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The Modernisation of the Welfare State in Italy:

Dynamic Conservatism and Health Care Reform, 1992 to 2003

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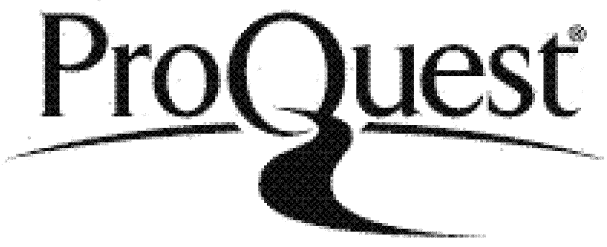

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Abstract

An institutional pattern of administrative inertia and resistance has traditionally characterised the reform of the Italian State. It is widely held that the historical development of the state has contributed to this immobilisme. The effect of the Italian system of party government on bureaucratic autonomy is also blamed for the failure (until recently) of attempts to reform the Italian state. However, definite changes affecting welfare administration in Italy reveal a radical departure from the status quo, as a result of particular reform mechanisms and the strategies of elites in handling blockages during the process of legislative implementation of delegating laws designed to introduce ambitious reform programmes. 'Dynamic conservatism' is the novel theoretical approach elaborated here to study policy change in such stalled administrative systems, and it offers an explanation of how it becomes possible to break historically determined immobilisme.

The case of healthcare reforms in Italy in the 1990s has marked an impressive departure from traditional administrative practice. The thesis argues that two key innovations have been accomplished: first, the emergence of public managers charged with extensive policy leadership at the top of regional welfare administration, increasingly legitimised by expertise and technical knowledge rather than political entrepreneurialism; secondly, the reconfiguration of traditional centre-periphery relations, triggered by the territorial disturbance caused by regionalisation. The consolidation of policy change, underpinned by the paradigm of the entrepreneurial state, was most noticeable at regional level. Such change was achieved, however, only by handling beforehand two major blockages: first, the opposition of political parties during the parliamentary process to the reconfiguration of the relationship between politics and administration; secondly, the adversarial response of interest groups to policy change.

To my grandfather, Dino Rella, who taught me the hope in a better world

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Lastly, I wish to acknowledge the French community of the Maison Francaise in Oxford for being my home away from home from 2002 to 2004, and for the intellectual opportunities I could benefit from during my residency. There I have received support and many intellectual stimuli from all the young *boursiers Lavoisier*.

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List of Acronyms

ANAAO	Associazione Nazionale Aiuti ed Assistenti Ospedalieri *National Association of Hospital Assistant and Junior Doctors*
AN	Alleanza Nazionale *National Alliance*
ANCI	Associazione Nazionale Comuni Italiani *National Association of Italian Municipalities*
ASL	Azienda Sanitaria Locale *Local Healthcare Enterprise*
ASSR	Azienda Servizi Sanitari Regionali *Agency for Regional Healthcare Services*
CCD	Centro Cristiano Democratico *Christian Democratic Centre Party*
CGIL	Confederazione Generale Italiana del Lavoro *General Confederation of Italian Labour*
CGIL-FP	Funzione Pubblica CGIL *Public Services CGIL*
CIMO	Confederazione Italiana Medici Ospedalieri *Italian Confederation of Hospital Doctors*
CIPE	Comitato Interministeriale per la Programmazione Economica *Interdepartmental Committee for Economic Planning*
CISL	Confederazione Italiana Sindacati Lavoratori *Italian Confederation of Workers*
CNEL	Consiglio Nazionale dell'Economia e del Lavoro *National Council for Economics and Labour*
DC	Democrazia Cristiana *Christian Democracy Party*
DS	Democratici di Sinistra *Democrats of the Left*
FIMMG	Federazione Italiana Medici di Medicina Generale *Italian Association of General Practitioners*
FIMP	Federazione Italiana Medici Pediatri *Italian Association of Paediatricians*
FISOS-CISL	Federazione Italiana Operatori Sanitari CISL *Italian Association of Medical Staff CISL*
FNOM	Federazione Nazionali degli Ordini Medici *National Association of Medical Groups*
FNOMCeo	Federazione Nazionale Ordine dei Medici Chirurghi ed Odontoiatri *FNOM Surgeons and Dentists*
INPS	Istituto Nazionale per la Previdenza Sociale *National Institute of Social Security*
IRI	Istituto per la Ricostruzione Industriale *Institute for Industrial Reconstruction*
LHA	Local Health Authority
NPM	New Public Management
PAL	Piano Attuativo Locale *Local Implementation Plan*

PCI	Partito Comunista Italiano *Italian Communist Party*
PLI	Partito Liberale Italiano *Italian Liberal Party*
PRI	Partito Repubblicano Italiano *Italian Republican Party*
PSI	Partito Socialista Italiano *Italian Socialist Party*
PSN	Piano Sanitario Nazionale *National Healthcare Plan*
RC	Rifondazione Comunista *Communist Refoundation Party*
SIDIRSS	Sindacato Dirigenti Servizio Sanitario *Healthcare Public Managers' Union*
SSN	Servizio Sanitario Nazionale *National Healthcare System*
SUMAI	Sindacato Unico Medicina Ambulatoriale Italian *Off patients Medicine Italian Union*
TAR	Tribunale Amministrativo Regionale *Regional Administrative Court*
UIL	Unione Italiana del Lavoro *Italian Labour Union*
UPI	Unione delle Province d'Italia *Association of Italian Provinces*
USL	Unità Sanitaria Locale *Local Health Authority*

Preface

> The scientific debate about the conditions of decay of the modern state is a way for political scientists, especially American and neo-Marxists, to create illusionary problems. The modern state is not in crisis: it is only much more complex, and more difficult to be fitted into the abstract models of political scientists (Giannini 1986).

Reshaping of the state by reducing the size, scope and resources of the public sector has led observers and scholars to claim that the state is in 'crisis'. The deliberate change to the structures and processes of public sector organisations with the objective of improving public services has been one of the most critical issues in contemporary government practice and policy reform in advanced industrial democracies. Scholars of administrative reforms in the 1980s and 1990s have associated the 'crisis' of the State with new rules of public authority and organisation, introduced with the alleged 'withdrawal of the state' from spheres of intervention which were previously at the core of its activity and legitimacy (Wright and Muller 1994). Most reforms in the 1980s stemmed from economic and financial tribulations confronting governments unable to pay for public sector expenditures without increasing taxation. However, the problem of the crisis of the state does not merely concern its financial capacity, but involves deep-seated ideological disputes about its nature and purposes.

Whether this reshaping of public sector functions and processes can be defined as a 'crisis' should follow a careful evaluation of the specific challenges that these new arrangements have posed to domestic administrative structures (Wright and Page 1999). Advocates of the 'entrepreneurial state' (Borgonovi 1988; Osborne and Gaebler 1992; Rebora 1995), however, have devoted less attention towards investigating the different responses of individual administrative systems to their

ideology.[1] Hence, insufficient attention has been drawn to the type of challenge that the alleged 'crisis' poses to firmly entrenched and historically determined bureaucratic traditions. As Wright argued, the general picture of state retreat 'may mask a partial, nationally differentiated, limited reality with perverse displacement effects and unintended consequences leading to renewed state activity' (Wright and Muller 1994). As Giannini's observation, quoted above, suggests, the 'crisis' of the state has been elevated into a universal phenomenon affecting the modern state, more as the result of scholarly debate about the ideology informing administrative changes than as an empirical investigation of particular challenges facing national administrative structures. This reasonably instils prudence in drawing sweeping generalisations about the most recent patterns of administrative reforms, such as the entrepreneurial or managerial revolution affecting the public authority tradition of the state.

The Italian state has been affected by administrative changes associated with the entrepreneurial state, although the scope and intensity of reform programmes have varied across policy sectors, pensions being noticeably less affected than health care and education policies. In spite of numerous attempts to reform the state and wide ranging and ambitious administrative programmes since the late 1970s, the distinctiveness of administrative reform activities in Italy has been their *immobilisme* and inertia (Cassese 1994). Committed efforts to reorganise the public sector have

[1] The 'reinventing government' framework in the United States (Osborne and Gaebler 1992) has several notions in common with New Public Management (NPM), a loose term referring to the most recent paradigm change in how the public sector is to be governed. C. Hood defines NPM as 'a shorthand name for the set of broadly similar administrative doctrines which dominated the bureaucratic reform agenda in many OECD group of countries from the late 1970s' (1991). 'Entrepreneurial state' refers to the doctrinal component of NPM linked to stress on private-sector styles of management practice, exemplified by greater flexibility in hiring and rewards, discretionary control of organisations from named persons at the top 'free to manage' (Hood 1991). NPM is related principally to the notion of 'hollowing out of the state', whereby many activities of the state have been reassigned (Rhodes 1994).

primarily been left 'on paper', with the introduction and enactment of a large number of reforms rarely being followed by any concrete implementation of the intended aims. This has been especially marked in the area of higher education policy (Capano 2003) and regulatory impact assessment.[2] This specificity has been at the core of the public administration scholarship in Italy, which has offered thoughtful and complex explanations for the historical legacy of immobilisme. Historical and juridical accounts predominated over other disciplines. The historical development of the Italian state combines with distinctive organisational and cultural traits and with the nature of political control of administrative resources to produce an outcome resembling Crozier's bureaucratic phenomenon and vicious circle (Crozier, 1964). If one decides to label this pattern of inertia as 'crisis', it appears to be not a new phenomenon, but a historical pattern.

Against this historical legacy of administrative inertia, significant and impressive changes to the *modus vivendi* of the Italian administration and its rationality have recently occurred. Recent reforms have yielded concrete results suggesting a departure from the pattern of inertia. The change has been most noticeable with respect to the introduction of private-like management arrangements and the decentralisation of the state, intended here as the transfer of primarily administrative competencies in specific policy areas to subnational governments. The case of health care reforms illustrates the pathbreaking change. In no other sectors of the welfare state has the entrepreneurial paradigm of administrative activity been so extensively adopted, and implemented in Italy, as it has for the national public health care system.

[2] For recent findings on the regulatory impact assessment in comparative perspective, see: European Council. (2004). A comparative analysis of regulatory impact assessment in ten EU countries. Dublin, Italian, Irish and Dutch presidencies of the Council of the EU. See also Radaelli (2004).

The paradigm was introduced into health care in 1992 by the Amato government, and soon became deeply rooted at subnational level, following regional legislation creating the conditions for the emergence of a powerful regional welfare administration, inspired by new public management ideas. Despite attempts at policy reversal towards the end of the 1990s, the entrepreneurial welfare state is sufficiently rooted to offer an alternative administrative model to the Weberian legal-rational model of bureaucratic rule. In other policy areas, most noticeably education, similar trajectories have been followed, with the establishment of managerial discretion and new responsibilities assigned to head teachers of high schools. Individual schools have also been granted greater administrative autonomy from the central administration (Brocca 1995; Ferroni 1997). However, the implementation of this reform has been slow, ambiguous and problematic, as such impeding considerably any fruitful empirical investigation. Furthermore, in this sector there has been no comparable decentralisation of administrative functions to the subnational level of government, as is the case for health care. Nor has the paradigm of entrepreneurialism and managerialism been accepted as readily as in health care. Recent public outrage against the Moratti education reform is a clear indication of this opposition to NPM.[3]

Against the backdrop of legacy of inertia and immobilisme, and in the light of concrete change in health care reform, the thesis aims to offer first an empirical understanding of how change under inertial conditions becomes possible. It investigates whether the traditional blockages to administrative reforms have been lifted or removed, whether elite strategies have changed from resistance to the

[3] 'Rivolta contro la scuola azienda', *La Repubblica*, 22 February 2002; 'Scuola, tagli come per la sanità', *La Repubblica*, 28 August 2002.

embrace of reforms, and whether new instruments have become available to push ambitious reforms through an otherwise ineffective policy making and law-making process. Secondly, on the basis of the analysis of the case of health care reforms in the 1990s, the thesis intends to elaborate a theory of dynamic conservatism that may be inserted into a more general model of policy change in stalled societies (Crozier 1970). A 'clinical' approach is one that bears upon particular cases and generalises only from an intimate understanding of these cases. Therefore, I do not start with *a priori* definition and general laws, but facts will be analysed to explore and discover what theoretical models they fit, or which models need to be built inductively to explain them more adequately.

Chapter I

The Reform of the Italian State: Doomed to Fail or Possible Change?

> A bureaucratic system is restricted in its possible rate of development, and evolution toward large scale organisations is not so unrelenting as Weber thought—it depends, to a large extent, on the ability of men to break out of the bureaucratic vicious circle (Crozier 1964).

The problem of change in a bureaucratic system may be posed in dysfunctional terms, emphasising the traits of public administration that lead inevitably to a pathological state of institutional inefficiency and malaise (Crozier 1970). With reference to the administrative reforms undertaken by the Italian Prodi government, one informed observer has sounded this warning: 'we are getting ourselves into a fix; we risk going back to the beginning with increased costs and inefficiency'.[1] To dramatise the effects of the 'vicious circle', however, may constrain our ability to explain change rigorously, when it does happen, and to explore the mechanisms that facilitate the break with the legacy of inertia created by the vicious circle. One may stand astonished in front of critical evidence of change, such as the international rating of the Italian public national health care system as second best in the world,[2] solving the puzzle of the break of inertia by attributing it to the fortuitous circumstances of the 'accidental logic' of historical events (Immergut 1992), or just favourable exogenous conditions generally defined as 'crisis' (Cassese 2002). Why is the intrinsic capacity of the administrative system to create change endogenously not sufficiently accounted for? The historical legacy of failed attempts at reforming the Italian administration indeed justifies in part the centrality of the problem of immobilisme in the study of administrative reforms. However, it risks sweeping

[1] With reference to the administrative reforms of the Prodi government, S.Cassese denounced the state of inefficiency and crisis of the public administration. See: Cassese,'La controriforma della burocrazia', *Il Sole 24 Ore*, 21 February 1999.
[2] 'Health Systems: Improving Performance', World Health Organisation, Geneva, 2000.

away, with an apocalyptic tone, the concrete recent achievements in the direction of modernising the Italian State, in particular in relation to the improvement of public services.

The historical development of state building after the unification process in 1861 has affected the pattern of institutional reform of the Italian state, which has been marked by pronounced inertia and immobilisme (Melis 1996; Pezzino 2002). This tendency is more obvious as far as the implementation of reforms is concerned. Yet dynamism and impressive legislative activism have characterised administrative reforms in the last thirty years, as the first part of this chapter highlights. Although the study of the Italian public administration has been dominated by public law scholars (Dente 1990a), historical studies may significantly advance our understanding of the developmental conditions that have created a cumulative hindering effect on the progress of reform, such as the feeble commitment to establishing a senior civil service and the centrality of the question of public employment. Similarly, the role of the doctrine of administrative law can also be appreciated by tracing its development through history, from protecting individuals against arbitrary power in the liberal state to its transformation in order to adapt to the emergence and consolidation of the welfare state, increasingly legitimised by a different rationality than merely the legal rule (Giannini 1990). Finally, the question of the arduous development of technical knowledge and bureaucratic expertise in the Italian administration is examined in relation to the pattern of political control of the bureaucracy, long characterised by clientelism and patronage (La Palombara 1963), but more recently moving towards a system of 'personalised trust' (Wright and Page 1999; Endrici 2000).

Scholarly work addressing the question of immobilisme in relation to administrative reform in Italy is reviewed in the second section of the chapter. This review emphasises the explanatory significance of historical development and its legacy in influencing the problem of change in the Italian administrative system. However, our task needs to take into account recent critical evidence of impressive and remarkable change, marked by the introduction of general management into key welfare policy areas and the decentralisation of welfare services to regional levels of government. This thesis explores an extraordinary case of the concrete possibility of 'men breaking the vicious circle', to use Crozier's terms, namely the 1992-93 health care reforms.

The exploration of the possibility of reform in practice of the Italian public administration does not only respond to the theoretical aim of developing a more general approach to the study of reform in stalled political systems, but it has also substantive policy significance in terms of the quality of services that citizens receive. When one reads accounts of the elderly having to queue for as many as eight hours behind the desk of a local health authority to collect their exemption stickers for the treatment of chronic and debilitating diseases[3], one wonders whether the reform of the state may be confined within the realm of institutional reforms or whether it pertains also to the core of the welfare state and policy reforms in advanced societies. The attention devoted to administrative reforms has been, unfortunately, inadequate as far as substantive policy issues are concerned. The last part of this chapter sets up the case of health care in order to advance our understanding of whether change in the Italian state is possible and, if so, by what mechanisms inertia can be broken and eventually defeated.

From the Giannini Report to Bassanini's Decentralisation: a History of Incomplete Achievement

A striking paradox runs through the Italian administrative reforms of the last thirty years. Ambitious programmes to reshape the state have been enacted by the adoption of various legislative initiatives. In substantive terms, reforms have repeatedly challenged the traditional models of public authority, by obfuscating the borderline between the public and private sectors. For instance, the privatisation of public employment has been pursued consistently since the mid-1970s as an attempt at introducing private sector management practices into public administration.[4] However, most reforms remain incomplete and unimplemented. This first part of the chapter aims to highlight the difficulty of reforming the Italian state by briefly describing the most significant attempts at introducing external and innovative models of public administration and their failure. In particular, attention is drawn to two themes: the administrative decentralisation of the Italian state and the introduction of private sector management associated with the 'managerial revolution' (Wright and Muller 1994). The administrative question in the 1990s was not only a matter of liberating civil servants from political control, as the separation of politics from administration constituted its *leitmotiv* (Dente 1999), but also addressed the transfer of administrative competencies from the central administration to subnational authorities in general and regional governments in particular (Falcon 1998; Furlong 2003).

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[3] 'Usl, dopo i bollini un altro calvario', *La Stampa*, 17 February, 1993.

[4] In the legislation and in the literature, the term 'privatisation' is used interchangeably with 'collective bargaining'. However, privatisation is not equivalent to collective bargaining because the former includes the latter and not vice-versa. Privatisation is a wider term and it implies that the entire system of public sector employment contracts, including pay and conditions, is brought under the realm of private law. More importantly, it implies the abandonment of rigid rules, and privileges for civil servants. See: Battini and Cassese (1997).

In the 1970s and 1980s, administrative reforms in Italy were piecemeal and *ad hoc*, triggered by immediate contingencies rather than a wider reform programme. It was not until the beginning of the 1990s that public management reforms became a more prominent theme of comprehensive and ambitious packages, such as those of Cassese and Bassanini, which took place in the years 1992-94 and 1997-99 respectively.[5] Although the Cassese and Bassanini reforms were the landmarks of administrative reform in the 1990s, they were part of a much larger set of government programmes to improve the delivery of public services, which included changing the system of administrative controls, public access to the administration, and other measures summarised in Table 1.1. below, which provides an overview of the large scope of reforms in the 1990s.

[5] The Cassese reforms were about improving the relationship between the citizen and the public administration; simplification of administrative procedures; improved efficiency and productivity; and the introduction of effective performance monitoring and control. From 1992 to 1994, Italy undertook its most extensive and incisive reform of public administration. The period witnessed a wide range of change: from the introduction of Public Services Charters, on the British model of the Citizens' Charter, to the simplification of administrative procedures, the reorganisation of central departments, the reform of civil service employment contracts and the creation of regulatory agencies. See: Cassese (1994). The Bassanini reforms refer primarily to the decentralisation of the State, aimed at the transfer of administrative responsibilities in certain policy areas from the centre to local authorities. Article 1 of Bassanini Law no.59 of March 15, 1997 authorises the executive to promulgate a number of decrees transferring responsibilities from the central administration to regions. Law no. 112 of 1998 (Bassanini Two) has also decentralised a wide range of responsibilities to the regions and local authorities. For example, Article 138 has given the regions the power to organise and rationalise the distribution of schools and responsibility for professional training. Article 139 confers on the municipal authorities responsibility over the use of facilities and control over 'collegial boards', education of professionals and other activities, all of which would seem better served by individual schools. For an analysis of the implications of the Bassanini reforms, see Gilbert (2000) and Dente (1999).

Table 1. 1. Administrative Reforms, 1992-2001

Reform Programmes	Type of reform	Legislation
Reduction in size and resources	Personnel cuts Reduction of administrative structures and procedures	Finance Law 1994 Law no.241/1990
Reduction in scope	Decentralisation Autonomy to local authorities	Law no. 59/94 and no. 127/1997 Law no. 142/1990
Dismantle statutory framework of civil servants	Privatisation of employment contract Reform of higher civil service	Executive Decree no. 29 /1993 and Law no.537/93 Executive Decree no. 29/1993 and Law no. 145/2000
Monitoring	Tightening financial controls Role of Court of Accounts	Executive Decree no. 143/1993 and Law no. 20/1994 Executive Decree no. 470/1993 and 143/1993
Management	Managerial autonomy to public managers	Law no. 59/1997 Law no. 142/1990
Reorganisation of administrative structure	Merger of ministries	Executive Decree no. 281/97
Transparency	Access to information	Law no.241/1990

Source: Author's elaboration

The introduction of alternative models of public administration to the predominant legal-rational one (Weber 1991) has been debated since the late 1970s. The paradigm of efficiency deriving from the obfuscation of the public-private juridical demarcation was at the core of the 1979 Giannini Report.[6] It was inspired by a reform-driven advocacy that owed much to the work of Giannini himself. [7] In the

[6] Ministero per la Funzione Pubblica (1982), 'Rapporto sui principali problemi dell'Amministrazione dello Stato'.

