Soviet Union. If Spanish society ruled by the Spanish Eurocommunists resembled any other, it would be Italian society.

The development of the right to strike and the solution for the Spanish Radio-television system, public enterprises and divorce would be on Italian lines--except for details, of course. And capitalists, employers and other well-heeled people can rest assured: The PCE program exudes as much socialism as a speech by Jimmy Carter.

Some 24 hours after that party's central committee decided on the PCE's election program in a Madrid Hotel, five Eurocommunist heavyweights explained in detail for CAMBIO 16 the basic principles on which they will base their campaign.

Secretary General Santiago Carrillo, together with Ramon Tamames, Nicolas Sartorius, Enrique Curiel and Ignacio Gallego of the executive committee, explained for 2.5 hours what they would do if they had to govern for the next 4 years and what battles they will wage in parliament in the more likely event of the ballot boxes giving them the role of his majesty's loyal opposition.

In Spain there are more people unemployed than the number of votes which the PCE won in the 16 June 1977 election. And unemployment is, in the communist leaders' opinion, "the No. 1 problem to be resolved in the country," to quote Nicolas Sartorius, who states that it must "be attacked from different angles in a sustained effort, until about 300,000 jobs per year are being created in the public and private sectors."

Sartorius sums up the solution in a single word--investment. "There must be investment in order to create jobs. And since private investment will not be very brilliant this year, there must be considerable public investment, and not of a subsidiary nature, as was already agreed in the Moncloa Pacts."

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Let the Treasury Press Down

"The unemployment problem can only be resolved," Ramon Tamames states, "with a public sector which will be not a mere part of monopoly state capitalism, as is the case today, but a dynamic sector which will pull the cart of the economy and at the same time help formulate planning with the private or mixed-economy sectors."

The money for these investments must come from taxes, according to the PCE. "The tax reform must continue and even be accelerated," Tamames advocates, "and we propose a quantitative target of tax pressure increasing by 1 percentage point of GNP over the next 4 years--that is four points of GNP over the 4-year period. This is a perfectly feasible plan."

Industrial Oligarchy

With respect to public enterprises, "we must end this business of the national institute of industry only taking the rough and not also the smooth. We must insure that public enterprise is where it ought to be and not just where the industrial oligarchy, which keeps the best sectors for itself, tells it to be."

In the opinion of this Eurocommunist--an economics expert--the solutions to unemployment and the economic crisis in general put forward by the Union of the Democratic Center [UCD] are inadequate. "Is that an economic program? Is that business about the decree law? If that is so, it is because, in the UCD's opinion, the less things change, the better. Because the aim of that program is that virtually nothing should change and to implement an incomes policy simply as a means of enforcing wage limits."

The PCE's economic plan also includes, among other measures, democratic control over and regionalization of savings banks, improvement of community employment, nondiscrimination against small and medium enterprises in granting credit and a foreign investments policy which will defend national interests.

"We are in favor of foreign investment," Tamames said, "provided that it helps bring in technology, create foreign markets and create jobs. We approve of the multinationals provided that they meet these requirements."

The plan also includes an important attraction for those 2 million young people between 18 and 21 years of age who will be voting for the first time in the election--a census of unemployed young people, together with experimental youth employment programs, community work and vocational training.

Nuclear Program

For the peace of mind of supporters of the market economy, the only nationalization proposed by the Eurocommunist Party is that of nuclear

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energy, "by means of a public enterprise which will gradually ası ıme control over the entire nuclear sector," so Tamames plans.

Negotiating Achieves Nothing

Carrillo speaks slowly when commenting on his party's solutions to the terrorist threat. "A government which has popular support is needed; that is, a government which citizens feel to be their own. The struggle against terrorism has still not been undertaken by the population as a whole, and this, in our opinion, is due to the fact that the population as a whole does not feel represented by this government."

