

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

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## **The Development of Health Care Policy and the New Governance of the NHS in Italy**

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## 1. Introduction

Health care reforms launched in the 1990s have significantly changed both the organization of the Italian National Health Service (Servizio Sanitario Nazionale, SSN) and the relationship between national and regional governments. Following political and administrative decentralization, Regional health care systems emerged and are currently consolidating also in those Regions where autonomous powers granted by the reforms have not yet been fully exploited.

Decentralisation of the SSN is particularly important for Italian Regions, given that organisation and management of health services are their most relevant tasks, at least financially, considering they receive more than two thirds of the resources allocated in Regional budgets. Moreover, health services allow politicians to handle very large sums of public money and vast resources, which can be used to build consensus and power by legal and illegal means (Ferrera, 1996a). In recent years the Regions' operating expenses for healthcare have been over € 100 million, while the staff employed by the SSN amounts to more than 650,000 people, most of whom are employed by organisations under the authority of Regional governments.

Lastly, in recent years, health care has also become a ground for moral issues and choices: Regions have been increasingly involved, expressing different ethical views, in decisions concerning the very concepts of life, illness and death. This is clearly shown by one famous case (the "Eluana Englaro" case) in early 2009 or by current debate about the use of RU486 pill for pharmacological abortion. Apart from that, health policy allows policy makers to set forth their principles concerning the State's and the citizen's role, the public and private sectors' interference, market criteria, and economic and social planning.

It is easy to understand why the decentralisation of the SSN has been a chance for Regional administrators to qualify the character of their government to the citizens while strengthening the institutional legitimacy of their government. Such opportunity was actualised especially in the implementation of 1992-93 national legislation introducing both managerialism and competition in the SSN, which gave Regions the opportunity to implement quite divergent policies, in terms of organisation and regulation of their Regional Health Services (Servizi Sanitari Regionali, SSRs).

In the regionalized SSN, national policy-making is increasingly negotiated between the central government and Regions, and takes place mainly in the Conference of State-Regions, an institutional seat as well as a body which plays a leading role in the governance of the health care system. The devolved nature of the SSN is destined to strengthen, given the recent approval of a constitutional reform promoting fiscal devolution.

In this context of differentiation processes among Regions and increasing devolution, one may wonder whether the new institutional arrangements and their implementation provide a favourable setting to tackle the inequalities existing in the services provided by Regional health care systems, or if they are unable to prevent their enlargement, thus worsening the traditional North-South divide.

It is certainly too early to give an answer to this question, given the existing uncertainty about the features of fiscal devolution and the possible related constitutional changes, such as the introduction of a "Senate of the Regions". However, the paper makes some considerations on this issue with a twofold objective.

First of all, it investigates the nature of the differentiation processes describing the emerging models of Regional health care systems, inspired either by the principles of managed competition (Enthoven, 1985) or managed cooperation (Light, 1997) and analysing their recent evolution, through a specific focus on dimensions such as the extension of the purchaser-provider split, freedom of choice, methods of payment of providers, accreditation systems and the kind of devices used to coordinate and control health care organisations. Then attention will be paid to Southern Regions and their possible difficulties in exploiting the acquired autonomy to establish and manage SSRs able to provide good quality and efficient services, thus bridging the gap with Northern Regions.

Secondly, the paper takes into consideration the new forms of national policy-making, as developed in the last decade. In this respect the role played by the State-Regions Conference in the emerging governance of the regionalized SSN will be analysed in some detail, trying to understand whether it is adequate to contain and reduce Regional disparities or if it favours the widening of long-standing differences.

This section provides the elements to make some final remarks on the possible evolution of the role played by the State in the new devolved SSN<sup>1</sup>.

## **2. The regionalisation of the Servizio Sanitario Nazionale (SSN)**

Following Rondinelli (1981) and Mills (1990), the concept of political decentralisation can be divided into three components: transfer of powers, attribution of related responsibilities and assignment of a significant degree of financial and fiscal autonomy. As far as the Italian healthcare system is concerned, decentralisation started in the 1970s, matched with the shift from the social insurance system to the SSN, which was instituted in 1978. In the first period (1978-1992) powers and responsibilities were

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<sup>1</sup> I would like to thank Franca Maino for the precious cooperation and the useful suggestions provided in the drafting of this paper.

shared in a very ambiguous and confused way among State, Regions and municipalities. Fiscal powers were kept in the hands of the national government.

The 1992-1993 healthcare reform acts (Legislative Decrees No. 502/1992 and No. 517/1993) started the actual regionalisation process of the SSN, concentrating the powers of organisation and management of the healthcare services in the twenty Regions and in the Autonomous Provinces of Trento and Bolzano, while legislative powers are shared between the central and regional tiers.

The regionalisation of the SSN has been both a decentralisation process from State to Regions and a centralisation process from municipalities to the intermediate level of government. Local governments were indeed deprived of the management powers they had held since 1978, beginning with the appointment of members of the "Comitati di Gestione" (Management Boards) of the local health authorities and, for the most part, of the possibility to intervene in healthcare decisions. Although municipalities regained some relevant powers with the 1999 healthcare reform (Legislative Decree No. 229/1999), regionalisation was substantially confirmed during the 1990s, until it was strengthened by the amendments to Title V of the Constitution introduced by Constitutional Act No. 3/2001.

In the current division of powers, Regions and the two Autonomous Provinces of Trento and Bolzano are responsible to guarantee the delivery of the (wide) service packages defined by the "essential levels of care" (Livelli Essenziali di Assistenza or LEA), which are set out by the central government, given financial resources transferred by the central tier (which must cover the LEA costs) and collected at regional level. Competence attributed to Regions comprise substantial powers in steering and management of the public organisations responsible for the health of the population and for the delivery of healthcare services, the Aziende Sanitarie Locali and the Aziende Ospedaliere, including the appointment of their managers who are accountable to Regional governments. Moreover, Regions enjoy a wide degree of freedom in defining the main features of the organisation and regulation of the healthcare system, as we will see in more details in sections 3.1 and 3.2. Regions may also decide the provision of publicly-funded services in addition to the package defined by the LEAs and may introduce co-payments, especially for medicines. Additional services must be financed by regional revenues.

