

**THE FUTURE OF THE WELFARE STATE:
PATHS OF SOCIAL POLICY INNOVATION
BETWEEN CONSTRAINTS AND
OPPORTUNITIES**

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**THE PERFORMANCE OF THE ITALIAN NHS
IN A TIME OF REGIONALISATION**

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1. *Introduction*

In the last 30 years Italy and a large part of Western European Welfare States have witnessed an increasing process of re-scaling in welfare policies with a shift of power and responsibilities from the national level to sub-national (often regional) ones (Norton, 1997). These processes of welfare state re-scaling and regionalization became more relevant in the Italian case since the beginning of the 90's and they strengthened quite dramatically the role of the Regional institution. As a matter of fact, nowadays in Italy:

- following the regionalization reforms of the 90's (see prf. 3), a good part of the regulatory public power in health care has shifted from the national State to 21 Regions; the former has maintained mainly two tasks (a relevant part of the financing and the setting of "homogeneous standards of health provision" over the country), the latter have received all other tasks (from planning to managing health care provision);

- health care is becoming for the 21 Regions one of the most important policy field, given the fact that at least two thirds of Regional spending in each Region concern health care provision.

This situation makes the study of Regional Health Care systems (RHS) relevant also for a second reason: the analysis of RHS becomes extremely interesting in order to understand the more general functioning and transformation of the regional institution in Italy. Given the increasing regional autonomy and the relevance of health funding in the life of Regions, the way the RHS is managed becomes an important tool for regional government in terms of regional institutional building (Banting, 1997): the RHS can serve as a mechanism to strengthen their legitimacy and consensus for institutional reasons (traditionally Italian Regions have been considered 'weak' if compared with the national state or municipalities). The RHS can also be helpful for political parties to obtain more consensus. In the last 10-15 years therefore Italy has witnessed an increasing attention paid by Regional governments not only on the function of the their own RHS but also on the communication to their public opinion on the "society" they have in mind when they choose their model of governance for the RHS. Regions like Lombardy have, for instance, introduced a quite developed 'quasi-market' governance model and they have

presented it also as a sign of what type of societal model they want to develop: a society with “less state, more community”. The choice to use welfare policies also as a field for communicating the ideas and ideologies of Regional governments is not something completely new in Italian recent history. During the 70’s and the 80’s the so called “red” Regions (those ones governed by the communist party, such as Tuscany and Emilia – Romagna) were the ones who thought welfare governance and provision also as a symbolic investment in the discussion in the national arena in order to propose a different model of society if compared with the prevalent (Cristian-Democratic) one. What changes in the 90’s is the fact that other Regions, also with different political orientations (such as Lombardy), have followed the same path, understanding how important RHS can be in order to obtain legitimation.

If this health care re-scaling brought new opportunities for Regional governments, at the same time it produced worries about the possible increase in the level of health inequalities related to the different capacities of the RHS. If local welfare can be seen also as a potential mechanism of “social investment” in a global competition (Esping-Andersen, 2002), those Regions with more difficulties in handling their RHS might even more lag behind the others than when the NHS was more centralized.

Given this scenario, the article tries to answer the following questions:

- i) can we measure RHS performance and classify the 21 RHS in terms of their level of performance?
- ii) Regionalization is bringing inside the NHS the building of 21 different RHS?
- iii) Since regionalization, is the Italian NHS more homogeneous in terms of average level of performance or is there a phenomena of increasing health territorial inequalities?
- iv) What are the factors related two possible differentiation in RHS performance level?

2. The transformation of the Italian health policy over time

From the State unification of Italy (1860) to the creation of the NHS (1978), the basic problem of Italian governments was to limit the inclusion of health care among the tasks of government and of public administration. Liberal governments, first, the Fascist government afterwards and, for a long time, also the Republic post-IIWW governments avoided the issue of the institution of a universalistic and institutional reform of the Health System (Vicarelli 1997). As a matter of fact, in the 50s, the Republican (Cristian-Democrats) governments chose to perpetuate the mutualistic fascist model, implementing criteria even more based on contacts, nepotism and political patronage.

All these measures exerted great influence on health care structures and in particular on the modernization processes of hospitals, since they prevented a direct intervention of the State on the issue: the State accepted the principle of deregulation and entrusted private providers and religious organizations with the matter. Besides, the flow of private charity, on which hospitals depended, was variable in quantity and, above all, widely varied from region to region: hospitals in richer Northern Italy could rely on generous donors sensitive to the new medical and technological needs, while hospitals in poorer Southern Italy received contributions less generous. No wonder, therefore, that at in the 50's Northern Italy could rely on around 8-9 beds per 1,000 inhabitants, while Southern Italy only had 2-3 beds (ibidem).

