

**The future of the welfare state: paths of social policy
innovation between constraints and opportunities**

Urbino, 17-19 September 2009

**Reforming the Italian health care system: a focus on financing
A history of revolution, evolution, and political devolution**

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By Lorraine Frisina¹

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I - Introduction

The 1978 inception of the Italian National Health Service (Servizio sanitario nazionale or SSN) represented a radical turning point in the history of the country's health care policy. Moving from a highly fragmented social insurance scheme to a highly centralized state-based system, the SSN embodied a revolution in both the values and organization of health care in Italy. Based on the British National Health Services (NHS) model, the SSN was founded on principles of universality, equality, and uniformity of access that were intended to rectify the inequalities produced by a system of social insurance contributions which had differentiated between professions and thereby education levels, but which also had reinforced the pre-existing socio-economic disparities between the Center-North and South (Fargion 2006; France 2006). By relying on centralized tax financing, the newly established SSN made it possible to redistribute resources from the wealthier regions of the Center-North to the poorer regions of the South or Mezzogiorno. However, whereas the British NHS coupled and centralized the roles of financing and the allocation of resources, the SSN combined central budgeting and planning with local control (Fargion 2006; France 2006). This split between financing and allocative capacities would soon be regarded as a source of great inefficiency in the SSN, and the necessity to reform the still nascent system became the rallying cry of politicians and health care experts alike.

With the start of the 1990s, this cry was met with a series of drastic reforms that have continued on into the present decade and which have ultimately redefined the nature of the

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financing of the SSN as it exists today. However, it would be misleading to see this evolution of the Italian health care system as the sole result of concerns for efficiency. Rather, the reform process has taken place within a larger context of political devolution which has afforded regions² greater autonomy in a number of key social policy areas including health care. More specifically, regions have been given responsibility for the financing of health care through regional taxes, as well as the exclusive organization and administration of services. What is left, therefore, is a system which, to a large extent, returns to the fragmentation and regionalization of its social insurance days; thereby also threatening to exacerbate the yet unresolved problem of the Center-North – South divide in access and quality of health care services (Fargion 2006; France 2005, 2006; Petretto et al. 2003).

The present contribution examines these various developments in two parts: first, the *nature* of health care reform in Italy is explored, with a particular focus on changes taking place along the *financing* dimension of the SSN over the past four decades. Once described, changes in the SSN are then *explained* in terms of their underlying causes. As concerns this second, explanatory part, it is the interaction between what will later be termed “problem pressure” (i.e., in this case the growing concern for efficiency) and developments taking place within the political and economic landscape both surrounding and infusing the Italian health care system that is established as the main source of reform. The study will then conclude by reflecting on what Italian health care reform means for the system’s current performance, as well as how it affects the mandate for social solidarity which once formed the basis of the SSN’s values.

² Italy’s regions are first level administrative divisions of the state that have varying degrees of autonomy depending on policy area, but also status. There are a total of twenty regions that comprise the Center-North and South or Mezzogiorno. In accordance with Article 116 of the Italian Constitution, five regions (namey, Sardinia, Sicily, Trentino-Alto Adige/Südtirol, Aosta Valley and Friuli-Venezia Giulia) entertain special status that grants them more authority in areas of legislation, administration, and economy.

II – Financing the SSN

From 1945 to 1978 the Italian health care system was characterized by principles of selective universalism, according to which citizens were insured on the basis of occupation, mainly agrarian versus industrial, but also in terms of geographic area, with Center-Northern regions as well as urban areas generally entertaining better access to primary and hospital care than their Southern and suburban counterparts (Fargion 2006). Within this system of social insurance, several sickness funds offered coverage that varied widely; and the provision of services rested informally with the family and formally with solidaristic networks of a secular, religious, or professional kind (Fargion 2006; Ferrera, 1993, 1998; Vicarelli 1997, 2007; Paci 1989). This left little or no space for public involvement in health care, and immense disparities between demographic groups quickly ensued. The decision to introduce the SSN in 1978, therefore, was made in an effort to rectify these inequalities.

Following the British NHS model, the SSN was to establish universality, equality and uniformity of services that were free upon point of delivery (Fargion 2006, France 2006). This presented a major break from the tenants of social insurance that had dominated the post-war era. However, it would be misleading to assume that this revolution in Italian health care policy was made up of only ideological issues: the sickness funds had essentially gone bankrupt by the mid-1970s and the imperative for reform made anything short of drastic change unthinkable to policy makers and the public alike. By turning to a British style NHS, not only could Italy solve the problem of selective coverage by introducing universalism, it was also argued that a centralized system of financing would allow the government to retain better control of spending. This would ultimately prove not to be the case, as SSN spending quickly escalated during the 1980s making a second round of reforms necessary in the years that followed.