From the second half of the 1990s and, increasingly, in the 2000s, the transfer of powers has been matched with the attribution of the related responsibilities, which mainly involved expenditures management – a crucial point considering Italy's commitments in joining the European Monetary Union. This led to several agreements between the central government and Regions (called "State-Regions Agreements") negotiated and signed in the Conference of State-Regions, which periodically takes place in Rome.

Finally, the attainment of financial and fiscal autonomy by the Regions has been quite problematic, but it might have recently come to a turning point. So far Regions have some fiscal autonomy, although

limited to a few local taxes and to a slight modification – within a range set by central government – of rates for the VAT and the additional regional personal income tax surcharge (Addizionale regionale IRPEF). This fiscal autonomy counts for less than 10% of any Regional health budget and it is constrained in its use by political priorities (cfr. Lega, 2008). This process of attribution of fiscal autonomy started in the second part of the 1990s, but then met severe difficulties, which made ineffective the relevant innovations introduced by the Legislative Decree 56/2000 and an amendment to Art. 119 of the Constitution in 2001.

At the beginning of May 2009, a bill was passed (Act No. 42/2009), which introduces forms of fiscal federalism giving Regions substantial powers of taxation. The Act also introduces significant innovations in the State-Regions relationships in the financial field. However, in order to be implemented, the reform will require the approval by the central government and Parliament of other bills in the next two years. This process should clarify the real character and impact of a reform whose functioning and effects are still unclear and in practice unpredictable, given the complexity, the ambiguity, and, in many respects, the vagueness of the approved reform.

### **3. Building the Regional Health Services: differentiation processes, emerging models and recent evolution**

#### **3.1 Differentiation processes in the Regional Health Services**

Along with regionalisation, the 1992-93 reform and subsequent legislation introduced managerialisation and in some ways managed competition, then converted in managed cooperation, in the provision of services. On a national level, only some general rules were established, calling Regions to a huge regulative intervention to give concrete shape and implement the reforms, with an ample leeway for autonomy.

Specifically, the regulations for introducing managed competition or cooperation force the Regions to define the institutional and organisational framework of their SSRs. Very different arrangements can be adopted in the configuration of supply and the mechanisms regulating the relationships among healthcare organisations operating in any SSR. As a result of different choices in these matters, Regions can emphasize the role of competition or, instead, that of cooperation and “negotiated planning” as the main principles for coordination and resource allocation in the healthcare system.

As for the configuration of supply, national legislation makes the separation between the functions of service financing and provision (the purchaser-provider split) optional. Therefore, Regions may decide

whether and to what extent to implement the purchaser-provider split, through the constitution of the above mentioned Aziende Ospedaliere (AOSPs), intended as public hospital firms separated from the Aziende Sanitarie Locali (ASLs), which are the health authorities responsible for the health of the local population.

The only Region which chose an almost complete separation between purchasers (the ASLs) and providers (the AOSPs, some other public autonomous hospitals and private providers) is Lombardy, which created 29 AOSPs gathering most public hospitals and outpatient health units. The others Regions chose a mixed or mostly integrated configuration of the public supply, establishing a limited number of AOSPs and leaving a significant part of hospitals within the ASLs. In some cases no AOSPs were created; in these situations, the ASLs continue to directly manage public hospitals and outpatient health units as was the case from 1978 to 1992.

Moreover, the Italian healthcare system is characterised by much territorial variation in the presence of private providers, working mostly for the SSN, both for profit and not for profit. Private supply is especially rich in several southern Regions, such as Calabria, Campania and Sicily, where contracted hospital services cover between one quarter and one third or more of the whole publicly-funded provision (the ratio is even higher in outpatient care); it is very significant in Regions like Lazio (the Region of Rome) where there are important Church-owned hospitals, Lombardy (the Region of Milan) and Emilia-Romagna. It is severely limited in other Regions, such as Veneto, Basilicata and Liguria, where contracted hospital services are not above 5-6% of the total amount of publicly funded hospital services.

Though being mostly the result of a centuries-old entwinement in the local environment (Vicarelli, 1997), the presence of the private sector on the territory can be favoured, or less so, by Regions through “institutional accreditation”, which is necessary for public and private providers to receive financing from the SSN. Accreditation can be used to widen the opportunity of choice available to citizens, allowing more providers to easily participate in the system, as was the case in Lombardy until a few years ago. Or, if there are concerns about limiting expenses, the entry of new subjects can be strictly limited and subject to the needs of Regional planning, as is the case in Emilia-Romagna, Marche and Tuscany.

The degree of supply integration is a relevant element since providers are paid through different mechanisms. Regions, who get most resources collected from general taxation through transfers from the central level based on a capitation system<sup>2</sup>, finance ASLs in turn on a per capita basis. As to providers, ASL labs and hospitals are mostly financed via internal budgeting, while AOSPs and private

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<sup>2</sup> The allocative formula, which is subjected to periodical bargaining both between State and Regions and among Regions, uses some weighting criteria, such as age and mortality rate as proxy for needs and a measure of interregional patient flows.

providers are mostly paid by ASLs, or directly by Regions, according to case-based tariffs linked to DRGs, which have been adopted in the SSN since 1995. As it is well-known, case-based tariffs linked to DRGs give potentially strong incentives to competition, aimed at attracting more patients in order to increase the activities remunerated with more advantageous fees.