This difficult path towards health care "statalization" continued until the second half of the 70s, when the creation of the NHS started a new phase, no longer based on the predominance of the private over the public, but rather of the public over the private, albeit with various forms of mixture and expediency. If the 80's represented the time when there was the first attempt to build a real NHS, already in the 90's new institutional changes took place.

1992-93 marked a turning point for Italian politics and also for the NHS: right during the political scandals (the so called "dirty hands" affairs), that wiped away a good part of the traditional post-war party system, and the financial crisis that hit Italy severely, two bills were passed by the Parliament (n° 502 and n° 517), aiming at reorganizing deeply the NHS. The transformation was similar and contemporary to the one started in many European countries,

where a wide process of costs containment or transformation of health policies took place (Vicarelli 2005b). In the discussion precedent and following the adoption of the bills two different coalitions and conceptions of the NHS emerged: one more liberal, aiming at the partial privatization of the NHS, based on broader rely on families, communities and market forces to foster health provision; one more social-democratic, with the goal to strengthen the NHS, also using a stricter financial control. In the last 15 years these two NHS conceptions have been advocated by the two main centre-right and centre-left political coalitions. As a matter of fact both coalitions, once they got into power, tried to implement their vision on the NHS but with limited results. Centre-Left governments between 1996 and 2000 (and for a short term between 2006 and 08) focused on the improvement of the NHS, also passing a bill (n° 229) in 1999, obtaining, anyway, a limited effect. Centre-Right governments tried between 2001 and 2006 to foster a process of (partial) privatization, increased competition and health expenditure limitation. The attempt to partially privatize the NHS failed as well as the one related to a strong health costs control.

One of the main reasons for these policy failures at the national level can be explained with the fact that, since the mid-90s, the NHS started to be regionalized, leaving more autonomy to Regions: therefore, the RHS became able to decide how much of the policies elaborated at the national level fitted their own health care priorities.

3. The regionalization of the Italian NHS

In the same decade when the NHS was introduced (the 70s), Regions started acquiring an institutional recognition, also in health care issues. However until the mid-90s their role in the NHS was limited and they were more “policy takers” (mainly concerned with the implementation of centrally set policies) than “policy makers” (France 2008). Only in the 90s, their role changed thanks to the marked process of strong political devolution, a process definable as “health care federalism”. Devolution was a typical feature of the health policy in the 1990s, above all in those countries with a NHS:

transfers of relevant decisional powers and financial responsibilities to lower levels of government had already been started in Italy, Spain, Greece, United Kingdom (at least as for Scotland and Wales), Belgium and in the Scandinavian Countries, where already existing trends were strengthened.

Since the 90's two different phases of NHS regionalization can be traced.

The first phase of devolution started in the 1992 with the bills n° 502 and n° 517 and it ended in 2001 when devolution was recognized at the constitutional level by an amendment to the art. 117 of the Italian Constitution, that, well beyond the health care sector, marked a further shift of the balance of power between the State and the Regions in favor of the latter. During the 90s the process of regionalization changed the way health policy took place: France and Taroni argue that “policy is (since then) made less in Parliament and in the central ministries and more through negotiations between the national government and the regions” (2005, p. 184). Therefore, inside a relatively loose national institutional setting, Regions have been able to develop their own RHS with different choices in terms of provision's organization. One of the striking features of this regionalization in the 90s was the asymmetry between health care spending by Regions and revenue raising responsibilities. Due to a nationally centralized taxation system, dating back to 1971, the NHS was entirely financed by the central State also in the first part of the 90s. In comparison to other European countries in the case of Italy the process of devolution in the 90s did not imply neither a tighter central control / steering nor the devolution of revenue raising responsibilities. The result was a policy of deliberate under-financing on the side of central government, on the other an increase in financial deficits, especially in those Regions with less cost control capacities.

The second phase of NHS Regionalisation started at the beginning of the present decade is characterized by the fact that what has become mostly relevant to central governments (no matter their political orientation) is finding a way to better control regional health expenditure, imposing harder budget constraints.

The first act in this direction was a negotiated Agreement between National government and Regions in 2001: on one side the National government agreed on helping financially Regions which had accumulated deficits, on the other the latter agreed to prepare

and to show plans for avoiding future deficits (also increasing regional taxation and co-payments).

