Non Conventional Medicine (NCM): Italy's Health Systems and the New Health Paradigms

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Abstract: *After analysing the factors behind the mounting demand for Non Conventional Medicine (NCM) worldwide, paralleling loss of ascendancy on the part of western biomedicine and its increasingly unsustainable cost, we focus on the new paradigm of Person-Centred Medicine, and how NCM holds pride of place within that paradigm. Our article goes on to analyse the Italian scenario in the light of the ever-greater insistence by individuals on personally-tailored treatment and the new health paradigms. Although legislatively Italy (2013) is one of the most backward countries on the European scene where NCM is concerned, the regional health systems are nonetheless responding to NCM. In order to show to what extent that is so, we focus on three major regions each typical of a health system approach and a geographical area: Lombardy, Tuscany and Campania. We show that Italy is indeed still in the first stages of including NCM or Person-Centred Medicine, and that the process varies widely across the independent regional health systems. Policy here is often dictated by factors in the local background.*

Keywords: Non Conventional Medicine; Person-Centred Medicine; Regional health systems; Sociology of health.
Cuvinte-cheie: medicină neconvențională; medicină centrată pe persoană; sisteme de sănătate regionale; sociologia sănătății.

Introduction

The phenomenon of Non Conventional Medicine (NCM) occupies a central place in sociology, since this social phenomenon is on the increase worldwide. Sociology also monitors individual and collective dynamics in health care, which is seen not only as a basic right for the individual but a prerogative that confers a sense of belonging and full status within society.

On the face of it, NCM might seem a marginal issue: but its social, individual and relational implications (including social and medicare relations) are making it increasingly important for the individual and surrounding society. As we study the pattern in which NCM is growing and spreading, and the underlying reasons for this, we gain a picture of the social and cultural transformations in progress where health is concerned (Tognetti Bordogna, 2011a, 420; Barry and Yuill, 2002, 23).

A word of clarification about nomenclature. Many countries adopt the name CAM (Complementary and Alternative Medicine). CAM has been grouped into five categories: biologically-based therapies, manipulative and body-based therapies, energy medicine, mind-body me-

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dicine, and whole medical systems. By contrast, the definition of Traditional Medicine issued by the World Health Organization (WHO) states that Traditional Medicine is the total sum of indigenous knowledge used in the maintenance of health; without distinction the concept extends to complementary alternative medicine (CAM), non conventional medicine (NCM), holistic medicine and natural medicine. Such terms are used interchangeably with traditional medicine in some countries, and refer to a broad set of health care practices that are not part of that country's own tradition and are not integrated into the dominant health care system.

Paradoxically, then, in Western countries indigenous biomedicine and alternative medicine may even come to coincide. We thus have a preference for talking about 'Non Conventional Medicine': this term is scientifically neutral and alludes to the conventional status appropriated by biomedical orthodoxy. The fact is that Non Conventional Medicine may be the first choice of people looking for well-being and health, and is not necessarily something posited against the dominant paradigm. 'NCM' reflects the now consolidated choice of terminology found in Italy. The term has also long been adopted by the European Parliament in its Resolution no. 75 issued on 29 May 1997, which deals with "The Status of Non Conventional Medicine".

The subject of how NCM is used is, again, of growing interest to the people of Europe. Country after country is debating the importance of providing people with appropriate, economically sustainable treatment options catering for cultural choice by the individual and respecting the principles of Person-Centred Medicine.

This differential view of therapy and the therapeutic relationship follows a Europe- and worldwide trend, and is keeping pace with the growing demand for NCM by Italians. There is research to confirm this trend. According to Health Monitor CompuGroup Medical-Il Sole 24 Ore Sanità (2011), over half the GPs recommend homeopathic products to their patients; according to Eurispes Italia 2012, 14.5% of the Italian population resort to NCM, and the figure rises to 16.2% in the Doxapharma survey from May 2012, which is based on consumption of homeopathic products.