In more specific areas, the PCE secretary general believes that "it is necessary in the new cortes rapidly to tackle and resolve the issue of the Basque statute and for a genuine Basque government with authority and power to be set up which will give the Basque population the feeling that it is governing itself and determining its own destiny, and which will thus isolate even further those who basically believe that only independence can give the Basque population that power."

All this should be accompanied, in Santiago Carrillo's opinion, by "a change of image" of the police. "We have inherited the remnants of the political and social brigade and large sections of the police who have received no vocational training for maintaining public order in a modern and democratic state." "The task confronting us from this viewpoint today," Carrillo explained, "is that of setting up modern, efficient and well-educated police services with proper intelligence resources."

A first technical step toward curbing terrorism in the Basque provinces lies, in Carrillo's opinion, in the setting up of an indigenous police force. "We have said from the outset that an indigenous Basque police force is vitally necessary in the antiterrorist struggle. The Basques must feel that the Basques themselves are enforcing order there."

Carrillo emphatically and succinctly condemns negotiations, with the Italian experience in mind: "We believe that there should be no negotiations with the terrorists. Negotiating with them achieves nothing. It resolves nothing. There is a lengthy experience in Italy in this respect. We believe that it is a demonstration of weakness."

In the field of foreign policy the PCE, like almost all political forces in the country, supports Spain's joining the EEC. However, it is a different matter as far as our joining NATO is concerned.

"We believe that Spain's entry into NATO would entail for Spain increased expenditure in our military budget which, in our opinion, would be better used in developing the national defense industry's own potential," Carrillo maintained. "Spain could pursue a freer and more independent policy outside NATO. We are as opposed to our country's entry into NATO

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as we would be to Spain's entry into the Warsaw Pact and are in favor of dissolving both. Our stance is one of promoting a policy of nonalinement with the blocs which is in keeping with the policy of neutrality which, with vicissitudes, Spain has historically maintained."

Let Them Decide

The U.S. bases in Spain constitutes no great problem for the Eurocommunists: "In order not to interfere in any way and thus disrupt the present balance," the PCE leader said, "we are willing for American bases in Spain to survive as long as other powers' military bases exist in other European countries."

And if the communists have their own way, let the voters be prepared, because it is possible that there will have to be further voting before 1983 to decide by referendum whether or not we join NATO. "The subject is almost as important as the constitution and the people must decide on it directly," Santiago Carrillo said.

Weapons Industry

One of the communists' plans is for a powerful Spanish weapons industry. "We will insist that the armed forces are equipped with effective means and will support the development of the military industry, which at present is practically nonexistent. In order to prevent our dependence and also to encourage scientific research linked to the development of this sector," Enrique Curiel asserted.

Research and development to the extent of constructing nuclear bombs? Carrillo said: "We must aim at their abolition everywhere and I would not say that we should make nuclear weapons for the time being. But nor would I deny once and for all the possibility of Spain one day planning to produce nuclear weapons."

Nor are the communists opposed to weapons exports: "If the whole world is doing it, why shouldn't we," asked Ignacio Gallego. "Of course, in weapons exports parliament must be informed of what is happening, because there must not be a contradiction between weapons exports and foreign policy. Rather than supplying weapons for crushing liberation movements or trampling human rights, a very responsible attitude must be adopted."

As for the armed forces, the communists reject a strictly professional army and advocate greater integration between the people and those responsible for their defense. To the extent that, although this is not in its program, the PCE is not opposed to military service for women. Some members of its executive, such as Nicolas Sartorius, are even enthusiastically in favor of it, although with reservations. In his view, infantry, for instance, would not be an entirely feminine branch of the forces.

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As for military training, Santiago Carrillo proved to be in favor of abandoning the civil war as a teaching model, "because in the brilliant history of the Spanish army there are many other wars against foreigners and, as far as modern wars are concerned, there are more recent examples, such as World War II or the Vietnam War, which are more interesting as subjects for study from a military viewpoint." The PCE also favors the disappearance of organizations such as the republican aviators' or combatants' organizations, in order to encourage the people's links with their army.