Even if the Agreement was a watershed in health care intergovernmental relations, replacing confrontation with competition, it proved insufficient to stop regional deficits (France, 2008). Therefore in 2005 another Agreement was agreed in which it was clear that the State assured the elimination of regional deficits but in exchange of stricter and more rigorous conditions posed on the Regions such as the reduction of hospital beds, a closer and regular national scrutiny on the operation of their health services, as well as all the other conditions already written in the 2001 Accord.

The Prodi government continued mainly along this line of action, signing in 2007 another Agreement. Given the fact that out of 21 RHS, 7 have relevant deficits, it is especially these seven Regions that have faced more a “return” of Central Government in their running health care: “the ‘seven regions in difficulty’ are in such dire financial straits that they have been prepared to accept severe limitations of their freedom of action. This exercise of central spending power represents a dramatic break with the period pre-2001 when state financing was granted virtually unconditionally” (France, 2008; p. 18).

Nowadays therefore, in comparison with the 90’s, the Central Government, using as a leverage the financing power, is regaining a more central role in the NHS and on the RHS, but this applies mainly to the (seven) Regions who have deficits. The other ones have a high degree of freedom to choose their models.

4. Measuring the RHS performance

In the last years in Italy and abroad there is a growing literature on health care performance with the diffusion of different health care performance indicators (OECD, 2002; Nuti, 2008). Looking at this literature what seems to be less present is the construction of synthetic indexes, able to account for the multidimensionality of health care provision. For instance in Italy the only study with this specific goal is the one from Mapelli (2007).

The way performance has been measured here is through running a Principal Component Analysis (PCA) on a set of variables, collected at the level of the 21 RHS. The variables used for the PCA were related to the following dimensions and aspects of public health care provision (see box 1).

The administrative capacity refers to how efficient the RHS is in using its own hospital resources.

Process results refer to a set of issues concerning: appropriateness (how to cure avoiding more expensive and more patient's aggressive treatments); direct and indirect (health mobility from a RHS to another) users' satisfaction; the capacity to develop a health care system not only hospital centered but also working through territorial care services (e.g. home care, etc.); prevention, given the fact that in the last 30 years the World Health Organization (WHO) considers prevention as one of the main tools to improve health quality and to reduce health costs.

Given the difficulty to measure outcomes, the dimension of final results refers to two different aspects: the level of mortality (the neo-natal one and the avoidable one) and the RHS capacity to reduce health inequalities, in terms of how well RHS allows the access to its facilities no matter the social class of origin of the potential patient.

Box 1. Dimensions and variables used to calculate the RHS performance synthetic index

Dimension	Variables	Interpretation of the indicator value in terms of performance
Administrative capacity	<ul style="list-style-type: none"> • Case mix index² • Average hospital stay (days) weighted for the case mix index³ • Average pre-surgery hospital stay 	<p>The higher the better</p> <p>The lower the better</p> <p>The lower the better</p>

² The case mix index is prepared by the Italian Ministry of Health and it measures the average complexity of health needs treated in the RHS hospital system (e.g. if a RHS treats relatively more than another oncological patients, it will have a case mix index higher).

³ In recent decades the main hospital policy is, given the complexity of the health need, to reduce the length of hospital stay in order to lower costs and to abbreviate patients' uneasiness in staying in hospitals, improving the use of day-hospitals (DHs) or other forms of out-patient care.

	(days) weighted for the case mix index <ul style="list-style-type: none"> • Turn-over rate for acute hospital beds utilization • Hospitalization rate (% of residents cured by hospitals)⁴ 	The higher the better The lower the better
Process results		
- appropriateness	<ul style="list-style-type: none"> • % of cesarean births • % of hospital discharges from surgery units but without surgery needs • Hospital discharges rate for asthma (every 100.000 residents)⁵ • Hospital discharges rate for diabetes (every 100.000 residents) 	The lower the better The lower the better The lower the better
- users' satisfaction	<ul style="list-style-type: none"> • % of citizens satisfied by medical care • % of citizens satisfied by nursing care • % of citizens satisfied by hospital hygiene 	The higher the better The higher the better The higher the better
- territorialisation	<ul style="list-style-type: none"> • Ratio between RHS % emigrants / % immigrants⁶ • % of over65 receiving nursing home care • % of over65 in nursing homes • % of long-term care patients who, once dismissed by the hospital, are cured at home (care continuity) 	The higher the better The higher the better The higher the better The higher the better
- prevention	<ul style="list-style-type: none"> • % women over40 doing mammography • % women over25 doing pap-test 	The higher the better The higher the better
Final results		
- mortality rate	<ul style="list-style-type: none"> • Birth mortality rate • Avoidable mortality rate 	The lower the better The lower the better

⁴ The same reasons for the lowering of the hospital stay are relevant for this indicator.