[7] M.Severo Giannini was one of the major public law scholars in Italy. He extended the investigation of administrative law to the questions of public finance and public management. Thanks to his contribution, scholars have investigated issues such as the constitutional aspects of public

report presented on 16 November 1979 in Parliament, Giannini, then-Minister of Public Services, urged a redefinition of the reform of the State from the focus on public authority to the management and delivery of more efficient public services.[8] For this purpose, he established within each department special administrative units for the analysis of organisational issues, so-called *Uffici organizzazione e metodo.* Moreover, the 1979 Giannini Report proposed the 'alternative option of privatisation' of public sector employment.[9] He intended to exclude from the jurisdiction of public law all public employment contracts except those of the *dirigenti*, that is, the higher civil service. This was soon to become the 'manifesto' of a radical upheaval of the traditional bureaucratic and hierarchical model of the administration, associated with traditional public employment (Melis 1996).

The Giannini Report and the 1983 reform of public employment[10] did not produce the expected results (Melis 1996), but reform activism, however, continued unabated. For example, administrative reform was a major aim of different governments in the 1990s, but the 1992-94 programme of reforms, under the Amato and Ciampi governments, was extraordinary and, thus, merits special attention. What was distinctive about this period was that reforms were part of a comprehensive programme of political and institutional change.[11] The objectives of reform included

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administration, the administrative organisation, and comparative administrative law. See Giannini (1970).

[8] Ministero per la Funzione Pubblica (1982: 733).

[9] Ministero per la Funzione Pubblica (1982: 738-9).

[10] Law no. 29/1983. This was an attempt to provide a homogeneous framework for the fragmented and specific statutes of public employment. For the first time this law applied to the entire public sector, and not to just ministerial departments. A central aspect of the reform was the division between matters to be regulated by law (the organisation of offices, for instance) and those to be regulated by collective agreements (salaries).

[11] Under the eleventh legislature of the Italian Parliament (1992-94), administrative reforms became a political priority for the government, for the first time in the history of the Republic. During those years, when a radical reform of the Republic looked very near, the governments, led by Giuliano Amato and then Carlo Azeglio Ciampi, introduced radical reforms as part of wider political change. In particular, the Minister of Public Services under the Ciampi Government, Sabino Cassese, a public law professor, produced a remarkably large legislative output, considering the short length of his tenure. He proposed to solve the urgent problems of inefficiency, waste and corruption, and the lack

the reduction of the public expenditure and of the deficit in political legitimacy, following the 1990s corruption scandals (Della Porta 1993). The ideas informing the reforms marked a great discontinuity from the past and from the traditional model of public administration (D'Albergo and Vaselli 1997). Moreover, the mode of reform distanced itself from the traditional method of 'accumulation' – creating new structures and administrative bodies without altering or removing old ones (Melis and Cassese 1990). By contrast, administrative reforms at the beginning of the 1990s emphasised 'reduction' and simplification.

The scope of traditional public authority has been reduced sharply by two reform trajectories: decentralisation and the introduction of private sector management practices (Wright and Muller 1994). As far as the former was concerned, the beginning of the 1990s marked the commitment to greater autonomy of regional governments and local authorities, such as health care authorities,[12] from central administrative supervision. However, the most active period for the decentralisation of the Italian State, since the establishment of regions in the 1970s, coincided with the 1997 and 1998 Bassanini reforms (Newell 1998; Gilbert 2000; Furlong 2003). This period was characterised by the intention to abandon any lingering state control over legislation in the policy areas constitutionally reserved to Italian regions. It also fully activated the power conferred by Article 118 of the Italian constitution upon the central government to delegate administrative powers to regions in other areas, such as education.[13] Beginning with Law no. 59/1997 and continuing through to

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of public confidence in the public sector. In June 1993, in a famous 'Report on the Condition of Public Administration', Cassese identified the fundamental problems of the Italian administration: lack of attention to citizens; predominance of a rigid statutory framework; inadequate distribution of ministerial responsibilities; length and complexity of administrative rules and procedure; inadequacy of traditional financial monitoring; and the lack of attention to European issues.

[12] Executive decree no. 502/1992, discussed in details in chapter II of this thesis.

[13] The longest article in the Law 59/97 was Article 21 which dealt with the reform of high schools, which were given greater autonomy over the curriculum, methods of teaching, course organisation,

executive decree no. 112/98, a series of legislative acts named after the minister of public services, Franco Bassanini, outlined a new framework of centre-periphery relations in Italy. Law no. 59 delegated to the executive the legislative authority to 'confer functions and tasks to the regions and other local institutions with the goal of reforming and simplifying the public administration'.[14] A second Bassanini Law, no. 127/97, addressed 'urgent measures of streamlining administrative activities and procedures of decision and control', as stated in its preamble.[15] On 31 March 1998, legislative decree no.112 implementing the delegating law was enacted.[16]

The second most important trajectory of reform activity in the 1990s has been changing the traditional management arrangements of the administration. This trajectory has developed as part of a wider management 'revolution' in governance (Pollitt and Bouckaert 2000), driven by new public management ideas originally developed in the British and American context.[17] D'Albergo and Vaselli provide a

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extracurricular activities and teacher training. It also provided the head teachers with managerial autonomy.

[14] Article 1 of Law no. 59/1997.

[15] In May 1997 the second Bassanini Law, no.127/1997, was passed in Parliament. This is a hugely complex piece of legislation pursuing the reform of local government and further administrative efficiencies. For instance, article 6 authorises both the mayors of towns over 15,000 inhabitants, and also the presidents of the provinces, to employ a 'city manager' with the task of increasing efficiency. Another important article, no. 16, dealt with the reform of universities. It granted individual universities the freedom to regulate their own teaching and courses. For more details, see Gilbert (2000).

[16] Legislative decree no.112 issued on March 31, 1998.

[17] The prescriptions of NPM (Osborne and Gaebler 1992) include: the separation of the purchaser role of public services from the provider role; the growth of contractual or semi-contractual arrangements; accountability for performance; flexibility of pay and conditions; the separation of the political process from the management process; the creation of internal markets or quasi-markets; an emphasis on the public as customer; the reconsideration of the regulatory role of the state; and a change in the general intellectual climate. The new approach separates policy-making, in the hands of politicians and the higher echelons of the public administration, from the delivery and production of public services, which can be devolved to independent agencies or even the private sector. In other words, the role of the public administration becomes not to manage the daily provision of public services but to provide general guidelines and standards in the interest of the citizens or 'clients'. One of the most important consequences of this distinction between 'steering' and 'rowing' is the extension of privatisation and the growth of contractual arrangements (Lane 2000). In contrast to the traditional hierarchical control of public organisations, internal contracts or semi-contractual arrangements are established. Many NPM prescriptions can be understood as attempts to change the culture of public services, dominated by the traditions of centralisation, hierarchy and regulation. The models of the market and commercial and private culture are influential. For recent theoretical analysis of public management reforms see: (Pollitt and Bouckaert 2000).

sociological framework to analyse the borrowing of new public management practices from the British experience, with particular attention to the problems of policy learning (D'Albergo and Vaselli 1997). Incentives to enhance the autonomy of public managers from political control have been introduced in many sectors, including education and health care. For instance, greater managerial discretion has been granted to individual head teachers of high schools.[18] The head teacher was granted managerial responsibilities and greater discretion over the budget and overall administration. The purpose of granting autonomy was to reorganise education in order to improve efficiency and quality of service. Local management of resources is assumed to enable the achievement of specific targets and performance reviews. A head teacher, so the argument goes, can allocate resources more efficiently than a remote central administration (Butera 1994). Autonomy was claimed to eliminate the fragmentation of responsibility for personnel management between the state and local schools produced by a complex system of public law regulations (Ventura 1998).

The empirical investigation undertaken by this thesis into the introduction of public management into health care in Italy is centred around a landmark reform of the national health care system enacted by the Amato government in December 1992, called 'Restructuring the National Health Care System'. This reform can be broken down into two major elements: the introduction of general management, and the regionalisation of administrative and policy functions from central to regional governments. One of the most noticeable innovations introduced in the 1992 reform was the introduction of general management as a result of a paradigm shift from a politico-representative to a technical-managerial type of health care administration. When the Italian health care system was created in 1978, it became immediately

[18] Articles 4 and 5 of Law no. 537/1993.

entrenched in the predominant administrative culture. Local health authorities became the fiefdom of local 'notables' who would establish their power base by distributing social benefits. This practice was perpetrated through management committees composed of local elected officials, doctors, and trade union representatives. Since political parties used management committees as an arena for party competition in local electoral politics, they have responded to the challenge of the creation of the new rank of the general manager with scepticism, at best.

Despite the thin parliamentary majority and public unrest, managerialism and entrepreneurialism were the aspects of reform that the Amato Government was most determined to pursue.[19] Managerialism was an idea that the Minister of Health was particularly committed to 'being very knowledgeable of the British reforms of the National Healthcare Service (NHS)'.[20] Although the introduction of general management is something transferred from the British experience,[21] the peculiar rationale for transferring it into the Italian politico-administrative system, to depoliticise management and to improve the transparency of the administration, determines its interpretation and the interests of actors involved within it. The Minister of Health explained to the Senate the need to abolish all types of collegial bodies from the management of health care authorities in order to clearly separate politics from management.[22] Therefore, the central rationale for introducing general management into the administration of health care was to overcome the collusion of interests and resulting distortion in the distribution of health care services.

[19] A.Tomassini, interview with author, Rome 25 July, 2002; Lucchina, interview with author, Varese 12 September, 2001.
[20] Nicola Falcitelli, Interview with author, Rome 23 September, 2002.
[21] The 1983 Griffiths Report marked the beginning of NHS's managerial change. The report states that NHS suffers from 'institutional stagnation'. Health authorities are not given policy guidelines and consensus decision-making leads to long delays in the management process. The Griffiths report's importance lies as much in the philosophy which shaped its recommendations as in the recommendations themselves.

Furthermore, managerialism is embraced by the government as a moralising mission. In this respect it becomes a rhetorical policy discourse to regain citizens' trust in political institutions. Most parties used the rhetoric of bringing politics back into the sphere of transparency and morality. During the 1980s, the health care sector was the most affected by corruption scandals (Della Porta 1999b). As a solution to this problem, executive legislative decree no. 502/1992 strengthens the auditing function and the role of the Board of Accountants, giving individual members the ability to exercise administrative and financial controls independently at any time on any administrative acts.[23] The claim for the private market's greater efficiency in delivering health care services would help the government in their purpose of regaining citizens' trust. According to Giuliano Amato, 'from competition we cannot draw anything else but benefits. Competition will transform the user from a state subject to a real citizen'.[24]

Central to new public management practices was the embrace of an output oriented administration (Hood 1991). Attention shifted from processes to results, with rewards linked to performance. Evaluation of results became a key element. Accordingly, the reform of administrative controls[25] has been inspired by the increasing dismantling of *ex ante* procedural controls in favour of cost-performance and cost-benefit analysis. The Cassese reform programme created internal control units to evaluate policies using cost-benefit analysis and strengthened the supervisory role of the Court of Accounts over these new units. The Court, more generally, expanded its controls over public management by the creation of a new control

[22] F. De Lorenzo, speeches to the Lower Chamber, Social Affairs Committee, 10 and 15 December 1992, and F.De Lorenzo, interview in *La Stampa*, 19 October 1992.
[23] Article 3, Executive Decree no.502/1992.
[24] G.Amato in *La Stampa*, 4 December, 1992.

function in 1994.[26] Moreover, financial control over collective employment agreements was strengthened.[27] The Court retained *ex ante* control only of executive acts.[28]

In the case of Italian public management reforms in the 1990s, a distinct and crucial part of this wider programme was the 'privatisation' of public employment,[29] as we mentioned earlier in relation to the Giannini reforms at the end of the 1970s. Yet, it was the Amato government in 1992-93 that pushed this project further and more convincingly.[30] The decision to merge the system of national collective agreements for the public and private sectors reflected a political will to inject the methods and techniques of the private sector into public administration. It has been claimed that a

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[25] Executive decrees no. 470 and 546 of 1993 and Laws no.19 and 20 of 1994.

[26] Law no. 20 of 14 January 1994 introduced a new type of control on management, so-called *controllo gestionale*. In exercising this new function, this Law establishes that 'the Court controls the legality and transparency of management. Accordingly, it monitors whether administrative targets are met by concrete results, analysing and benchmarking costs, instruments and timing of the administrative activities'. This control function applies throughout the administration and it is a direct function of it. The Court can require any type of administrative and other information from the internal control units of any administration, central, regional or local. This control over management applies also to autonomous local authorities.
In addition to control over management, the Court is responsible for two other types of controls: the *ex ante* legality control over administrative acts, and financial and economic control. These two are defined by Article 100 of the Italian Constitution.

[27] Article 51 of Legislative Decree no.29/1993.

[28] Legislative decrees no. 470/1993, no.546/1993, and Laws no.19 and 20/1994. In general this legislation reduced the administrative control on procedures, which was the predominant type in the Italian administration. By contrast, this reform programme introduced controls on outcomes. See Cassese (1994).

[29] The reform of public sector employment contracts has been debated since the beginning of the 1980s. However, it has gained more impetus and salience in the 1990s. Two reasons for the timing of the reform can be identified. First, as Cassese has mentioned, the crisis of the political parties, resulting from the widespread corruption and bribery scandals, and the de-legitimisation of the entire political system, have created a window of opportunity for trade unions. They have exploited this opportunity successfully by taking the entire matter of employment contracts away from parliament and political parties. Secondly, Italy's public deficit became visible in the 1990s. The fiscal crisis was one of the most important circumstances to influence the reform of public administration. The problem of public sector employment and personnel management was also a problem of wasted financial resources. For the literature on the privatisation of public employment, see Cassese, Dell'Aringa, et. al (1991), Vandelli, Bottari, et. al (1995), Capano (1993), Battini and Cassese (1997).

[30] Executive Decree no.29 of 1993 and amending decrees no.470 and 546.
In 1992-93, the interests of the Amato Government and of the three major trade unions coincided on at least the first stage of the reform programme. Both government and unions encouraged the move from administrative law to national collective agreements as far as pay and conditions of employment were concerned. This move is sometimes referred to as 'privatisation' in the text of the legislation. The basic expectation of the reform was that the counterpart of collective bargaining would cease to be a functionally-irresponsible parliament, who had a strong electoral incentive to grant generous wages and working conditions.

public administration that aims to be more decentralised, more flexible, and financially more transparent and more accountable at different decision-making levels, needs to be governed by flexible employment contracts rather than rigid legal procedures (Rebora 1999). The precondition for this is the dismantling of the traditional statutory framework for civil servants. Since the 1957 Statute of Civil Servants established the privileges of civil servants, the public sector has been regulated by administrative law. Executive decree no. 29/1993 instituted a radical change: the transfer of public sector employment contracts from the realm of administrative law to that of national collective agreements. However, despite this legislative output there are few civil servants on short-term contracts, [31] it is not now easier to dismiss civil servants, and performance related pay has not replaced equal pay for people of the same rank.

Most of the scholars who have written about the reform of public sector employment have stressed the fact that no other European country has felt the need to privatise the employment contracts of civil servants so radically (D'Antona 1997). A possible explanation is that in the 1990s this system became financially unsustainable. Executive decree no. 29/1993 was introduced in the context of fiscal crisis and budget constraint. The government's priority was to cut public expenditure and to reduce financial distortions related to public sector employment. The 'privatisation' of employment contracts, with its emphasis on collective bargaining, was the policy instrument used to keep salaries under control. On one hand, the formal 'privatisation' of public employment has been successful to the extent that the

[31] The labour market for public sector employees is still highly rigid in Italy compared to other OECD countries. Only 2.5% of total civil servants had a part-time job in 2000. See: 'Innovazione e valorizzazione delle risorse umane', Forum Pubblica Amministrazione, May 2003, Rome.

necessary legislation was issued.[32] On the other hand, their implementation has not occurred, so they have remained in reality 'reform on paper' (Cassese 1995a). S.Cassese, when stepping down from the office of Minister of Public Services in 1994, expressed his frustration: 'the work I have started is mostly unaccomplished' (Cassese 1995a).

The Constitutional Court has approved the 'privatisation' process for employment contracts. In 1996 it rejected the claim that public law-based employment contracts for *dirigenti* were necessary to ensure impartiality.[33] Therefore, the court has judged the 'privatisation' of their employment contracts to be constitutional. The court's decision implies that *dirigenti* can no longer defend their privileges by appealing to Article 3 and Article 97 of the constitution, regarding the 'impartiality' of the public administration. The Court's decision reconciles the practice of collective bargaining, typical of the private sector, with the constitutional and legal obligations of civil servants, namely, impartiality and good management. Some scholars have emphasised the innovation of the Constitutional Court's interpretation that law and contract are not necessarily antithetical (D'Antona 1997).

To summarise, the attempts at reforming the Italian state discussed so far were mainly defeated by the difficult task of putting them into practice. The effort to grant senior civil servants greater areas of discretion and managerial autonomy had been the core trajectory of reform programmes in the 1990s. It was aimed at running services more efficiently, but also at avoiding the collusion between parties' interests and reform objectives, a point developed in greater detail later in this chapter. Political control of the administration has been characterised by a high level of

[32] Law no. 29 of 1993, 'Rationalisation of organisations in the public administration and revision of public sector employment'.

politicisation in the upper echelon of the civil service, as set out by the scholarship on the Italian version of party government (Katz 1987; Vassallo 1994). Decentralisation reforms, especially at the end of the 1990s, represented the second most important reform of the Italian state. Local authorities, such as local high schools and local health authorities, were granted more managerial responsibilities and self-government by the central departments. Both trajectories constituted a critical part of wider reform programmes to move the Italian state away from the tradition of legal-rational public authority and closer to that of public service. Yet, most efforts were defeated in practice. The next section reviews the explanations for this immobilisme as set out by other authors.

The Inertia of the Administrative System

The historical pattern of development of the Italian state reveals certain characteristics that continue to affect the outcome of reforms. These are the centrality of public sector employment for promoting social cohesion, the lack of a long-established senior civil service, and the constitutional position of the administration as defined by the Constitutional Assembly in 1948, which favoured parties over the administration as instruments of democratic consolidation (Morlino 1986). Moreover, the history of the Italian public administration has been interwoven with the evolution of the doctrine of public law, and administrative law in particular. At the core of this doctrine there is a theory of the state which encourages legal and procedural formalism against arbitrary power (Giannini 1986). Administrative law has developed and changed to a remarkable degree in light of the process of democratisation in the 1970s and the introduction of economic planning (Melis 1996). The significance of this tradition for the modernisation of the state not only

[33] Judgement no. 313/1996, Corte Costituzionale.

rests in its rigid formalism, but also in the fact that it supports the shared values of the tightly bound policy community of administrative reformers (Dente 1990; Dente 1999). As such, it provides the administration with a formidable means of resilience and continuity in the face of social and political change.

The explanations offered by the historical pattern and by the development of administrative culture reveal the propitious conditions for the distinctive usage of state resources and structures by political parties and political elites (Zuckerman 1975). Italian political parties do not compete on policy programmes, but on opportunistic office holding, guaranteed by the distribution of state resources among parties' factions. These practices defeat innovation and change, which are usually only enacted at the beginning of a new coalition government to respond to electoral demands. The problem of political control of the administration, though, is not merely related to the 'use' of administrative resources by parties. It also pertains to the role and status of civil servants in the politico-administrative system (Page 1992; Wright and Page 1999).

Historical State Development

From historical studies of public administration it is possible to extrapolate some main features of the Italian state's development since political unification in 1861. [34] The growth of the public sector in Italy has acted to integrate social and economic functions during the development of a capitalist economic structure.[35] Unlike other

[34] Until the 1970s the juridical formalist approach had impeded an autonomous development of historical studies about public administration. The work of G.Melis is a successful attempt to establish the centrality of a detailed historical account of Italian public administration. See Melis (1994).

[35] In the early years of political unification public sector employees made up less than 1% of the population. At present they represent approximately 10% of the population. The number of ministries has increased from 9 in 1861 to 22 in 1992.

European countries, administrative growth, that is the increase in the size, functions, and resources of the public sector, was not concurrent with the process of political unification, but started four decades later. Yet, its simultaneous development with rapid industrialisation meant that public administration internalised all the contradictions and difficulties of industrial development (Cassese 1974). Thus, public administration did not govern the process of economic development, as in France, but it remained at the margins (Pezzino 2002). The growth of the public sector played a key social function as a remedy for the gap between an industrialised North and a rural South. In particular, public sector employment in the central administration became an instrument of social cohesion (Pezzino 2002).

In Italy, administrative expansion was closely intertwined with the 'southern question' (*meridionalizzazione*). The pace and timing of public sector growth coincided with the recruitment of employees from the agrarian South. In the late nineteenth-century liberal state two thirds of senior civil servants came from Piedmont, but during the twentieth century, the proportion of northerners and southerners in the central administration reversed (Cassese 1974). The implication of the process of 'southernisation' was that public administration was exclusively perceived as a source of public employment and job security (*posto*) for young, middle class, and otherwise unemployed southerners. The consequences were far reaching because aspirations were for status and security rather than risk-based opportunities. Cassese argues that the resulting cultural model was the antithesis of Weberian rationality. Rather, it was based on a rural and proprietary conception of public sector employment (Cassese 1994).