The increase can be set down to a number of factors. Going by the sociological literature (Melucci, 1987, 87; Tognetti Bordogna, 1989, 80; Tognetti Bordogna, 2005, 7; Tovey et al., 2002, 15; Hess, 2004, 698; Varga et al., 2006, 41; Ho et al., 2013, 179), it is both a concrete post-modern expression of people's desire for self-determination and free choice on health matters, and a sign of change, as the biomedical paradigm loses its sway and individuals are encouraged to take responsibility for their own health (Colombo and Rebughini, 2003, 78). This is a cultural trend, ushering in a new way of representing disease and cure. Consumption patterns are also linked to the growing phenomenon of immigration, at least in Italy, and the connected cultural preference for traditional health care.

The WHO (1995, 198) is itself increasingly advocating NCM forms of treatment as a way of containing health costs. Indeed, any study on NCM needs to reflect on new interpretive paradigms and the nature of the transition afoot in health systems.

It is the purpose of this study to review the changing dynamics of our new social relationship with medicare, and our growing awareness of individual rights, but also responsibilities in this regard. As the doctor – patient relationship changes, the individual is beginning to enjoy a greater range of choice as to the line of therapy he/she may follow, while the doctor, already overworked and harassed by pressure to contain costs, is likewise challenged to adopt a new and more

collaborative attitude to the former patient (now promoted to 'user'). We discuss how the person-centred approach fits many of the new demands on both parties, and may relieve the pressure on the laboring healthcare system as a whole.

We, then, proceed to examine how far this potential is being exploited in the highly varied scenario of Italian regional welfare which is still in the throes of adaptation to structural and legislative changes introduced in the Nineties and the early years of the new millennium. Since great scope has been allowed for regional diversity, we analyse the healthcare patterns that have emerged, and compare three types of policy that, together, well represent the nation's response to the new paradigms.

New knowledge, new skills, new paradigms

The demand for health and the systems of fostering it are undergoing a major transformation, as our previous remarks have hinted. One glimpses amid this transition how recourse to NCM may be a valid response to the new cultural changes and the need to contain the health budget. Organizations are having to reckon with the individual in centre place, a protagonist who has needs, but also know-how.

Throughout the world, health systems are steadily becoming more alike in their practices and procedures, their slow but constant decentralization and regionalization, and their growing regard for NCM (Roberti di Sarsina and Iseppato, 2010, 141). But the process calls for specific knowledge and skills if it is to be effective and suit the new health requirements and demand for therapy.

The need for ever-new knowledge is due not just to changes in health-system policy and organization, but also to crippling and pandemic new chronic pathology calling for specific awareness by national health systems, new health network modes of operation, and also 'virtuous' synergy involving multiple subjects. This is the only way to cope with forms of illness that afflict the individual for years and years. Then, there is an ever-more urgent need for concrete health prevention strategy. And always, the mounting expectation that the citizen freely choose what style of treatment or health care best suits his needs, beginning with NCM. It is increasingly necessary that we view both the objective and the subjective health world as part and parcel of the treatment process. Health presupposes that the individual perceive where well-being lies and learn to take an active part in the way the social system works (WHO, 1978, 879).

We feel a consequent need for a key to understanding our society's changing pattern of health care and health experience. Change that has to be framed in relevant health policy and health solutions.

As already mentioned, one of the prime requirements of Public Health is to find alternative strategies to prevent and control crippling chronic disease. Many diseases can only be prevented by non-medical methods put into practice from early childhood onwards via a low-cost programme of health education (Alivia, Guadagni and Roberti di Sarsina, 2011, 384). To achieve that goal we have to establish meaningful dialogue between members of the community and health workers. This will lead to involvement of the individual in handling his health affairs.

It has been pointed out that the health professional's job is to support and find options that enable individuals to take informed decisions. The real role of the doctor in public health seems an eminently cultural one. That the individual should know and be personally involved are major factors in the achievement of optimum health. A deep knowledge of self is called

for. And that also means having a sustainable lifestyle. Failing this, the individual is heading for disequilibrium and disease. Health is the outcome of a complex process entailing balanced behaviour and significant relations at every personal level.

