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The Italian National Health Service after the Economic Crisis: From Decentralization to Differentiated Federalism

O Serviço Nacional de Saúde italiano após a crise económica: da descentralização ao federalismo diferenciado

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THE ITALIAN NATIONAL HEALTH SERVICE AFTER THE ECONOMIC CRISIS: FROM DECENTRALIZATION TO DIFFERENTIATED FEDERALISM

Abstract: This essay analyses the evolution of the National Health Service (NHS) in Italy after the beginning of the financial crisis of 2008, focusing on some trajectories of change underway in the NHS governance. It starts with a reconstruction of the economic and financial framework of the NHS in the last 10 years, briefly describing the austerity policies implemented in the health sector. It then outlines the NHS institutional framework as it emerged from 1990s reforms, which is based on intergovernmental relations and joint policy-making between the State and the Regions. In the third part, it shows how the response to the economic crisis has had a significant effect on these relations, triggering a transformation in the NHS governance. This change, which is far from being concluded, could seriously undermine the universalistic nature of the Italian NHS and its ability to pursue the values of equity and solidarity, especially at a territorial level.

Keywords: decentralization, economic crisis, governance, health care, national health service.

O SERVIÇO NACIONAL DE SAÚDE ITALIANO APÓS A CRISE ECONÓMICA: DA DESCENTRALIZAÇÃO AO FEDERALISMO DIFERENCIADO

Resumo: Este artigo analisa a evolução do Serviço Nacional de Saúde (SNS) na Itália após o início da crise económica de 2008, focando-se em algumas das trajetórias de mudança ocorridas sob a governança do SNS. Aborda, inicialmente, a reconstrução da estrutura económica e financeira do SNS nos últimos 10 anos, descrevendo brevemente as políticas de austeridade implementadas no setor da saúde. De seguida, delineia a estrutura institucional do SNS a partir das reformas dos anos 1990, que se baseiam nas relações intergovernamentais e na formulação conjunta de políticas entre o Estado e as regiões. Na terceira parte, mostra como a resposta à crise económica teve um efeito significativo nestas relações, desencadeando uma transformação na governança do SNS. Esta mudança, longe de estar concluída, pode comprometer seriamente a natureza universalista do SNS italiano e a sua capacidade para seguir os valores de equidade e solidariedade, especialmente a nível territorial.

Palavras-chave: crise económica, cuidados de saúde, descentralização, governança, Serviço Nacional de Saúde.

1. The Economic Crisis and the National Health Service in Italy

Italy was one of the European Union (EU) countries hardest hit by the recession that began in 2008. The prolonged economic crisis presented a fluctuating trend, characterized by two peaks (Table 1): the first was in 2008 and especially in 2009, when the Italian Gross Domestic Product (GDP) declined by 1.1% and 5.5% respectively from the previous year. There was an overall weak recovery in the following two years, while in 2012 the crisis heightened and the GDP dropped by 2.8%, followed by a further decline of 1.7% in 2013. In 2014-2015 the GDP growth trend was very slack and became a little more sustained in recent years (1.1% in 2016 and 1.6% in 2017), although, in real terms, in 2017 the GDP had not recovered the pre-crisis level yet, being more than 5% below that of 2007 (Eurostat database). Provisional data for 2018 and forecasts for 2019 seems to indicate a substantial weakening in the recovery. In all these years, the GDP growth rates were considerably lower than those of the 28 EU countries (Table 1). Similar differences emerge also comparing Italy only with the countries of the Euro area.

Table 1 – GDP Rates (Percentage of Change from Previous Year)

	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
Italy	1.5	-1.1	-5.5	1.7	0.6	-2.8	-1.7	0.1	0.9	1.1	1.6
EU 28	3.1	0,5	-4.3	2.1	1.8	-0.4	0.3	1.8	2.3	2	2.4

Source: Eurostat – National Accounts and GDP Dataset (accessed on 27.12.2018, at https://ec.europa.eu/eurostat/data/database).

The recession had a very strong impact on the relationship between the GDP and public debt. Since 1991-1992, this ratio had always been at more than 100%, one of the highest in Europe – except for 2007 (99.8%). However, since the start of the economic crisis it has progressively increased reaching close to 130% of the GDP in 2013 and surpassing even this peak in the following years, with a tendency to level off (Table 2).

Table 2 – General Government Gross Debt in Italy (Percentage of GDP)

2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
99.8	102.4	112.5	115.4	116.5	123.4	129	131.8	131.6	131.4	131.2

Source: Eurostat – General Government Gross Debt Dataset (accessed on 28.12.2018, at https://ec.europa.eu/eurostat/data/database).

Beyond the data, the financial crisis became particularly serious in 2011-2012, since it was accompanied by the widespread perception – by the international markets and European institutions – that the Italian government was no longer able to cope with the situation and bring the debt under control (Jones, 2012). As is known, this resulted in a sovereign debt crisis, expressed by the increased interest rates on Treasury bonds and the spread relating to German government bonds. Politically, the crisis resulted in the fall of the Berlusconi Government, at the end of 2011, which was replaced by a "technical" executive, headed by the economist Mario Monti.

In the context of a protracted financial crisis and lack of confidence of the international environment, as well as prolonged stagnation and recession, strict measures had to be taken to control the budget deficit, reduce expenses and increase public revenues. In some areas, these measures were accompanied by structural reforms, as in the case of pensions and, later, of labour market, while this was not the case in health care.