The analysis of the historical development of public administration (Calandra 1978; Melis and Cassese 1990; Romanelli 1995) also reveals that, contrary to conventional wisdom, the Italian public administration has not remained attached solely to the original Cavour organisational model. The original model suggested by Cavour in 1853 was structured around departmental ministries headed by ministers responsible to Parliament. The minister had the power to appoint his own *cabinet.* The organisational units of the ministries were in a descending order of hierarchy: general directorates, divisions, and sections. Originally ministries had a secretary general, but in 1888 this office was abolished. The central administration had its own field services that remained in place even after the establishment of regions in 1970. The structure was based on the French model of public administration. Unlike the French model, the institution of the 'grandes écoles' was not present.

Other types of public organisations, such as state-led enterprises, public authorities, local administrations, and, more recently, independent regulatory agencies have paralleled the departmental ministries. However, the multiplicity of organisational models has never been conducive to the simplification and rationalisation of the existing structures. The final result is the coexistence of different organisational models within an uncoordinated and highly fragmented system. 'Everything is created and nothing destroyed' (Melis 1998). Similarly, an historical investigation reveals the existence of a plurality of administrative cultures. The development of the predominant administrative culture of administrative law during the period between 1885 and 1923 should not be taken for granted (Cassese 1976). Until the fascist period, the administration had a relatively strong technical element, including engineers and technical experts (Cassese 1976). The conflict between the original technical expertise and pluralism, and the increasing predominance of administrative

law reflects the conflict between reformists, on one hand, and supporters of the status quo and formalism on the other (Cassese 1976).

One of the most striking features of the Italian administration, compared with the French and British administrations, is the absence of an intentional effort to create a senior 'caste' of civil servants (D'Alberti 1990; D'Alberti 1994). Thus, for many years the structure of the administration resembled a pyramid without a head. The first major attempt to create an administrative elite occurred only in 1972 through Legislative Decree no.748. The 1972 reform has been defined as the most significant organisational change made to the Italian public administration in Republican history (Meoli 1995). A new administrative elite was juridically created from the existing upper level of the public administration, the so-called *dirigenza*, formally responsible for the financial and administrative management of partially legitimated offices.[36] The reason was to unburden the minister of a range of decisions, in particular approval of contracts and spending plans. Unfortunately, the original intention of creating a functional role, the *dirigenza*, has become entrapped within a formal career grade system. Originally, the aim was to create an autonomous higher civil service (Cerase 1999). Yet, the *dirigenza* has become a rigid and formalistic definition of status, pay scale and responsibilities (Cerase 1999).

Therefore, it was not until 1972 that public managers acquired their own, distinct areas of competency. There have previously been instances of autonomous responsibility but they were exceptional. In accordance with the 1972 reform, management functions were allocated *a posteriori*. The specification of newly defined responsibilities was of secondary importance to the paramount priority of formally positioning public managers in a pre-existing organisational structure.

Public managers have the role of 'guiding, co-ordinating, and monitoring their offices, in order to ensure the legality, impartiality, efficiency, and responsiveness of the administrative activity to the public'.[37] With regard to efficiency, despite the predominance of the traditional paradigm of administrative law, public managers were made responsible for the achievement of results. In the case of poor performance, higher civil servants were forced into early retirement. From 1972, autonomy was defined in comparative terms with the management functions of the private sector. For instance, the reform envisaged the possibility of negotiating short-term employment contracts for the achievement of specific objectives, so-called *incarico speciale*. However, in practice this remained an exception. The Minister retained the prerogative to override acts and decisions taken by higher civil servants and to call their administrative responsibilities back upon himself. Although this power has rarely been used, it has strong anticipatory effects (Plutino 1999). The strictly hierarchal relationship between the senior civil service and the Minister continued, though in a tempered and more mitigated way than before 1972.

There are two reasons for the difficulty experienced in creating a powerful senior civil service within the Italian administration. On one hand, the highly political implications of personnel questions inside the public sector have made ministers reluctant to relinquish control over such issues. Secondly, the role of the trade unions has been crucial in opposing the creation of an administrative elite (Panebianco 1991). In fact, the 1972 legislation coincided with the start of a period of increased unionisation in the public sector (Cammelli 1995). Even today, there is strong resistance to pyramidal organisational structures with power concentrated at the top. In particular, representatives of trade unions contended against the

[36] Article 2, Legislative Decree No.748/1972.
[37] Article 2 of Legislative Decree No.748/1972.

recruitment of outsiders with proven management skills and experience into the senior civil service (Panebianco 1991; Dente 2001).

The failure in creating a unified top civil service transcending departmental loyalties, combined with the fact that the administrative elite in Italy is largely closed and compartmentalised, enhanced the process of *cloisonnement*, literally compartmentalisation, of different administrative units and worsened the problem of coordination and communication between them (Cassese 1983). Therefore, another obstacle to effective reform of the state is the high level of fragmentation of the public administration, which in Italy is particularly high. Government beyond the departmental ministries consisted of autonomous administrations, such as the *Ente Nazionale per le Strade* (ANAS, National Road-Building Agency), the *Amministrazione Autonoma dei Monopoli di Stato* (State Monopolies Agency), the postal service (*Poste Italiane*) and the railways (*Ferrovie dello Stato*). Another group was the so-called 'state–holding' corporation, for example the *Istituto per la Ricostruzione Industriale* (IRI, Institute for Industrial Reconstruction). Its purpose was to facilitate state-led industrial development in areas where private industry was slow in achieving it. There is a full range of non-departmental agencies, some having a social security function, such as the *Istituto Nazionale per la Previdenza Sociale* (INPS, National Institute for Social Security, being the most notable), and others having supervisory functions, like the Bank of Italy.

The marginal constitutional role of public administration, combined with conflicting definitions in the Constitution about what its role should be contributed to its subordinate position vis-à-vis political parties (Franchini 1994). Not only does the Italian public administration lack an administrative elite like the British

establishment or the French *grand corps*, but also it does not enjoy any distinctive place in the Constitution (Cassese 1974a). Its constitutional role is defined with ambiguities and contradictions that exacerbate its institutional weakness. Whereas in France the state structure has been built upon public administration, in Italy public administration was remarkably not emphasised by the Constituent Assembly in 1948, unlike the judiciary and political parties (Cassese 1974a).

The different definitions found in the Constitution reflect the conflicting positions attributed to public administration by the Constituent Assembly: an institution dependent on the executive, an impartial and autonomous structure, and an institution in the service of society (Hine 1993). As part of the executive,[38] public administration is dependent ultimately on political parties. Yet the principle of impartiality (Article 97) requires the administration to act as an independent body, relieved from the political control presupposed by its executive function. Thirdly, the Constitution emphasises the link between society and public administration,[39] which ultimately responds to popular sovereignty. Therefore, the Italian constitution reflects multiple and conflicting conceptions of public administration, being simultaneously dependent on the executive and exempt from its political control. These conceptions have all coexisted and none has prevailed at the expense of the others, as Franchini argues (Franchini 1994).

Administrative Law and Culture

'Administrative culture' as an explanation for the difficulty of reforming the Italian State has two dimensions. One refers to the 'internal' culture, that is the culture

[38] Article 95 of the Italian Constitution applies only to departmental ministries.
[39] Article 98 of the Italian Constitution states that: 'public sector employees serve the State'.

produced by the administration's rules and procedures, and the other to the 'external culture', that is the image that members of the policy community of reformers have of public administration (Dente 1999). In the Italian case what characterises the latter is not necessarily a common representation of interests on specific policy issues, [40] but a common sense of trust and affinity owing to their common legal background (Dente 1990b). The distinction between internal and external culture is important because the interaction between them contributes towards determining the degree of change and continuity, as we will go on to elaborate. Dente writes that: 'public law constitutes the predominant culture of public administration. Its principles are based on the ideology of administrative reform, and the fortune of public law is that of Italian public administration' (Dente 1995). [41]

In Italy, the internal administrative culture coincides with the external one. This homogeneity is claimed to be one of the reasons for the difficulty of reforming the state (Capano 1992). The administrative culture is shaped by the doctrine of administrative law to the extent that it is difficult to disentangle the two. Public law has been the hegemonic academic discourse for the reform of the State, as Dente argues (Dente 1990b). Economics, political science and sociology have been of secondary importance and have not been given equal recognition. The policy community of public lawyers shares the same system language in a hegemonic way (Dente 1990b). This language is dominated by an emphasis on the technical details of legislation. Thus, law has a profound impact on Italian politics and administration,

[40] Heclo suggests that the interest of policy community is to strengthen the sense of closed 'community' rather than their position on specific policies. See Heclo and Wildavsky (1974).

[41] Political scientists in Italy have a marginal role in the debate of the reform of the State due to a mixture of factors: academic division, the problem and rigidity of the empirical methods, lack of interest in the research questions that social scientists pose about the administrative system, and probably the unwillingness to be in the uneasy position of giving policy recommendations. See the argument set out by Dente (1990).

and administrative law, in particular, becomes the backbone of the administrative culture of the Italian bureaucracy.

What characterises the Italian public administration is an organisational structure of French origin, upon which a doctrinal development of German administrative law imposed itself after political unification (Cassese 1995a). The essence of administrative law is the relationship between public authority and society. Functional, organisational and financial aspects of public administration have been of secondary importance (Cassese 1995a). The major task of *droit administratif* was the limitation of the political and administrative power of the executive in order to protect citizens from its arbitrary action. The predominance of liberalism and positivism at the end of the nineteenth century and the dualistic split between the executive and legislature influenced the view that the 'law' was the strongest constraint upon administration.[42] Consequently, administrative law was imposed upon the administration rather than being the product of it. Hence, administrative procedures themselves came to be regulated by a complex series of laws, decrees, and regulations.

The existence of a separate judicial system for administrative matters is a central element backing up the system of administrative law. The presence of a distinct judicial code for administrative matters was criticised in certain countries as creating privileges and being ultimately illiberal.[43] The distinctiveness of administration from society was further enhanced by the development of institutions for dispensing

[42] The origin of this constraint rests in the concept of the *stato di diritto* – the rule of law- which came to replace the state based on feudal privileges. See: Giannini (1986).

[43] De Tocqueville, whose influence on Dicey was evident, expressed his doubts about the development of French administrative law in two respects: the incompatibility of centralisation of command with representative institutions; the existence of a *justice retenue*, by which the conflicts between the administration and the citizens were resolved by the *Conseil d'Etat*, which was only a consultative body of the executive (De Tocqueville 1966).

administrative justice, such as the *Consiglio di Stato* (council of state) and the *Corte dei Conti* (court of accounts). They are separate from the ordinary court system. In addition to its consultative role, the council of state, since 1971, has been the court of appeal of a system of regionally based administrative courts of first instance (*Tribunali Amministrativi Regionali*, or TAR). The court of accounts has a more direct impact on proceduralising the administration. Its control functions are both 'preventive' (giving approval in advance) and *ex post facto*. The court also produces annual reports to Parliament which offer advice not just on legal aspects but also on government policy. This procedural administrative justice has been increasingly supplemented in the 1990s by the intervention of the criminal justice system, with regard to the investigation of corruption (Della Porta 1999a).

The centrality of administrative justice characterises the entire development of administrative law from its inception (Giannini 1970). This development reflects a profoundly Weberian rule that is based on the notion of legitimacy in the form of procedural legality, the distribution of functions by the law (the principle of 'competence'), the administrative hierarchy and the pervasiveness of preventive controls (Weber 1991). These bureaucratic rules were so entrenched in the doctrine of administrative law that it adapted only painfully to the modern welfare state (Giannini 1970). For instance the creation of new ministries, a necessary consequence of the expansion of welfare services, was accepted with scepticism by administrative law scholars, who argued that, according to the Italian Constitution, the number, competencies, portfolios and organisation of departmental ministries must be defined strictly by law (Giannini 1970).

The doctrine of administrative law is influenced by two main traditions. The first one, deriving from a lack of trust in public authority, advocates the centrality of the administrative law judge and his formal control of the legality of administrative procedures (Giannini 1970). Administrative law of this kind is not concerned with public administration as a whole, but with the control of its activities. This is the more liberal aspect of the original doctrine. On the other hand, the focus is less on safeguards against the executive but rather on ensuring the effective provision of public services. In accordance with this second tradition, administrative law extends to all the rules defining the organisation and internal functioning of public administration (Giannini 1990). The coexistence of these two traditions, the liberal and the social-democratic, has been overlooked by the critics of administrative law, who have stressed the dichotomy and conflict between private law, imbued with liberal and market values, and public law, which is the bastion of state authority (Giannini 1970).

The doctrine of administrative law, however, does no longer adequately account for the changes in the nature of the state. This is firstly because the activities of public administration are geared towards the delivery of public services. Thus, the dialectic between public authority and society no longer represents a normative problem. Secondly, administration by departmental ministries has lost the centrality that public law scholars continue to attribute to it. The growth of 'parallel administrations' and the decentralisation do not support their perspective (Dente 2001).

The descriptive inadequacy of the original doctrine of administrative law became more evident in the political context of the centre-left governments of the 1970s, when a new model of governmental activity emerged -- the economic planning

model (*programmazione*). It is difficult to exaggerate the effect of the new planning model on the Italian administrative culture. Dente argues that the economic planning method represented a watershed (Dente 1990a). The most important implication of the use of 'plans' was that administrative law had to reconfigure the problem of political control of the bureaucracy in terms of ensuring effectiveness and coordination. Since economic planning implies policy coordination and centralised decision making,[44] with the creation of new collegial bodies, interministerial committees, and offices within departmental ministries, it presupposes political leadership and control of the bureaucracy. The creation of the national health care system in 1978 is an example of the new method of planning. National and regional health care plans are integrated in a vertical and hierarchical system of administrative planning, for defining the organisational arrangements of health care services.[45] The health care system was, then, to be administratively coordinated by the centre.

The old politicisation of the bureaucracy by the DC slipped during the 1970s into a newer and less controllable *assemblearismo*, as one scholar argues (Di Palma 1980). Trade unions proposed 'a new model of economic policy': they demanded not only representation for labour issues, but also for the management and delivery of public services like housing, health care and education. The new model had to be participatory. By the end of the 1970s the unions had become a privileged negotiating counterpart to government policies at the highest level, with the effect of transforming democratic participation into 'an assembly system for permanent agitation', the so-called *potere assembleare* (Sartori and Ranney 1978).

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[44] As Giannini explains, the adoption of a 'plan', so-called *piano*, has become an inevitable tool in the case of many-years administrative and activity. He emphasises the juridical complexity of drafting an internally coherent system of laws. Planning requires institutional capacity such as centralised administrative units in charge of co-ordination, like the Comitato Interministeriale Programmazione Economica (CIPE), interministerial committee for economic planning. See Giannini (1996).

[45] Law no.833, 23 December 1978, established the Italian National Health Care System. Article 53 deals with the National Health Care Plan, the Piano Sanitario Nazionale.

The effect of the introduction of the economic planning model and democratisation was a doctrinal *revirement* of administrative law (Giannini 1986). If classic administrative law was guided by the need to ensure impartiality of administrative activity and the independence of the administration, to be subject only to Parliament and popular sovereignty, the 'new' administrative law of the 1970s had to concentrate on the problem of political control for facilitating the effective delivery of public services. For the first time, the possibility of direct political appointment of senior civil servants was envisaged. This new condition was introduced by the Giannini Report of 1979.

Despite the challenges of planning and democratisation, administrative law showed a high degree of resilience. On the one hand, the reason for the survival of administrative law as the predominant culture of the Italian administration was the lack of alternative models that could more readily accommodate the new economic and social demands. On the other, the leftist and the trade unions opposition contrasted reforms driven by the rationale of economic efficiency because they contended against a strong executive and coherent technically oriented bureaucracy, in their view a plan of neo-capitalist inspiration (Di Palma 1980). As Di Palma maintains, 'there was leftist opposition to anything smacking of modernisation from the top' (Di Palma 1980).

Whereas the 1970s were characterised by the primacy of politics, the 1990s reforms were marked by the restoration of a more technically oriented administration. The debate about the need to strengthen the administration, however, did not sufficiently take into account that the policy community of reformers had always tended to

choose traditional organisational and cultural models. Challenged by new economic and social forces in the 1970s and again in the 1990s, defenders and supporters of the status quo associated with administrative law have tended to create new bodies (participatory bodies), new acts (participatory acts), and new procedures, without replacing the old with the new and without opening up to alternative perspectives and academic disciplines.

Political Control of the Administration

What distinguishes the Italian reform of the state in the 1990s from reforms introduced in the United Kingdom and USA under Thatcher and Clinton, which were based mostly on economic efficiency and cost considerations, is the political strategy to reintroduce the separation between policy and administrative functions as a way of defeating clientelistic relationships. The purpose of the reform programmes was to reconfigure the dichotomy between politics and administration by adopting new public management arrangements (Dente 1999). Reform programmes[46] have tried to strengthen the managerial autonomy of senior civil servants, by devolving to them the task of defining objectives and identifying required financial resources.[47]

The problem of political control is defined by Weber and the public administration literature that builds upon his work as the question of how the bureaucracy relates to political leadership (Weber 1991; Page 1992). Politicians and political parties are important in preventing bureaucratic dominance (Page 1992). According to Page and Wright, three distinct approaches to political control can be discerned (Wright

[46] Legislative Decree No.748 of 1972, Legislative Decree No.29 of 1993, Legislative Decree No.80 of 1998 and Law No. 145 of 2002.
[47] For a discussion of the reform of the Italian senior civil service, see D'Alberti (1990), D'Alberti (1994), Cerase (1999), Cerase (2000).

and Page 1999). The first approach reflects the normative theory developed in the *ancien regime* of the political neutrality of the civil service. Non-partisanship is a fundamental feature of this type of administration. Despite the fact that empirical evidence does not support the claimed separation between politics and administration, research into public administration in Italy is still culturally bound to the normative question of how to control the bureaucracy so that democratic government can be ensured (D'Alberti 1994). Effectively, it is widely accepted that professional civil servants have an active role in policymaking (Dogan 1975; Page 1992).

The second approach, the 'commanding heights approach', is characterised by senior appointments within national bureaucracies that are subject to direct partisan influence. This is the system predominant in France, Sweden and Germany. Page and Wright argue that it is possible in Europe to detect a trend of political control in this direction (Wright and Page 1999). Taken further, this approach characterises the Austrian and Belgian administrations, where party affiliation is the basis for recruitment and career progression within the administrative elite. In the Italian case, rigid legalism has ensured that senior civil servants are the reluctant guardians of the dichotomy between policy and administration (Cassese 1983). Senior civil servants prefer to avoid overt partisan involvement because this can interfere negatively with the seniority-based promotion systems (Cassese 1983).

On the whole, Italy has opted for political neutrality (Wright and Page 1999). Senior civil servants have traded job security for policy-influence, so that they have a relatively modest influence on policymaking (Cassese 1995b). It is claimed that senior civil servants are appointed on the basis of seniority and ministers rarely

interfere with this internal system (Cassese 1995b). The impartiality of the Italian administration is also sanctioned by the Constitution. Yet, it is tempered by a *cabinet* system of ministerial advisers largely drawn from the civil service.

In the '*parastato*' the reality of impartiality is quite different.[48] Overt politicisation of senior civil servants in non-departmental administration is the rule. The state provided the ruling party of the Christian Democrats with innumerable opportunities to ally itself with important sectors of society through its ability to manage the targeted distribution of resources. The partisan management of the 'parastato' allowed the hegemonic party to control its internal exasperated factionalism by distributing posts (Vassallo 1994). At the local level, local health authorities were subject to party influence in purchasing and hiring decisions. For this reason, local health authorities' management committees proved to be profoundly ineffective institutions (Torchia 1997). They were colonised by political parties, who filled them with people with little managerial skills, but a voracious appetite for the exercise of political patronage (Maino 2001). Thus, there is little tradition of non-partisan public agency management outside the formal ministerial bureaucracy in Italy, where party influence is difficult to eradicate.

How much autonomy, then, does the bureaucracy have in governing itself and its functions independently from political parties? According to La Palombara's analysis of *parentela* [49], the bureaucratic autonomy is limited (La Palombara 1964). During the 1960s bureaucrats tended to be more receptive to the demands of groups that were closely allied to the party in power, the Christian Democrats. Until 1992

[48] The *parastato* refers to the administration beyond the departmental ministries.
[49] *Parentela*, which in Italian means kinship, is the second major pattern of interest-group intermediation with the bureaucracy. It characterises in particular the relationship between a group

the hegemony of the Christian Democrats until 1992 and its parentela groups on bureaucratic recruitment and promotion extended considerably beyond commanding heights and involved administrative levels that are supposed to be staffed strictly on merits and seniority. A group like Catholic Action could remove uncooperative bureaucrats or could have them transferred to an unattractive position (La Palombara 1964). The issue was not whether a party was ready to intervene, but how far it was willing to push for having its particularistic interests adopted.

The ability of a group to utilise the dominant party to make its influence felt in the bureaucracy will also depend on certain salient structural characteristics of the latter. The Italian ministerial bureaucracy has been characterised formally by an extreme organisational centralisation of authority (Rebora 1999; Dente 2001). The director general is at the apex of formal authority and there may be as many as fifteen categories of civil servants between a junior bureaucrat and the Minister. However, while authority is highly centralised, real power is somewhat dispersed. Thus, a considerable amount of *de facto* decentralisation of decision-making exists within a department. The rigidity of the administrative hierarchy increases the discretionary power of the lower-level official who formally would have very little. Thus, lower level officials can have a considerable amount of discretion that makes them the target of group pressures.