As with all the parties, the Eurocommunist party regards it as a preeminent and pressing task that the parliament which results from the 1 March election discuss the laws which will complete the constitution and the state's democratic reform: The fundamental law on local government, the law on public office, the organic law on judicial power, the autonomous governments finance law....

Out with the D'Hont Law

In this field the communists will be introducing two plans to the Cortes: The workers' statute, as indicated by the constitution, following the PCE's proposal, and a new electoral law.

According to the communist leaders, the former gives special attention to retired people and proposes the establishment of a national institute for the retired, to coordinate all activities imaed at resolving the problems of retired people.

The PCE's draft electoral bill will attempt to take over from the controversial D'Hont law which, according to the communists, prevents real representativity in parliament: "We believe that proportionality and the strengthening of democracy go hand in hand and we believe that if a party gains 9 percent of the votes but holds only 6 percent of the seats, this constitutes a distortion for the section of the population which that party represents, while other parties with 25 percent of the votes holds 33 percent of the seats."

Strike Law

If the UCD, or any other party, submitted a strike bill for parliamentary debate, the communists would examine it under a microscope and it is likely that they would vote against it: "We are not in favor of a strike law," Sartorius said, "or at least one that has not been negotiated. The right to strike is a constitutional right which exists, and since strike regulations almost always constitute a restriction of the right to strike, we believe that it is unrealistic. It would be more productive not to legislate, but to do as the Italians have done: To bring about self-regulation of strikes by the trade unions themselves, as far as the public services are concerned. In Italy experience has imposed the law and the state has accepted it."

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WEST GERMANY

BONN CONTINUES HEAVY SUBSIDIES TO AIRBUS

Hamburg STERN in German 18 Jan 78 pp 128-133

[Article by Kurt Breme: "Flying Barrel Without a Bottom"]

[Text] The federal government must count on the fact that despite rising sales figures, the airbus is becoming a losing proposition for the state treasury.

It was still a dream for the governments in Bonn and Paris 10 years ago: The joint development of a European commercial aircraft. The airbus A300 is today no longer a dream, but has become a pie-in-the-sky dream for federal chancellor Helmut Schmidt. For the aircraft builders get the thrust for the high altitude jet flight for the most part from the Bonn treasury: up to now, one billion marks in subsidies and a guarantee of over two billion. Further subsidy requests are already foreseen.

The Germans and French would never have dreamed that the medium range aircraft would one day become a bottomless subsidy barrel when they established the "Airbus Industrie Groupement d'Interet Economique"* in 1969. The aircraft components are manufactured in seven European locations, including Hamburg and Bremen, and assembled in Toulouse (France).

The purpose of the state supported aircraft marriage: The Europeans did not want to reliquish the world market solely to the American aircraft super-companies of Boeing and McDonnel Douglas, but wanted to build up their own aircraft industry, which could then also supply aircraft and spare parts to the military to a greater extent and thereby make a contribution to keeping Europe from falling behind technologically.

After a weak start, the airbus became a sales competitor. By the end of 1978, there were 123 confirmed orders, and 53 options (preliminary orders). From the American Eastern Airlines to Lufthansa, up to now 20 international aviation

* Besides France, Spain and Great Britain, the German partner is Deutsche Airbus GmbH at 37 percent. The German-Netherlands VFW-Fokker aircraft company is a 35 percent participant in it and the Messerschmitt-Boelkow--Blohm (MBB) aircraft company represents 65 percent.

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companies want to fly the large capacity jet. Despite this, it is still a poor business for Bonn. Helmut Haussmann, economic policy spokesman of the FDP and on the budget committee of the Bundestag the reporting member for the budgeting section, from which the money for the airbus flows, notes "The schizophrenic aspect of the matter is that one must be pleased with each airbus sold because of the 5,000 to 6,000 jobs it provides, though as finance policy maker, one argues against it because we cannot bring the thing into the profit range."