Austerity policies, the details of which will be further discussed, had crucial goals for government expenses, including staffing costs. The restrictive measures taken since 2008 have focused on the public sector with varied intensity (Bordogna and Neri, 2014), fully involving health care. In this sector, the overall effect of these measures has been to recalibrate expenditure levels already lower than the average values recorded in comparable continental and Northern European countries, and in line with the other countries of Southern Europe (in particular Spain and Portugal). In Italy, in 2015-2016, the total health expenditure in fact amounted to 8.9-9% of the GDP (+ 0.7-0.8% compared to 2007), two points (or more) below than in France, Germany and Sweden, which traditionally have expenditures higher than Italy, and also nearly a point less than in the United Kingdom (UK), which has always been a very parsimonious country. Provisional data for 2017 and estimations for 2018 confirm this trend (OECD Health Statistics).[1]

If we look only at public expenditure, the picture does not change. In terms of GDP, public expenditure is lower than in the main continental and Northern European countries (Table 3). Starting from a pre-crisis value of 6.3% (2007), the Italian government expenditure-GDP ratio did not grow even by half a percent in the following decade (6.6% in 2016 and in 2017 estimation), despite the inevitable increase in demand for services – with a steadily aging population – and despite the increase in the costs of implementing new technologies in diagnostic and therapeutic services. Similarly, public expenditure per capita on health services increased of less than 19% from 2007 to 2016, a share

[1] Accessed on 30.12.2018, at http://www.oecd.org/els/health-systems/health-data.htm.

much lower than in the main continental and Northern Europe countries reported in Table 3.

Italian trends in public expenditure on health are more similar to those of other Mediterranean European countries such as Portugal and Spain, although, from 2007 to 2016, the growth of expenditure per capita in Spain was considerably higher (24.5%). Again, estimations for 2017 confirm the picture emerging from Table 3.

TABLE 3 – Levels of Current Public Expenditure on Health Care

	Share of GDP (%)			**Per Capita (US$PPP)**			**Growth of expenditure per capita (%)**
	2000	2007	2016	2000	2007	2016	2007-2016
France	7.5	7.8	8.7	1,977	2,715	3,957	45,7
Germany	7.8	7.6	9.5	2,120	2,773	4,612	66,3
Sweden	6.3	6.6	9.2	1,856	2,681	4,466	66,6
UK	4.8	6.1	7.7	1,242	2,144	3,312	54,5
Italy	**5.5**	**6.3**	**6.6**	**1,488**	**2,150**	**2,554**	**18,8**
Portugal	5.9	6.3	6.6	1,114	1,601	1,846	15,3
Spain	4.9	5.7	6.4	1,047	1,857	2,320	24,9

Source: OECD Health Statistics (accessed on 30.12.2018, at http://www.oecd.org/els/health-systems/health-data.htm).

At the same time the share of private health expenditure over total expenditure on health, while diminishing in France, Germany and Sweden, increased in the UK, Italy and in other Southern European countries (Table 4). In Italy, from 2007 to 2016 it shifted from 22.5% to 25.5% of total health expenditure, therefore coming to represent more than a quarter of total health expenditure (with OECD provisional data and estimations showing a further increase for 2017). This brought the level of private health expenditure closer to that of Spain.

TABLE 4 – Private Health Expenditure in Share of Total Health Expenditure (%)

	2007	2016	Difference 2016-2007
France	22.8	17.1	-5.7
Germany	24.9	15.4	-9.5
Sweden	18.1	16.5	-1.6
UK	18.3	20.5	2.2
Italy	**22.5**	**25.5**	**2.5**
Portugal	31.3	33.6	2.3
Spain	27.3	28.8	1.5

Source: OECD Health Statistics (accessed on 30.12.2018, at http://www.oecd.org/els/health-systems/health-data.htm).

In the Italian case the out-of-pocket component is very high, being more than 90% of the total private health expenditure. However, the growth of private health expenditure during the crisis was due to the insurance component, even more than the out-of-pocket factor. In this regard, one of the most recent transformations that has taken place in Italy in relation to private health expenditure is the spread of supplementary, or integrative, occupational health funds for workers and their families, introduced or reintroduced from national negotiations or unilateral initiatives made by companies. Almost non-existent at the end of the 1990s, supplementary occupational health funds have rapidly increased in the last decade, to cover 35% of the total number of employed persons. This threshold is particularly high when compared with the more marginal role that such insurance programs play in health care in other European countries (Natali and Pavolini, 2014). The increasing popularity of occupational health funds is due primarily to the dynamics inherent in the industrial relations system during the crisis. However, it also reveals the state of health and coverage of the Italian National Health Health Service (NHS). By increasingly funding the provision of basic health services, such as diagnostics and specialized care that should be covered by the NHS, it is clear how these funds are often operating in substitution of the NHS, rather than as a complement to the latter, as required by law (Neri, 2012). As these funds are concentrated on employees in the medium and big firms, mainly located in the north of Italy, the spread of occupational funds brings serious risk to deepen the traditional differences existing in service access and quality between the north and the south of the country (Arlotti *et al.*, 2018).

2. Austerity Policies in the NHS

Within a general approach aimed at reducing public expenditure and the weight of the public sector in the economy, the austerity policies directed to the NHS had as main objective the containment and control of public health expenditure, if not its reduction. This was done in a context where health expenditure (public or private) is expected to grow in the medium and long term, for the reasons we have already briefly mentioned.