Before discussing the key reform on fiscal federalism in 1999, which is the main focus of the present section, it is first necessary to understand what had gone wrong during the first

decades of the SSN's existence and why. To answer these questions one must begin by looking at provisions for financing set up in the originally established SSN in 1978. These included a three tier structure involving the national government, the regions, and local health districts (referred to as the *unità sanitarie locali* or USL), the latter of which were organized by local governments in order to reflect the balance of power existing between locally elected political parties. Whereas the central government was tasked with the setting of ceilings on spending by regions, as well as with redistributing tax financing through the National Health Fund (NHF) which favored the poorer South, it was the USL that ultimately decided on how funding would be spent within the regions. Indeed, as Fargion (2006, 1992) reports, this policy did initially succeed: whereas in 1977 regional health care expenditure varied from 36 percentage points above the national average in the Center- North and expenditure in the South fell 28 percentage points below the national average in the South, by 1987 this variation had been successfully halved.

Despite the success of reducing inter-regional disparities, the decoupling of centralized financing and decentralized spending, together with poor oversight and monitoring on the part of the central government led to gross fiscal irresponsibility during the 1980s (France 2006, France 1994) and ceilings set by the Treasury were regularly exceeded by the regions' USLs. In part, this was due to the fact that these ceilings were systematically set low by the Treasury (Fargion 2006) thereby making it necessary for regions to spend beyond their means. Consequently, budget deficits became the norm and continue to be so at present.

This unfavourable constellation of factors quickly led to the need for reform. As a result, two laws were passed under the center-left Amato and Ciampi cabinets in 1992 and 1993 (Legislative Decree Numbers 502 and 517, respectively) that gave regions greater responsibility in covering deficit spending for any costs not associated with centralized standards for care, the latter of which became the main focus of the central government. However, the ongoing under-funding and poor monitoring of regions resulted in little change

in the SSN's spending performance and an additional round of reforms would soon be necessary during the late 1990s. Mainly, changes surmounted in the regionalization of financing with the establishment of a regional tax (IRAP) in 1998 which replaced compulsory contributions. This tax was to be levied directly by the regions on all production and professional activities and therefore signified a critical departure from the centralized redistributive efforts of the NHF which nevertheless remained as a supplement to regional taxes. Following this change, a major reform – law number 113 on fiscal federalism – handed over power to the executive to redefine the SSN's financing arrangements, a move which was deemed necessary due to discrepancies in health services between the regions but also due to various political pressures, both of which will be discussed in a subsequent section of this paper.

With the executive now authorized to reform health care financing, the then in power D'Alema cabinet introduced the groundbreaking Legislative Decree Number 56 in 2000, which created a radically new financing system which was to be phased in starting in as early as 2001. This system did away with the earmarked funding coming from the NHF, and instead established revenue sharing between regions based on valued added tax (VAT) and an increased share in excise duties on oil products and, to a lesser extent, income tax (Fargion 2006). This new financing mechanism was to complement regional revenues from IRAP. The concept behind this move on the part of the central government was to better couple economic trends with health care expenditure (Bordignon et al. 2004). Moreover, an Equalization Fund was created to redistribute financing to regions on the basis of geographic and population size, health care needs of the population, and fiscal capacity. The latter of which criteria was intended to rectify the ongoing differences in provision of services between the Center-North and South.

By giving regions various sources of financing for their health care services, they were also to be held more accountable for their spending. Moreover, in an agreement that was