The cost to be paid for the partisan penetration of the bureaucracy was that the state remained largely unreformed. The success of party control over interests and factions with blackmailing power relied heavily on keeping institutions as they were: permeable, large and incoherent. Moreover, a crucial factor has contributed to the

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and a hegemonic party. Where parentela exists, interest groups that enjoy special access to institutions can exercise considerable influence over policy.

inertia of the Italian public administration, namely the system of clientelism. This is based on the logic of reciprocal exchange between civil servants, private interests and political parties. It is this particular feature that highlights most the deviation of the Italian public administration from the Weberian ideal type. J. La Palombara, in his seminal work on the structure of interest group relationship with the bureaucracy in Italy (La Palombara 1964), defines *clientela* as the type of access and influence that exists when an interest group succeeds in becoming the natural expression and representative of a given social sector in the eyes of an administrative agency or a ministry. He describes the various branches of the Italian public administration as the feudal holdings of the various interest groups.

Clientelism increased the institutionalised dependency of the administration on information provided by interest groups, aggravating the existing problem of lack of *corps techniques*. However, the technical weakness of the administration was not only the consequence of clientelism but was also a condition favouring its development (Cassese 1992). It was in the area of public works that this deficiency was particularly detrimental. Civil servants would delegate to public work contractors the critical stage of contract definitions, requirements and standards. Accordingly, over the time, private interests would succeed in establishing their 'respectability', which was a function of their power and leverage on the administration (La Palombara 1964).

Another consequence of clientelistic relationships is based on the value-oriented consideration that the administration exists, in part, to help or assist particularistic interests and its objects of regulation. This is a critical issue because it implies that in the clientela relationship something more is at work than merely the need to

regulate. La Palombara suggested that the Ministry of Industry in the 1960s defined its core institutional mission as serving the demands and needs of Italian industrialists rather than society at large. The clientela-induced distorted ethics of public administration is obvious also as regards the delivery of public services.

Although clientelism should not be confused with corruption, the conditions determining them are remarkably similar: technical weakness of the administration, inefficiency of internal control mechanisms, well organised interest groups which enjoy access through the committee system (Cammelli 1980), legislative hypertrophy and lack of simplification, and the process of regionalisation. A certain degree of collusion between politicians, civil servants and private groups had always been endemic. However, in the 1970s the phenomenon of corruption was aggravated and involved local government even more than central administration.

The regionalisation process in the 1970s enhanced clientelism by opening up opportunities to bargain over the allocation of state resources that were transferred from the centre to the periphery. Political parties certainly did not miss the opportunity. In this decade, political parties were becoming institutionalised and started to manage and distribute state resources to their clientele. The administration was not able to become the channel of mediation between the centre and the periphery and to govern the process of regionalisation. This process gave a *de facto* recognition to the role of political parties as distributors of resources and consequently highlighted the relative weakness of central administration. Despite the costs at the national and local level,[50] the clientelistic centre-periphery relations have

[50] S.Tarrow's analysis emphasises the cost of clientelism. The clientelistic system is very expensive to operate because it spends and distributes a lot of resources. Besides encouraging inflation, clientelism also establishes a number of vested interests with veto power when reform programmes are

been essential to the administrative system operating successfully. Local politicians are obliged to become political entrepreneurs with a variety of contacts at different levels and in different bureaucratic organisations.[51] Clientelism is a way of overcoming, through the politics of distribution, the stalemate at the centre and the blockages of the bureaucracy.

The inefficiency of internal control mechanisms represents another propitious condition for the development of clientelism in the public administration. Excessive legalism and formalism has privileged formal control, that is checking the compliance of administrative acts with the legal rules. Thus, legal internal controls have concentrated on procedures and neither on outputs nor performance.[52] The economic cost-benefit analysis was introduced by the Cassese reform only in 1993. Besides formalism, internal controls were often organised and carried out by internal committees made up by partisan appointment. The inefficiency of internal control mechanisms is another case of the incapability of the Italian administration to govern itself independently from the influence of political interests. In 1993, an attempt was made to solve this problem by strengthening the role of the Court of Accounts, which now includes direct control of procedures and careful examination of internal control mechanisms.

To conclude, the Italian state has developed without a strongly positioned and empowered senior civil service, despite a well developed doctrine of administrative

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considered. Clientelism also decreases the legitimacy of institutions among the public. See Tarrow (1977).

[51] Whereas French local officials know exactly where to go for support for their projects, Italian ones have to find their way in the maze of central administration. Moreover, clientelism uses up an enormous amount of energy and political credit in order to gain policy benefits that ought to be routine. As Tarrow (1977) argues, 'political entrepreneurship is the correlative at the individual level of a clientelistic system of policy allocation flowing through the party system'.

[52] Law, legal categories, and most fundamentally, legal controls dominate the culture and training of senior civil servants.

law that has provided a system of shared values and perceptions of the administrative role. The administrative elite's deficit has been supplanted by political parties' control of state key resources to distribute to their clienteles, or of offices that can be filled with their political appointees. It is not surprising that the efforts to reform the public administration came from within the administration rather than being pursued by political elites' strategies. The 'available' state served the interest of political elites in mobilising consensus through occupation of the administration. Against this backdrop of an administrative system that is permeable and incapable of resisting parties' penetration, few reforms achieved concrete results.

The Case of Health Care Reforms

As Paul Pierson suggests, 'hemmed in by popular sensitivities, powerful interests, and economic realities, governments generally find health care to be a cause of political headaches rather than a target for successful retrenchment' (Pierson 1994). In few policy areas has the debate about the reform of public services, influenced by the logic of the market and competition, been as contentious as in health care. Health policy discussion in Europe reflects the clash between the moral imperative of maintaining solidarity and the fiscal one of cost control (Ferrera 1998). In the 1990s efficiency has been the *leitmotiv* of health care reforms around the world (Moran 1998; Marmor and Hacker 1999). Productivity and efficiency imperatives originate from the search for ways of meeting rising health care demands while limiting public expenditure.

The Italian national health care system is no exception to the trend towards marketisation in health care. Despite different meanings attributed by different countries to 'markets', 'competition' and 'private sector' (Ranade 1998), the

underpinning logic of the major Italian health care reforms at the beginning of the 1990s was that market competition would contribute to optimal allocation of resources (Mapelli 1999). As we will see, the Amato government enacted an ambitious programme of health care reforms, strongly inspired by the 1989 Thatcher government's White Paper, 'Working for Patients'. There were three major aspects of change: first, the introduction of the internal market in a predominantly public integrated health care system created in 1978;[53] second, the introduction of general management in hospitals and local health care authorities and the abandonment of participatory and consensual decision-making;[54] third, the devolution of administrative, planning and legislative functions regarding health care policy from the state to regional governments.

This single case study is used as a pre-theoretical exercise, leading to a generalisation to theory rather than to other events. This strategy is what R. Rose calls the 'extroverted case-study'.[55] The purpose of empirically investigating the case study of health care reforms is to explore fully a single case-study, with the existing theories in mind, expecting to elaborate and advance an alternative model of change associated with the reform of the state. Health care is the policy area, compared with other sectors, in which the adoption and implementation of change has gone furthest. It would be empirically tautological to analyse cases of immobilisme in order to conclude that change has not occurred because change was resisted. Those cases

[53] When created in 1978, the national health care system, Servizio Sanitario Nazionale (SSN), was intended to be financed entirely from general taxation. Instead, until the late 1990s the SSN was financed by compulsory employer, employee and self-employed contributions (around 50%), general taxation and borrowing (42%), patient co-payments (4%) and other revenue sources.

[54] An important feature of the pre-92 health care system was 'democratic participation', whereby local health authorities were governed by management committees whose membership was to reflect the representation of political parties in the local government council where the local health authority was located.

[55] With the strategy of the 'extroverted case-study' the researcher has identified an important exception to the prevailing theory, or a case which demonstrates a phenomenon that previously had been excluded from the literature. The single case study, in this context, becomes a pre-theoretical exercise, leading to a general statement about the phenomenon. See: Rose (1991).

would not be critical tests for the proposed theory of dynamic conservatism, which I will develop in Chapter VII.

In addition to this case selection on theoretical grounds, health care is also a good case for methodological reasons. This case allows us to maximise variance by using subnational units from within a single country, that is regional governments in Italy (Yin 1994). Although the major policy episodes of health care reform were pursued by national and centralised programmes, the analysis also includes the regional dimension as implementation was left to regional legislation. Hence, regional governments' legislative implementation of national laws constitutes embedded units of analysis. However, the purpose of this research design is not to conduct a comparative analysis of the outcomes of change in different Italian regions. This would change the nature and objectives of this analysis which remains firmly anchored to the question of the modernisation of the State. I am concerned with regions as far as regional legislation was needed in order to put into effect the national framework programme, and as far as neutralising instruments were introduced or removed at the subnational level.

Another reason why health care is a good case relates to the intrinsic nature of this sector. Health care is at the core of the welfare state. Involving matters of life and death, it is often the site of heated controversy. Because it is also an area of extensive economic activity, representing the largest part of regional budgets, a staggering array of powerful interests compete over reforms. It has a fairly crowded policy arena in which a wide and extremely diversified range of interest groups form policy monopolies (Baumgartner and Jones 1993), traditionally linked to the state by neocorporatist arrangements (Freddi and Bjorkman 1989). Given the high degree of

bias in this policy sector, conflict is a continual latent possibility and is likely to be easily triggered by policies aimed at increasing residualism or removing entitlements (Ferrera 1995).

The introduction of market-type mechanisms to contain health care rising costs and regulate demand had also a great impact on the political system as a whole. Three of these were the more contested issues in the health care policy debate at the beginning of the 1990s: the introduction of high co-payments, the opt-out clause, and the creation of the internal market. These were policy tools aimed at containing cost and redefining entitlements. Co-payment, where people have to pay, has changed the relationship between citizens and the national health care system. It has yielded an increasing degree of selectivity, affecting the perception that citizens have of the state. This instrument of demand regulation has undermined universalism, based on moral solidarity, which has traditionally been an integral part of the Italian political culture. For instance, due to popular resentment the Amato government was forced to abandon the plan to design different layers of users based on income in favour of more politically acceptable age and risk (Ferrera 1995). With the opt-out clause, the government envisaged the exclusion of a large sector of the population from the national health care system. The decree encourages more autonomy from public provision for those[56] who have an income above 20,000 Euros. This was achieved through the opt-out clause by which citizens could voluntarily opt out from the national health care service. However, high-income strata protested against their exclusion from the national health care service[57]. There was no other European state that, at the beginning of the 1990s, had adopted this provision and excluded such a wide section of the population.

[56] In 1992 the population above this level was approximately 15 million.

The internal market belongs to the 'marketisation' category of public management reforms because it does not imply selling public sector assets to private providers (privatisation), but rather 'privatising from within', namely adopting organisational arrangements and management systems tested and developed in market conditions (Le Grand, Bartlett et al. 1998). The logic behind the internal market is to separate strategy, planning and purchasing functions from execution, administration and provision. The internal market transforms the public integrated health care system in three ways: granting hospitals autonomy from local health authorities' planning and management; introducing contractualism and competitive tendering, which are practices outside public law; and mobilising private providers. With respect to the first aspect, an important precondition for the successful implementation of the internal market was to correct the distorting collusion between local health authorities and their public hospitals, which usually received cross subsidies.[58] However, in Italy, health care authorities lacked the capacity to exert leverage against providers' dominance in negotiating service agreements (Zanetta and Casalegno 1999). Second, the policy instrument of 'contracts', which is at the core of the internal market, is not juridically applicable by public law. For this reason, local health authorities became 'hybrid' organisations, namely juridically public bodies but subject to private law. As a government official explained: 'we wanted to introduce a competitive environment, but not competition. We believed that competition would only drain resources away from the public sector. Public hospitals were not ready to compete with private providers'.[59]

[57] Deductibles established for high-income strata were annual charges up to 52 Euros for pharmaceuticals and specialist care, and up to 44 Euros for primary care services.
[58] This raised complaints from the Italian Competition Authority, which in 1998 urged the government to address the issue of unfair competition in health care between private and public providers (Zanetta and Casalegno 1999).
[59] Nicola Falcitelli, Interview with author, Rome, 23 September 2002.

The determination to marketise health care is not only motivated by the priority of cost containment,[60] which certainly triggered the introduction of pro-competitive ideas, but also in part by a deregulatory and neo-liberal ideology. The underpinning philosophy is that when dirigiste regulation of the welfare state is particularly heavy, consisting in imposing constraints on the behaviour of civil servants to limit their discretion and responsibility in order to ensure formal procedures rather than effective results, then public services are necessarily of low quality and inefficient (Amato 2002). G.Amato uses the following analogy to describe the crisis of the state: 'Once there was the sovereign state. It was ungrateful and inefficient, but he was like a prince. Today the prince is without a crown, and even worse he risks exile' (Amato 2002, p.54).

In addition to the introduction of pro-market ideas, another major innovation introduced by the 1992 reform was the transfer of health care competencies from the central state to regional governments. This included granting regional governments policy-making power over the organisation and finances of regional health care systems. Health care became the pioneering sector for a steady stream of administrative reforms to decentralise the Italian state in the 1990s, aimed at reducing the size, resources and scope of the public sector (Meny and Wright 1994). The beginning of the 1990s marked the start of continual commitment to greater autonomy of local government and health care authorities.[61]

[60] Amato moved decisively in tackling Italy's impending financial crisis. The national debt had risen by 10.5% of GDP just in 1992. Sweeping cuts to public spending and an emergency budget were introduced.

[61] Executive decree no. 502/1992, discussed in details in chapter II of this thesis.

The 1992 reform is path breaking with respect to the decentralisation of the state, a process which has been consistently sustained throughout the 1990s. M. Keating, however, argues that regionalisation in the Italian case is merely a manoeuvre by political parties to retain control rather than a real intention to reform the state (Keating 1998). Thus, he argues, Italian regions do not have much scope for independent action, but must work closely with national departments within tightly-defined national sectoral programmes. Keating writes that 'Italian regions have been a disappointment to those who thought they could democratise and transform the state' (Keating 1998).

Throughout the 1970s and 1980s regional government was seen in Italy as a contribution to the administrative and political modernisation of the state. Decentralisation was a strategy to enhance functional efficiency and to diminish the administrative and political burden on the centralised state. Conversely, the significance of the 1992 health care reform rests in the redefinition of regionalisation from merely an administrative and functional process into a political one. Although the process of decentralisation has been a piecemeal transfer of functions from the central administration to its regional counterpart, inhibiting cross-sectoral coordination, the outcome has been the emergence of a new 'decision space', not only functionally but also territorially defined (Sharpe 1993). The 1992 reform of health care breaks with the traditional course of regions being only the outgrowth of functional decentralisation with an elected element, the 'weakest form of regionalism' (Keating 1998).

By analysing the 1992 reform of health care from an administrative reform perspective, rather than its welfare policy implications only, it is not merely an

immediate and budgetary response to conjunctural factors[62]. Contrary to the widely accepted labelling of the reform as a 'public finance measure' (Reviglio 1999; Olla and Pavan 2000), the 1992 reform is a structural change of the state and represents one of the greatest challenges to the administrative tradition. It aims at reducing the scope and the direct leverage of the State. Nicola Falcitelli, Director General of the Ministry of Health from 1992 to 1996, revealed that 'we wanted to privatise everything. Our was not only a measure of financial rigour and austerity, but a structural reform of the health care administration and of the state'.[63] The structural significance of the reform was also publicly admitted by the Prime Minister himself. He presented the reform as the 'privatisation of the health care system'.[64]

Chapter Outline

Following this introductory chapter of the thesis, Chapters II to V analyse empirically the case study of health care reforms in the 1990s in Italy. The time boundaries of the narrative span from September 1992, when the Amato government introduced an omnibus bill in the Italian Parliament to delegate legislative authority to the executive for comprehensive reforms in health care, pension, local finance and civil service, to December 1999, when the then-Minister of Health Care, Rosy Bindi,

[62] Administrative reform had been one of the priorities of the XI th Legislature (1992-94). The need for reform stemmed from:
-financial difficulties: public expenditure had grown faster than taxation. In 1991, public debt was at 103 per cent of GDP, the budget deficit was at 9.9 per cent, and inflation was at 6.9 per cent.
-ethical crisis: corruption and illegal party funding;
-institutional gap: modest performance of public services and political instability; and
-European integration and the Maastricht convergence criteria.

[63] Nicola Falcitelli, Interview with author, Rome, 23 September 2002.

[64] The term 'privatisation ' is used improperly in the Italian debate of the reform of health care with reference to:
-the change of the administrative structure and juridical status of local health care authorities, from public authorities to public firms;
-the introduction of greater flexibility in public sector employment.
'Privatisation' refers also to the limitation of the use of 'law' as an instrument to regulate the state-society relationship.

was replaced in a Cabinet reshuffle, thus irreversibly halting the implementation of her 1999 health care reform, a policy reversal of the earlier 1992 reform episode.

In Chapter II the parliamentary process of enactment of the 1992 reform is analysed to assess how the executive was able to adopt a radical change and push the reform through parliamentary blockages. The empirical data focus on the parliamentary debate to extrapolate the parliamentary majority's degree of cohesion and individual parties' positions with respect to the themes of general management and regionalisation of the health care administration. The mechanisms used by the executive to secure the enactment of the reform are discussed as provisional indicators for the latent difficulties and fragile consensus on an overly ambitious reform programme. The challenge posed by the creation of the new post of general manager to political elites is elicited from the way political elites framed the issue in Parliament. A detailed analysis of the legislative work of parliamentary committees is carried out, as obstacles are built in the law-making process. Empirical data include a considerable high level of legal technicalities and interpretation of legislative clauses, and legislative techniques.

The impact of the state-groups system of intermediation on the consolidation of policy change enacted in 1992 is then assessed. Chapter III studies a second legislative process, that is the amendment of the 1992 Amato reform, according to the rule by which an executive legislative decree can be amended only by a new executive legislative decree, to be politically approved by parliamentary committees. The major difference between these two distinct but interlocked legislative processes is the active role of interest groups in the policy making process and the repoliticisation of juridified issues which leads to the re-emergence of political and

social conflict in 1993. During the process of legislative amendment of the Amato decree in 1993, professional groups were able to influence the final outcome of the process more effectively than with the original 1992 decree, as far as their particularistic requests were concerned. However, in the face of mounting opposition, the government responded to vigorous direct action by deepening commitment to the two major reform themes of the Amato reform, namely the introduction of general management and the regionalisation of health care policymaking. The system of interest mediation is a key contributory factor towards understanding the way in which the original process of reform, triggered by the adoption of radical change, was consolidated rather than halted, against any expectation, through the enactment of a second legislative decree.

Following the discussion of changes associated with administrative reforms in the 1990s at the national level in Chapters I and II, Chapters IV and V go on to consider the regional experiments and instruments put in place to block the emergence of rising general managers. This second empirical part of the thesis relies heavily on data gathered at the regional level because the health care reforms were put into effect there. Chapter IV concentrates on the policy instruments and solutions adopted by three regions, Emilia Romagna, Lombardy and Tuscany, to reassert the primacy of politics over technocracy, while legislatively complying with the reforms of health care, between 1993 and 1999. Empirical data and interviews contribute towards comparing regional differences in the solutions adopted to create opportunities for general managers. Following a discussion of change, the analysis shifts to the reappraisal of the centrality of the role of the mayors in health care policy, which was legally corroborated at the end of the 1990s. After a brief discussion of the 1999 general national framework, we compare the differences across selected regions to

assess the overall degree of departure from the status quo and the real transformation of the relationship between political and administrative elites at the subnational level of government.

Chapter V considers another type of resistance against change, that of the central government and administration against emerging regional elites and their increasingly autonomous role in shaping health care policy in light of the territorial disturbance. The 1999 health care reform episode is also discussed in the context of conserving the traditional public authority tradition of the Italian state in the provision of public services. The chapter does not intend to analyse politics *about* the territory but rather politics about health care issues that are fought *across* territories and different institutional levels of government. Empirical data drawn from the position of the parliamentary opposition, during the debate over the Bindi reform in both chambers of parliament, are particularly revealing of the issues at stake in the recentralisation of health care organisation and planning. A detailed investigation of the legislation itself also contributes to evaluating the instruments used to curb administrative autonomy, such as centralisation of control functions and vertical administrative arrangements. The outcome of this process of neutralising regional autonomous capacity is assessed as a possible indicator of the final outcome, produced at this secondary stage of the process of reform.

Chapter VI draws upon the empirical analysis of policy change in the health care sector in Italy from 1992 to 1999 to assess the relationship between the introduction of private sector management arrangements and regionalisation. The two themes are examined in their interaction and how they reinforce each other. The chapter also highlights the most impressive traits of change in health care, given the existing

blockages, and reflects upon what type of change this represents. This is achieved first by reviewing the main empirical innovations and secondly by applying the existing theories of policy change to the Italian case to assess their usefulness, and their limitations. As regards the theoretical conclusions of the thesis, chapter VII proposes an explanation of how change became possible by focusing on the mechanisms of the process. A novel approach that advances our understanding of the process of policy change under inertial conditions is offered. Dynamic conservatism is an explanation for the most recent pattern of institutional reforms in Italy, conducive to a departure from the status quo. In this final chapter I consider also the external status of the theory, that is the possibility of using the model of dynamic conservatism as a vehicle for further future investigation of other countries.