Such principles which underlie and foster good health are the basis of NCM. NCM is grounded in universal principles – not confined to any one ethnic group of culture. It is *person-centred*, hence inter-cultural, which is essential if the existing health systems are to *interact*. The cultural model underlying NCM seeks to revive traditional local values (Alivia, Guadagni and Roberti di Sarsina, 2011, 382).

NCM advocates prevention strategies including health promotion, individual awareness, incorporating ethics and spirituality into health systems. Applied to health management, these improve the perceived and objective quality of life, pave the way to healthy old age, cut down the use of medication and reduce the social burden of chronic disease (Roberti di Sarsina and Iseppato, 2011b, 7).

The health requirements are new; the paradigms are broadly (if not universally) recognised.

Paralleling all this is the fact that biomedicine is losing its absolute ascendancy over the western world. This is partly because that medicine is failing to work, at least with certain pathologies. Many conventional doctors are themselves growing intolerant of western medicine's rigid doctrines as practised in the second half of the twentieth century. In the last twenty years, by way of defending its authority, biomedicine has come up with the Evidence-Based Medicine (EBM) movement.

It must be admitted that biomedicine has achieved successes in certain preventive areas (mass screening for breast cancer, colon cancer, etc.). But it is only minimally concerned with prevention, concentrating on coping with the *effects* of a polluted environment and bad lifestyles. The removal of risk factors at best takes second place, yet that alone ensures prevention.

Another weak point in biomedicine relates to death and dying: 'conventional' doctors have come to regard it as a failure, not a meaningful moment. There has likewise been resistance to allocating steady resources to palliative care, which is greatly under-funded. Though this branch of medicine has made great strides and is in the noblest tradition of the medical profession (making the inevitable end more bearable), it has come in for little acknowledgment. More and more widespread is the impression that biomedicine has lost its claim to infallibility (Roberti di Sarsina, 2009, 29).

Another spreading phenomenon that carries a high price, in terms of demand for treatment, is that people think they are better informed about all kinds of pathology thanks to tools like the Internet. But much of the time they are victims of over-exposure to information, not to say misinformation. Late twentieth-century medical success stories have themselves raised people's expectations inordinately (Roberti di Sarsina, 2007, 45). In the wake of such successes doctors have been asked to cope with categories of patient who were once excluded. This has led to swamping of facilities, and an intolerable workload for the health professional.

Doctors are, again, under a series of double binds. They are held responsible for patient health and survival, when death is a natural, universal occurrence. By contrast, the patient is "free" to conduct an inappropriate lifestyle, incurring health problems that might have been avoided. Doctors are also under pressure to prescribe the most costly diagnostic tests and treatments, while administrators nag them to contain costs.

We said that we were looking for a key, and that key may be found in the person-

centred approach. Person-Centred Medicine (PCM), indeed, makes up for most of the deficiencies of biomedicine. It works in synergy, fills the gaps, bears part of the burden and rectifies the equilibrium (Von Ammon et al., 2012, 39).

PCM draws on a gamut of traditional alternative and complementary approaches, among which the well-informed "patient" can choose, as various authors have shown (Alivia, Guadagni and Roberti di Sarsina, 2011, 381; Roberti di Sarsina and Iseppato, 2011a, 448).

The term "traditional" does not mean prehistoric: it refers to traditions other than biomedicine – traditional practices that antedate the rise of "scientific" western medicine. The person is seen as a whole, with all the physical, emotional, mental, social, spiritual and environmental factors bearing on health. This draws the person as a whole into achieving a personalised lifestyle that enhances health, without ignoring points like physical exercise, proper diet, healthy living and emotional wellness that nourishes resilience.