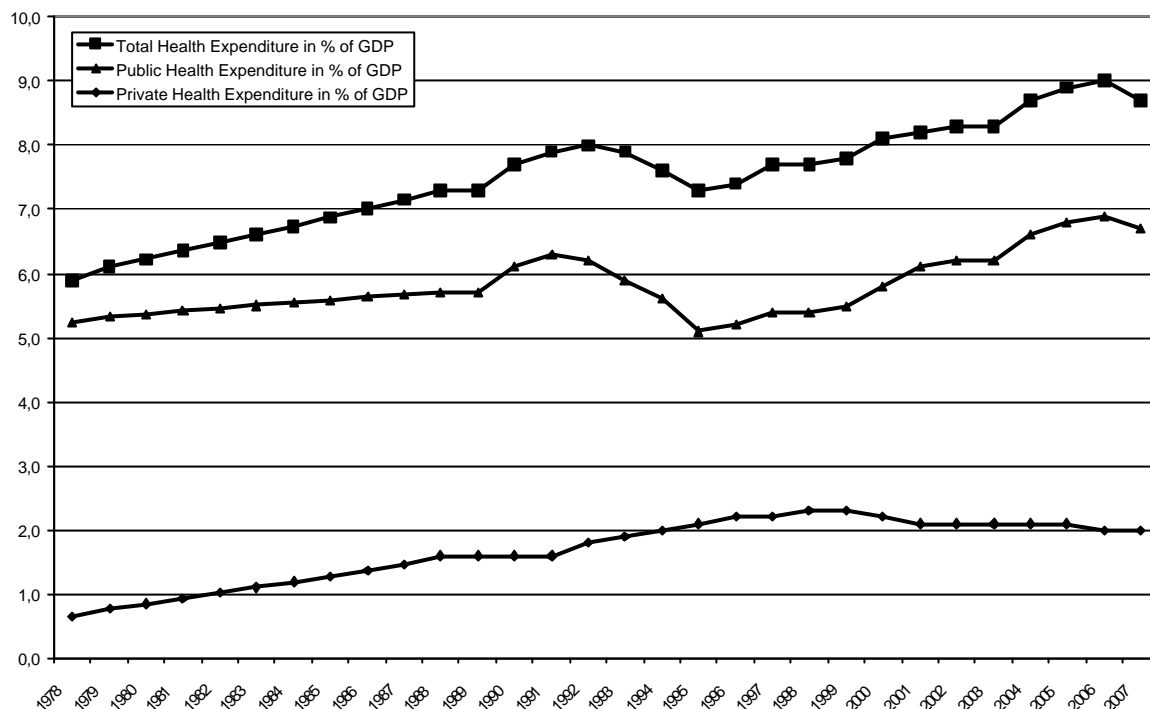
reached in August 2000, the central government gave regions the green light on various other means of fund raising for any costs exceeding regional thresholds. This meant the introduction or increase of patient co-payments, the introduction of a regional addition to personal income tax, and the possibility of further increases to IRAP (Fargion 2006). These changes were tantamount to a next to total regionalization of health care policy, however, this took place alongside a growing focus on national standard setting, according to which minimal level of standards for care were created (livelli essenziali di assistenza or LEA) by the central government. This helped to serve as a counterweight to the more substantive trend in regionalization.

As the Amato cabinet gave way to Berlusconi's second term in office in 2001, health care financing in the SSN saw further changes in the way of a new emphasis on privatization and with the passing of a constitutional amendment in 2001 that re-emphasized the rights of Italian residents to health care services that are free at the point of delivery. This placed greater pressure on regions to assure their populations' coverage in line with the LEA. Given the fact that regional expenditure on health care amounts to 75-80 percent of all regional spending, fiscal federalism has meant a great deal of autonomy, yet also a significant increase in accountability and pressure on regions to stay within their means while also providing comprehensive services. This process of devolution of health care financing has yet to reach a conclusion: at present the Italian Parliament is reviewing a bill that defines broad elements of the new fiscal federalism it plans on introducing in the coming years. This bill will increase the powers of regions to raise revenues by enjoying a larger share of national VAT and income tax (France forthcoming). This bill has already been approved by the Senate and is expected to be passed by the national Chamber of Deputies, where the Berlusconi administration entertains a majority. Taken together, developments in financing reflect a strong emphasis on cost containment and accountability of spending through the

regionalization of health care policy. However, this begs the question: what do the numbers actually show?

Examining total, public and private health care expenditure in terms of the percentage of the Italian GDP (see Figure 1 below) one easily observes that – barring an episodic dip in public spending at the mid 1990s, following 1992-3 health care reform that introduced greater fiscal responsibility on the part of the regions, bringing the percentage down to an all time low of 5% – health care spending has been on the rise over the past four decades. Increases in spending are particularly salient during the late 1980s and early 1990s, when fiscal irresponsibility was at an all time high. But the mid 1990s to the present also show steady increases in spending, leaving the SSN in 2007 with a percentage of GDP about two points higher than that of where it began in 1978. Increases in expenditure are also observable in the case of private spending for health care, which shows a steady and consistent increase over the years 1978 to 2007. Not surprisingly, private spending increases about the time when public spending falls; thereby serving as a supplemental source of expenditure. Taken together, total health care spending, which reflects patterns in public and private expenditure, demonstrates a nearly consistent year to year increase in spending with the exception of the aforementioned dip in public spending during the mid 1990s. While it is impossible to know how trends in expenditure would look in the absence of the reviewed health care reforms, at first glance it would appear that they have not succeeded in containing the financial burden of health care that they set out to achieve.