⁵ This measure as the following are based on the assumption that a RHS working well should have a low level of patients in hospitals for health needs curable through territorial ambulatory care: the high presence of patients with asthma in hospitals means that the territorial care facilities do not work as they should.

⁶ The ratio measures the % of patients from the RHS "i" who decided to be cured in another RHS over the % of patients from other RHS who decided to be cured in the RHS "i": it measures the attraction capacity of a RHS for its own inhabitants and for those from other NHS.

- inequalities	<ul style="list-style-type: none"> • Ratio between high educated / low educ. women doing mammo-graphy⁷ • Ratio between high educated / low educ. women doing pap-test 	<p>The closer to 1 the better</p> <p>The closer to 1 the better</p>
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The PCA for the list of variables referred to the year 2005 gave the following results⁸:

- The first component extracted explains around 60% of total variance;
- The two following components extracted explain 8-10% each of total variance.

The first component extracted measures the RHS performance in a relatively satisfactory way, due to the fact that all 3 above dimensions tend to be represented through it⁹: therefore this first component extracted has been considered the general synthetic performance indicator.

The PCA was supposed to include also another variable, the relative incidence of RHS budget deficits on total public health care expenditure, as an indicator of economic performance. However this variable was the only one in the list that did not relate to the first component extracted and therefore was considered separately from all the other variables in box 1.

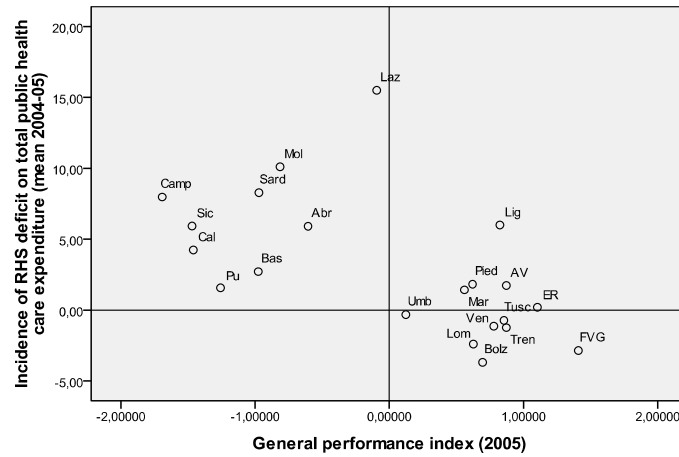
Graph 1 shows where the 21 RHS are located in terms of the two (general and economic) performance dimensions.

⁷ This index and the following measure how well a RHS is able to reduce the role of social class (here calculated in terms of level of education) in the access to health care.

⁸ The PCA has been repeated also for all the years from 1998 to 2004. The results are quite the same as the ones showed here.

⁹ There is a strong correlation (.891; Pierson) between our synthetic index and the one developed, through another methodology, by Mapelli (2007). It means that, even using different methodological tools (PCA in our case, a weighted additive index for Mapelli), the results tends to be quite similar.

Graph 1. The RHS performance



Trying to classify¹⁰ all 21 RHS on the base of their general performance indicator (GPI) and their economic one (EPI), we obtain, at a more general level, 3 types of RHS:

- the RHS from Central-Northern Regions (all the ones in the bottom-right part of the graph), with high GPI and generally low or no deficits;
- the RHS from Southern ones (all those in the upper-left part of the graph), with lower levels of GPI and low to severe deficits;
- Lazio stays in an intermediate position in terms of GPI, but scores high in terms of deficit level.

Adopting a closer look, it is possible to frame 5 RHS clusters:

- 1.a a group of RHS with good GPI and no deficits, representing the Regions with relatively highest performance, made by North-East Regions, together with Lombardy and Tuscany;

¹⁰ The 3-5 different RHS clusters have been obtained through a hierarchical cluster analysis (ward method) on the two performance variables.