In the Italian highly regionalized NHS, control of health expenditure by the central government was pursued primarily through extremely limited increases and, in some cases, reductions in the level of funding attributed by the central government to the Regions to finance the "Essential Levels of Health Care" (*Livelli Essenziali di Assistenza*, or LEAs), that is the set of services to be provided nationwide. Absolute values and percentages of annual funding increases confirmed a stagnation in the central government appropriations from 2010 onwards, with generally very reduced surges but also drops compared to the previous years, in 2013 and in 2015 (Table 5).

Table 5 – Financing of the Central Funding for LEAs

	Financing (in millions of €)	Percentage of change from previous year
2007	97,6	-
2008	101,6	4.1
2009	104,2	2.6
2010	105,6	1.3
2011	106,9	1.2
2012	108,0	1.0
2013	107,0	-0.9
2014	109,9	2.7
2015	109,7	-0.2
2016	111,0	1.2
2017	112,6	1.4
2018	113,4	0.7

Source: Ministero della Salute (accessed on 31.12.2018, at http://www.salute.gov.it/portale/home.html).

One could object that in the first part of the 2000s the yearly growths were more substantial. However, we should remember that the restrictions in the central funds allocated in the last seven-eight years would, comparatively speaking, have had an impact on very low expenditure levels (Giarelli, 2017).

The level of annual funding of LEAs is calculated in the budget laws, called "stability laws". The level is negotiatied between the State and the Regions within the State-Regions Conference (see below) and ratified in official acts and documents such as the State-Region Agreements or the Pacts for Health. However, the Parliament and the central government can modify the concerted funding levels, as has always occurred in fact, after the beginning of the crisis with reductions in the originally agreed funds.

Besides the containment of general central funding, austerity policies addressed the control of specific sources of expenditure arising from the acquisition of production inputs. The main cost containment programmes started in 2009-2010 and intensified in the following years, culminating in the so-called "Spending Review" on public administration, promoted by the Monti government in 2012 (Law Decree No. 95/2012).[2] The austerity measures then continued roughly until today, albeit with less intensity in 2017-2018. Targets like the following were pursued:[3]

1) "rationalization" policies on pharmaceutical expenditure, which included spending caps on the global expenditure, passed from 16.4% of the total NHS financing in 2008 to 14.85% in 2017, incentives for generic drugs, reductions in quotas attributable to pharmaceutical companies, wholesalers and pharmacists on the sale price of drugs, as well as a general review of the remuneration system of the drug distribution chain;
2) reduction in hospitalization rates, setting, in 2012, the target of 160 total admissions for 1,000 inhabitants (of which 25% for the outpatients), against a rate which in 2010 was calculated at 175-180 admissions for 1,000 inhabitants. In the same year national legislation introduced also a mandatory statute, by Regions, to reduce the number of hospital beds from 4 to 3.7 per 1,000 inhabitants, including 0.7 beds for rehabilitation and long-term nursing care. The reduction was borne by the public providers for a quota of not less than 50%;
3) redefinition, in a generally restrictive sense, of the criteria used to set the regional tariffs (linked to DRG-like systems), for inpatient and outpatient services provided to the NHS;
4) general restrictions of the expenditure on purchases of goods and services. In 2012-2013 there was a 10% reduction of all existing contracts for the

[2] Law Decree No. 95, 6 July 2012, converted into Law No. 135, 7 August 2012, "Conversione in legge, con modificazioni, del decreto-legge 6 luglio 2012, n. 95, recante disposizioni urgenti per la revisione della spesa pubblica con invarianza dei servizi ai cittadini" (text available at https://www.gazzettaufficiale.it/eli/id/2012/08/14/12A09068/sg).

[3] For a broader review of the austerity measures approved over the years, see the documents published on the website of the Chamber of Deputies (la Camera dei Deputati, one of the two branches of the Italian Parliament), on "issues of parliamentary activity", for the health sector, available at https://temi.camera.it/leg17/, last access on 31.12.2018.

procurement and supply of goods and services stipulated by the NHS health authorities. These drastic measures were progressively accompanied by instruments that monitored and controlled the conclusion and implementation of purchase contracts;

5) increasing revenues: by increasing the co-payments for citizens, with the introduction or rescheduling of copayments on first aid, specialized outpatient and pharmaceutical industries. In this field, the most discussed measure was the "superticket", a sharing of the expense of 10 euros for each prescription for outpatient diagnostic and specialized services, introduced at the end of 2011. The Regions have made different choices regarding the superticket, accepting it indiscriminately, and modifying it according to income or, in some cases, denying it. This last option is spreading in 2018-2019.

These measures were added to those aimed at controlling staff expenditure in all public services (Bordogna and Neri, 2014), which are of particular significance due to the importance of human resources in the health sector. There were two main types of measures addressed to NHS staff: measures aimed at gradually reducing the number of employees and others at containing wages and salaries.

In the first case, at the end of 2006, and thus before the start of the crisis, a cap for personnel expenditure for 2007, 2008 and 2009, equal to the "corresponding amount of the year 2004 reduced by 1.4%" (including costs for temporary employees and autonomous workers) was introduced in the NHS. This measure was first confirmed for the three-year period 2010-2012, establishing that the cap was to be considered as net of expenses arising from contract renewals occurring after 2004. Then the same constraint was extended to 2013-2014 and in the following years, having been in force until 2019. To meet the cap, Regions could adopt several measures of health facilities and service re-organization. However, a predictable result of the cap and other similar measures was a slow down and substantial stop in the staff hiring and turnover within the NHS health care organizations.