PCM is also based on respect for "the patient's right to choose", which decidedly raises his obligation to live responsibly. It focuses on assessing how well multiple physiological sub-systems are working, since these are reciprocally inter-related with our state of health.

Its emphasis on prevention and quality of life enables PCM to lighten the cost-burden of biomedicine, and share responsibility for keeping people healthy. It also boasts a whole range of choices, which suits our increasingly multicultural society. Finally, it has a healthy respect for illness and death, as being meaningful events.

Person-Centred Medicine and Non Conventional Medicine

Research (Robinson et al., 2010, 275) into healthcare quality, carried out in the USA, Europe and Italy, has found that if patients are asked to judge the quality of medical treatment, their priority will go to its human, personalised side, the need to be properly informed in a comfortable setting, and to be free to choose one's own healthcare pathway.

In recent years, the scientific debate over NCM and how it interacts with biomedicine (Alivia, Guadagni and Roberti di Sarsina, 2011, 381) has stoked increasing demand. A cultural transformation is in progress, changing lifestyles and shifting the focus from symptoms to the idea of, and quest for, personal well-being. There is, likewise, more attention on self-healing, tapping our individual potential for boosting the benefits of treatment.

Health policy should, accordingly, be helped to change. Modern professional ethics require that a satisfactory relationship be established between doctor and patient, a new ability cultivated to listen and understand. Attention must be paid not only to the microscopic side of the organism, but the natural social environment in which man lives and falls sick. This all calls for a medicine based on trust, and on patient awareness in choosing his/her individual health programme.

Person-Centred Medicine has the ability to give the individual that psychophysical equilibrium which is the starting point for sustainable social equilibrium embracing society as a whole. A human being is not a simple bundle of physical, molecular data, but a psycho-patho-socio-biographical continuum, the outcome of interactions. It is these that inform that ability to listen, assess and treat which underpins the person-centred, and not symptom-oriented, approach to the patient.

Part of PCM's job is educational, as well as therapeutic. It has to help biomedicine think multidimensionally, multifactorily, multidisciplinarily, and profit by Anthropological Health Systems, as found in traditional medicine. That way, the

diagnostic-therapeutic approach will cater for the whole man, the 'holos', the intrinsic unity of being, embracing a physical, mental and spiritual dimension; for it is on these interacting levels that every human being achieves his/her unique structure, and this forms the true object of understanding and treatment. Anthropologically-based medicines propose just such a broadening of medical knowledge and practice.

The evolution of medical thinking, since the end of the nineteenth century, has made undeniable strides. To face up to the twenty-first century and its new demands we need to draw on the epistemological legacy of traditional medicines: our diagnostic and therapeutic horizons need to be extended beyond the Cartesian bias of scientism, rationalism and materialism.

A view that centres on the person as a being endowed with qualities is *ipso facto* sensitive to the complexity of natural phenomena: man's relation to the environment, interaction between psyche and body, the meaning of spiritual wholeness, the patient's own active part to play in healing and in maintaining good health.

The paradigm of person-centred medicine is becoming an acutely felt need. If the doctor starts by empathising with the patient's viewpoint – an NCM principle – the latter may find it triggers the will to overcome "the prison of disease". Empathy lends concrete substance to the "therapeutic alliance", it galvanises the patient's resources and that triggers the willpower to get better, and take to heart the right preventive measures.

The next section will focus on Italy's health system and gradual process of including NCM, in an attempt to see to what extent it is responding to the new trend.

Italian regional welfare and NCM/PCM

In the foregoing sections we have examined the changes afoot, and the new health demand which joins with the issue of cost containment in providing the new challenge to western public health. In this section we shall see how NCM methods, and PCM in particular, could provide the winning solution to these issues as they affect Italy (Vicarelli, 2002, 69).

One of the principal policy areas in which power has been transferred to the Italian Regions is the health service. This slow process began in the 1970s and has come to fruition in the last fifteen years. The present set-up stems from the passing of Laws 502/92 and 517/93 which accorded the Regions a new institutional responsibility for health, with a framework of national law designed to build competition among health organizations into the NHS mechanism. Within the rival organizations, the managerial methods were to be those of private industry (Neri, 2006, 120).