As suggested in some works (e.g. Formez, 2007), it is possible to consider the percentage of beds in providers non integrated with ASLs (AOSPs, accredited private providers and other providers such as a specific kind of research hospitals called IRCSSs and other autonomous hospitals) on the whole accredited beds, as an indicator of the potential extent of the managed competition, or that of the "quasi-markets" (Le Grand and Bartlett, 1993). Considering an Italian average of 63% of beds in providers non integrated with ASLs in 2006 (Ministero della Salute, 2008), the situation is quite diversified. There are Regions with almost complete (Lombardy) or prevailing separation, with two thirds of beds or more outside ASLs (Sicily, Lazio, Friuli-Venezia Giulia, Campania, Calabria) and Regions characterised mostly by organisational integration, where available beds in non-ASL providers are one third or less of the total (Veneto, Molise, Sardinia, Abruzzo, plus the Autonomous Provinces of Trento and Bolzano and Aosta Valley wherein all providers operating on behalf of the SSN are directly managed by the local ASL).

An extended purchaser-provider split fosters the conditions necessary to managed competition, but is not enough to implement it. To this end, rules defining the relationship between providers and purchasers are critical, especially those concerning the definition of the kind and amount of services provided by AOSPs and private providers on behalf of any ASL, through purchaser-provider contracts, and the corresponding SSN expenditures.

In this regard, all Regions provided for the definition of targets or caps for SSN-provided services or expenses, with a prevalence of the latter as time went on. Caps may be imposed on the activity of single providers, as most Regions did, or may be put on the general budget to finance the whole of the providers. The first solution allows the planning of the activities of each provider, public and private, promoting cooperation and integration, and not competition, among healthcare organisations. The second one gives more space to competitive behaviour, as we will explain more thoroughly with the case of Lombardy.

Lastly, from the year 1992 in the SSN patients' freedom of choice is a right guaranteed by law, but there have been different interpretations of this principle. In the 1990s some Regions (such as Emilia-Romagna or Tuscany) imposed some limits on this freedom (especially concerning the choice of private providers). However, in light of the principle of patients' freedom of choice and movement, guaranteed by Italian laws and confirmed by the European Court of Justice, such limits have progressively lost their significance and are a less and less relevant differentiating element between SSRs.

### 3.2. Emergent Regional models and their recent evolution

Based on the elements of Regional differentiation described in the previous paragraph, it is possible to identify some emerging governance models to which the Regional cases may be matched, with varying accuracy. The following can be identified<sup>3</sup>:

- a model based on competition between healthcare organisations, characteristic of Lombardy;
- a model based on cooperation and integration between healthcare organisations, to which Centre-North and Northern-East Regions can be matched;
- a third model, which largely employs the traditional bureaucratic governance mechanisms, present in many Southern Regions but which looks increasingly residual.

In Lombardy the Centre-Right government, which has been in charge without any interruption since 1995, has experimented with a markedly competitive regulation. Lombardy SSR opted for an almost complete separation between purchasers and providers, following the UK example. There is only one ASL in Lombardy managing a hospital, whereas the 29 AOSPs have incorporated hospitals and most outpatient specialised services. In the mid-long term, ASL are supposed to gradually abandon also the direct management of community and intermediate care services, assuming the role of organisations only entrusted with purchasing or commissioning functions.

This choice is consistent with that of adopting regulation aimed at promoting competition among public and private providers. To this end, besides the purchaser-provider split, between 1996 and 2002 Lombardy expanded the number of accredited private providers and ensured the maximum degree of patients' choice of providers in the whole Region. As to the providers' payment system, it adopted Regional tariffs based on DRGs, extending the scope of their application to an extraordinary range of services (including, for example, psychiatric and women's health services) compared to the other Regions.

Moreover, Lombardy did not use purchaser-provider contracts with expenditure limits on individual providers, but only put a limit on the whole budget to finance providers' services, known as "system cap". The allocation among single public and private providers was made only *ex post*, after the end of any financial year. In case of non-compliance, it resulted in a proportional lowering of fees applied to all providers in order to fit within the defined overall limit. The decrease in fees is not calculated on the volume of services provided by each single provider, since it is not defined *a priori*, but on the overall volume of provided services in the whole Region, or related to the group of providers within each ASL.

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<sup>3</sup> Among literature on emerging Regional models here it is possible to mention some studies, such as France (1999), Neri (2006), Fornez, (2007).

The system cap contains incentives which are quite different from the ones used in contractual agreements with each provider. It allows a bonus to providers which attract the most patients, according to the principle of “money follows the patients”. The ability to attract a high number of patients, and therefore to provide a higher number of services, is considered an indicator of a higher quality of services provided.

The arrangements designed by the Lombardy government proved to be difficult to sustain, because of the presence of clear incentives to overproduction, overspending and to the creation of excessive capacity in those medical services with most profitable tariffs (e.g. heart surgery). Moreover, the attempts made by the Regional government to cut providers’ remuneration in order to respect the budget limits caused litigation, because private hospitals and treatment centres refused to be subject to curtailments in payments for services rendered.

Therefore starting from 2002 Lombardy decided to abandon this system adopting less competitive arrangements for regulation of the provider-purchaser relationship. As in some other Italian Regions, they introduced contracts for individual providers (the “service agreements”), which include expenditure limits for single providers and limited access to the publicly funded system to new private providers. Because of the persistent political will to ensure the greatest freedom of choice to patients, the application of the new arrangements is subject to some compromises and variations compared to that of other Regions like Emilia-Romagna or Tuscany, but their introduction certainly point out an important change in Lombardy health policy.

A “revisionist” approach is evident also in the evolution of the role attributed to public-private partnerships and, in particular, to foundation hospitals. In the 2002-04 Regional Health and Social Care Plan approved in 2002, the Regional government expressed the intention to gradually convert all the public AOSPs in public-private foundations, ruled by private law, as is happening in the UK, even though internal governance and legal regime of the foundations seem very different in the two cases making, perhaps, the model followed in Lombardy more similar to those adopted in some Spanish cases. However, in recent acts the Regional government has considerably softened this orientation, carrying out the transformation only for a few local hospitals and for the IRCCSs.