Between 2007 and 2015 the staff of the Italian NHS passed from 682,197 to 648,663 units, a drop of 33,534 units (-4.9%). The decline would be more pronounced (-6.5%) if we took as reference the initial year of 2009, when the staffing of the NHS amounted to 693,716 units (Ministero dell'Economia e delle Finanze, 2018). The decrease in the number of staff during the crisis was stronger in other areas of public administration, such as the central and local government, but it was nevertheless a significant drop, considering that the Italian health care service is understaffed compared to many European countries (Vicarelli, 2015).

Staff hiring was re-opened in 2017-2018, especially after that the new national NHS collective agreeement signed in 2018 opened the possibility to hold extraordinary public competitions for the new recruitment of doctors, nurses and technical health personnel. These measures were confirmed by the stability law for 2019, which suspended new hiring in a great part of public administration until November 2019. However, the pace of recruitment seems inadequeate to face the lack of health care staff within the NHS, which will become more serious in the next years considering the predictable wave of retirements connected to an aging labour force, especially among doctors (Vicarelli and Pavolini, 2015).

Furthermore, a second type of measures was introduced in 2008 and reinforced in 2010-2011, which concerned the containment of wages for civil servants (Law Decrees No. 78/2010[4] and No. 98/2011[5]). These measures also affected employees in the NHS, as well as independent professionals working for the NHS, starting from the general practitioners and paediatricians.

After very moderate wage increases in 2008-2009, equal to half of the increase established in renewals for the periods 2004-2005 and 2006-07 (ARAN, 2011), national-level collective bargaining was suspended for two years, in 2010, for all 2.8 million contractualized public employees, including NHS staff. The suspension was then extended until 2015, when a sentence of the Constitutional Court forced the government to re-start the collective bargaining process in the public sector. A new national NHS collective agreement for the period 2016-2018 was signed in May 2018, with modeste pay increases. Collective negotiations at decentralised level in the public sector, including the NHS, were not frozen, but were put under very strict financial constraints. The overall effect of these provisions was to freeze the salaries of NHS employees for eight years, substantially to the levels of 2010.

In addition to these measures, there were also specific measures addressing the Regions in conditions of high deficit in the health sector and therefore subjected to a recovery plan, which will be dealt within the second part of the article.

[4] Law Decree No. 78, 31 May 2010, converted into Law No. 122, 31 July 2010, “Conversione in legge, con modificazioni, del decreto-legge 31 maggio 2010, n. 78, recante misure urgenti in materia di stabilizzazione finanziaria e di competitivita' economica” (available at https://www.gazzettaufficiale.it/eli/id/2010/07/30/010G0146/sg).

[5] Law Decree No. 98, 6 July 2011, converted into Law No. 111, 15 July 2011, “Ripubblicazione del testo del decreto-legge 6 luglio 2011, n. 98 (in Gazzetta Ufficiale – Serie generale – n. 155 del 6 luglio 2011), convertito, con modificazioni, dalla legge 15 luglio 2011, n. 111, (in Gazzetta Ufficiale – Serie generale – n. 164 del 16 luglio 2011), recante: ‘Disposizioni urgenti per la stabilizzazione finanziaria’” (available at https://www.gazzettaufficiale.it/eli/id/2011/07/25/11A10000/sg).

3. The Consequences of the Financial Crisis on Inter-Governmental Relations

The economic crisis and the austerity policies have favoured a partial reversal of the trend in the evolution of relations between different levels of government compared to previous decades. The increasing regionalization of the system, started at least since the 1990s, has given way to a complex set of dynamics characterized, on the one hand, by a re-assertion of the role of the central government in national health policies with a significant impact on spending, on the other hand, by a substantial (more than formal) differentiation in the powers and responsibilities among the Regions, depending on whether or not they are subject to a plan for the reduction of health deficits. To understand these dynamics, it would be useful to reconstruct the reasons and the characteristics assumed by the regionalization of the NHS starting from the 1992-1993 reforms (for an historical and updated reconstruction).

3.1. Decentralization in the NHS: The Rise of Regionalism (1992-2008)

Unlike the oldest national health services, such as those of England or Sweden, the Italian NHS has always had a decentralized structure, in line with the Italian Constitution. In a first phase (1978-1992) the powers and responsibilities were divided among the State, Regions and local government. With the reforms of 1992-1993 (Legislative Decrees No. 502/1992 and No. 517/1993), instead, the regionalization of the NHS was introduced, together with its managerialization (France and Taroni, 2005; Giarelli, 2017). Although they drew origin from the debate launched in the mid-1980s on the crisis of the NHS, the reforms were approved in the midst of the political and judicial earthquake after the general elections of 1992 and the impressive wave of corruption scandals known as *Tangentopoli* ("Bribesville"), which brought to the collapse of the old political system of the First Republic (1946-1992). To this, we must add also the context of the economic and financial crisis, which led to the devaluation of the national currency (the Lira) in September of that year. It was therefore necessary to intervene on an expenditure area as important as health care with not only urgent austerity measures (cuts, expenditure caps, copayments and new taxes), but also with structural measures. Apart from the contingent emergency, the reforms were considered necessary to allow the entry of Italy into the euro currency, in compliance with the convergence criteria laid down in the Maastricht Treaty signed in February 1992.

In this context, regionalization is the result of a convergence of objectives between the policy makers operating at national and regional level (Maino, 2001). On the one hand, the central government and the Parliament were more than willing to transfer powers and responsibilities when, presumably, it would have been necessary to undertake a policy of austerity and retrenchment in health care for several years.