Policy change in Italy is pursued primarily by the force of law. Were the reforms only announced, but not enacted, or were paradigms embraced by policy makers only as policy 'labels', then change would not create credible threats to the equilibrium. In order to analyse dynamic conservatism at work and in operation, case studies of concrete legislative adoption offer the best explanation. Paradoxically, to study dynamic conservatism in operation one needs to look not at cases of stability but at cases of big change. This design will be persistent throughout the thesis. Otherwise, Hayward's claim that a dynamic conservative resistance is difficult to observe remains indisputable (Hayward 1976).

Conclusions

The Italian state remained largely unreformed for a long period of time and rather impermeable to administrative changes resulting from the committed effort of few enlightened technocrats, whose diagnosis and cure of the Italian malaise has been frequently supported by the most complex and resourceful analyses. Three main explanations for these blockages tend to dominate the academic literature. First, historical accounts of the development pattern of the Italian state have emphasised the social and economic integration function of the central administration, which was the response to the problem of unemployment in the agrarian South. This implied a proprietary and paternalistic conception of the state and the centrality of the question of public sector employment for reforms. Another important factor emerging from historical studies is the deficit of the elite which characterised the development of the Italian administration, lacking an administrative establishment at the top who could guide reforms. Secondly, public law scholars have argued that the implications of the legacy of administrative law go much beyond procedural legalities and include cultural values and civil servants' perception of their role. Administrative law is *the* predominant culture of Italian civil servants, who define their role and functions accordingly, making the acceptance of alternative service-driven paradigms very difficult. Thirdly, the system of *parentela* and *clientela*, characterising the nature of political penetration and control, or better 'occupation', of administrative resources rendered the Italian state 'available' to the distribution of particularistic benefits as a way of mobilising political consensus. The use that parties have made of the administration has significantly constrained the reform of the Italian state.

In the last ten years the reform of the Italian state has been pursued along two main trajectories: the reform of management arrangements so as to provide greater autonomy to senior civil servants, and the decentralisation of administrative, political and, most recently, legislative functions from the centre to subnational levels of government, most noticeably regions. Both directions point to the common goal of running public services with greater efficiency and liberating the bureaucracy from the traditionally high level of partisan control. Thus, the wide programmes of administrative reforms in the 1990s respond mainly to the redefinition of the doctrine and practice of political control of the bureaucracy. However, the historical legacy of inertia and failed attempts would not seem to offer promising prospects. Against the backdrop of political elites and parties eager to distribute state resources to particularistic clienteles, of the senior civil service hardly autonomous to partisan interests, and of an administrative culture imbued with rigid formalism, the radical change embraced by the Amato government in 1992 would not seem to enjoy a brighter future than earlier attempts.

Notwithstanding the legacy of administrative inertia associated with an unreformed state, change in the health care sector was pervasive and had a concrete impact. By the end of the 1990s, not only had the organisation of health care services changed from central to regional control, but the tradition of public authority had been severely challenged by alternative ways of conceptualising and legitimating administrative activities. Local health authorities and hospitals have become self standing public enterprises with managerial freedoms and control of financial and human resources, increasingly open to public scrutiny and citizens' higher demands. General managers of these administrative structures have acquired the highest level of status and discretion in the administrative system. On the political level, regional

governments have firmly established centrality and responsibility for health care policy, which was only ten years ago the bastion of national and centralised health care planning. Regions have gained ample scope for discretion.

The following empirical core of the thesis, Chapters II to V, traces the process of how change has become possible under inertial conditions. As a first step, the next chapter aims to discuss how the Amato government was able to enact through the parliamentary process a radical reform, being debated in parliament since 1989 but always failing to see the light because of the political elites' resistance. The analysis of the law-making process and of the issues associated with health care policy change reveals the commitment and instruments used by the executive. It also highlights the overall resistance by the parties to the introduction of general management.

Chapter II

The 1992 Amato Reform of the Italian National Health Care System

E debbesi considerare come non è cosa più difficile a trattare, né più dubia a riuscire, né più pericolosa a maneggiare, che farsi capo a introdurre nuovi ordini. Perché lo introduttore ha per nimici tutti quelli che delli ordini vecchi fanno bene, e ha tepidi difensori tutti quelli che delli ordini nuovi farebbono bene. * (Machiavelli, Il Principe)

The challenges posed by the 1992 health care reform were not substantially different from those posed by other administrative reforms, being part of a wider political and institutional change. But this reform attempted to go much further than other similar reforms. After a failed attempt in 1989,[1] the Italian Parliament passed a law delegating legislative authority to the Amato executive to carry out structural reforms of the health care administration. The enactment of this reform is particularly impressive, given the small size of the legislative majority enjoyed by the Amato Government and the structural impediments put in the way of ambitious reforms by the parliamentary process. This chapter examines how the executive was able to defeat the parliamentary blockage.

Two major themes run through the 1992 health care reform. The first is the introduction of private-sector management practice, which has led to the creation of the new post of general manager to head the administration of local health care authorities and public hospitals and the 'privatisation' of the public sector

* And it should be realised that taking the initiative in introducing a new form of government is very difficult and dangerous, and unlikely to succeed. The reason is that all those who profit from the old order will be opposed to the innovator, whereas all those who might benefit from the new order are, at best, tepid supporters of him. (N. Machiavelli, Il Principe, Capitolo VI, translation by Russell Price, Cambridge University Press, 1988).

[1] During the Xth legislature (1987-1992), a large number of bills were introduced in Parliament to make the health care services more efficient. See: 'Modifiche alle legge 23 dicembre 1978, no. 833, concernenti alcune strutture del SSN', parliamentary act no. C0245, introduced on 2 February 1987; 'Conversione di decreto legge no. 382 del 25 Novembre 1989 recante disposizioni alla spesa sanitaria e sul ripiano dei disavanzi alla USL', parliamentary act no. S1979 or C4458.

employment contract. The second is the decentralisation of administrative responsibilities to regional levels of government, which has been conducive to a restructuring of relationships between different levels of government, to the emergence of regions as a new political locus of power, and to a fundamental reshaping of local politics. What might at first appear to be an incoherent and fragmentary legislation is much more consistent when the overall purpose of the reform – to reconfigure the division between politics and management in health care administration, traditionally characterised by political patronage and clientelism (Ferraresi 1980; Ferrera and Zincone 1986)– is considered.

In addition to discussing the substantive issues of the 1992 reform and the major policy change it introduced, this chapter explains how it was possible for such a reform to become law, in the light of the institutional constraints of the Italian parliamentary process (Furlong 1990), and the general opposition from political parties. Despite the procedural characteristics of the Italian legislative process, which are conducive to institutional ineffectiveness (Manzella 1991), the fragmentation of the party system, which leads to coalitions that are not cohesive (Pasquino 2002), the historical legacy of policy failure, and the deeply rooted rational-legal model of public administration (Weber 1991; Page 1992), the Amato Government was able to introduce an ambitious reform, with formal parliamentary approval. This reform still forms the core framework of the organisational and managerial arrangements for the national Italian healthcare system. Following analysis of aspects of the 1992 legislation associated with the introduction of general management and regionalisation, and of the challenge posed to the old system of health care management, this chapter examines the parliamentary blockage and how the executive strategy was able to defeat it through the parliamentary process,

including the use of procedures such as the question of confidence.[2] The arguments and positions of political parties in parliament are a primary focus, as they offer an indication of the fragile consensus and the resulting difficulties which would follow during the implementation process.

The Introduction of General Management

The greatest novelty of the 1992 reform was the shift from a politico-representative to a technical-managerial type of health care administration (Rebora 1999). When the Italian national health care system was created in 1978, local health authorities became a fiefdom of local 'notables' who would establish their power base by distributing social benefits. This practice was perpetrated through management committees composed of locally elected officials and trade union representatives (Ferrera 1989; Hine 1993; Maino 2001). Since political parties used these management committees as an arena for party competition in local electoral politics, they have generally opposed the introduction of general management and the creation of a new executive post at the head of local health authorities and public hospitals, claiming that the rise of powerful bureaucrats would undermine supposedly democratic representation. However, as political parties decreased their 'veto power' (Immergut 1992), the fiscal and political crisis of 1992-1994 created propitious conditions for pushing through a ground-breaking reform affecting the public management of health care.

[2] According to Article 116 of the Lower Chamber's Regulations, modified last on 24 September 1997, the Government may call for a *questione di fiducia*, literally question of confidence, on the parliamentary approval of any amendment or article of a government bill. If the question is called on an article of the bill, the final vote is taken after the presentation of all amendments to the article. If the question is approved, all amendments are considered defeated. If the bill is made of one single article, then the Government may call the question on the entire bill. The vote on the question of confidence is a roll-call vote and takes place no earlier than 24 hours after the Government's presentation of the question of confidence. The President of the Chamber gives the right of speech to only one Member of Parliament per parliamentary group.

The Political and Administrative Context in 1992

The political context in which the healthcare reform was introduced was marked by a severe delegitimisation of the political system, due to widespread corruption scandals (Della Porta 1993). The context was an 'ethical and moral crisis of the state' (Della Cananea 1996). Voters were discontented with the excessive power of political parties and the ineffectiveness of the party system (Pasquino and McCarthy 1992). In response, the Amato and Ciampi Governments were determined to close the distance between the administration and the citizens. Economically, there was a severe financial crisis, with a soaring budget deficit as its most evident aspect.[3] At the same time, the Government decided to commit Italy to European Monetary Union. The need to meet the Maastricht convergence criteria and the resulting pressure on public expenditure was one of the key factors that revealed the need for budget cuts and geared administrative reform in that direction (Ciampi 1996). According to Prime Minister G. Amato, who had been directly sponsoring health care policy change, the 1992 reform represented 'the reform of the reforms', consisting of a departure from politicised management of health care and lack of financial discipline.[4]

[3] The public debt amounted to 102.5% of the country's GDP in 1992, in contrast with the 60% convergence criteria set out by the EU Maastricht Treaty (Article 109J). The budget deficit was 10.7% against the Maastricht requirement of 3%. Moreover, the lira came under strain and was devalued by 7% in September 1992. For an account of the financial context and the impact of the Maastricht financial convergence criteria on Italy see Monti (1992).

[4] In its 1991 Annual Report of the State, the Court of Accounts launched an urgent invitation to the Government and Parliament to address the very serious mismanagement of local health care authorities and their alarming budget deficit. Despite 3 billion Euros increase in the size of the 1990 national health care fund (32 billion Euros), health care authorities had accumulated a total budget deficit of 6 billion Euros. Personnel costs had increased by 16% from 1990, health care procurement by 11%, and public resource to finance private providers by 10%. (Parliamentary Act, XI Legislature, Doc. XIII, no.2-quinquies).

The April 1992 general election signalled a noticeable decline of established parties. Although the electoral support for the Christian Democrats, the largest party of the government coalition in the post-war period, had been slowly eroding since 1983, it was not until 1992 that the party achieved the lowest support ever by losing as much as 4.6 per cent of the vote.[5] The Socialist Party lost 0.7 per cent of the vote. The Northern League's strong showing was at the expense of these two parties.[6] This newly formed party was the beneficiary of the people's disenchantment with the party system. The local elections in September and December 1992 consolidated the decline of the Christian Democrats and the Socialist Party and the breakthrough of the Northern League (Leonardi and Kovacs 1993). Despite the electoral shift, the results did not deliver a different government from the old four-party coalition, so-called *quadripartito*, which consisted of the Christian Democrats, the Socialists, the Liberals and the Social Democrats. The *quadripartito* had a bare majority of 15 seats in the Lower Chamber and five in the Senate.[7] Giuliano Amato was appointed leader of the coalition for his economic background and expertise on institutional reforms. He was then vice-secretary of the Socialist Party.

The narrowness of Amato's majority constituted a paramount obstacle to gaining parliamentary approval of the 1992 health care reform. It is clear that such a coalition government, based on 'instrumental goals', such as office seeking (Laver and Schofield 1990)[8], would encounter legislative paralysis and run a high risk of defeat. But the risk posed by the Northern League to the traditional parties made the potential political costs of bringing down the Amato Government higher than usual.

[5] 'Il terremoto elettorale', *Il Sole 24 Ore*, 8 April 1992.
[6] 'L'effetto Lega sprona i partiti', *Mondo Economico*, 25 April 1992.
[7] For the 1992 upheaval see: Pasquino and McCarthy (1992); Cotta and Isernia (1996); Fabbrini (2000).
[8] In the absence of a workable parliamentary majority for any individual party, government in Italy has invariably been based on coalitions.

This is why it became slightly more realistic to expect that such a radical reform could be pushed through the parliamentary process.

On 23 December 1992, after the formal approval of the parliamentary committees, in the middle of unrest and threats to bring the provision of health care services to a complete halt by medical staff,[9] the Council of Ministers finally issued the 'legislative decree of the discord'.[10] The vehement protest[11] and unrest of many professional associations and trade unions[12] did not make for optimism about the chances of the reform being implemented smoothly. Nevertheless, the Amato Government exhibited remarkable determination and policy leadership throughout the legislative process. In particular, the Government showed the greatest degree of determination in abolishing the executive boards of public hospitals and local health care authorities, despite the vast opposition of the majority of parties involved in the policy making process.[13]

[9] 'In trentamila hanno manifestato ieri a Roma per protestare contro la riforma della Sanità, il giorno della piazza', *Il Sole 24 Ore*, 17 December 1992.
[10] G. Amato in *Il Sole 24 Ore*, 22 December 1992.
[11] These were the most contested issues in the health care policy debate at the beginning of the 1990s: the introduction of high co-payments, the opting out clause, and the creation of the internal market. These were policy tools aimed at containing cost and redefining entitlements. Co-payment has changed the relationship between citizens and the national health care system. It has yielded an increasing degree of selectivity affecting the people's perception of the state. This instrument of demand regulation has undermined universalism. Yet, due to popular resentment, the weak coalition government was also forced to abandon the plan to design different layers of users based on income in favour of the more politically acceptable age and risk. See Donatini and Rico (2001). For an institutionalist discussion of the transformation of the welfare system in Italy see Ferrera (1998) and Ferrera (1995).
[12] Chapter III analyses the societal conflict and influence of interest groups.
[13] The executive board is retained in both the Senate and Lower Chamber's legislative proposals.

Managerial Autonomy and the Creation of a New Post: the Direttore Generale

The reform embraces private sector managerialism in order to debureaucratise and depoliticise the health care administration. One of the deficiencies of the 1978 law[14] was the creation of a health care system which did not give clearly defined responsibilities to individual managers (Borgonovi 1988). The preferred decision-making process was *ad hoc* collegial co-ordination. Article 3 of the 1992 decree creates the post of *direttore generale*, literally general manager, of local health care authorities and public hospitals. The Minister of Health describes the introduction of general management in this way: 'Public hospitals and local health care authorities will become public firms. It will be possible to identify a person responsible for outputs. Management committees will disappear, so will all executive boards made up of politicians. Finally local health care authorities and public hospitals will have a *direttore generale* who is not involved in politics.'[15]

The review of management arrangements had been debated since the introduction of law no. 111/1991, which first created the new post of *amministratore straordinario*, or special manager. This signalled the initial challenge to collegial management practice by introducing single executive posts. In addition to the *amministratore straordinario*, the 1991 law established an executive board invested with policy

[14] Difficulties and poor administrative performance emerged immediately after the creation of the National Health Care Service in 1978. The 1978 reform was a response to the clientelistic system of health care of the 1960s and 1970s, based on 100 health care funds with huge indebtedness. See Mapelli (1999). Law no.833 of 1978 offers universal access and democratic participation to all citizens. The reform is also the expression of the participatory culture supported by the unions and the Communist Party at the time. The law was passed by the National Solidarity Coalition which included Communists in government for the first time. The creation of the national health care system was concurrent with regional reforms. Yet law no.833 was not clear about the division of responsibilities between different levels of government, especially between municipal and regional ones.

[15] F. De Lorenzo in *La Stampa*, 19 October 1992.

functions[16] and an accounting committee for internal auditing. Departing from past practice, the 1992 decree eliminated the executive board and all the residual mechanisms for collegial decision-making.[17] It was claimed that the Government's proposal to concentrate all management functions in one single post would improve the efficiency of decision-making by reducing the democratic representation of local interests, and by diminishing the political control of local politicians over managers (Borgonovi 1988; Rebora 1999). Municipal councillors, trade unions and medical representatives made up the management committees in order to represent the demands and interests of the local community. But this wide representation of local interests compromised the efficiency of management and decisional mechanisms (Zanetta and Casalegno 1999).

In order to give managerial discretion to the *direttore generale*, two preconditions were introduced: the 'privatisation' of the director's employment contract[18] and the introduction of the *aziendalizzazione*, literally enterprise formula, the transformation of local health care authorities into 'public enterprises', independent from the municipal administration. With regard to the first precondition, the 'privatisation of public sector employment contract',[19] the range of powers granted by a private

[16] Executive board responsibilities include: general policy guidelines, approval of the budget and of the closed budget, oversight of administrative activities, division of local health care authorities in districts (law no.111 and law no. 412 of 1991).

[17] An executive board of five members appointed by the local councils was included in the delegating bill proposed by the Government. The Senate maintained this provision. But in the final draft of the executive decree no.502/1992 presented to the parliamentary committees the executive board is abolished and the *direttore generale* remains the only decision-making authority of the local health care authorities.

[18] The phrase 'privatisation of public sector employment contracts' is used in the context of Italian administrative reforms to indicate the change of jurisdiction from public to civil law. This includes the possibility of having fixed term contracts, or dismissing staff more easily or measuring results and performance.

[19] Article 2 of the delegating law no. 421, 23 October 1992, is devoted entirely to the reform of public sector employment and civil service. It is stated that the purpose of the reform of public employment is to 'increase the efficiency of the administration to European standards, rationalise personnel costs, and slowly integrate public and private law'. This reform is not as radical as the health care reform. There is no explicit reference to the possibility of using fixed term contracts for other sectors, or

contract[20] is wider than the more limited ones of public employment. For instance, administrative decisions by senior civil servants can always be overturned by any elected official (Papadia 1993). Although general managers of local health care authorities were to be employed with a fixed term contract, under civil law, this new type of contractual hybrid raised some issues of incompatibility with public law. For instance, some jurists have highlighted the incompatibility of being appointed by an administrative act while being responsible for job specifications set out in a private contract.[21]

Although the objective of the 'privatisation' of the employment contract[22] was to increase managerial discretion and responsibilities, the appointment procedure appeared to weaken the autonomy of the *direttore generale*, who depended on the regional executive for the offer and renewal of his their fixed term contract, by means of a relationship of trust.[23] Luciano Azzolini, Under-Secretary of Health from 1992-1993, admits that 'the debate about the appointment procedure of the *direttore generale* turned into a quarrel'.[24] The parliamentary debate reveals the concern of some MPs about what appears to be a great risk and perhaps an incentive for a new

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flexibility in hiring, or performance related pay. Access to all managerial positions remains firmly anchored in public competition. The health care reform seems to go further with regard to the highest level of medical managerial positions. Article 15 of the legislative decree regulates the functions and access to managerial positions for medical staff. Managerial levels are reduced from three to two, dropping the position of 'assistant doctors'. The highest level of doctors is appointed on the basis of a curriculum vitae and an interview by a committee chaired by the director general of the local health care authority. Unlike all the senior positions in other sectors, for this highest category of doctors access is not through public competition.

[20] Private sector contracts are regulated by the Civil Code, Volume V, Title II, Part 1, Sections II and III.

[21] The incompatibility is between the method of appointment, by an administrative act, and the employment contract regulated by private law. Since the appointment occurs through an administrative act, the content of the contract cannot be agreed between the two parties, as it would be the case in the private sector. The content of any contract for which an appointment is made is decided by a ministerial administrative act, upon the proposal of the Minister of Health. See: Papadia (1993).

[22] A.Tomassini, interview with author, Rome, 25 July 2002.

[23] Carlo Lucchina, interview with author, Varese, 12 September 2001.

[24] Luciano Azzolini, interview with author, Rome, 19 September 2002.

type of subordination of the administration. One MP expresses his fear in relation to this: 'How can we guarantee the autonomy of senior civil servants? Not with private contracts, I think. The 1980s scandals of corruption prove that we need a bureaucracy which is recruited according to its merits and not partisan appointments. The bureaucracy must be proud of serving the state and needs to be autonomous, loyal only to the laws of the Republic, and an effective counterweight to the power of political parties, which will end up controlling directly appointed public managers.'[25]

The 1992 decree opted for the so-called *intuitu personae* method of appointment.[26] The President of the Region appoints the *direttore generale* by choosing from a national list of candidates drawn by an *ad hoc* committee of experts and senior civil servants at the Ministry of Health.[27] The decree does not specify the conditions for inclusion on the list. Alternative proposals for the appointment included a regional rather than national list of candidates, a ranking system, a public competition system, appointment by a committee made of doctors from the competent local health authority, and contracting out the recruitment process to private headhunting firms. Even the latter option, arguably the most depoliticised, invites the scepticism of Antonio Tomassini, current President of the Health Care Committee in the Senate, who is convinced that: 'in Lombardy they use head-hunters to recruit directors. I think this is a good idea that helps meritocracy. In truth, political control is still possible though.'[28]

The second precondition for bringing general management into effect is the establishment of the 'enterprise formula', the change in the juridical status of local

[25] Mr Bertoli, DC, Constitutional Affairs Committee Meeting, Lower Chamber, 25 September 1992.
[26] Article 3 sections 6 and 9 and Article 4 Section 1 of Executive Decree no. 502/1992.
[27] Article 3 section 10 of Executive Decree no. 502/1992.
[28] Antonio Tomassini, interview with author, Rome, 25 July 2002.

health care authorities and public hospitals from public bodies to public firms.[29] The 1992 reform granted all local health care authorities and selected public hospitals juridical autonomy. They were given organisational, administrative, and accounting discretion from municipal administration.[30] The enterprise formula aims to shift the health care administration from a rigidly legalistic to a managerial one, moving away from formal controls, and introducing efficiency criteria. Public firms plan their own activities according to local demands, allocate their budget without municipal participation, and establish rigid accounting systems.