However this latter case is important because it shows the persistency of significant differences in health policy compared to the other Regions: the IRCCSs conversion in foundations (though ruled by public and not private law) was a national policy promoted by the Centre-Right government in 2003, but only Lombardy substantially implemented it. The trend to “marketisation” seems even to continue in other ways, through the extension of quasi-markets to intermediate care and social services, or the promotion of the use of project finance in a quite similar form to British PFI.

Another governance model can be identified, which is based on the principles of cooperation between public and private healthcare organisations. In this model, which can be matched to Centre-North and Northern-East Regions, Regional policy is aimed at building integrated networks of care, wherein each organisation, public or private, is an irreplaceable node and is complementary, and not in competition, with the other nodes. Integration is aimed at reducing excessive capacity and redundancy in services, pursuing targets of clinical appropriateness and rationalisation in the use of resources. In Regions such as Emilia-Romagna, Tuscany, Veneto, the purchaser-provider split is limited; AOSPs do not represent the “ordinary” public provider like in Lombardy, but they have been established to concentrate most of the highly-specialised and complex services such as oncology, heart surgery, neurosurgery, or transplant centres, provided for a wide territory or for the whole Region. The gathering of these services in fewer, large structures is aimed at leveraging economies of scale made possible by a very high volume of services, and also to obtain a better quality of service.

Moreover, the use of tariffs is not as extended as in Lombardy, both because of the greater role played by ASLs and because of the limitations of the range of tariff-based services; the role of the purchaser-provider contracts (called “service agreements”) is emphasized, with strict limits of expenditures for single providers (especially for the private ones); there are some limitations to the patients’ freedom of choice and the accreditation of new providers has always been subordinated to the needs identified by Regional planning.

These Regions differ in the way they pursue integration. Some Centre-Northern Regions, such as Emilia-Romagna and Tuscany, strongly rely on negotiated planning involving public and private organisations both at Regional and local level. In negotiated planning, the governance of the SSR is obtained through the definition and implementation of agreements, plans, regional and local programmes devised via processes, both formal and informal, of negotiation and mutual agreement with all subjects involved in designing and managing healthcare and social services.

On the other hand, some Northern-East Regions, such as Veneto and Friuli-Venezia Giulia, put less importance on mutual agreements and local negotiation and are more concerned with centralised planning on a Regional level. In this context, the use of contracts or service agreements with AOSPs is absent or very limited, since financing is defined directly by the Region via budgeting. The governance of the SSR is mainly ensured by the extensive use of top-down planning and managerial tools. Even contracts and agreements with private providers are mainly defined on a Regional level, with scarce intervention of ASLs and limited space for local negotiation.

Along competition and cooperation or integration models, there are other Regions (Lazio, Campania, Sicily and most of the Southern Regions), which did not make a clear choice for one or the other option, often showing a tendency to sway back and forth between the two models. In the already quoted

research by Formez (performed by Vittorio Mapelli), these Regions are included in a bureaucratic model, where traditional command-and-control mechanisms are matched with a scarce ability to ensure the governance of the healthcare system.

In some cases, in the late 1990s and early 2000s some organisational and regulative choices seemed to be functional and favourable to competition. The configuration of supply, with a significant degree of purchaser-provider split and the relevant presence of private providers, was instrumental in that respect and there was a set of rules which, if not outright favouring competition, at least did not hinder it. This seems to be the case especially of Campania and, until very recent times, Sicily. However for these and other Southern Regions the impression is often that the space devoted to competition was not the effect of a deliberate action but of the absence or operational failure of the mechanisms which, elsewhere, weaken or nullify its effects. This refers to the scarce use or effectiveness, in these Regions, of purchaser-provider contracts, the weakness of managerial control, the difficulty to identify a clear design, responding to a definite policy, in the choices made in the accreditation of new providers or in the providers' remuneration systems.

In Lazio, during the Centre-Right coalition government (2000-2005) some choices were made, such as adopting the system cap, which made the orientation towards competition quite explicit. However, such orientation changed with the change of government, whose interventions, such as abolishing the system cap, are aimed at promoting a regulative framework inspired by forms of cooperation between healthcare organisations. Campania also seems to be following the same route. A similar trend towards the integration model may also be observed in many other Southern Regions, such as Calabria, Sardinia, Apulia and Sicily. In these last two cases, the reorganization of SSRs led to a partial reincorporation of the hospitals inside the ASLs, with a partial reintegration of purchasers and providers.

#### **4. Southern Regions and the governance of the SSRs**

While in the 1990s divergent trends prevailed in the solutions adopted by Regions, the last few years show a mixed picture in which converging elements towards a model based on cooperation or integration have increasing importance. The convergence regards both Lombardy, although it partially maintains its particular market-oriented regulation, and the Centre-Southern Regions, which are developing institutional arrangements and organisational solutions similar to Centre-Northern and Northern-East Regions.

A possible explanation for this evolution is the concern for expenditure growth and the need to reduce public debt, which is very high in Regions such as Lazio, Sicily and Campania, and causes

permanent confrontation with the central government. In this context, the integration model seems to be more consistent with rationalisation processes of the provision and offers more guarantees in controlling costs.

If institutional and organisational differentiation among Regional healthcare systems might increase the differences in the efficiency and quality of services provided, then its slowdown and the beginning of convergence trends might reduce this risk and, thus, that of widening the gap traditionally existing between --Northern and Centre-Northern Regions and -- Southern and Centre-Southern Regions.