Regional decentralization was thus seen as a way to share or remove highly unpopular decisions.

On the other hand, regionalization was considered an opportunity for Regional administrators to make visible and legitimize their level of government which, unlike the municipalities, had only been established for some decades and was perceived by the citizens as distant and not very visible. In particular, the implementation of 1992/1993 reforms allowed Regional Governments to initiate policies that could instate principles and core values (trust in the public or in private sector, the State or the market) that were distinct and clearly recognizable by the general public. In particular, the adoption of managed competition (Enthoven, 1985), which evolved into managed cooperation (Light, 1997), gave Regions the opportunity to implement quite divergent policies, in terms of organisation and regulation of the single Regional Health Services.

Regionalization responded not only to political, but also economic rationality criteria. The Regional level of government seemed in fact to be in the best position to plan service organisation and distribution on the territory, being able to respond adequately to local demands and needs and, at the same time, to keep under control the local "particularisms" that had emerged in an uncontrolled manner in previous decades. In fact, the regionalization of the NHS undertaken from 1992-1993 was at the same time a process of decentralization from the State to the Regions and of centralization by the local government to the regional level. Moreover, there was the conviction that greater autonomy and empowerment of the Regions could push those of the South to promote policies to reduce existing disparities in service access and quality, more effectively than what the central State had been able to do up to that point.

The main powers in planning, organization and management of health services were then attributed to the 20 Regions and the Autonomous Provinces of Trento and Bolzano. New NHS providers, the local health authorities (*Aziende Sanitarie Locali*) and the autonomous hospitals (*Aziende Ospedaliere*) were instituted as Regional entities and were organized according to the New Public Management principles.

Regionalisation was then strengthened by the Constitutional reform introduced in 2001 and confirmed by the failures of subsequent attempts of Constitutional reforms in 2006 and 2016. According to current regulation, the State is in charge of defining the above-mentioned Essential Levels of Health Care, or LEAs, and should guarantee Regions the economic resources necessary for LEA provision. NHS central funding for LEAs is defined through negotiations between the central government and Regions.

The Regions have great freedom in organization and management of their Regional Health Services. Starting from the second half of the 1990s, different Regional health care models emerged, characterized by regulatory structures marked by hierarchical

integration, cooperation or competition between purchasers and service providers (Mapelli, 2007; Neri, 2011). These institutional and organizational differences among Regional Health Services still exist, although some convergence processes emerged in the 2000s (Maino and Neri, 2011).

NHS regionalization included a certain degree of fiscal autonomy, even if very restricted (see Bordignon *et al*., 2002), as well as the possibility of introducing co-payments for drugs and outpatient services at Regional level. In 2009, fiscal decentralization could have expanded considerably after the approval of Law No. 42;[6] however, the implementation of this law was hampered by many difficulties, and the economic and financial crisis caused its postponement.

3.2. The Re-Assertion of the Role of the State

The division of powers that emerged from the decade 1992-2001 required a permanent mechanism of negotiation and, possibly, cooperation between the State and the Regions to define national health policy. In fact, after 2001, the State (the central government and the Parliament) could not approve structural reforms such as those of the 1990s without the consent and involvement of the Regions, which was essential for reform implementation. However, the central government retained a considerable control over financial resources, in particular those intended for the financing of the LEAs. Moreover, as the last ten years has clearly shown, the central government and the Parliament retained a significant capacity of affecting NHS management and organization at Regional and local level, by introducing national regulation which Regions are then called to implement.

Since the late 1990s, the national health policy, like that of other policy sectors with high decentralization, has developed mainly through negotiated or joint forms of policy-making, which is based on a system of Conferences between the State, Regions and local government. Among those Conferences, the most relevant to health is the State-Regions Conference, established in 1988 and then reinforced in 1997 and 2003. In the State-Regions Conference, central government and Regions are represented at the highest political level. Central (that is, national) government is represented by the Prime Minister and the National Ministers, while each Region is represented by its Regional Governor and the Regional Ministers. In the case of health care, the National and Regional Ministers involved in the policymaking will be the National Minister of Health and the Regional Minister of Health (one Minister of Health for each of the 20 Regions). The majority of the most important health policy decisions are thus taken through

[6] Law No. 42, 5 May 2009, “Delega al Governo in materia di federalismo fiscale, in attuazione dell’articolo 119 della Costituzione” (available at https://www.gazzettaufficiale.it/eli/gu/2009/05/06/103/sg/pdf).

"Agreements" or "Pacts" deliberated by the State-Regions Conference and translated into law by the Parliament (Carpani, 2006; Fargion, 2006).

The role of the State-Regions Conference was central to the process of making the Regions responsible for managing expenditure, which had become a crucial element in ensuring the convergence of Italy to the Maastricht parameters, then translated into the European Stability and Growth Pact. In a decentralized institutional framework such as that of the 2000s, the involvement of the Regions was essential and ensured by means of acts, such as many State-Regions agreements and pacts (usually called "Pacts for Health"), which have been signed within the State-Regions Conference between the central government, on one side, and the Regions, on the other, over the last 20 years.

Although none of regulatory changes had modified the balance of the powers we have described, the economic and financial crisis weakened the role of the Regions in national policy making, in favour of greater importance of the role played by the central government, the Ministry of Economy and Finance (MEF) and, indirectly, by the European institutions. This was not a trend limited to health care, but in this area it was perhaps more significant as regional decentralization was extended and consolidated in other areas. Faced with this change, the State-Regions Conference lost, in substance though not in form, some of its importance in defining the national health policy, in favour of a more one-sided process that took place within the central government, in cooperation with the EU and the European Central Bank.