The significance of the introduction of the enterprise formula does not rest only in its juridical implications, but also in its underpinning model, characterised by a view of public administration based on the private sector.[31] The paternalistic state (Cassese 2001), from which citizens derive their social rights, such as health care,[32] is now challenged by the process of 'customerisation' (Self 1993). The introduction of a new system of public management in health care inevitably led to the redefinition of the relationship between citizens and the administration by transforming them into 'clients'. This entails a radical change in the administrative culture of civil servants, from a self-referential to a public service one (Pipan 1995).

To summarise, the central aspect of management reform of the health care sector is the replacement of management committees with a single executive post covered by

[29] Article 3 Section 1 of Executive Decree no. 502/1992. The Italian term is *azienda con personalità giuridica*, literally 'firm with juridical personality'. According to public law, a public body can only exist as an autonomous firm with respect to its economic and financial autonomy, but not with respect to its juridical autonomy. Thus, a public firm is constrained by the principles of legality of acts, impartiality and good administration.

[30] Article 6 of Law no.111/1991 anticipated the change established by the Executive Decree no. 502/1992.

[31] See Chapter I for discussion of new public management ideas.

[32] Article 32 of Italian Constitution: 'The Republic safeguards health as a basic right of the individual and as an interest of the community, and grants free medical assistance to the indigent'.

a high status and powerful general manager. The representation of local interests was sacrificed in favour of the concentration of executive power into one post. This was claimed to speed up decision-making procedures and to ensure greater transparency, as only one person was responsible and accountable for performance. Thus, the general manager was granted considerable discretion and managerial autonomy by the legislation. However, there was some scepticism regarding the system of appointment. The political trust relationship established between the manager and the regional executive caused some concern about the possibility of renewed politicisation (Endrici 2001). The departure from the traditional practice of political control depends on the commitment of regional executives and leaders to a reformed health care system, which will be discussed later. This is facilitated by the new role played by the regions in providing, organising and financing health care services.

The Regionalisation of Health Care Policy: from Administrative to Political Process

The regionalisation of health care – that is the transfer of administrative competencies to regional governments – is a remarkable programme to reshape the state.[33] Article 2 of legislative decree no. 502/1992 grants regions authority to plan, organise, finance and deliver health care services. Previously, health care was entirely the responsibility of the municipal administration and the Ministry of Health. Although the involvement of regions in this sector was not a novelty, as it is sanctioned by the Constitution and law no. 833/1978, the aim of the 1992 reform is

[33] Analysis of the regionalisation of health care reflects the focus of this thesis on the implications for the modernisation of the Italian state. The purpose of regional reforms in Italy was to modernise and transform the state. Regional governments were a means of removing patronage and clientelism from the local administration.

to activate the formal powers of regional government in health care. This process entails tighter regional control over local health authorities.[34]

The Government's plan was to transfer administrative and financial responsibilities to the regions, at the expense of municipalities and provinces. This strategy was pursued in two different ways. First, administratively, by establishing regional control over local health care authorities and public hospitals.[35] In the executive decree local health care authorities become 'public bodies of regions', that must re-draw their territorial boundaries according to the area of provinces.[36] Secondly, politically, by investing the directly elected President of the Region with the power to appoint all general managers of local health care authorities.[37]

Interviews[38] have suggested that managers are indeed 'political' appointees.[39] One interviewee offered this picture: 'the regional government wants to control the general managers because in this way they can manipulate the appointment of the heads of hospital divisions and increase their political legitimacy. Regionalisation is a way to mobilise political consent.'[40] Investing regional governments with some of the mechanisms of political appointment suggests that regionalisation was something more ambitious than merely a functional decentralisation.

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[34] Article 3 section 5 of the Executive Decree no. 502/1992 establishes that 'regions are responsible for the organisation and financing of local health authorities'.
[35] Article 2 of Executive Decree no. 502 establishes the regional competencies.
[36] Article 3.5 Executive Decree no. 502/1992.
[37] Article 3.4 Executive Decree no. 502/1992.
[38] Renato Botti, interview with author, Milan, 21 June 2001, 24 July 2003; Gianni Giorgi, interview with author, Milan, 24 July 2003.
[39] 'Political appointees' refers to the practice of 'trust' and personalised appointments, which goes beyond partisan criteria. For a discussion of the tendency to 'personalised' appointments in the administration, see Wright and E. C. Page (1999).
[40] Rosy Bindi, interview with author, Oxford, 25 October 2002.

In fulfilling the delegating law, the executive decree creates the conditions for the regional government to become a space for political decision making.[41] The regional *assessore* becomes the political leader of a complex network of regional, provincial and municipal health care authorities. The regional *assessore* of health care is the regional minister, who is a member of the regional council, directly appointed by the president of the regional *Giunta*, which is the executive. It is the regional minister's responsibility to propose the regional reorganisation of health care services and health care plan to the regional council, as well as to distribute financial resources among local authorities, define the accounting and financing procedures, authorise purchasing, and negotiate contracts of public procurement.

One of the major logical fallacies of law no. 833/1978 was the definition of local health care authorities according to their territorial area rather than their functions: they are defined as 'the aggregation of all health care offices, including the municipal administrations, over a particular territory'.[42] The division of responsibilities between different subnational levels of government is unclear in the 1992 reform and is likely to become an obstacle during the implementation of the decree, especially considering that communes fear the closer control of regions more than they do the central state.[43] The decree provision on territorial mergers exacerbates intergovernmental conflict, as Chapter IV shows. The decree envisages the merger of local health care authorities and public hospitals by redrawing their territorial

[41] L. J. Sharpe defines the *meso* as a 'decision space' rather than a level of government. This definition is useful in bridging the traditionally separated functional and territorial definition of the region. See Sharpe (1993).
[42] Articles 10 and 15 of Law no. 833/1978.
[43] S. Cassese suggests that by the end of the 1990s municipalities had started to strengthen their links with the central administration to bypass regional control. See Cassese (2001).

boundaries.[44] The reduction was from 659 to 228 local health care authorities, each including approximately 400,000 to 600,000 inhabitants.[45]

In addition to decentralising administrative competencies and granting regions new political opportunities, regionalisation was designed to make central planning more efficient. Planning was to remain the predominant style of policy-making. The 1992 decree establishes that the regional government should define the organisation of health care services with a regional health care plan.[46] However, regional planning was the logical extension of national planning (Keating 1998). The national health care plan during the 1980s had always been nothing more than a list of broad policy objectives. 'It was a book of dreams', as one interviewee describes it.[47] In order to avoid this shortcoming, the decree established that the national health care plan should contain specific policy priorities, a clear definition of the uniform levels of care, thematic priorities in biomedical research, and a clear indication of personnel training policies.[48] Notwithstanding, planning continues to isolate regional bureaucrats from the managers of health care authorities because it is a highly political function reserved exclusively for administrative and political elites (Ricciarelli 1992). Planning reinforces the division between policy and management and the isolation of operational concerns from policy making.

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[44] Article 3 section 5 of Executive Decree no.502/1992 establishes that regions must reduce the number of local health care authorities and redraw territorial boundaries so that the area covered by a local health care authority coincides with that of a province.
[45] Article 3 section 5 and article 4 section 1 of Executive Decree no.502/1992.
[46] By the end of 1992 only 12 regions had adopted a regional health care plan. Among the reasons for the incredible delay in drafting regional health care plans is the tension between central administration and regional governments. The central administration was using a huge number of 'administrative acts of co-ordination and policy' to regulate health care (*atti di indirizzo e coordinamento*). For more details see Maino (2001).
[47] A. Tomassini, interview with author, Rome, 25 July 2002.
[48] Article 1 of Executive Decree no. 502/1992.

The decentralisation of administrative competencies was accompanied by new financial responsibilities for the regions, and this part of the reform raised the greatest controversy among regions.[49] The executive decree indicated that the national health care plan should establish the minimum standard levels of health care provided by each region. The central and northern regions were already providing services above these levels of care and did not want to see their share of the national funds reduced.[50] The decree established that the regions had to pay for everything that was not financed by the *per capita* allowance transferred to them.[51] The 1992 decree also placed the burden of financing the budget deficits of local heath care authorities and public hospitals entirely on regional governments, where this was previously the responsibility of the central state.[52] This is a huge financial burden.[53] With this provision, the decree aimed to make regional governments more financially responsible for health care expenditure in order to prevent chronic overspending of centrally set budgets. In addition to financing local health authorities' budget deficits, regions must pay up to 80 per cent of the total costs of public hospitals with their share of the national fund transferred from the centre.[54] But the 1992 reform, for the first time, gave regions their own resources.[55] The reform also established that compulsory health contributions should be assigned to the region of residence of insurees. This was an important concession of the state to the regions and a first

[49] Chapter III considers in part the institutional response of regional governments and their appeal to the Italian Constitutional Court.
[50] Social Affairs Committee, Lower Chamber, 15 December 1992.
[51] The decree established that compulsory health care contributions were assigned to the region of residence of medical insurees. The region's entitlement was equal to the gross entitlement (per capita allowance) minus revenues from compulsory contributions.
[52] The Constitutional Court declared unconstitutional the transfer of the entire financial responsibility to finance budget deficits to regional governments, suggesting instead a gradual implementation of this change. (Constitutional Court's Decision no. 355 of 1993).
[53] The annual aggregate deficit averaged 20% of the expenditure ceilings in 1990. See: 'Relazione sulla spesa sanitaria', Doc. XXVII, no. 3, Parliamentary Act, Lower Chamber, December 1992.
[54] Article 4 Section 7 of the Executive Decree no. 502/1992.
[55] Article 13 of the Executive Decree no. 502/1992.

move towards granting them some fiscal autonomy, albeit limited, in 1992.[56] A recent decree-law no. 347/2001 has launched the process of 'fiscal federalism' in health care.[57] It gives regions the power to raise taxes and introduce co-payments for pharmaceuticals.[58]

The Amato Government was criticised for what appeared to many politicians to be a 'centralising' reform.[59] The recovery of the national health care plan,[60] the creation of national candidates lists,[61] the centrally set minimum standards of care and entitlement,[62] suggest that central government intended to keep a strong hold on planning and co-ordination. One interviewee said: 'as the Amato Government was in favour of regionalisation, it was also defining the rules and conditions of *how* to do it'.[63] The parliamentary debate of regionalisation is thus characterised by severe criticism of the Government's 'centralising' approach.[64] The Democrats of the Left are particularly critical. The party accuses the Government of 'disguised' regionalisation for what, in their opinion, is only a transfer of the burden of budget deficits unaccompanied by the necessary financial resources.[65] For instance, the party points to the legislative prescriptions by which regions can redraw territorial

[56] Executive decree no.56 of 2000 establishes that from 2001 the financing of the health care system will no longer be based on the transfer of central grants. Regions are given a pre-established share of revenues raised in their jurisdictions from value-added tax, individual income tax and fuel tax.
[57] Decree Law no. 347, converted into law and enacted by Parliament on 15 November 2001. See 'Sanità, le spese passano alle Regioni', *Il Sole 24 Ore*, 16 November 2001; 'Cura dimagrante per la spesa sanitaria', *Il Sole 24 Ore*, 5 November 2001.
[58] 'Sanità, vertice da Tremonti. No dei sindacati ai ticket: è come aumentare le tasse', *La Repubblica*,17 June 2002.
[59] Formal Opinion, Constitutional Affairs Committee, Lower Chamber, 17 December 1992. The majority spokesman, Mori, was also critical of the centralisation (Social Affairs Committee, Lower Chamber, 10 December 1992).
[60] Article 1 of Executive Decree no. 502/1992.
[61] Article 3 of Executive Decree no. 502/1992.
[62] Article 11 of Executive Decree no. 502/1992.
[63] L. Azzolini, interview with author, Rome, 19 September 2002.
[64] See plenary meetings of Lower Chamber on 7, 8, 9 October 1992, when discussion was focused on the delegating law no. 412 enacted on 23 October 1992. For a comprehensive and complete collection of parliamentary acts regarding the 1992 reform of health care, see 'Delega in materia di sanità, pubblico impiego, previdenza e finanza territoriale. Lavori preparatori alla Camera dei Deputati'. Rome, Camera dei Deputati, 1992.
[65] Trupia Abate (PDS), Lower Chamber, plenary meeting, 7 October 1992.

boundaries of local health care authorities only according to national criteria.[66] The creation and maintenance of a national, rather than a regional, list of candidates, suitable for appointment as managers of local heath care authorities, confirms tight central control.[67]

But zealous parliamentary rhetoric in favour of regionalisation has not been substantiated by legislative decisions. Most parties in Parliament declare that they support the regionalisation of health care, with the Democrats of the Left being the most enthusiastic advocates.[68] But the Lower Chamber put a maximum ceiling on regional own resources, amending the Senate's text which was more inclined to grant regions fiscal autonomy.[69] The regionalisation rhetoric appeared to be motivated more by the need to provide an urgent political response to the electoral success of the Northern League in 1992, and the strong fear that the League could eventually join a new government.[70]

In addition to the discrepancy between the publicly held support for greater regionalisation and the legislative decisions to retain central involvement, political support for the new regional level of government is contradicted by the resentment felt for the lost powers of municipal and provincial governments.[71] The opinion expressed by the Constitutional Affairs Committee in the Lower House confirms parliamentary criticism of the Government for not pursuing regionalisation as established by the delegating law.[72] In particular, the Committee calls for greater

[66] Battaglia (PDS), Lower Chamber, plenary meeting, 7 October 1992.
[67] Battaglia (PDS), Lower Chamber, plenary meeting, 7 October 1992.
[68] Finocchiaro, PDS, Lower Chamber, plenary meeting, 7 October 1992.
[69] Saretta (DC), Lower Chamber, plenary meeting, 9 October 1992.
[70] Occhetto and D'Alema, PDS, Lower Chamber, plenary meeting, 9 October 1992.
[71] Ciaffi (DC), President of Constitutional Affairs Committee, Lower Chamber, 29 September 1992.
[72] Formal opinion of the Constitutional Affairs Committee, Lower Chamber, on the draft legislative decree, 17 December 1992.

respect for articles 117 and 118 of the Italian Constitution and suggests that the heavily centralising approach of the decree be reconsidered. But the Committee's opinion condemns disrespect for the delegating law, which defined local health care authorities as 'local public firms',[73] whereas the executive decree defined them as 'instrumental public bodies of the regions'.[74] The Committee's argument for criticising the 'centralising' government approach also contradicts the public rhetoric of support for regions when it calls for more participation by elected officials in the policy making process of local health care authorities. It is clear that democratic representation is best sought at local rather than regional level. Also the Social Affairs Committee's opinion on the draft decree emphasises the need for mayors to retain centrality in the policy making.[75] Some MPs suggest that regions should have a planning role, but not managerial or organisational competencies, which should be left to municipal governments.[76]

Had parties in Parliament been genuinely in favour of regionalisation, as they publicly claimed,[77] they would not have voted against amendments to propose that regions be granted full legislative and administrative functions not reserved for the state, to create a new institution at regional level for the policy co-ordination of health care, and to give regions exclusive responsibility for defining the territorial boundaries of local health care authorities or selecting public hospitals to be granted

[73] Article 15 of Law no. 833/1978 established that local health care authorities were 'public bodies of the municipalities' and Article 10 of Law no. 421/1992 (delegating law) establishes that they are 'public firms'.
[74] Article 3 Section 1 of Executive Decree no. 502/1992.
[75] Formal opinion, Social Affairs Committee, Lower Chamber, 17 December 1992.
[76] Ciaffi (DC), President of Constitutional Affairs Committee, Lower Chamber, 29 September 1992.
[77] For the position of the parties, see the parliamentary debate at the plenary meetings (note 63). Plenary debate is less technical than that in committees, giving scope to political rhetoric and overall partisan arguments. For example, for the position of the Christian Democrats, see the speeches by Iodice, for the PDS see D'Alema, Finocchiaro, Trupia Abate, for the Communists see Sestero Giannotti, for the Greens see Bettin and Pecoraro Scanio, for the Northern League see Formentini, for the extreme right (MSI), see Gasparri, for the Socialists see Renzulli, for the Republicans see Pannella.

'enterprise' status.[78] The many contradictions and incoherencies so far disclosed make the support of political parties for the regionalisation process unconvincing. Parties, in general, lack commitment to reform of the state that would greatly challenge the political power base of clientelistic ties between bureaucrats and local politicians, by dismantling management committees and marginalising mayors and municipalities in favour of a new level of government (Maino 2001).

As is shown by analysis of the main issues associated with the introduction of general management, the second most important reform theme, there were problems of implementation at the regional level, such as limited financial autonomy. The legacy of failure in the emerging regions dating from the 1970s, when they were created, did not augur well for the transfer of administrative responsibilities from the central to the regional administration. But the organisational opportunities offered by giving responsibility for local health care authorities to regions, and taking it away from municipalities and mayors, while creating geographically vast authorities to serve the territory of the province, provide institutional incentives for increasing regional capacity. The regional level of government has been entrusted with considerable scope for influence in health care policy making, at the administrative level and as an autonomous political entity, as has been highlighted, especially with regard to the appointment of general managers directly responsible to the presidents of the regions or to the regional ministers of health. Parliamentary criticism of the Amato programme of regionalisation of health care as excessively centralising does not seem credible, because legislative amendments that would have enhanced

[78] Social Affairs Committee, Lower Chamber, meeting on 17 December 1992 for final opinion on the draft legislative decree and final voting. The result of voting was: Christian Democracy and Socialists (in favour), Northern League (against), and all other parties gave a vote of abstention (Social Democrats, Democratic Party of the Left, Communists, Republicans, Extreme Right, Greens, Network Party).

regionalisation were neither approved nor supported by the same parties that labelled the reform as 'centralising'.

The Challenge to Political Parties and their Opposition to the Reform

This section addresses the problem of parliamentary blockage of the executive decisions and strategies outlined earlier. This derives from partisan opposition on substantive issues and procedural constraints associated with the Italian legislative process. An analysis of parties' positions during parliamentary debate of the 1992 reform reveals the issues of contention, especially the challenge to local politics. After discussion of the parties' interests in maintaining the *status quo*, procedural constraints related to the legislative process of the Italian parliament are briefly examined. In 1992 the legislative majority was the governing one in the sense that the executive had difficulties in managing party discipline in Parliament.[79] Consequently, it is not surprising that the executive could not easily secure parliamentary support. The Amato Government was able to secure parliamentary support by the use of the question of confidence, an instrument which alters the relationship between the executive and legislature and that merits special attention.

Parties' Positions in Parliament

With regards to specific parties' positions, the parliamentary debate suggests that the Christian Democracy, the largest party in the majority, was against the abolition of management committees and complained about the marginal role played by the

[79] For a discussion of the difference between the governing and legislative majority and the changing relationship between majority and opposition in the Italian parliament see Lippolis (2001).

mayor and municipal administration under the new system.[80] Its resistance resulted in the provision of an 'executive board' in the delegating law,[81] which the Government later abolished when issuing the final executive decree. One Christian Democrat MP argued: 'we need to avoid the director of the local health care unit or public hospital becoming a powerful regional bureaucrat. We cannot think of a national health care system without politics. We must all agree that the director does not enjoy any democratic accountability. For this reason, only the mayor must be responsible for health care policy.'[82]

The party was not solidly positioned against the enterprise formula, however. The introduction of this formula, namely the transformation of local health authorities into 'public enterprises', was a divisive political issue within the Christian Democracy (DC). The majority spokesman represented the faction of the party that seemed more inclined to support the Government's plan to drive reforms of public services by the efficiency rationale.[83] Another MP supported this view by saying: 'Privatising public services is a response to the need to regain efficiency. This is the underlying criterion of this delegated legislation. If there is one thing Italians ask of the Government, when they are protesting on the street, as is happening now, it is to improve the efficiency of public services. This is the rationale of this reform.'[84] However, a large part of the party was extremely sceptical about 'plagiarism of Anglo American models, which have already shown their limits'.[85] Another MP was critical of the 'myth of privatisation' and declared himself 'satisfied' that the DC was

[80] Iodice (DC), Lower Chamber, plenary meeting, 7 October 1992.
[81] Article 1.3 of Law no. 421/1992.
[82] Saretta, DC, Social Affairs Committee, Lower Chamber, 15 December 1992.
[83] Mr Iodice, DC, Lower Chamber, plenary session, 7 October 1992.
[84] D'Onofrio, DC, Lower Chamber, plenary session, 7 October 1992.
[85] Casilli, DC, Lower Chamber, plenary session, 7 October 1992.

able in the Senate to 'oppose the simplification of the logic of the market, which creates a false illusion'.[86]

Divisions within the DC about support of the 1992 reform did not help coalition cohesion.[87] But fragmentation of the parliamentary majority was an even more serious problem. The Socialist Party, which had the premiership, was a zealous and unambiguous advocate of the bill. The divergence between the two parties was exemplified in the vehement exchange of opinions between the President of the Constitutional Affairs Committee and one Socialist MP, who made the most convincing appeal for the introduction of the enterprise formula. To the Socialist argument that 'health care is the most important business of the State. As any other private business, it must be competitive and need frequent modernisation programmes',[88] the President of the Constitutional Affairs Committee in the Lower Chamber responded by emphasising the public authority tradition of the state. His speech was imbued with an *étatiste* spirit: 'the public function is an authoritative function and it should remain this way'.[89]

On the other side, there was a great difference between the 'constructive' opposition of the Democrats of the Left, the largest Opposition party, and that of Communist Refoundation.[90] The analysis of committees' work manifests a remarkable degree of collaboration between the majority and the Democrats of the Left,[91] which is also

[86] Saretta, DC, Lower Chamber, plenary session, 9 October 1992.
[87] L.Azzolini, interview with author, Rome, 19 September 2002.
[88] Landi, Constitutional Affairs Committee, Lower Chamber, 24 September 1992.
[89] Ciaffi, DC, Constitutional Affaire Committee, Lower Chamber, 29 September 1992.
[90] The Communists contested the constitutionality of executive delegated authority. See Brunetti, MP, Lower Chamber, 7 October 1992.
[91] As already noted, the Democrats of the Left abstained and did not vote against the formal opinion formulated by the Social Affairs Committee. See the speech of Battaglia (PDS), which suggests that there was collaboration between the majority and Opposition during the meeting of the Social Affairs Committee, Lower Chamber, plenary session, 7 October 1992.

confirmed by one interviewee: 'we got along really well with the Democrats of the Left. Their opposition was mild.'[92] One MP argues that 'the Left supports the Government instead of policy change'.[93] Another openly refers to 'an opening to the Christian Democrats because Italy is a Christian state and we need to find agreements with those parties that support the solidaristic values'.[94] The fact that the opposition to the enterprise formula was not as fierce as expected can be explained in four ways. First, the ideological distance between the Government majority and the Left was somewhat reduced after the break of the Democrats of the Left (PDS) from the Communist Party in 1991 (Sassoon 2003). Secondly, given the weakness of the Amato Government, they might have been ambitious to enter the next government, as the extreme right party (MSI) argued.[95] Thirdly, the PDS enjoyed a powerful base of political support in many regions, mostly in Tuscany and Emilia Romagna. Introducing the enterprise formula, which was associated with neo-liberal ideology, was a costly political decision for the PDS. If it was decided by the centre it could only be blamed upon the central government. Fourthly, collaboration between the legislative majority and opposition had been a crucial element of the Italian policy making process (Furlong, 1990).