However, early research findings (Formez, 2007; Pavolini, 2008) seem to suggest that, within the general framework of a national health service, the influence of different regulative models could be less relevant than other factors, such as administrative tradition and strength of territorial bureaucracies or socio-economic factors. These long-term elements would advantage Northern and Centre-Northern Regions, regardless of the adoption of a competitive or cooperative regulation.

As to administrative factors, the presence of bureaucracies provided with adequate structural, technical and human resources, and able to be autonomous by particularistic pressures of private interests, is fundamental to ensure a satisfactory governance of the Regional health care systems. This is true both in case of quasi-markets and in those of cooperative or traditionally integrated command-and control systems. And these features of bureaucracies and administrative bodies have always been more lacking in the South than in the North part of Italy. Among public administrations, the lack of technical resources and adequate expertise seems to be particularly strong within Regions, which do not share the long tradition of government owned by municipalities or State administration.

The weakness of Regional bureaucracies and, in general, that of Regional political and administrative systems has been sometimes identified by specialised literature as one of the main elements at the root of the inefficiency and poor performance shown by the SSN in the South (France and Taroni, 2005). In this line of thought, the weakness of Regional and also local public administration is a dimension of the general "lack of stateness" traditionally suffered by Italy as a whole but especially by Southern Regions, which strongly contributes to determine unsatisfactory governance and frequent subordination of the public interest to private needs. The lack of stateness, which is connected with specific features of political class and of traditional relationship between politics and society existing in the South of Italy, would characterize not only the healthcare service but also the other welfare sectors (Ferrera, 1996b).

As to the devolution processes, it is possible to maintain that the weakness of bureaucracies and Regional administrations has undermined the capacity of Southern Regions to exploit the powers acquired since the 1990s in order to set up SSRs able to provide efficient and good quality services.

This weakness is a factor which may help to explain the delay in choosing a regulation model after 1992-93 national legislation. Moreover, the lack of expertise and deficiency in structural and technical resources might impede a good management of the regulative devices at last adopted in the last years by Southern Regions. In this respect, two problems seem to be evident, especially in the light of both the recent resurgence of scandals and cases of malpractices, and the persistent difficulty of controlling health expenditure.

The first issue concerns the management of the relationship with private providers. The role of private providers in the SSN is well-established and historically consolidated (Vicarelli, 1997; Vicarelli *et al.*, 2007). As happened in the social insurance period, private providers' activity and expenditure has proved to be extremely difficult to control for public authorities (France and Taroni, 2005). This is true especially for Regions such as Lazio and the Southern ones where, on one hand, as we have said, public administration is traditionally weaker and more susceptible to the pressure of private interests, on the other hand, public healthcare systems mostly rely on private provision. In Calabria, Campania or Lazio contracted hospital services cover between one quarter and one third or more of the whole publicly-funded provision, against a national average of about 20 per cent, while the proportions are even higher in outpatient care. As a matter of fact, in these Regions a relevant proportion of public expenditure for health is out of the control of public authorities, making it difficult to define and implement a cost containment policy.

This situation was already evident in the 1980s, a few years after the institution of the SSN, and was not changed by the 1992-1993 reforms and subsequent legislation, which made private providers subject to a three-level control system<sup>4</sup>, in the attempt to monitor service quality and subordinate them to regional planning.

In building the SSRs, Regions showed two different attitudes towards the private sector. Lombardy, initially followed by other Regions such as Lazio, tried to create a level playing field for competition between the public and private sector as a means to increase the level of efficiency and quality in provision. Centre-Northern Regions preferred to rely on negotiated planning to regulate and control provider activity. The latter solution is now spreading in the Centre-South mainly because it seems more promising in terms of monitoring private providers' activity.

One of the best examples of negotiated planning involving private providers is represented by the case of Emilia-Romagna, which has a significant presence of the private sector, unlike other Regions

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<sup>4</sup> Public and (especially) private providers are required to obtain from public authorities (Regions and ASLs) first an authorization to work, which is necessary to provide any health service; then the above mentioned "institutional accreditation" which allows providers to work for the SSN; if they have institutional accreditation, providers can enter service agreements with ASLs, or directly with Regions.

adopting the cooperation or integration model such as Tuscany or Veneto. Emilia-Romagna opted for a massive use of negotiated planning and contracts to regulate private provision, integrating independent health centres and hospitals in local and regional networks of secondary care services (Fiorentini and Ugolini, 2003; Ugolini and Nobile, 2003). Through Regional and local contract systems the activity of private providers is aimed as much as possible to pursue Regional targets, limiting incentives to provide unnecessary services.

To be successful, this policy requires strong government capacity both in terms of ability of negotiating with private interests and resisting their pressure, and in terms of administrative ability to monitor and assess private providers' performance. Unfortunately, as we already said, this capacity is traditionally not widespread in the Italian public administration, being negligible in many Centre-Southern Regions.

Therefore private provider control is still a prominent issue, especially for Centre-Southern Regions. Here it can be considered in three ways. First, there is an evident difficulty to involve the private sector in plans for service rationalisation and in restrictive policies aimed at reducing health expenditure deficits, which are very high in many Centre-Southern Regions, such as Abruzzo, Calabria, Campania, Lazio, Molise and Sicily. As already mentioned, public expenditure for contracted services is often, *de facto*, out the sphere of influence of Regional policy makers, as shown precisely by the case of Lazio (the Region of Rome), with the highly influential presence of a Church-owned hospital sector and of important private healthcare corporations (Minerva, 2009).

Second, where market mechanisms have been effective, in particular the DRG-based remuneration system, the private sector has shown itself capable of exploiting them, even developing opportunistic behaviour, not only in the provision of unnecessary or inappropriate examinations and operations, but also in false invoicing to the SSN for services which have never been provided. Apart from the legal implications, the evidence of opportunistic behaviour highlights the existence of a clear flaw in controlling private providers. This happens both in the North and in the South, but it risks being more serious in the latter because of the delay and lack of control systems, as we will see in a short while.