In Bonn cabinet circles, "With each report of an order", according to one participant, "You hear the motto: oh Lord, oh Lord, now it gets even more expensive for us." So the gentlemen of the cabinet just recently had to boost their pledge from 1.8 to 2 billion marks in order to secure the credit which Deutsche Airbus GmbH had to obtain from the banks. For the planned smaller version, the A-310, the cabinet had to additionally assume guarantees of 750 million marks up to 1984. Besides this, in the previous year alone Bonn provided 57 million marks of additional production subsidies and 84 million marks of marketing assistance. The aircraft price is kept down with this tax money, so that more contracts come in.

Here's how it goes: The airbus purchasers pay 10% of the purchase price, and the rest is spread out in installments over the long term, but they pay interest on this which is far below the normal interest level. The difference between the low interest and the normal interest is payed by the credit establishment for the reconstruction of the Deutsche Airbus GmbH. The credit establishment then receives the money from the Bonn state treasury. Government director Hans Eberhard Birke, who is the competent authority for the irbus in the Bonn economic ministry, "This is our free market economy original sin."

It would be normal if the aircraft required fewer subsidies with increasing sales success. With the airbus, it is the other way around: in order to be able to deliver the aircraft ordered, the production at this time of two machines per month must be doubled by 1981. In order to meet the hoped for additional demand, the production should be increased to six or even eight aircraft a month by the middle of 1985. But that will be too expensive for Bonn. Federal finance minister Hans Matthoefer has had his competent officials calculate that then:

--The federal subsidies will have to be raised to 2.4 or even 3 billion marks, and

--The production assistance for the 200 purchased airbuses increased to 528 million marks. If 360 airbuses are ordered, Bonn will have to pay 2 billion marks primarily for the establishment of 1,500 additional jobs, because - according to the reliable expert opinions of the finance ministry - "German industry is not in a position without the assistance of the federal government to provide for the financing of its work as well as the deliveries."

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It is uncertain whether the Bonn state treasury will get back the additional subsidies, as already stipulated in the contract, to any appreciable extent from Deutsche Airbus GmbH. For the airbus builders will not get into the profit range until 860 aircraft have been sold - a goal considered unrealistic by experts because of American competition. Up to now, only about 30 million marks from sales have found their way back into the Bonn treasury. The competent officials in the finance ministry fear that the federal government will one day even have to answer for the bank credit for aircraft builders: "The risk of the federal government of having to make good on the subsidies is still high."

And it is not just because of the financial risk that the Bonn government managers are indisposed. The Schmidt team has also made a considerable departure from free market economic principles with airbus subsidies and thus confirms the assertions of the Hamburg SPD Mayor, Hans-Ulrich Klose ("The state is the repair plant of capitalism"). For the state must not only clean up the "capitalist" airbus enterprise, but it has even created the repair plant itself. Besides the ship building industry which gobbles government subsidied and the German builders of large computers which could not exist without state assistance, Bonn has now tied itself to another project which requires restoration. The FDP political economist Haussmann sees in this proof of the fact, "That it is difficult where the state disables the free market economy, to again retrieve the situation."

For this reason, Bonn wants to bring the airbus out of the red as fast as possible, in order to give free play to the forces of the merket economy. The airbus managers and the chairman of their board of directors, Franz Josef Strauss will keep a closer eye on things in the future, "Becuase a bad subsidy recipient mentality" (Bundestag member Haussmann) has developed, and there are complaints about organizational deficiencies in planning and production.

The federal cabinet has up to now not approved the future program proposed by the company management, because in the words of economic minister Graf Lambsdorff, it does not appear "to be sufficiently thought out" (governmental spokesman Gruenewald), and the budget committee of the Bundestag approved two million marks for an industrial consulting firm, which now is to examine Airbus GmbH for weak points. Furthermore, the economic ministry is pressing for more efficient operation. Governmental director Birke: "The costs must come down."

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