This shift that started before the crisis grew from 2008-2009 and became particularly evident after the explosion of the sovereign debt crisis of 2011-2012. The need to take urgent measures – able to signal to international markets and the EU the willingness and ability of the national government to bring the public debt under control – have prompted approval of austerity packages by the central goverbment, which in great part had not been agreed upon and basically not even discussed with the Regions, Parliament and organized interests. The minimization of room for discussion and negotiation was motivated by the lack of time and alternatives in the face of the commitments made with the EU and the need to reassure the markets. In this sense, justifying the making of unpopular decisions with the overriding need to abide by overwhelming external restrictions was a very effective strategy to avoid negotiation, using a combination of blame avoidance and credit claiming (Bonoli and Natali, 2012).

These dynamics did not occur only in Italy but were common to all the European countries most affected by the financial crisis and sovereign debt, namely those of Southern Europe (Portugal, Spain and Greece) and, in a partially different form, Ireland (Pavolini and Guillén, 2013; Pavolini *et al.*, 2015; Asensio and Popic, 2019; Léon *et al.*, 2015; Sotiropoulos, 2015). All the last mentioned countries were forced to adopt

structural reforms and strict austerity measures decided by the central government, with more or less direct interventions of the EU and, unlike what has happened in Italy, in various other situations of international financial institutions such as the International Monetary Fund (Greece, Portugal, Ireland). In this context, national governments and, within it, Prime Ministers and the Ministers of Economy and Finance have become guarantors and accountable at European and international institutions for the adoption of interventions or negotiations, according to each case, imposed by such institutions in exchange for direct or indirect financial support. Applying these measures quickly and with little margin for change than those already defined at European or international level, had somehow determined an exclusion of traditional negotiations with the parliaments, local government and organized interests.

In the Italian case, these trends seemed particularly evident in some reforms like those of pensions in late 2011 and the adoption of austerity packages on public expenditure and staff (Bordogna and Neri, 2014). In the health care sector, the heart of the decision-making process was shifted from the complex mediations between the central government, Parliament, Regions and also organized interests (i.e. doctors) to the top-down relations between European institutions and the central government, within which the role of the Prime Ministers and the Ministers of Economy and Finance stand out (Marangoni and Tronconi, 2014; Frisina-Doëtter and Neri, 2018a; 2018b).

The role of the Regions has significantly weakened in the definition of health policy and, consequently, also that of the State-Regions Conference, even if there were no changes in the legislative assignments. This was particularly evident in the process of determining the annual NHS central funding for LEAs. The definition of the allocations took place through a negotiation between the State and the Regions, which resulted in agreements, such as the Pacts for Health 2007-2009, 2010-2012, 2014-2016. However, since 2010, the agreed funding has almost always been revised downwards by the stability laws or other austerity packages, with decisions substantially taken by the central government and, in particular, by the MEF, and has involved very limited possibilities or even the absence of modification by the Regions.

According to information gathered in some interviews carried by the author of this article with some managers and officers of the State-Regions Conference in 2016, the most striking example of this process took place in the case of definition of the NHS central funding for 2013. In this circumstance, the Regions protested loudly, but to no avail, against the downward revision of the NHS funding for 2013, which was significantly lower than that of 2012, both in percentage terms and in real terms (see Table 5).

The weakening of the role of the Regions in national policy making is not only due to political and institutional dynamics set in motion by the financial crisis, but also, in part,

by a series of scandals related to corruption or misuse of public resources, featuring Regional governments both in north and in the south of Italy. In the eyes of the public, Regional politicians thus began to appear among the major representatives of a "caste", i.e. the political class, unable to administer public affairs efficiently and dedicated almost exclusively to its own particular interests. For a "young" institution like the Regional one, introduced only in 1970, this phenomenon translated into a rather serious loss of legitimacy, to the point that, even in the national press, some commentators began to wonder what the Regions were for. Doubts about regionalization or, at least, the way it was began to spread also among experts, in the light of research that highlighted the persistence if not an increase in regional inequalities, after 20 years of regionalism (Pavolini and Vicarelli, 2012; Toth, 2014).

4. From Territorial to Institutional Differences? North and South between Greater Autonomy and Central Protection

In a comparative perspective, OECD data show that, according to many indicators, the Italian NHS performs quite well in terms of health equity, service access and quality, as well as of overall efficiency. Always in comparative terms, these performances by and large have not changed (or not yet), after the economic crisis (Mapelli, 2012; Giarelli, 2017; Terraneo, 2018), although there are some signs of increase in health inequities among social groups (Sarti *et al.*, 2017) and some current trends – NHS underfunding, increase in the share of private health expenditure, spread of occupational funds – have a great potential to undermine the universalistic nature of the Italian NHS (Neri *et al.*, 2017).

However, as it is well known, data at national level hide the existence of relevant inequalities between North and South in the service access and quality, as well as in the efficiency of the Regional health care systems. Although these differences are historically rooted, since 1990s they have increased rather than decreased (Pavolini and Vicarelli, 2012; Toth, 2014, 2016; Sarti, 2017). Although over time the NHS exerted a significant effort to reduce territorial differences in expenditure for health services (Mapelli, 2012), this was not translated into a correspondent reduction of the differences existing in terms of service quality and efficiency between different areas of the country. Quite the opposite, the North-South gap was widened in the years of NHS regionalization, instead of filled (Toth, 2014).