Graph 1: Italian Health Care Expenditure, % of GDP*

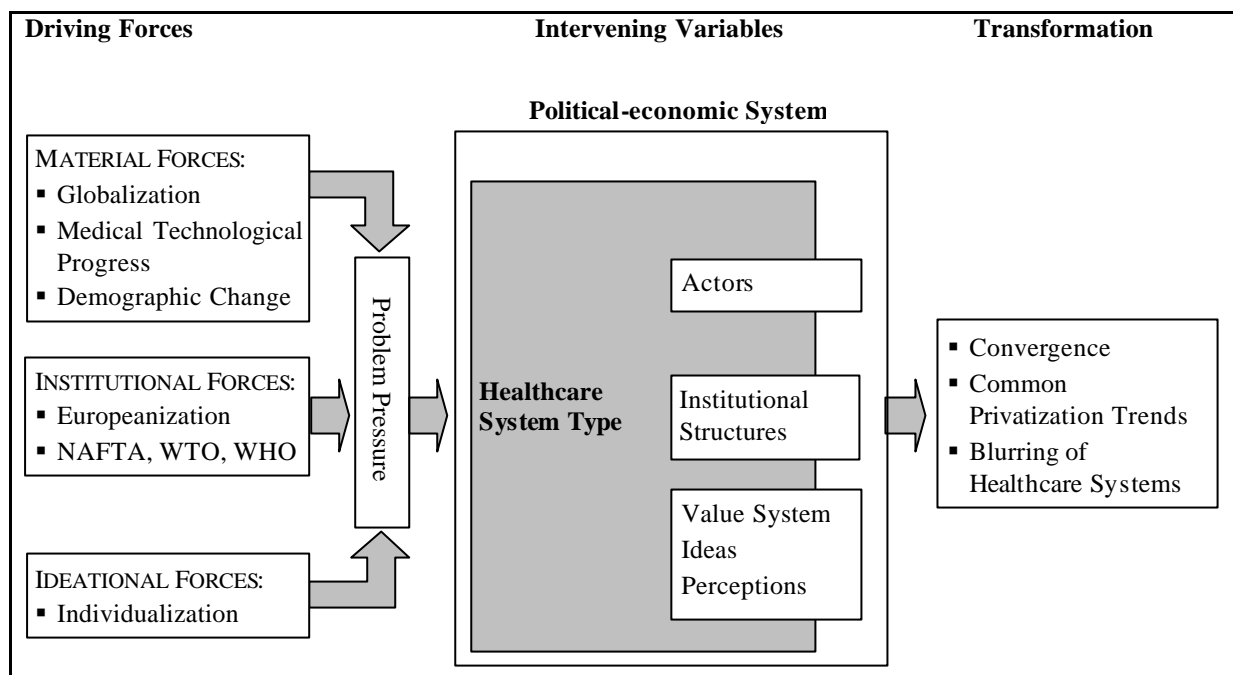


* Source: OECD Health Care Data 2008 except for years 1978-9 for which data is based on an expert interview and for years 1980-7 for which data was interpolated based on steady growth rates for years 1979-88.

III – Problem pressure and change

According to Cacace et al. (2008) (see Figure 2 below) it is the interaction between a phenomenon referred to as “problem pressure” and the political-economic system surrounding and infusing a health care system that brings about changes in health care financing, service provision, and regulation. Problem pressure constitutes various material, institutional, and ideational factors which are said to culminate in change in three distinct ways: convergence across health care systems, common trends in privatization, and the blurring of system features. For the purposes of this paper, which focuses on changes in financing, Cacace et al.’s (2008) model can be used as a heuristic device to help frame the question: why has the financing of the SSN changed? Or, more specifically, what factors have contributed to problem pressure and has the institutional setting of the SSN responded to problem pressure in its financing reforms and patterns of expenditure?

Figure 2: Model for health care system change



Source: Rothgang et al 2008.