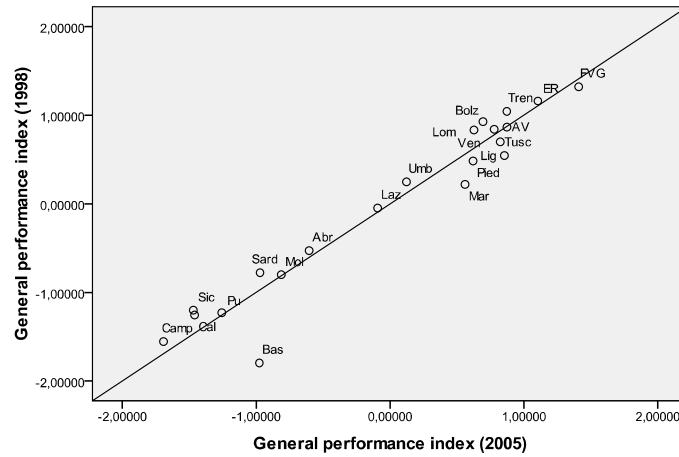
- 1.b the North-Western RHS (Lombardy excluded), together with the ones from Umbria and Marche, that present either (light) deficit problems (Liguria is the only relevant exception) or still positive but lower GPI results;
- 2. Lazio remains by itself;
- 3.a the RHS with a low performance on both indicators, typical of the bigger Southern Regions (Sicily, Campania, Calabria) and, partially Puglia;
- 3.b the RHS where there is a trade-off between (better) GPI and (worse) EPI, except Basilicata.

5. *Convergence or divergence among the RHS in a time of regionalization?*

One of the main issues in the Italian debate about federalism deals with the impact of such an institutional setting on territorial inequalities. Italy is one of those countries where territorial differentiation reaches a high level (Cartocci, 2007). Therefore, the regionalisation of the NHS, undergone in the last 10-15 years, is a good testing ground for evaluating the possible impact of federalism on a more general scale, not just referred to health care. Trying to connect regionalization with RHS performance, it means asking if the distances between lower and higher performance RHS have decreased (convergence) or increased (divergence) over time.

A first hint comes from graph 2, where it is shown how RHS performed in terms of GPI both in 1998 and 2005. It seems clear that the relative position of each RHS has remained quite the same, with only few exceptions (for instance Basilicata improved, whereas Sicily got worst): the Pierson correlation index is equal to ,969.

Graph 2. The RHS performance over time



Graph 2 offers us a clear sight of a *path dependency* process in the Italian NHS. In order to better understand what happened, the research focused specifically on the process of convergence / divergence among the 3-5 types of RHS, introduced in the prior paragraph.

In order to evaluate this process, the following analysis has been set:

- i) a group of variables from box 1, referred to the different dimensions of performance, have been chosen;
- ii) for each of these variables the average value was calculated in reference to two different time phases (mid-90s and mid-2000) at the RHS cluster level;
- iii) the distance between RHS clusters in terms of difference between the average values was calculated both for the mid-90s and the mid-2000;
- iv) the last step was the calculation of the variation between the differences in the mid-90s and the mid-2000s.

An example will make clearer the procedure:

- i) one of the indicators used is the relative incidence of cesarean births, which rose in Italy between 1995-2005, showing a decrease in the level of appropriateness;
- ii) this rise, negative in terms of performance, was differentiated in the various RHS clusters; in 1995 the incidence of cesarean births was equal to around 23% in the Centre-North, 30% in Lazio and in the South; in 2005 the incidence rose to 31% in the Centre-North, 41% in Lazio and 50% in the South;
- iii) therefore the rise in the incidence between 1995-2005 was equal to around +8% in the Central-Northern RHS, +11% in Lazio and +20% in the Southern RHS;
- iv) therefore, the distance between the 3 different RHS types grew between 1995-2005; in particular the distance between Central-Northern RHS and Lazio increased by around 3% and the one between the former and Southern RHS by around 12%; in the case of caesarean births a phenomenon of performance divergence is visible.

Table 1 shows for the whole set of variables used how it has changed the distance between the cluster of RHS with the highest GPI score (the North-East, Lombardy and Tuscany for the 5 RHS typology) and the other 4 RHS types. To facilitate the interpretation of table 3 also symbols (-, =, +) are used, indicating the direction of the diachronic variation (decrease, steadiness, increase). Among the 25 variables used the PCA illustrated in paragraph 4, 13 have been chosen for the following analysis, representing the different dimensions of performance.