Third, the necessary negotiations and monitoring of private providers can promote a setting for collusion and bribery, as emerged in several scandals under inquiry by Police and public prosecutors. Where the collusion involves the Mafia and other criminal organisations, which control some private providers and, indirectly, even some local authorities (ASLs), as in Sicily and in Calabria, the issues concerning the relationship between public and private in healthcare takes on a very different aspect and makes debate about planning, competition or contracts unrealistic and artificial.

Issues of monitoring and controlling providers' activity do not concern only the private sector but also public organisations. In the SSN the development of systems of performance management and control can be traced back to the 1992-1993 managerialisation. With significant differences among them, Regions developed monitoring systems of the ASLs and AOSPs performance, focusing first on standards and targets concerning managerial efficiency and cost containment, but then extending their attention to quality issues, at least in some Centre and Northern Regions.

Compared to the systems adopted in other countries, such as UK or the Scandinavian ones (cfr. Neri, 2009), the performance systems used in Italian Regions show scarce connection between poor performance and financial or managerial consequences on the healthcare organisations and even the link between the assessment results and the evaluation of ASLs and AOSPs management has always been weak or absent, leaving real evaluation to the discretion of Regional ministers and politicians. Whether or not this is a benefit, it is consistent with a system where evaluation suffers of a lack of publicity, or it remains an issue to settle between the Regional government and the chief executives of the healthcare organisations.

The lack of direct consequences of poor performance on top management can be considered an element of flexibility in the organisational structure of the Regional Health Services, but, in many cases, it makes performance evaluation of ASLs and AOSPs little more than fiction. Further, it allows Regional ministers and, broadly speaking, the Regional political class, to make political logic prevail in the choice and in the evaluation of management. Thus, in the North as well as in the South, top managers are evaluated more on their political loyalty than on managerial performance. Whether this matches with service quality and value-for-money depends on the objectives of the Regional ministers.

However in recent years there have been some signs of change of this attitude, especially in some Regions such as Tuscany, Umbria and Liguria. Tuscany is perhaps the most relevant case. Starting from 2004 this Region has implemented a sophisticated performance assessment system, which allows a systematic evaluation of the action of ASLs, AOSPs and other healthcare organisations (see the essays published in Nuti, 2008). Although the system, in its complexity, seems to be designed mainly for evaluation made by the Regional government and the highest levels of Regional management, performance results are published, allowing public scrutiny. Targets, which concern both hospital and community care, cover a wide range of issues, such as health outcomes (using death rates as indicators), clinical quality, managerial efficiency, patient and staff satisfaction. Moreover, the Tuscan system establishes an explicit connection between performance results and top management evaluation; trying to make managerial evaluation more real than it has always been, with top managers traditionally meeting more than 90% of targets on an average.

Apart from the above mentioned cases, similar systems are under design or current implementation in many Centre and Northern Regions, trying to fill an evident gap in their health care systems. Generally speaking, Southern SSRs seem to be delayed in this respect, depriving Regional governments of fundamental instruments of expenditure control and service quality monitoring. Along with political will, not always clear given the potential limitation of discretionary power associated with a systematic performance evaluation system, the scarce development and resources devoted to control activities within Regional bureaucracies is an important factor explaining the delay and often substantial lacking of effective monitoring instruments.

This delay may partially explain policies of partial re-integration in public provision adopted in Regions such as Apulia and Sicily, given that controlling directly-managed units can be considered easier than monitoring autonomous providers, even public, which require more sophisticated skills and activity control systems. However, these policies risk being useless as they are not matched with a significant development in top-down management and control systems and they obviously do not respond to the needs of controlling private providers.

As a result, control activity is practised mostly *ex post* by national audit bodies such as the Corte dei Conti, or by prosecutors who are increasingly acting as a substitute for political and administrative control, as has already happened in other branches of public administration. This evolution characterizes the North as well as the South of Italy, but it is particularly evident in the Centre-Southern Regions. Obviously in these cases the nature of control changes radically. In particular, judicial control is certainly necessary to unveil the complex webs of interests, pursued in legal and illegal ways, involving local or national politicians, powerful bureaucrats, private companies and also criminal groups, but it does not represent the best way to promote the improvement of quality and efficiency in health services. One might consider judicial action useful to provoke a shock in the system in order to promote radical changes, but past experience seems to show that this therapy has only short-term effects.

## **5. National policy-making in the devolved SSN**

In the new regionalized SSN, the role of the State and of national policy-making is considerably changing. Changes concern also the possibility to intervene promoting the reduction of interregional disparities and supporting Regions with particular difficulties or disadvantages.

In the balance of powers which emerged from 1990s legislation and, especially, the 2001 constitutional reform, the State may find it very difficult to implement significant reforms without the

consent and the involvement of Regions. This is true not only for reforms aimed at changing the organisation and management of the healthcare system, but also for any policy aimed at pursuing relevant health targets and, in part, also at containing the healthcare costs. Moreover, Regions seem to have the power to approve specific health policies or introduce structural changes in their SSRs, which could jeopardize the “national” character of the SSN.

In reality the 2001 constitutional reform has not deprived the State of all powers and responsibilities in the healthcare sector. Instead, it seems to call central and regional governments to a permanent political and technical confrontation that might result in a substantial paralysis in national health policy-making or in the development of negotiated policies, to be implemented in close collaboration between State and Regions.

In this context, concerted policy-making has been developing from 2000 onwards, leading to a series of “Accordi” (agreements) or “Patti” (pacts) signed in the Conference of State-Regions and then converted into acts and bills by the Parliament. The Conference was instituted in 1998 by Act no. 400. Its functions were enhanced by Act 59/1997 to allow Regional governments to play a key role in the process of institutional innovation concerning the transfer of functions and competences from the centre to sub-national levels of government. Its composition includes the Prime Minister as President of the Conference, the Presidents (or “Governors”) of the Regions or other ministers whenever matters related to areas of their competence are discussed. The central government consults the Conference for any legislative initiative related to areas of Regional interests.