As elsewhere, regionalization in Italy dovetailed with the process of turning the NHS into health trusts, via adoption of so-called "administered competition" (Enthoven, 1985, 67), which later turned into "administrative cooperation" (Light, 1997, 338; Vicarelli, 2002, 87). The process consisted in a national framework law that brought organization and management of health services under the power of fully independent regional control, which would lead to differing Regional Health Service (RHS) models. The Regions had the power to organize and regulate public health for themselves and, in fact, devised their own specific systems.

In terms of supply, the Regions can choose between combining funding and production within the Local Health Trust (LHT), or separating the two functions, keeping the former under the LHT and passing the latter to Hospital Trusts, which concentrate service production facilities under their own management, away from the LHT (Neri, 2006, 179).

Thus, to a greater or lesser extent, within the Italian health system, a series of

accredited private producers and facilities have taken their place beside the public structures. All the Regions have set health budget ceilings (Cantù and Carbone, 2007, 265), and the citizenry can choose to patronise public or accredited private facilities. Amid these and other variables listed by the literature (Mapelli, 2012, 75; Neri, 2008, 111), three distinct RHS models have emerged:

- *The Competitive model*, based on competition among health organizations.
- *The Cooperative or integrated model,* embracing a range of health organizations, which we find in the centre, centre-north and north-east regions, based on negotiated planning.
- *The Residual-incremental model* where there are still largely traditional bureaucratic mechanisms that manage the system; this is found especially in the southern regions.

As examples of these three models, we have chosen three major regions: Lombardy as representing the first, Tuscany, for the second, and Campania for the third. We shall see the degree to which NCM has been included within each of these as a response to the new healthcare demand and need to contain costs.

We then go on to consider whether NCM enjoys differing forms of recognition, according to the above styles of RHS, and whether points of differentiation exist, due to local variables and independent of the organization model. By and large, be it said in advance, the NCM scenario still varies widely from Region to Region.

Since there is no national regulation of NCM, the reform to Title V of the Constitution decrees that the Regions shall have autonomous legislative power over the professions, including recognition and promotion of NCM.

In February 2007, a coordination conference of Regional Health Assessors voted to set up an "Interregional technical group for complementary medicines", coordinated by Tuscany. This group approved a research project to be promoted and coordinated by Emilia Romagna Region, and a document stating the general criteria for training in complementary medicine. More recently (2013), the State – Regions Conference – a technical body that jointly defines Italian health policy – has produced another guideline document on NCM training. In the last decade, Emilia Romagna has not only set up an NCM Observatory, but drawn up a draft national law. It has funded experimental projects and provided training for specific professional profiles. The Regions of Friuli-Venezia-Giulia and Lazio both admit NCM in their general framework of regional planning. Liguria is moving towards authorisation of bio-natural disciplines, as is Piemonte. Other Regions, such as Umbria and Valle d'Aosta, are financing experimental projects.

Regions like Lombardy, Tuscany and Campania have approved many schemes of promotion and experimentation, and have set up specific bodies to study and monitor NCM. It was fact that prompted our choice of these three Regions for a more detailed analysis of how NCM is coming to be recognised in relation to specific models of RHS (Roberti di Sarsina and Tognetti Bordogna, 2011, 361).

Lombardy belongs to the first RHS model outlined. Its stance towards NCM is that of searching specifically for scientific evidence, following a rigorous method of scientific assessment. Its approach to complementary medicine may be called a scientific bias: while acknowledging the importance of NCM, it invests regional resources to make sure that health practices drawing on NCM are strongly structured. This applies to the quest for scientific evidence and the insistence on training. Only doctors or professionals possessing training certificates can practise NCM

within the RHS. In collaboration with the University and WHO, the Region is promoting clinical trials to assess non conventional therapies. In July 2007, Lombardy Region approved, and allotted funding for, public and private organizations to study, research into and clinically experiment with NCM (Tognetti Bordogna, 2011b, 420).