Table 1. Single performance variables and their evolution over time: a comparison among the 5 RHS (mid-90s and mid-2000s)

	Variation of the % distance between the best CN RHS and:			
	The rest of CN RHS	Lazio	'Small' Southern RHS	Other Southern RHS
Cesarean births	-0,4(=)	-4,5(-)	-11,8(-)	-14,7(-)

Women doing mammography	,6(=)	5,3(-)	-1,6(+)	8,7(-)
Satisfaction of medical care	-3,3(+)	-2,6(+)	-3,1(+)	-,6(=)
Satisfaction of nursing care	-4,7(+)	-6,5(+)	-2,5(+)	,9(-)
Turn-over rate for acute hospital beds utilization	-1,9(+)	-12,1(+)	-3,5(+)	-5,0(+)
Birth mortality rate	4,2(+)	8,5(+)	4,3(+)	-3,4(-)
Incidence of RHS deficit	,5(-)	7,5(-)	-3,2(-)	-3,5(-)
Case Mix index	-,02(+)	,05(-)	,06(-)	,04(-)
% of hospital discharges from surgery units but without surgery needs	2,6(+)	2,7(+)	2,9(+)	2,6(+)
Ratio between high educated / low educ. women doing mammography	-,04(=)	-,35(-)	-1,01(-)	-1,32(-)
% of over65 receiving nursing home care	-,67(+)	,39(-)	-,17(+)	,62(-)
Hospitalization rate	,5(=)	-19,8(-)	-8,8(-)	-5,5(-)
Average hospital stay (days)	,0(=)	,2(+)	-,2(-)	-,3(-)

(+) Convergence (=) Stability (-) Divergence

First of all, it can be noticed a relative process of convergence between the two types of Centre-Northern RHS: the distances between them decreased in the period 1995-2005 (7 variables show convergence and 5 stability, with only the deficit indicator showing divergence).

The two Southern RHS show signs of differentiation: the smaller RHS type partially reduces its performance gap from the North-East RHS benchmark, whereas the other Southern RHS witnessed a growing distance with the North-East RHS.

Lazio tends to converge to the North-East RHS for some dimensions, but not for others.

Over all, the NHS regionalisation in the last 10-15 years in Italy has brought so far not a strong and generalized process of convergence in the performance level of the RHS. If the Centre-North becomes more homogenous and Lazio together with the 'small' Southern RHS show signs of convergence (or, at least, not

divergence) with the Centre-Northern RHS, the rest of the South (where lives around 81% of total Southern population and 29% of the total Italian population) is diverging and, in relative terms, is worsening its RHS.

6. *Factors related to RHS performance*

Given the differences in the RHS performance level described in the previous paragraphs, it becomes relevant to focus on which variables might be related to GPI and EPI. A dataset with the 21 RHS cases was created where the following information were included: two sets of variables were included, along with the GPI and the EPI; the data were related to each year between 1998 and 2005, in order to have a sort of time series data.

The two sets of (potentially) independent variables were related to:

- *organizational factors* (human, financial and other types of available resources at the RHS level, governance tools and capacity)
- *contextual factors*, referring to the political and socio-economic environment.

Specifically the *organizational factors* are the following. Two variables refer to resources availability in the RHS:

- the *per-capita health care expenditure*;
- the relative diffusion of *health care (diagnostic) technology* (the number of Magnetic Resonance units per 100.000 inhabitants).

Other two variables refer to RHS governance capacity:

- the *weight of small hospital facilities* (less than 200 beds) among the overall RHS hospital supply¹¹;
- the *capacity to regulate / to control private contracted-out provision*¹².

¹¹ The % incidence of small hospital beds among the total number of beds is considered an indicator of the capacity of a RHS to avoid inefficient production and also to interact in a efficacious way with municipalities which are usually 'jealous' of 'their' community hospitals: RHS usually manage to close small hospitals only when they are able to convince municipalities.

¹² A CERGAS study (2007) measured the RHS capacity to develop appropriate and effective procedures for the "accreditation" of private providers. In the present study an index was created from GERGAS data, varying from 0 (no real

Two last variables related to basic RHS supply structure:

- the relative diffusion of acute care *day-hospital discharges*, given the fact that DH is considered a solution that should be more diffused than what it usually is;
- the *incidence of private providers*, measured in terms of % discharges in hospital care by private contracted-out facilities.