In this context, the economic crisis triggered relevant changes in the NHS governance and in the relationships between State and Regions. First, as described in the previous paragraph, the crisis had contributed to determine a partial but significant re-centralization of national health policy making. Moreover, it promoted the re-assertion

of the role of the State in the governance of the Italian NHS, by highlighting the importance of some institutional mechanisms, which had been created before the crisis. Even in this case, the central government was called to re-affirm its role to tackle problems of financial nature.

In fact, already in the mid-2000s, the inability of some Regions to keep their health service in a financial equilibrium had clearly emerged. Disputes between the State and the Regions on the responsibilities of health deficits had been frequent since the birth of the NHS. However, during the 2000s European commitments made regarding the containment of the public debt as well as NHS regionalization saw the opportunity of defining a mechanism, which allowed the central government to intervene to ensure control of health expenditure at regional level. This mechanism became essential in the years of financial crisis.

On this purpose, the budget law for 2005[7] and, above all, the State-Regions Agreement of 23 March 2005[8] (with subsequent adjustments) defined a multi-tiered monitoring mechanism of health expenditure, debt settlement and recovery. In the event that the deficit in the management of the RHS persisting in the fourth quarter of the financial year surpasses some pre-defined caps (which have become stricter by 2010), the Region is considered to be in a situation of financial imbalance. Once that the excessive deficit is definetely assessed by a monitoring unit set up by the State-Regions Conference, the Prime Minister warns the Regions to take the necessary measures to ensure rebalancing by 30 April of the following year. Within 30 days the Region had to approve a recovery plan from the operating deficit, which has to be approved by the monitoring unit and the State-Regions Conference within the subsequent 45 days.

If the plan has not been submitted or has been rejected by the State-Regions Conference, the Prime Minister (and the MEF) shall appoint a Commissioner to prepare the plan and its implementation. Moreover, a series of actions for the settlement of the deficit are activated, entailing the increase of the regional taxes, a total blocking in staff hiring and turnover and the ban of undertaking non-compulsory expenditures. In case of inertia of the Region, these measures are automatically triggered within 30 days from the appointment of the Commissioner. Following the approval of the debt recovery plan, the MEF allocates the 40% of additional resources deemed necessary for payoff. The

[7] Law No. 311, 30 December 2004, “Disposizioni per la formazione del bilancio annuale e pluriennale dello Stato (legge finanziaria 2005)” (available at https://www.gazzettaufficiale.it/eli/id/2004/12/31/004G0342/sg).
[8] Conferenza Permanente per i Rapporti tra lo Stato, le Regioni e le Province Autonome di Trento e Bolzano, 23 March 2005, “Intesa, ai sensi dell'articolo 8, comma 6, della legge 5 giugno 2003, n. 131, in attuazione dell'articolo 1, comma 173, della legge 30 dicembre 2004, n. 311” (available at https://www.gazzettaufficiale.it/eli/id/2005/05/07/05A03665/sg).

remaining 60% is granted on a quarterly and annual basis after assessment of the implementation of the plan.

In 2007, the recovery plan was activated for seven Regions and other three were added in 2009 and 2010. Eight over ten Regions are still subject to this mechanism. These Regions include all Southern and Southern-Central Regions, except the small Basilicata, while only two Northern Regions were forced to approve a recovery plan and were never commissioned.

One of the most delicate and most discussed passages of the recovery plan procedure was the appointment of a Commissioner. This role was attributed to the Governor of the commissioned Region itself, until this practice was banned in 2014. However, playing the role of Commissioner, even the Governor of the Region was highly restricted in its freedom to define health policy, being forced to implement decisions mostly taken by the MEF and central government. Moreover, the central government could also appoint Subcommissioners, chosen from persons of proven technical competence in the area of health.

Despite differences between individual cases, the recovery plan mechanism was largely effective in securing a debt reduction of the Regions. Between 2009 and 2014, the deficit of the Regions involved passed from 3.5 billion to 275 million € (Corte dei Conti, 2016). However, experience has shown that, once the plan procedures began, it was extremely difficult to abandon them. On the basis of the documentation available on the website of the Ministry of Health with regard to the single plans and their processes, and the information collected in some interviews, we can assume that this was due not only to the presence of particularly demanding financial targets in years of economic crisis, but also to the existence of objectives beyond purely economic aspects that impacted on quality and access to services. In many cases these objectives were not easy to meet, considering that recovery plans inevitably required retrenchment policies, which entailed severe cuts and other kind of restrictions in service provision.

From the point of view of the inter-governmental relations, the recovery plan mechanism severely restricted the autonomy of Regional governments in the development of health policies, including those relating to service management and organization. Central government and, in particular, the MEF, directly or by means of the monitoring unit of the State-Regions Conference, not only exerted a penetrating supervision and monitoring of the plan implementations in the Regions concerned, but often played a proactive role in defining specific measures of debt relief. Moreover, they gained the right to exert a sort of veto, in the face of Regional policies that involve increased expenditure. Although the formal division of powers between the levels of government has not changed over the past decade, regional decentralization proved in

fact to be much weakened in favour of an increase of the Central State's regulatory role, embodied by MEF rather than by the Ministry of Health (Frisina-Doëtter and Neri, 2018a; 2018b).