Tuscany may be seen as *the* model region for its regulatory basis, legal norms underpinning normal practice. Towards NCM, its policy has been to institutionalise and consolidate the growing trend via regulations and funding, ensuring that complementary practices are a service available at every Local Health Trust.

The Region has included a special chapter on NCM in its Regional Health Plan; acupuncture is provided free at LEAs, while when homeopathy, phytotherapy, acupuncture and traditional Chinese medicine are offered by various regional health clinics, patients are asked to pay a supplementary contribution. In 2000, the Region appointed a technical scientific committee to assess and monitor NCM-based projects; this was later confirmed for a further period. There is, likewise, a Regional NCM Commission and an NCM Regional Reference Centre.

A fund is also allocated to integration of NCM in health operations conducted by specialised ambulatory care, as well as funding for projects run by individual Local Health Units.

Campania belongs to the bureaucratic model of regional health. Its policy is to promote scientific debate, train practitioners and facilitate use of NCM, but not to dispense it directly. Various laws have been approved to support NCM experiments on the part of public and private facilities across the Region. However, these ventures seem primarily to stem from individual health facility initiative, and only later receive a certain support from the Region.

Such laws, as have been passed, largely refer to training and project-funding. In March 2001, a Regional Commission for Non Conventional Medicines was officially appointed. In 2003, the Region allocated 3 million euros to NCM, and, subsequently, raised this to 4 million (Tognetti Bordogna, 2011b, 418).

Campania's regional initiatives may be seen as preliminary to any concrete or thorough provision of NCM services in public facilities.

A nutshell conclusion might be that, yes, the three models have certain common features (starting up training projects, and funding certain NCM operations and experiments), but they each have their own peculiarities.

The Lombardy model seeks to validate NCM practices scientifically, keeping them within the medical hierarchy (Roll of Physicians, WHO, the medical professions). It is a scientistic model, strictly monitored and validated by the regional authorities.

The Tuscan route to guaranteeing NCM efficiency is to develop a tight network with the provinces and Local Health Trusts (so as to create at least one NCM centre in every part of the territory). The process of institutionalising and integrating NCM entails sensitising the population and enlisting local representatives. The Region goes beyond the monitoring and funding role, and has worked to set up NCM-dispensing units throughout its territorial area.

In line with the traditional model of bureaucratic health policy, the Region of Campania is based on bureaucratic authority: it answers to top-down directives and circulars, rather than to the pressure of strong bottom-up initiative, and, in reality, is confined to financing specific projects.

The Regions differ, besides, in terms of supply and consumption (Tognetti Bordogna, 2011b, 415). From ISTAT (2007, 3) data it transpires that the energy with which a Region promotes and/or

sanctions the NCM sector is not strictly proportional to use or consumption of NCM services. It is not brisk consumption that causes NCM to figure more prominently in an RHS; witness the fact that Lombardy and Tuscany occupy top positions in consumption, not Campania. It would seem that health policy in those regions is steered by individual public decision-makers; on them depends the difference in NCM inclusion.

If one excepts Tuscany, the individual RHSs of Italy do not yet appear to have taken on board the need for new paradigms of health and therapy, such as PCM, still less promoted independent patient responsibility for choosing alternative treatment. This clashes with the theoretical position of some models, like Lombardy, which profess support for individual freedom of choice. How NCM has hitherto been introduced by the Italian Regions does not seem based on a new awareness or people's new skills/demands, but on fairly random decisions, connected with the availability of allocated funds (Tognetti Bordogna, 2011b, 420).

Though there is widespread debate, Italy appears to be marking time when it comes to proposals for actual legislation acknowledging NCM.