The set of *contextual variables* has been the following:

- the level of *socio-economic development*, as it has been measured by Putnam et al. (1990) (using a PCA on variables such as per-capita GDP, etc.);
- the level of *civiness*, defined mainly as in Putnam and his colleagues (1990);
- two variables related to the *functioning of the political system*, one referred to the presence of Centre-Left or Centre-Right Regional governments, the other to the stability of these governments (how often they remained into power or had to change due to difficulties among the winning coalition parties);
- a *demographic variable* related to the total regional population, thinking there might be a correlation between performance and the size of the RHS;
- a variable related to the intensity of *health care needs*, measured by the dependence index (the incidence of over64 and under15 on the overall population).

The number of potential independent variables ($K = 12$), in relation to the number of cases ($N = 21$), even using time series FGLS regressions, does not allow to use all the K . Therefore the decision has been to run two separate regressions using separately the two sets of (organizational and contextual) variables. The results are reported in table 2 and 3, respectively for the GPI and the EPI.

Table 3. Cross-sectional time-series FGLS Regression: dependent variable GPI

	Coeff. Standard.	Coeff. Standard.
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accreditation system was introduced in the RHS) to 1 (a complex and appropriate accreditation system was completed).

	model 1	model 2
% private hospital discharges	-,150	
Capacity to regulate private provision	,577*	
% beds in small hospitals	-,411*	
Health care expenditure p-c	,102	
MR diffusion	,032	
% DH	,225	
Regional governments instability		-,100
Centre-Right regional governments		-,005
Socio-economic index		,388*
Civicness index		,393*
Population (milions)		-,059
Health care needs complexity		,201

Coefficients: generalized least squares; Panels: heteroskedastic with cross-sectional correlation;

Model 1: Correlation: common AR(1) coefficient for all panels (0.532); Number of obs = 168; Number of groups = 21; Time periods = 8; Wald chi2(5) = 1023.56; Prob > chi2 = 0.0000.

Model 2: Correlation: common AR(1) coefficient for all panels (0.589); Number of obs = 168; Number of groups = 21; Time periods = 8; Wald chi2(5) = 1127.71; Prob > chi2 = 0.0000.

* Sign. < 0,005.

Table 3. Cross-sectional time-series FGLS Regression: dependent variable EPI

	Coeff. Standard. model 1	Coeff. Standard. model 2
% private hospital discharges	,172	
Capacity to regulate private provision	-,440*	
% beds in small hospitals	,420*	
Health care expenditure p-c	,251	
MR diffusion	,234	
% DH	,186	
Regional governments instability		-,556*
Centre-Right regional governments		,034
Socio-economic index		-,159
Civicness index		-,251
Population (millions)		,078
Health care needs complexity		,219

Coefficients: generalized least squares; Panels: heteroskedastic with cross-sectional correlation;

Model 1: Correlation: common AR(1) coefficient for all panels (0.627); Number of obs = 168; Number of groups = 21; Time periods = 8; Wald chi2(5) = 42.41; Prob > chi2 = 0.0000.

Model 2: Correlation: common AR(1) coefficient for all panels (0.325); Number of obs = 168; Number of groups = 21; Time periods = 8; Wald chi2(5) = 39.43; Prob > chi2 = 0.217.

* Sign. < 0,005.

The most relevant variables in both regressions are quite the same. In the case of GPI there are four significant variables: two organizational ones, both connected to the concept of governance capacity (positive correlation); two contextual ones, referred to the level of economic development and civicness (positive correlation).

In the case of EPI, the factors partially change: the only significant contextual variable is the one referred to regional governments stability, whereas the relevant organizational variables remain the same as for the GPI.

In conclusion the level of available resources and the political dimension, strictly defined in terms of government ideological orien-

tation, do not have an impact on performance. The level of governments' (in)stability plays a role on EPI.

Another interesting finding is that a difference must be made between the governance capacity and the model of governance. The governance capacity deals with the “strength” of a public administration to regulate a complex network of private and public actors. Instead, the model of governance deals with the type of mix in public-private provision (more privates and the use of quasi-markets, less private and the use of managed cooperation). What seems to differentiate the RHS performance is not how spread is contracted-out private provision, but the capacity of the RHS to regulate such actors, as well as others (professionals, etc.), once they become part of the public health care system (Vicarelli e Pavolini, 2009).

The last two significant variables are the level of civicness and socio-economic development. Due to the fact that it was not possible to run a regression model with all 12 independent variables, no control was made trying to evaluate at the same time the role of contextual and organizational variables: a simple Pierson correlation analysis between the two significant governance variables and the two significant contextual ones shows there is a high and significant connection between the first two and the latter ones (table 4), indicating that probably civicness and economic-development have also an indirect impact on performance, influencing also the governance capacity.