The clearest and most unequivocal opposition to the enterprise formula came from the Communist Refoundation party (RC). Its opposition to the introduction of the efficiency paradigm focused around three claims. First, the bill violates Article 32 of the Constitution: 'the Republic safeguards health as a basic right of the individual and as an interest of the community, and grants free medical assistance to the indigent'. RC argued that by introducing private insurance and the possibility of opting out

[92] N. Falcitelli, interview with author, Rome 23 September 2002.
[93] Mr Ravaglia, PRI, Lower Chamber, plenary session, 8 October 1992.
[94] Ferri, PSDI, Lower Chamber, plenary session, 7 October 1992.
[95] Plenary session of the Lower Chamber on 7 October 1992.

from the national health care system the Government was transforming a social right into an income-based one.[96] Secondly, the party accused the neo-liberal ideology of the Government. One MP clearly pointed to the 'Thatcher ideology that is driving the Government'.[97] Thirdly, the Communists were convinced that the introduction of general management would never solve the problem of extensive politicisation of managers in the Italian public administration. One MP mentioned the example of Sicily where the discussion between parties for the allocation of their candidates as managers of local health care authorities had been so inconclusive that eventually they decided to hold a draw.[98]

Some parties did support the reform. The Republican Party and the Northern League claimed that the bill was too timid in introducing market-type mechanisms and were thus in favour of 'privatisation'. However, a Republican MP said: ' the Government's announcements that they want to depoliticise health care are pure rhetoric'.[99] The Northern League was in a similar position with respect to the reform of public employment. Although it supported the introduction of general management, it also expressed scepticism about the possibility of depoliticising the health care system. In the vivid language typical of this party, one MP suggested: 'the aim of the 1978 creation of the health care system was to create at local level a political fiefdom in the periphery. Local health care authorities are centres of clientelistic recruitment. The logic of the 1978 reform was to contract out health care to political parties.'[100] This scenario was also confirmed by an interviewee, who

[96] The Communist party was preoccupied that the 1992 reform would alter the universal provision of health care services by creating a two tier system with different access according to the financial position of patients. See the speech of Crucianelli, Lower Chamber, plenary session, 8 October 1992. For a discussion of changes affecting universalism see: Saraceno and Negri (1994).
[97] Sestero Giannotti, RC, Lower Chamber, plenary session, 7 October 1992.
[98] Lento, RC, Lower Chamber, plenary session, 7 October 1992.
[99] Poggiolini, PRI, Lower Chamber, plenary session, 7 October 1992.
[100] Petrini, Northern League, Lower Chamber, plenary session, 7 October 1992.

stated that: 'public managers of local health care authorities are continuously stressed by politicians. This is the reality.'[101] The Greens were also in favour of the enterprise formula, but did not expect that politicisation would be eliminated.[102]

There are various reasons for the lack of commitment to the 1992 reform by the majority of political parties. The failure to modernise the public administration of many reforms in the past produced the expectation that the 1992 health care reform would to share a similar outcome.[103] Politicians were convinced that the political subordination of civil servants was so entrenched in the administrative system that any change would be difficult.[104] Some influential MPs also genuinely defended the public tradition of the state, viewing the private and public sectors as incompatible and the introduction of private-sector management practices as challenging civil servants' impartiality.[105] The Council of State's opinion supports this point because it sets the limits for the privatisation of public employment and establishes 'an ontological and insurmountable difference between private and public employment'.[106]

However, the thrust of criticism of the 1992 reform is the marginalisation of local government, which the parties consider a potential constraint on their ability to 'occupy' local health care authorities (Ferrera and Zincone 1986). These are key political arenas for a party's local power base. As one interviewee explains: 'the

[101] A.Tomassini, interview with author, Rome, 25 July 2002.
[102] Bettin, Greens, Lower Chamber, plenary session, 7 October 1992.
[103] Giuntella, MP, La Rete, Lower Chamber, plenary session, 9 October 1992, argues that the Amato Government's plans to depoliticise health care administration are not credible 'because the local health authorities' predators are in government now'. See also the speech of Petrini (Northern League), Lower Chamber, plenary meeting, 8 October 1992.
[104] Asquini, Northern League, Lower Chamber, plenary meeting, 8 October 1992.
[105] Ciaffi, MP (DC), Speech to the Constitutional Affairs Committee, Lower Chamber, 17 December 1992.
[106] Council of State Decision no. 10, 31 August 1992.

administration of local health care authorities has been constantly composed and recomposed according to party competition and parties' influence'.[107] Political parties in Parliament were not against the creation of the new post of *direttore generale* as such, but rather its implications, such as the marginalisation of local elected officials from the policy making process.

The Amato Government's proposal to abolish management committees raised serious concerns for a technocratic management of health care undermining democratic mechanisms of political control and representation. The Minister of Health, a member of the Liberal Party, explains the reform's aim in this way: 'our objective is to "purge" the entire health care sector from the germs of *partitocrazia* and *lottizzazione*, and to liberate the system from bureaucratic ties and paternalistic protection'.[108] Accordingly, the bill introduced in Parliament in September 1992 established the incompatibility rule for public managers of local health care authorities with political offices.[109] Despite the Lower Chamber's amendments to keep the management committees in place, the final executive decree issued disregarded them, demonstrating the Government's determination to introduce general management in the health care sector.

Parliamentary Process and the Question of Confidence

Opposition from political parties was not the only type of parliamentary blockage. The institutional ineffectiveness of the Italian Parliament forced the executive to

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[107] N. Falcitelli, interview with author, Rome, 23 September 2002 and B. Leone, interview with author, Rome, 24 September 2002 and A.Tomassini, interview with author, Rome 25 July 2002.
[108] Minister De Lorenzo, interview in *Il Sole 24 Ore*, 13 August 1992.
[109] Bill no.1568, Art. 3, Section 9 establishes that general managers cannot be elected to local, regional or national offices, unless they resign 180 days before the election.

exercise fully its prerogatives. The following analysis of the procedural instruments used by the executive to overcome this institutional blockage is particularly helpful when assessing the feeble consensus generated by the reform of health care. The procedural mechanism to overcome the parliamentary blockage was the question of confidence, which will be covered in detail. Before investigating the implications of its use, the legislative process associated with executive legislative authority is briefly discussed.

Article 70 of the Italian Constitution attributes legislative authority mainly to the Parliament. The conception of the legislative function embodied in the Constitution reflects the value attributed to the 'law' to maintain democratic safeguards, or *garantismo*, rather than regulation. Parliament must ensure the legislative co-ordination of all the bodies with the constitutional power to initiate legislation, such as the Government, regions, trade unions, and the people. It was only with the expansion of state involvement in the economic sphere that the function of the 'law' changed, from general and abstract to detailed and technical (Manzella 1985). The unresolved tension between these two conceptions of the legislative function, the legal principle that the law is the safeguard of the legislative autonomy of all players, and the political principle that the law regulates policy sectors, does still affect executive-legislature relationship (Di Ciolo and Ciaurro 2003). The use of delegated legislation increased substantially during the 1980s (Morisi 1988), and the use of delegated legislation to push through redistributive and controversial reforms reached a particularly high level during the years 1992-1994.[110]

[110] The total number of legislative decrees increased throughout the 1990s. In the Xth Legislature (1987-1992) the total number of legislative decrees issued by the executive was 129, and in the XIIIth (1996-2001) it raised up to 425 (of which 242 derive from enabling laws not connected with the implementation of European directives). This quantitative increase is combined with their increased centrality as mechanisms for implementing far reaching and complex reforms. The reforms of the

The executive primarily submits two types of legislation to Parliament. The first type is represented by government bills initiated by a single ministry, without the interference of the Cabinet. The second type is represented by delegated legislation. Under exceptional circumstances, the Constitution allows emergency legislation[111] to take the form of government decree-laws; their force of law ceases if Parliament does not approve them within 60 days. Thus the Constitution grants the executive scope for legislative initiative. In the case of the 1992 health care reform, a bill was presented by the Prime Minister's office to Parliament requesting the authority to legislate on four areas with direct public finance implications: health care, pensions, civil service, and local finance. The result of the parliamentary debate was a law, the *legge di delega*, delegating to government the authority to issue legislative decrees, *decreti legislativi*, on each area. The *legge di delega* is a framework type of legislation, which does not prescribe detailed recommendations about the implementation process. The Amato Government had 60 days to present an executive draft of the legislative decrees to the competent parliamentary committees for a compulsory, non-binding, and formal opinion. After the amending process of the draft decree and the formal approval of the competent committees, the Government issued the legislative decree in December 1992, after only 15 days of committee debate. Once issued, any legislative decree can be amended within a

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welfare state, of public employment, of administrative decentralisation have mainly being pursued by delegated legislation instead of ordinary legislation and government bills. See Capano and Giuliani (2001).

[111] Articles 76 and 77 of the Italian Constitution sanction the use of delegated legislation as follows:
Article 76: the exercise of the legislative function may be delegated to the Government only after having established principles and criteria, for a limited period of time and for specified objects.
Article 77: the Government may not, unless delegated by the House, issue decrees having the value of ordinary law. When, in exceptional cases of necessity and urgency, the Government issues on its own responsibility emergency decrees having the force of law, on the same day it shall submit them to the Houses for conversion into laws.

period of one year, but only by a new legislative decree which goes through the same process of parliamentary approval.

Despite the use of delegated legislation, Italian executives' capacity to steer the parliamentary process has always been poor (Manzella 1991; Chimenti 1992). In addition to the constraints attributed to the party system, the Italian Parliament has traditionally been considered an ineffective institution (Di Palma 1976; Di Palma 1977) as regards the enactment of ambitious and wide ranging reforms. This decisional ineffectiveness owes much to the inability to reach agreement on content, and also on decisional rules. However, according to Polsby's distinction between transformative and arena parliament (Polsby 1971), as far as the amending powers of draft executive legislation are concerned, the Italian Parliament is a transformative Parliament, with a strongly institutionalised committee system and a high level of decentralisation (Di Palma 1977).

Committees of the Italian Parliament are decisional autonomous spaces in the sense that they have extensive power as regards enacting legislation without referring it to the assembly (Furlong 1990). The most interesting aspect of standing committees is their authority to pass laws without approval by the floor. According to Article 72 of the Constitution, Parliament may, with few exceptions,[112] give such authority to committees. According to the standing rules, the president of each house, upon assigning a bill to a committee competent by reason of subject matter, decides at his complete discretion whether the committee shall be empowered to enact it with the force of law or shall report to the floor for final approval. Committees examine a bill in three types of sessions: in *sede deliberante* (decentralised procedure), *consultiva*

[112] Exceptions concern the budget, ratification of international treaties, laws on constitutional and electoral matters, and the delegation of law-making power to the Government.

and *referente*. According to the first, a standing committee has the power to legislate without reporting back to the floor. In *sede consultiva*, a bill is referred to a standing committee which has limited power to formulate a non-binding opinion. In *sede referente*, the most common procedure, a committee analyses a bill in great detail, amending it and then referring it back to the assembly for a final vote. Another characteristic of the Italian parliament is that, under any of these procedures, the legislation reported to the floor may bear little resemblance to the original bill because of the extensive powers of amendment of Italian parliamentary committees (Chimenti 1979; Cotta 1994; Della Sala 1998).

The 1992 government bill was assigned to the V Committee, the Budget Committee, under ordinary procedure (*sede referente*) for amendments, and to the I and XII Committees, respectively Constitutional Affairs and Social Affairs, for a non-binding opinion only (*sede consultiva*). According to the subject matter, the 1992 bill should have been referred to the competent committees for amendment, the Social Affairs Committee in the Lower Chamber and Health Care Committee in the Senate. However, the Government secured with the presidents of the houses that the bill be assigned to the Budget Committee, which would be more concerned with reducing budget deficits and cutting costs. The committees are not only the place where legislation is enacted, but they are the place where smaller parties and opposition parties have the greatest opportunity to influence government legislation through amendments (Rebuffa and Raiteri 1995). Not only was the bill assigned to the Budget Committee for amendment, but also the decentralisation procedure was avoided. In fact, the decentralised procedure would have weakened the Government's legislative leadership by leaving the Opposition a good margin of initiative and influence within committees. This is not surprising, because the

decentralised procedure is used mostly for micro-sectional legislation, for producing *leggine*, the technical legislation on minor issues most likely to find easy support in the committees.

The Government has no power of veto over private bills and amendments, unless it raises a question of confidence, which was precisely the instrument the Amato Government had to use to force the legislation through Parliament. This implies that all amendments are no longer examined. The use of the question of confidence alters the executive-legislature relationship, distorting the constitutional balance and undermining the centrality of the parliamentary legislative function because the debate is blocked by the executive. Among the reasons for the use of this instrument the most prominent are the existence of an incohesive parliamentary majority, the legislative opposition strategy of obstructionism, and generally ineffective parliamentary procedures (Manzella 1991).

In the specific case of the 1992 reform, the Amato Government, supported by the opinion of the Court of Accounts, calling for urgent austerity measures, decided to use the instrument of the question of confidence because of the expectation that parties would not be solidly committed to the unpopular reform of health care and the fear that the parliamentary debate would carry on for a long time in an ineffective way.[113] The question of confidence was a procedural mechanism reflecting an attempt to overcome the effects of the structure of party competition on parliamentary coalition cohesion.

[113] Speech of Minister Reviglio, Budget Minister, calling for a question of confidence, Lower Chamber, plenary session, 9 October 1992. See also speech of Bianco, MP, who argues that the question was called for the obstructionism of the Opposition, Lower Chamber, plenary session, 9 October 1992.

On one hand, the question of confidence made the reform of health care possible. In the previous legislature (Xth Legislature), a bill introducing general management in health care was discussed but defeated by partisan conflicts and by the early end of the legislature.[114] On the other hand, the question of confidence built in deep-seated resentment for the reform. The decision to call for a question of confidence presupposes the difficulty of the executive in gaining a cohesive parliamentary majority and the high degree of opposition to the Amato reform, coming mostly from the largest party in the majority, the Christian Democrats.

On 18 October 1992, when the heated debate in the Lower Chamber was almost coming to a close, the Minister of the Budget, Reviglio, called for the question of confidence. It was received with a mixture of surprise, anger, and relief, according to each party's internal political divisions and positions.[115] The Opposition became more vociferous and mounted an attack on the Government's abuse of executive prerogatives and challenge to the centrality of the Italian Parliament. One MP's remarks summarise the opposition: 'The Government fears its own majority. The Government accuses Parliament of being the victim of lobbies and parties. It is trying to delegitimise Parliament. In truth, the real problem lies within the parliamentary majority.'[116]

The implications of the question are more political than formal. There are four plausible reasons why the executive decided to control the parliamentary process in this way and did not wait for the final vote, which was due only two days after the question had been called. Parliamentary debate had advanced according to the

[114] The 1989 reform of health care proposed by Minister De Lorenzo (see note 1) was approved by the Senate, but failed to go back to the Lower Chamber for the anticipated end of the legislature.
[115] Lower Chamber, plenary meeting, 9 October 1992.
[116] D'Alema, PDS, 8 October 1992, Lower Chamber, plenary session.

agreed schedule and tight timescale, and there was no apparent need to put on further time pressure. First, the executive faced insurmountable obstructionism from the Opposition. Secondly, the executive wanted to challenge the centrality and legitimacy of Parliament, thus addressing the citizens' revolt against the party system. Thirdly, the executive feared a Cabinet crisis and wanted to avoid it. Fourthly, the executive imposed coalition cohesion on undisciplined members of the political majority in order to pass the bill.

First, the objection to the constitutional question raised by the Communists[117] suggests that obstructionism was a real concern of the executive. An interviewee said: 'If we waited for Parliament to decide on the bill, it would have taken us years to pass it, given the great number of amendments.'[118] The party of Communist Refoundation presented almost 300 amendments to the bill. The party was accused of being particularly irresponsible given the public finance emergency.[119] On the whole, the obstructionism explanation is not entirely convincing for three reasons. First, when the question was called, the agenda of parliamentary work was on schedule and the Communists had withdrawn most of their amendments already during the plenary session in the Lower Chamber.[120] Secondly, the ideological resistance of the Communist Party was expected and anticipated by the Government from the outset, given that the bill under discussion was delegating legislative powers to the executive to reform the core of the welfare state, including pensions. Thirdly,

[117] The Communist party raised a question of constitutionality before the plenary debate of the delegating law no. 421 of 1992, Lower Chamber, plenary session, 7 October 1992. The party's claim was that the bill no.1568, by which the executive requested the delegation of authority, violated article 76 of the Italian Constitution as it achieved an unconstitutional level of details and prescriptions. It also supposedly violated article 117 as it encroached upon regional legislative functions.
[118] L. Azzolini, interview with author, Rome, 19 September 2002.
[119] Bianco, MP, Lower Chamber, plenary meeting, 8 October 1992.
[120] Parliamentary Act no. 1568, plenary session, Lower Chamber, 8 October 1992.

interviews confirm the original executive strategy to 'get the bill out of Parliament as soon as possible'.[121]

The second explanation for the use of the question is suggested by MPs during the Parliamentary debate.[122] She argues that the question was raised as the result of an institutional conflict, to enhance the executive's autonomy from Parliament and to challenge the latter's centrality in the Italian political system. This claim could be supported by the authoritarian style of the Government's participation to parliamentary work.[123] The Minister of Health rarely participated in parliamentary work to respond to questions and was not keen on participating in parliamentary debate, as one majority MP said.[124] But there is not sufficient evidence to suggest that the Government intended to undermine parliamentary prerogatives for an institutional conflict. Although there are signs of executive determination, these are the result of the expectation that this reform was likely to share the unfortunate destiny of the one defeated in the previous legislature.

A possible third explanation for the use of the question of confidence is the attempt to avoid a Cabinet crisis. Considering the size of the majority in Parliament this was a realistic risk. Yet, according to interviews, 'nobody thought the Government was going to fall'.[125] Moreover, it is reasonable to expect that the Opposition would have supported the Government, had it feared that it was going to fall causing the Northern League to enter the next coalition. Paradoxically the fact that the Opposition voted solidly against the Government suggests that the question of

[121] N. Falcitelli, interview with author, Rome 23 September 2002.
[122] Finocchiaro, PDS, Lower Chamber, plenary session, 7 October 1992.
[123] On October 9, 1992, when the question of confidence was raised, the Minister of Health was not present.
[124] L.Azzolini, interview with author, Rome, 19 September 2002.
[125] L.Azzolini, interview with author, Rome, 19 September 2002.

confidence was not used to avoid a Cabinet crisis. The fall of the Amato Government was not realistic in December 1992. The fourth and most convincing reason suggests that the question was used to force coalition cohesion on the parliamentary majority, otherwise fragmented across party lines and within party factions.

To summarise, the parliamentary blockage can be attributed to the combined effect of institutional ineffectiveness to enact wide-ranging reforms and political parties' opposition to the challenge to traditional partisan control of the administration. Notwithstanding, the Amato Government was committed to using the question of confidence to pass the 1992 reform of health care. The legislative decree was issued by the executive in a difficult climate of institutional resentment, partisan opposition, and civil society direct action, as the next chapter shows. Although the Government was able to pursue its programmes, the real significance of enacting policy change with such a fragile political consensus remains to be assessed. The question of confidence allowed for a short-term opportunity, but in the long term consensus would need to be built on different grounds if an ambitious reform is to be sustained.