As a first step at answering these questions, it is necessary to have a more encompassing perspective of the Italian case in which changes in financing have taken place. This means essentially contextualizing these changes in terms of what was going on in and around the SSN at the time of reforms. This paper, in line with Cacace et al. (2008), takes the various factors listed under the driving forces of problem pressure as exogenous, as they are expected to play a part, albeit to varying degrees, in change affecting all health care systems. Of particular relevance, though, for the Italian case are the factors of demographic change and Europeanization. As concerns the former, the topic of demographic change has been on the political agenda since the 1990s. Italy's workforce is aging and replacement rates through childbirth are notoriously low with about 1.3 children per family or 8.36 births per population of 1,000. In the past three years alone, the child rate has consistently decreased from -1.91% of change to -2.11% and the population growth rate lingers at -0.019% as of 2008. Meanwhile, the age structure of the population reveals a larger percentage of seniors versus those entering the workforce: *0-14 years* 13.6%; *15-64 years*: 66.3%; and *65 years and over*: 20% (as of 2008).

Regarding Europeanization, the EU has placed certain constraints on Italy that have affected the amount of financing that can go into social welfare policies such as health. The main challenge for Italy has been balancing financial obligations to the European Stability Act and the management of an increasingly imbalanced finance system at home (Fargion 2006, Vandelli, 2002). Moreover, the regionalization of SSN financing through IRAP has also come under scrutiny by the EU, as the tax was initially deemed as incompatible with the EU's Article 33 of the Sixth VAT Directive.³ The European Court of Justice ultimately decided in favor of IRAP, but not without producing significant legal hassles for the Italian government.

Having established at least two sources of problem pressure for the SSN, it is now possible to take a closer look at the political-economic climate (i.e. Rothgang et al.'s (2008) intervening variable) which also conditioned Italian health care reforms. Here, one must speak of the role that the conservative separatist party Lega Nord has played in the political system since the early 1990s. As noted by Fargion (2006), "the Northern League was not only successful in channelling creeping malaise and mobilizing local protest within which subculture areas, but it actively contributed to shaping a new national identity." The author further argues that by yielding sufficient pressure on incumbent administrations, the Lega Nord was successful at decentralizing various policy fields including health. Only regional solutions would help to quell the party's separatist agenda, hence the reforms of the early and late 1990s that resulted in fiscal federalism.

Whether or not the Lega Nord played as significant a role as is argued by Fargion (2006), one thing is clear regarding the Italian health care system: policy makers acknowledged the need to regionalize health care policy in order to make the SSN more efficient. As illustrated by Figure 1 above, this has proven not to be the case, as health care expenditure is still on the rise. Assuming, however, that in the absence of such reforms efficiency would even be worse and spending greater, the question still arises: has the concern

³ Case C-475/03, 2006.

for efficiency come at the cost of quality of care. That is, what are the effects that reforms have had on the performance of the Italian health care system, particularly given the disparities between the Center-North and South? Looking at data on patient mobility and hospitalization rates sheds some light on this question.

Beginning with patient mobility (Table 1 below), figures reported for as recent as 2000 to 2003, for example, indicate both the active and passive⁴ mobility of patients between regions (Pellegrini 2005). These numbers demonstrate that Center-Northern regions, on average, take in 60,445 patients annually who actively migrate to their hospitals and specialists; moreover, on average, 36,845 patients annually passively migrate from these regions to seek out care elsewhere – presumably remaining within the Center-North however. As for the South, one finds that only 22,688 patients actively migrate to these regions for hospitalization and specialist care, whereas 49,293 passively migrate by leaving these regions to seek out stationary and specialist care elsewhere (Pellegrini 2005). Taken together, what these figures starkly reflect is an inadequacy in availability, access, and quite possibly quality in health care provision in the South, thereby suggesting that Italian redistributive measures in financing have not, in and of themselves, concluded in a uniformly high performing health care system.

Hospitalization rates tell a similar story. Figures reported by the health ministry for 2002 demonstrate that on average the Center-North's hospitalization rate (ordinary hospitalization + day care hospitalization) is lower than that of the South, with 203.21 persons hospitalized versus 238.9 persons hospitalized (Center-North and South, respectively). This data can be interpreted in various ways, however, given the fact that access to specialist ambulatory care is lower in the South than in the Center-North, patients are more likely to seek out such care in a hospital setting which also means the generation of greater costs in the

⁴ Data for previous and subsequent years has not been made available. Active mobility refers to incoming patients from other regions, whereas passive mobility refers to patients leaving the region to be hospitalized in another region.

treatment of illnesses. Taken together, patient mobility and hospitalization rates reflect a discouraging trend in performance of the SSN, with Center-Northern regions continuing to outperform their Southern counterparts. This begs the question as to whether the SSN is “A national health service or 20 regional services?” (Fargion 2006). If the latter is true, the Italian health care system stands to defy its foundational values of providing universal, equal and uniform care across the country. In this case, the SSN does more than just compromise its values and performance; it contributes to the deterioration of social solidarity underpinning all welfare state policy.

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