Table 4. Pierson correlation among the main independent variables

	Socio-economic index	Civicness index	% beds in small hospitals	Capacity to regulate private provision
Socio-economic index	1	,713**	-,712**	,665**
Civicness index	,713**	1	-,475*	,704**
% beds in small hospitals	-,712**	-,475*	1	-,567**
Capacity to regulate private provision	,665**	,704**	-,567**	1

This set of direct (and indirect) correlations between these contextual variables and performance needs to be understood more. In the following final paragraph some hypothesis about this issue are presented.

7. *Conclusions*

Trying to answer to the questions posed at the beginning of this essay, the analysis provides a picture with some spotlights, but also many worrying issues.

No doubt that the Italian NHS has improved in the last 10-15 years: there is a broader diffusion of territorial services (with a higher level of health and social services integration), as well of as prevention programs, the efficiency in using hospital facilities (average stay, etc.) has increased and children mortality rate has decreased.

Along with these improvements there are also others aspects less positive in terms of universalistic provision. There is a clear-cut division among the RHS in terms of performance, a division that runs from Centre-North to South.

The idea that regionalisation would have brought 21 different (in terms of performance) RHS does not hold true, but 2 broad types of RHS are easily identifiable, along with a third specific one referred to Lazio.

Inside these two broad RHS clusters there are important differences; in the South, along with the worst RHS in Italy in terms of performance, there are 4 Regions which show a relatively less negative GPI, although maintaining EPI problems; in the Centre-North there are two sub-clusters, both of them performing, anyway, better than all the other areas of the country.

The process of institutional regionalization of the NHS in the last 10-15 years has scarcely helped to reduce the performance

gaps among the two main RHS types; more frequently it appears that the distances have improved, leading to a NHS that is even less universalistic in terms of rights of health care access.

Looking more in depth, it seems that a process of convergence took place among the Central-Northern RHS and partially interested also Lazio and those 4 Southern Regions less problematic in terms of performance, whereas the remaining 4 Southern RHS (which present 29% of the total Italian population) increased their distance from the rest of the country.

The emergence (and the strengthening) of different health care 'Italies' seems difficult to change in the short-medium term. This impression is confirmed also by the variables that seem to influence performance: two of them (the level of civicness and of economic development) can be modified only in the medium-long run. Politics, the only variable (perhaps) able to change the description given in the short-medium term, does not matter too much.

The governance organizational variables play a role, but, again, this capacity requires time to develop: there also seems to be a strong correlation between governance capacity and the two main contextual variables (civicness and economic development), meaning that, perhaps, the latter help the development of the former.

What might be the social 'mechanisms' that explain such strong correlation between civicness and socio-economic development with performance? One of the main critics to Putnam and colleagues analysis is based exactly on this issue (Bagnasco et al., 2001; Mutti, 1998; Sciolla, 1997): a correlation is shown by Putnam, but there is not a punctual reconstruction at the micro level of how (which mechanisms) these 3 variables interact with each other, creating as an output macro differences (Barbera, 2004).

On this relevant issue, the present paper can offer just some hints, that will need more in depth empirical and analytical analysis.

The correlation between civicness and performance might be explained through the following mechanisms.

The capacity and the will of the citizens of a certain territory (RHS) to use the 'voice' option à la Hirschman, instead of adopting the 'loyalty' or the 'exit' option, and therefore to put pressures on local politicians, directly or through patients' associations, in order to obtain better health care; for instance, the 'exit' option is quite diffused in Southern RHS where many residents decide simply to go and to get cured in other (Centre-Northern) RHS, given the NHS right to health care 'migration'.

Civicness does not concern only citizens and RHS users, but also the RHS workers; as indicated by Mintzberg (1968), health care is typical professional (post-)bureaucracy, where the activity and the relative quality is made by professionals (first of all doctors, than nurses, etc.); in a NHS where there are such broad governance and civicness differences, it is possible that professionals' opportunistic behaviors might change; where there is less control, in a context of more unequal relationship between professionals and patients, opportunism might rise.

The positive correlation between performance and socio-economic development can be explained in a relative straightforward manner: in those regions (RHS) where there are serious economic development problems public health care does not have only a (manifest) function of producing care, but also a (latent) one of job opportunities and economic chances creation. Among the (demographic) biggest Western European countries, Italy is the one where deepest is the gap, in terms of socio-economic development, between the poorest and richest regions (Cartocci, 2007).

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