As far as healthcare is concerned, the Minister of Health (now Minister of Welfare) and its corresponding positions responsible for health in each Region sit in Conference. The Conference of State-Regions, which has periodical session, is provided with several “technical” units where central and Regional high level officials debate, bargain and define common solutions to more technical problems, preparing the ground for political decisions. The Conference is responsible for the allocation of financial resources to each Region through a process of negotiation based on forecast expenditures. Funds are allocated with a weighted per capita criterion (mainly based on age structure, with decreasing importance of historical expenditure) and a part of them is also attributed to infrastructural and technology investments and to specific projects of development.

So far, the most relevant agreements signed in the Conference have concerned the control of expenditure growth, being one of the main instruments employed by central government to involve Regions in the respect of financial conditions agreed with the “Pact of Stability” among European Union countries. Of these agreements, the most important are perhaps the ones of August 3, 2000 and August 8, 2001, the Intesa (Entente) signed March 23, 2005 and the “Patto per la salute” (Pact for Healthcare) entered into on September 26, 2006.

The Conference of State-Regions and the agreements held a major role in the configuration of SSN governance which emerged after the year 2000. They respond to the need to ensure means of close cooperation and well-timed collaboration between State and Regions, respecting, at the same time, the decentralised nature acquired by the SSN.

However, notwithstanding remarkable progress over the years, concerted policy-making still seems unsteady and inadequate to provide a satisfactory governance of the healthcare system. Negotiated policy-making has been mainly focused on financial matters and the issue of regional deficits. Expenditure growth is a general concern for Italian health policy-makers and cost-containment policy has always been prominent in healthcare policy-making. Cost containment policy is not determined by high health expenditure, which is relatively low by international standards<sup>5</sup>, but it is motivated by the enormous public debt, one of the highest in the EU, which is constantly over 100% of GDP.

Disputes between State and Regions about the attribution of responsibility for deficits and recovery interventions have been very frequent since the birth of the SSN, but after entry into the Monetary Union and decentralization processes it became urgent to define stable arrangements to tackle the problem. In the 2005 Entente, then confirmed by the Pact for Health in 2006, central government and Regions have agreed on a multi-step mechanism of Regional expenditure monitoring and recovery plans in case of excessive deficits. In case the Regions accumulate serious deficits and miss spending targets, the agreement includes the activation of automatic mechanism (like an increase in Regional taxes) and that of a penetrating supervision of Regional expenditure policies by the Treasury. The Treasury may decide for the SSR administration by a commissioner and impose specific measures to reduce deficits, such as the introduction of co-payments for pharmaceuticals or the restructuring and closure of hospitals and health services.

So far, the recovery plan mechanism has been implemented for seven Regions, all located (apart from Liguria) in the Centre-South (Campania, Lazio and Sicily, which together count for more than two third of the total Regional deficits, Abruzzo, Calabria and Molise). Among these the case of Lazio proved to be very critical in 2008, generating serious conflict between the Treasury and the Regional government. The same situation occurred in summer 2009 in Calabria and Campania, whose Governors contested the decision of the Treasury to arrange administration by a commissioner. This is explained by the fact that, although the commissioner is represented by the President of the Region itself, the shift to this kind of administration introduces severe limitations to the Regions' autonomy, placing them under significant guardianship by central government.

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<sup>5</sup> In 2008 public health expenditure was about 7,0 percent of GDP and total health expenditure was 9,0 percent of GDP (OECD, 2009).

The focus on financial matters has put all other issues aside, absorbing most of the efforts of the policy-makers. Not much attention has been devoted to quality or equity issues, or to relevant problems such as the promotion of long-term care services which are largely inadequate to needs and show very different levels among Regions. Even the pursuing of health targets mainly rely on traditional planning, without adequate monitoring, evaluation or sanctioning systems shared by State and Regions or unilaterally determined by central government.

The lack or weakness of national targets and that of monitoring and evaluation systems, except in financial issues, risks being very detrimental to Southern SSRs. These Regions are oppressed by overriding debts and financial constraints and also deprived of central support, even in the form of control, necessary to stimulate the improvement of organisational performances and quality of services provided. Such support would help to reduce the gap existing in the provision of specific services with the North like those dedicated to long-term care, or in the diffusion of highly specialised treatment centres.

In a devolved SSN, deals and agreements signed in the State-Regions Conference could be used to set agreed national targets, allowing local adjustments, which could help in controlling and reducing Regional disparities (cfr. France, 2003). The same instruments could be used to design rules and organisations aimed at monitoring the meeting of targets by SSRs and healthcare organisations, such as, for example, the Healthcare Commission in the UK.

As to this latter point, there are some proposals concerning the institution of an authority for the SSN at a national level, and some innovations could come from the reform of public administration and public employment, recently approved by Parliament. However, because of the marked decentralisation in the governance of the SSN, the establishment of an independent body with statutory monitoring and performance assessment duties of healthcare organisations, as well as the definition of national standards and targets for the SSRs, need to be undertaken with the involvement and the consent of Regions. The State-Regions Conference may therefore be the right place to start negotiations and a shared path towards defining a performance management policy adequate to SSN needs, without risking poor implementation or even being unconstitutional.