Conclusions

Despite the sizable number of private facilities providing NCM, and although consumption is growing faster than in other European countries, Italy and her Regions are dragging their feet about recognising and validating NCM. In this they lag behind Europe, with the exception of a few areas where such therapy has been experimented and tested in Hospitals, Health Trusts and regional facilities.

As has been pointed out (Stepan, 1983, 295), Italy stands in the ranks of those countries where restrictive "monopolistic exclusive" legislation views non-doctors practising medicine as illegal. This markedly contrasts with a country like Romania, for example, which itself has a health system undergoing transformation, but has fully legalised NCM in practice and in training (Vlădescu, Scîntee and Olsavszky, 2008, 87; Goldura and Gotia, 2010, 206-210).

In Italy, great variety still exists in the way NCM is included or promoted within the regional health systems in general, and, likewise, among the three healthcare models we have analysed. The lack of any national regulations firmly recognising NCM as part of overall and regional health continues to vex the process of legitimating NCM in this country.

One common feature does transpire from our analysis of the three RHS models: regional policy decisions are not based on the principle of ensuring health care uniformly, but rather on a selective principle informing local decision-making. The differing options that emerge in the three RHS models illustrate a diverging attitude from region to region. Their approach seems to be influenced by the extent to which orders of physicians or scientific research institutes happen to be stronger in one region than another. Even though indirectly, this seems to 'condition' the public decision-makers (Tognetti Bordogna, 2011b, 420).

One example of such 'conditioning' can be seen in Lombardy's inclusion model. This is moving towards "traditional" clinical validation of NCM, according to guidelines drawn up in collaboration with concerns that have traditionally espoused biomedicine. It should be remembered that Lombardy is not only a hotbed of synthetic drug manufacturers (Sironi and Tognetti Bordogna, 2009, 65-80), but also host to one of the major pharmacological research centres – the M. Negri Institute – whose

management loses no opportunity of branding NCM as "ineffectual".

Another factor behind the decision to include NCM is the kind of organisational set-up the various regional welfare systems have chosen. A network model linking the various health resources, as in Tuscany, is more likely to open its doors to new alternatives to biomedicine. That region also happens to contain numerous well-known manufacturers of natural and homeopathic products – and politicians (health managers) who have taken a clear decision on NCM.

In Campania, one may talk not so much of a planned decision to include NCM, as a bureaucratic opening towards NCM in response to certain pointers, without there being strong factions for or against, as we glimpse in the other two Regions.

Although RHS policies on NCM are still only partial, it does seem clear that institutional acceptance of NCM, however embryonic in some cases, lies with the governing body rather than the organizational model as such. Tuscany is not just most favourable to NCM, but has activated serious local experiments in health trusts and hospitals. Lombardy shows a more cautious try-and-see attitude. In Campania there is specific regional financing, but the process of experimenting and validating is still very much uphill work; the only forces capable of driving it are the corridors of regional bureaucracy.

In Italy as a whole, therefore, we may speak of a slow road to inclusion, involving adjustment to local circumstances, as we have explained elsewhere (Tognetti Bordogna, 2005, 8). Once again, it is scientific medicine that dictates who may practise NCM. The position of the Italian Roll of Physicians on this is emblematic, and so too are the rulings given by the Constitutional Court whereby only certain NCM are legal, provided they be practised by doctors in medicine (Tognetti Bordogna, Gentiluomo and Roberti di Sarsina, 2013, 6).

More recently, a stand has been taken by the State – Regions Conference on NCM training, while the Autonomous Province of Trento has approved a law on training pathways for various professional profiles.

So things are still moving in a fragmentary manner on the NCM scene in Italy, despite the presence of certain common trends. The opportunity afforded by Regional Health System redefinition seems not to have been fully or uniformly exploited by all Regions, even in the face of a growing demand for treatment and therapy preferences for individual subjective freedom to choose, which is typical of Person-Centred Medicine.

Much remains to be done on an institutional level, but sociology, and especially the sociology of health, still has wide scope for probing the reasons behind certain local policies, that fly in the face of the mounting demand for NCM.

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