If Central and Southern-Central health care have been subjected to these strict forms of control during the years of crisis and until now, this has not been the case of the Northern and Central-Northern regions, except for two cases (Piedmont and Liguria). In most of these Regions, the ability to maintain fiscal equilibrium or limited deficit has allowed them to consolidate and strengthen the autonomy of Regional health policies. Certainly, the austerity measures previously described, taken at a national level, represented constraints with which Regional governments had to come to terms with, in any part of the country. However, this did not prevent the "virtuous" Regions from safeguarding, substantially, their autonomy in health care management and organization. The structural reforms of the Lombard and Tuscan health system adopted in recent years are two examples of the clear persistence of autonomous and unchanged powers compared to the past in the organization and regulation of services, by the Regions not subject to recovery plans.

Moreover, some of these Regions (Emilia-Romagna, Lombardy and Veneto) have requested "particular forms and autonomy conditions" (Article 116, clause 3, Italian Constitution), both in the health sector and in other policy sectors, which would make them more similar to the five Italian Regions provided, from the 1950s, with a special autonomy for historical or ethnical reasons. This showed the will to move towards a more clearly oriented structure of powers in the federal sense.

After the consultative referendum held in Lombardy and Veneto on 22-23 October 2017 – which saw the success of the initiative promoted by the Regional governments – and the formal request of the Emilia-Romagna government between August and October 2017, a negotiating table was opened with the central government, according to the procedure laid down in Article 116 of the Italian Constitution. While negotiations are still underway in 2018 and 2019, other Regions requested greater autonomy.

Although the contents required by the "greater autonomy" still have not been explicitly defined, it is quite clear that it should concern not only the management of resources but also regional tax capacity, today very limited, so as to take a significant step towards a more complete accountability of the Regions. The most delicate issue concerns the possibility to retain most of fiscal revenues collected within any single Region, limiting the process of central redistribution. Given the very relevant differences in fiscal capacity between the north and the south of Italy, the potential effects of this change could be highly detrimental for Southern Regions.

5. CONCLUSION

The tendency to move towards a substantial recentralization of decision-making in national health policies with relevant impact of expenditure is linked to the need to respect the restrictions imposed by the process of European integration and Monetary Union and the globalisation of international markets, in a situation of a severe financial crisis. That condition has enhanced the role of central government, able to participate in decision making at supranational level and to influence economic dynamics and international finance, albeit with many limitations. In this sense, centralization seems to be determined primarily by factors exogenous to the health care system, which have to do with “external constraints” (Ferrera and Gualmini, 2004) to the Italian economic and welfare system. These constraints are not new, but in the last decade they acted with a strength and cogency unknown in the past.

However, the re-affirmation of the role of the central State in the NHS depends also on factors endogenous to the health care system, such as the characteristics and shortcomings in the NHS governance, which were emphasized by the economic crisis. As we have described, the institutional framework that emerged after the 1990s had led to the construction of mechanism of joint policy making between the central government and the Regions based on the State-Regions Conference. This system has shown serious limits in conditions of economic crisis. The ability of the central government, even more than the Parliament, to determine ultimately the amount of NHS funding through legislation resulted in the affirmation of the prevalence of this level of government, highlighting the substantial supervision on financial resources from the centre. The imbalance in powers exercised in this field is also accentuated by severe limitations that exist in the Regional fiscal autonomy. In addition, central control, an element often overlooked, is not limited to financial resources but extends to the determination of the other major health sector inputs (labour, drugs, equipment, and medical devices), as highlighted by the austerity measures imposed by the Government in recent years.

These trends were not limited only to the years of financial emergency arising from the sovereign debt crisis, but were manifested, in part, already earlier and somehow seemed to continue in more recent years, favoured by the persistent state of the Government’s financial difficulties due to the high public debt. In this sense, we can assume that they will continue, perhaps in a milder form, even under conditions of economic recovery.

Other factors have contributed to the re-assertion of the role of the central government, such as the overwhelming incapacity of at least half of the Regions to manage the health system efficiently, as well as to guarantee adequate quality services, and also the legitimation crisis of the Regional institution.

The story of the debt recovery plans and, at the same time, the request for greater autonomy from Northern Regions lead us to affirm that the NHS is not directed towards a simple re-centralization, at least in the regulation of the system, but rather towards a search on new balances between centralization and decentralization.

The most probable hypothesis is that all this can lead to the end of the traditional distinction between five Regions provided with special autonomy and fifteen Regions provided with a uniform set of powers and responsibilities, in direction of a system of powers and responsibilities that differs according to the conditions of each Region or of different groups of Regions. On the substantive level, in fact, what happened in the last 10 years represents an evolution towards different forms of decentralization or federalism in the NHS. In the coming years, the change could find greater recognition also on a formal level.

The evolution towards a “differentiated federalism” (Frisina-Doëtter and Neri, 2018a; 2018b) presents risks and opportunities for the NHS. On one hand, it responds to unquestionable territorial differences in the economic and financial resources, administrative tradition and capacity as well as population needs, which the previous NHS governance did not take into account. On the other hand, there is the serious risk that existing territorial differences will be exacerbated, thus further widening the gap between the north and the south of Italy and resulting in the deflagration of the “National” Health Service. To prevent this from happening, at least two conditions are needed. First of all, the formal attribution of greater autonomy to Northern Regions will be devised by finding institutional and regulatory mechanisms able to ensure the principles of equity and solidarity which are at the base of the NHS. Second, the State will necessarily go beyond its current prevailing role of financial watchdog, in charge of implementing retrenchment policies, and actively help Regions with lower performances improve the quality of their health services by developing innovative forms of planning and cooperation. At the moment, both of these conditions seem far from being satisfied.

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