In previous years there have been some experiences which would be possible to build on, like the implementation of national targets for health outcomes at the end of the 1990s (France and Taroni, 2000), or some interventions included in the already mentioned "Patto per la Salute" signed in 2006, but these experiences have not been fully implemented or institutionalised. Moreover, an important role could be played by the "Progetto Mattoni", instituted by the State-Regions Conference at the end of 2003. In this ongoing project fifteen workgroups, composed of Regional and Ministerial experts and

bureaucrats, cooperate to make structural, activity and performance data from healthcare organisations comparable, defining shared methodologies and instruments of collection, classification and elaboration of information. The project could be fundamental in creating the conditions for setting up a performance monitoring and evaluation system. However, it often seems to suffer from structural weakness and scarce institutionalisation of interregional and State-Regions cooperation, faults which make its work slow and substantial implementation uncertain. The same could be said about some interregional workgroups devoted to single issues such as accreditation or tariffs, which however give an important contribution in spreading Regional best practices and successful experiences.

Besides, it is the Conference of State-Regions itself which suffers from a lack of institutionalisation, to which both central government and Regions have contributed. The first has often interpreted its role exclusively in terms of being a “financial watchdog”, emphasizing the functions of monitoring and control of the Regions’ expenditure behaviours. Moreover, central governments in charge after 2000 have shown different views and attitudes towards the Conference and, generally speaking, cooperation with Regions; also, their actions often seemed erratic and contradictory. Taken as a whole, Centre-Right governments, in charge from 2001 to 2006 and then since 2008, have shown a limited interest in developing concerted policy-making, insisting more on controlling the compliance to financial duties by Regions. On the other hand, they have just approved the fiscal devolution reform which should shift the present balance of powers between the different levels of government in favour of Regions. The Centre-Left government, in charge from 2006 to 2008, made a significant investment on the development of negotiated policy-making and was more willing to give value to the Conference as a governance mechanism, but it proved too weak and unstable to give continuity to its action.

The weakness of the State-Regions Conference and, generally speaking, that of instruments of institutional cooperation and negotiation between central government and Regions might become a serious problem for the governance of the SSN, given the current trend towards further decentralisation shown by fiscal federalism reform. Deprived of technical support, the risk of widening the gap between “rich” Northern Regions, with high quality services, and Southern Regions, with average or mediocre service quality, oppressed by serious financial constraints, is very high.

## **6. Concluding remarks**

The analysis developed in the previous pages has shown how divergence processes among Regions, prevailing in the 1990s, are now matched with convergence trends in the institutional

arrangements. The slowdown of the processes of institutional and organisational differentiation might reduce the risk of increase of the disparities in performance of the Regional health care systems. However, within the general framework of a national health service, differences in regulation models might not be as relevant as the differences in the ability to ensure the governance of the healthcare system. And this latter kind of difference seems to be persistent among Northern and Southern Regions, with roots in variations in long-term factors, among which previous discussion has specifically considered the strength of bureaucracies and, more in general, the degree of stateness.

The Southern Regions' lack of ability to ensure satisfactory governance of the health care systems would contribute to bring about serious difficulties in using the institutional devices provided by national legislation to run the SSRs, managing relationship with private providers and setting up adequate performance evaluation systems. This in turn makes financial and quality service problems more serious and difficult to tackle.

In a devolved but still "national" health service, action to reduce such disparities and to support disadvantaged Regions should come from central government. But the new forms of governance which have emerged in recent years do not seem appropriate to perform this task. So far concerted policy-making, practised mainly through agreements and pacts signed in the State-Regions Conference, has looked unsteady and inadequate to provide a satisfactory governance of the SSN. This seem to be mainly due to two features of negotiated policy-making: its over dependence on the erratic attitude of central government towards negotiated planning with Regions and, above all, its almost exclusive focus on the problem of Regional deficits and expenditure, with not much attention to quality and equity issues.

The shortage of shared goals concerning access, quality and provision of services risks causing an increase in the differences among Regions instead of reducing them. This is especially the case for those Regions where a lower standard of services is accompanied by the most serious financial problems, as occurs in many Southern Regions.

Even if it is very difficult to make any forecast given the complexity and vagueness of the approved reform, fiscal devolution could worsen the financial situation of many Southern Regions. According to some estimations, the new mechanisms of resource allocation based on the "standard cost of services provided" would most penalize Lazio and Campania, two of the three Regions with the highest deficits, even though, maybe surprisingly, fiscal federalism would reduce also the resources attributed to a "rich" Region such as Lombardy<sup>6</sup>.

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<sup>6</sup> "Il Sole 24 Ore Sanità", 28 July – 3 August 2009, pp. 8-9.

In this context, the governance of the SSN and the role of the State in it might evolve in two possible directions. First, SSN should slowly move towards a sort of differentiated federalism, at least in practice if not in the constitutional and legal framework. Efficient Regions providing good quality services would enjoy autonomous powers necessary to shape their SSRs in order to meet population needs, while central government would act as a substitute for Regional governments which proved to be unable to meet spending targets and provide adequate health services. This scenario, where some signs are already present in the activation of the recovery plan mechanism, might prevent Southern SSRs from many of the risks predictable at present. However, it would deprive Southern Regions and population from the benefits generally associated with regionalisation, that is the attribution of powers in management and organisation of the health care system to a level of government capable of meeting the demand and planning the provision of services better than the central tier.

An alternative evolution, suggested in the previous section, would require the development of shared national targets, concerning both population health and SSR performance in terms of organisational efficiency, service quality, equity on access and provision. This should be coupled with the establishment of independent bodies in charge of monitoring and assessment tasks, as well as the introduction of positive and negative incentives to Regional behaviour. Such a framework, matched also with more supportive actions performed by technical bodies like the national Agency for Regional Health Services (Agenzia per i Servizi Sanitari Regionali or ASSR) strengthened in its powers and resources, would provide useful stimulation and support to Regional governments, respecting at the same time their autonomy.

This second option would be consistent with the nature of a regionally-based national health service, where the State steering and coordination action needs not to be eliminated, requiring instead to be strengthened at least in the Italian context, but it has certainly to be performed in more indirect ways than in a traditional, centralised command-and control health care system.

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