Conclusions

The parliamentary process of enacting a reform of the national health care system alongside a major review of the predominant administrative structures and processes seemed an insurmountable task to the Amato Government from the start. The small legislative majority supporting the four-party heterogeneous government coalition was dominated by the Christian Democracy, who had promoted and created the national health care system in 1978 and generally opposed any major retrenchment

of the welfare state. In addition to diverging political preferences within the majority, the structural properties of the Italian Parliament did not facilitate grand schemes of reforms, but rather technical minutiae. Although the legislature granted ample delegated legislative powers to the executive for the reform of health care, civil service, pensions, and local finance, it soon tried to get it back by extensive co-legislation in relation to implementing legislative decrees. Parliamentary committees were very involved in drafting the executive draft of implementation legislation of the 1992 health care reform. The amending powers of parliamentary committees put the commitment of the Amato Government to radical change at risk. Despite these blockages, the executive was able to push its own draft legislative decree through the parliamentary process, with little consideration for parliamentary amendments and mounting opposition, owing to the use of procedural devises, such as the question of confidence. The result was that change was enacted successfully, but could not enjoy wider political consensus.

The reform of management arrangements was at the core of the 1992 legislation. Collegial decision-making mechanisms were radically substituted by a single general manager entrusted with a greater degree of autonomy from political interests and pressures of interest representation. Powerful regional technocrats, appointed by the regional executives, were to be positioned at the top of all health care administrative structures and public hospitals transformed into juridically public enterprises. These were put under the administrative supervision of regional governments and thus removed from municipal administration, which had traditionally managed local health authorities and the delivery of health care services. The merger of administrative structures offered considerable opportunity for heightened regional administrative scope and eventually capacity, especially in those regions with a

tradition of relatively high standards of administrative activity. But the process of regionalisation of health care policy included the possible emergence of an autonomous political space represented by the representative territorial level of the region. Regional elites were directly engaged in the policy making process, the appointment of general managers being a significant means of political control and leverage on the health care administration.

As Macchiavelli claimed, the more radical the reforms, the greater the resistance expected. The Amato Government's commitment to an alternative mode of operation for the administration, driven by concrete results and targets rather than formal rules and abstract procedures, was met with wide and deep opposition in the parliamentary arena. The parliamentary blockage was not only a function of institutional constraints, but also specific policy positions. National political elites contested both the emergence of powerful technocrats at the head of the administration and the emergence of new alternative intermediate arenas of political representation and mediation. The 1992 reform was about introducing new mechanisms of political control of the senior level of the administration, departing from traditional patronage and clientelism, and also about restructuring local politics so as to curb traditional patterns of political mobilisation. Such a radical challenge was met not only with the scepticism of political parties, but also with the vehement protest of civil society outside the parliamentary arena. Professional groups and pressure groups exerted a considerable and prominent influence in the aftermath of the issuing of the legislative decree. The next chapter examines their influence, action, and effects on the policy making process of change.

Chapter III

Interest Groups' Blockage to the Amato Reform and its Legislative Amendment

The far reaching change introduced by the 1992 reform of the national health care system, imposed by the Amato government on a divided and recalcitrant parliamentary majority, achieved with limited political consensus and produced without comprehensive consultation of the affected medical groups, backfired against the new Ciampi government in 1993 because of vehement and disruptive protest by professional groups. The implementation of the reform was temporarily halted by outright opposition and the groups' lack of cooperation with the government. Immediately after the decree was issued, the majority of medical associations met in Rome to launch the proposal for a referendum to abrogate the reform entirely.[1] The reform of the Italian health care system had rarely generated such a vociferous and potent clamour as at the beginning of 1993. The opposition of the medical profession took the form mainly of direct action and endemic conflict, especially immediately following the Amato decree. On December 17, the Minister of Health, De Lorenzo, was confronted by 30,000 general practitioners who blocked his car in Piazza Colonna and stopped him walking to Parliament.[2] Such protest represented the second most important blockage, after the parliamentary one, against the reform of the national health care system. Consultants' opposition threatened to

[1] On December 30, 1992, the majority of medical associations, led by FIMMG, *Federazione Italiana Medici di Medicina Generale*, which was made up of 60,000 general practitioners, agreed to take every action to abolish the Amato decree. The creation of an abrogative referendum committee was launched then. For further details, see: 'Al via il referendum contro la riforma sanitaria; I medici di famiglia minacciano il blocco', *Il Sole 24 Ore*, 30 December 1992.

[2] The demonstration on 17 December represented the climax of many days of strikes and demonstrations. 30,000 doctors convened in the centre of Rome and were screaming slogans such as 'buffone', literally 'fool' or 'dimissioni', literally 'resign' and 'sei come il mago di Napoli', literally 'you are like the wizard of Naples', alluding to underhand practices in the Minister's city of origin. See 'Bloccata l'auto, insulti a De Lorenzo; in piazza 30 mila camici bianchi', *La Stampa*, 17 December 1992.

throw the reforms off course and posed a real obstacle to the new Ciampi government and the new Minister of Health, Maria Pia Garavaglia, appointed in May 1993, the second woman from the Christian Democratic Party to hold the position in the history of the Republic.[3]

The purpose of this chapter is twofold. First, it analyses the influence of interest groups on the policy making process of the 1992-93 reforms. This impact has different dimensions: it refers to the effect on substantive issues and legislation, to the strategic choice of 'pressured' institutional venues and to the effect on the government's strategy and response to civil society's opposition. Groups' influence on the process was most evident in their ability to trigger a new legislative episode, that of the amendment of the Amato reform through a new legislative decree. Executive Decree no. 517 was issued by the Ciampi Government in December 1993 after a lengthy parliamentary discussion and amendment process. The second purpose of the chapter is to analyse how the executive handled this blockage and eventually succeeded in avoiding the policy reversal of the Amato reform, threatened by interest groups' adversarial mode of action. In fact, the Ciampi government was also committed to the underpinning programmes on regionalisation and the introduction of general management. Legislative activism and the formalistic response to interest groups' demands is hereafter assessed, though, against the real changes introduced by Executive Decree no. 517/93 to the original Amato reform.

The chapter firstly analyses the medical associations and trade unions' demands to the Amato government after the decree was issued. The most sensitive issues were those related to pubic sector employment since the public health care sector was the

[3] 'I ministeri che cambiano – La responsabile della Sanità punta al ritorno allo Stato sociale', *Il Sole 24 Ore*, 5 May 1993.

third largest employer after education and local government.[4] An investigation of the positional strategies of groups and their modes of action contributes to understanding how far groups have shaped the parliamentary process of the amendment to the Amato reform, undertaken by the new Ciampi government in 1993 in the context of financial austerity.[5] This is important for the overall thesis because groups' activism has triggered a new legislative process. Pressure groups' demands are systematically compared with the legislative amendments proposed by parliamentary committees at the end of 1993 in order to evaluate their influence on the policy process. The last part of the chapter considers governmental strategies in handling groups' demands to secure policy continuity and minimal modification of the original reform. These include gaining wider political consensus and political legitimacy through parliamentary approval, engaging in wider and more open consultation with trade unions and all medical associations, and eventually making public concessions to the medical profession over employment legislation. This strategy led to a policy making process geared towards consultation with groups rather than adversarial politics.

Interest Groups' Demands

This first part of the chapter aims to elicit from the political debate generated during the amendment of the Amato reform the key issues of controversy and the demands of the professional groups and trade unions, which were at first conveyed by outright conflict. The Amato executive decree laid out the sequence of administrative steps to be taken to bring the health care reforms into effect. These included the

[4] In 1991, the national health care system employed 657,438 public employees, compared with education with 1,073,468 employees and local governments with 727,718 civil servants. See: 'Relazione sullo Stato della Pubblica Amministrazione, Doc. XIII n.2-quinquies, 10 November 1993.
[5] Financial austerity was one of the priorities of the Ciampi Government.

formulation of the 1994-96 National Health Care Plan, the definition by the regions of the geographical boundaries of newly merged LHAs, the selection of hospitals to be given public enterprise status, the definition of entitlements by means of the so-called 'minimum levels of care', the formulation of regional health care plans, and the identification of quality and efficiency indicators. The implementation of the Amato reform was suspended by the launch of a new legislative process aimed at amending Executive Decree no. 502/92, which sought to introduce the enterprise formula and regionalisation in the health care sector, and producing a new decree. From December 1992, when the executive decree detailing the delegating law no. 421, which delegated legislative authority to the executive for the reform of health care, civil service, local finance and pensions, was enacted by the Amato government, until November 1993, when an amended version of the decree was issued by the Ciampi government,[6] health care reform gained a prominent position[7] in the political agenda of reforms associated with financial austerity and in the public debate.[8] As regards the centrality of health care on the government reform agenda, one interviewee suggested that the drafting and groups' consultation took place at the Prime Minister Office.[9]

[6] The new Executive Decree no. 517 was issued by the Ciampi Government on 24 November 1993.
[7] The Minister of Health De Lorenzo declared that 'the decree has been drafted at four hands', *La Stampa,* 22 December 1992. Another reason for the predominant place of health care over other sectors was the financial non-sustainability of soaring public deficits. One of the priorities of the Ciampi Government was financial austerity. The 1992 Court of Accounts estimates clearly indicate the alarming financial situation of local health authorities. Real expenditure exceeded the 1991 budget by 4.5 billion Euros. The Court blames for the deficit the lack of implementation of national minimum standards. It does also lament the fact that cost containment had been achieved through higher co-payments rather than structural and programmatic change. For instance, the fixed cost of prescriptions to be paid by patients had gone up by 50 per cent in 1992, according to law 412/1991. See: 'Decisione e Relazione della Corte dei Conti sul Rendiconto Generale dello Stato', Corte dei Conti, 1993.
[8] An analysis of media coverage from December 1992 to November 1993 of three national newspapers, that is *Il Sole 24 Ore, La Stampa, La Repubblica,* has shown that health care reforms made the headlines almost every day over a prolonged time.
[9] Falcitelli, interview with author, 25 November 2003.

The protest of the professional groups representing the medical profession contributed significantly to raising public interest for the health care reform. As soon as the Amato reform was enacted by the government, the medical profession mounted fierce opposition. Protest was characterised by street demonstrations,[10] by general strikes,[11] by the disruption of health care services, such as general practitioners' threat of prolonged surgery closure,[12] by the refusal to negotiate with the government and in particular with the Minister of Health, De Lorenzo, whose style was criticised for being authoritarian.[13] FNOM, *Federazione Nazionale degli Ordini dei Medici*, the peak association representing all the different categories of doctors, took up the fight against the Minister.[14]

The medical profession was most sensitive to three issues: public employment and renewal of contracts;[15] the institutional representation at different levels of various decision making processes,[16] such as in the composition of the selection committees

[10] Among the demonstrations, ANAAO, *Associazione Nazionale Aiuti e Assistenti Ospedalieri*, went on strike on the 18, 21 and 22 December 1992. See: 'La DC: eccesso di delega', *La Stampa*, 24 December 1992.

[11] On December 16, 150,000 doctors went on strike against the government. All the medical associations supported the strike. See 'In trentamila hanno manifestato ieri a Roma per protestare control la riforma della Sanità, il giorno della piazza', *Il Sole 24 Ore*, 17 December 1992.

[12] FIMMG, *Federazione Italiana Medici di Medicina Generale*, threatened to close down general practice ambulatories for a couple of weeks from mid-January 1993. See: ' I medici di famiglia minacciano il blocco', *La Repubblica*, 30 December 1992.

[13] Mr Sizia, Secretary of CIMO, *Confederazione Italiana Medici Ospedalieri*, attributed the reason for such a fierce opposition to the exclusion of the medical profession from any contribution to the drafting of the reforms of the national health care system. See 'In trentamila hanno manifestato ieri a Roma per protestare contro la riforma della Sanità, il giorno della piazza', Il Sole 24 Ore, 17 December 1992. For additional evidence, see the hearing of CIMO to the Social Affaire Committee, Lower Chamber, 3 February 1993.

[14] 'La Federazione nazionale decide su referendum abrogativo e nuovi scioperi', *Il Sole 24 Ore*, December 29, 1992.

[15] 'La Federazione nazionale decide su referendum abrogativo e nuovi scioperi; e oggi summit sindacale anti-decreto', *Il Sole 24 Ore*, 29 December 1992.

[16] It is possible to extrapolate the centrality of the issue of the institutional representation of the medical profession by the demands made to the parliamentary committees by the majority of medical associations. This is discussed in greater detail in the following part of the chapter. For the hearings given to the medical associations in Parliament see: 'Audizioni del 28.1.1993 and del 3.2.1993, del 4.2.1993 and 17.2.1993,' Camera dei Deputati. For attention to the issue of representation, see the hearing of FNOM, *Federazione Nazionale Ordini dei Medici*, 3 February 1993.

for recruiting heads of hospital divisions and evaluating committees;[17] and access to the highest level of *dirigenza* in the medical profession. The request for formalised representation was also made in relation to the formulation of the regional health care plans and the negotiation of fees for service.[18] As for employment policy more generally, the entire medical profession opposed the reform,[19] and some categories of doctors were more hardened than others, such as the general practitioners.[20] Also, hospital practitioners, ambulatory care specialists, and primary care practitioners, organised respectively in *Confederazione Nazionale Medici Ospedalieri* (CIMO), literally National Association of Hospital Practitioners, *Sindacato Unico Medici Ambulatoriali Italiani* (SUMAI), literally United Syndicate of Italian Ambulatory Care Practitioners, and *Federazione Italiana Medici di Medicina Generale* (FIMMG), literally National Association of General Practitioners, were dissatisfied with the changes with regard to terms and conditions of employment. These categories of doctors also feared the non-renewal of their employment contracts.[21] The Amato reform implicitly indicated that some categories of doctors would no longer receive public sector salaries and would be forced to become independent contractors with the public sector or self-employed.[22] Not only public employment

[17] Hearing of FNOMCeo, *FNOM-Chirurghi ed Odontoiatri*, at Social Affairs Committee, Lower Chamber, 3 February 1993. This association asked for the participation of representatives of the medical profession in the selection committees for recruitment, in the employment negotiations at national level, and in determining the organisational plans of hospitals.

[18] Hearing of CIMO at Social Affairs Committee, Lower Chamber, 3 February 1993.

[19] The medical profession in Italy is represented by a diffuse system of independent unions. Doctors in Italy must belong to regional semi-public organisations, so-called *ordini*, organised in a national top-level association called *Federazione Nazionale degli Ordini Medici*, or FNOM. This body has two roles: self-regulation of the profession, regulating registration and licensing, and political representation and lobbying. Despite the privileged position that FNOM has traditionally secured with the Ministry of Health, representation of the medical profession since the 1980s has been increasingly fragmented along the divisions of general practitioners vis-à-vis specialists, specialists against each other, ambulatory and local care consultants vis-à-vis hospital practitioners, junior vis-à-vis senior doctors.

[20] Dr Milillo, interview with author, Rome, 31 July 2003.

[21] The number of doctors risking their job was approximately 45, 000. See:'Bloccata l'auto, insulti a De Lorenzo; In piazza 30mila camici bianchi', *La Stampa*, 17 December 1992

[22] This was the case of hospital emergency doctors and local ambulatory care specialists, analysed later on in this section of the chapter. Doctors in public hospitals are salaried civil servants.

and institutional representation, but also access and promotion to the higher levels of the *dirigenza* were issues of controversy, especially for the younger generation of doctors who found insurmountable difficulties in achieving a fast and rewarding career within public hospitals.[23]

Given that the different categories of doctors were affected differently by the reform and were organised in separate unions, their requests and proposed amendments varied. For instance, CIMO, *Confederazione Italiana Medici Ospedalieri*, which represents hospital practitioners in public hospitals, who are salaried civil servants, generally contested the Amato government's refusal to accept the parliamentary committee's amendments.[24] More specifically, it criticised the lack of representation for the profession on the committees for recruiting and evaluating the heads of hospital divisions, so-called *primari*, belonging to the second and higher level of *dirigenza*.[25] CIMO sought to have a second-level doctor as member of the expert committee selecting the *primari*, who was also an official representative of the association. It also wanted an official representative of the profession to be included on the doctors' performance evaluation committee.[26] CIMO also asked for a greater

[23] According to the press coverage, the majority of doctors demonstrating against the government in December 1992 were young. See: 'Bloccata l'auto, insulti a De Lorenzo; In piazza 30mila camici bianchi', La Stampa, 17 Decemebr 1992. This is quite understandable because the position of hospital assistant doctors was taken up by young entrants in the medical profession. Moreover, most doctors on duty in Italian hospitals are young entrants. These two categories were those threatened by the reform. See Article 8, 'Erogazione delle prestazioni, Legislative Decree no. 502/1992.

[24] Lower Chamber Hearing, 3 February, 1993. For the policy position of CIMO, see: 'Decreto legislativo 502/92 sulla Sanità in attuazione dell'art. 1 della legge delega 421/92'.

[25] Hospital doctors are divided in two levels, each representing an economic and legal category of *dirigenza*. The first level, the lower one, includes assistant doctors, and more generally all junior positions. The second level comprises all doctors with managerial responsibilities of specialist divisions within hospitals. The doctors in charge of the divisions are called *primari* and they represent the highest level of the hierarchy of the hospital practitioners. At all levels hospital doctors have public sector employment contracts.

[26] Article 15 of executive decree no.502/1992 establishes the method of recruitment to the higher level of hospital doctors. The Expert Committee draws up a list of candidates for the position of 'primari'. It is composed by the *Direttore Sanitario* of the hospital and by two experts: one is chosen by the Region and the other is chosen among the second level doctors by the *Consiglio dei Sanitari*, the elected consultative body of doctors in the hospital. The selection of the *primari* is based on an

role in the preparation of regional health care plans and the negotiation of fees for service. [27]

The demands of the ambulatory care specialists[28] were not much different as far as lack of institutional representation of their unions was concerned. SUMAI, *Sindacato Unico Medicina Ambulatoriale Italiana*, represented the specialists working in local health care out-patient units, supplementing the specialist services and diagnostic treatment offered in public hospitals. This function was maintained and its role confirmed by the Amato reform.[29] Whereas the 1992 executive decree explicitly provided for the renewal of the general practitioners' contract with the public sector, it did not address ambulatory care specialists.[30] Consequently, SUMAI represented the concern of this entire category for the government's plan not to renew their employment contracts. They would have to become self-employed and would be paid on a fee-for-service basis,[31] and they would lose the job security and privileges associated with public sector employment. SUMAI claimed that the exclusion of their category from the decree could be interpreted as the government's plan to privatise ambulatory care in general.[32] Considering the crucial supplementary function that ambulatory care has always performed for the local hospitals, and the

interview. The employment contract is for five years, renewable after their performance evaluation by an Evaluation Committee.

[27] Dr Zucchelli, interview with author, Rome, 18 July 2003.

[28] In 1993 there were approximately 20,000 ambulatory care specialists.

[29] 'Richieste del SUMAI in merito alla modifica del Decreto Legislativo 502/1992', Social Affairs Committee, Hearing on 3 February 1993.

[30] Article 8, Legislative Decree no. 502 /1992.

[31] In most other European countries, such as Germany and France, ambulatory care practitioners are either independent contractors with the public sector or self-employed. In Italy only general practitioners and general paediatricians are independent contractors, namely they earn their income from capitation and service payments (Freeman 2000).

[32] The policy position of SUMAI can be found in the written proposal 'Richieste del SUMAI in merito alla modifica del Decreto Legislativo 502/1992', Social Affairs Committee, Hearing on 3 February 1993.

government's plan to encourage a cost-efficient dehospitalisation process[33], the demand for local ambulatory care services was expected to rise. SUMAI was not against competition and privatisation of the service *per se*, but contested the exclusion of its doctors from the public sector.[34]

The ambulatory care specialists were not the only category of doctors 'neglected' by the 1992 executive decree reforming the national health care system. Emergency doctors were also excluded from any clear definition of their contractual arrangements with the public sector. The omission of the 30,000 'emergency medicine' doctors was particularly problematic for the general practitioners because there was the risk that emergency doctors would be included in the same contract as general practitioners,[35] thus enlarging the supply of doctors in this category. FIMMG, *Federazione Italiana Medici di Medicina Generale*, claimed that the lack of distinction between general and emergency medicine meant that the latter would soon 'invade' the job market of the former, as the general secretary claimed. [36] Not only did FIMMG reveal its discontent with the undifferentiated status granted to general practitioners and emergency doctors, but it was also vigorously against the establishment of health care private funds.[37] FIMMG has traditionally been the union most committed to defend the publicly integrated and universal national health

[33] Law no. 412 of 30 December 1991, anticipating many aspects of the Amato reform, launched a major restructuring of the network of public hospitals and encouraged vigorously a dehospitalisation process by fostering day hospital service and limiting long stays in hospitals. This was also consolidated by the delegating law n.421/1992, Article 1, comma 2, letter n).

[34] 'Richieste del SUMAI in merito alla modifica del Decreto Legislativo 502/1992', Social Affairs Committee, Hearing on 3 February 1993. The exclusion not only reflected a fear of job losses, but also the denunciation of an illegitimate governmental strategy, because SUMAI had originally signed the existing national collective agreement.

[35] In 1993 there were approximately 60,000 general practitioners.

[36] Mario Boni, General Secretary of FIMMG, explained that 'it is not true that emergency doctors will remain; these doctors will be included in general medicine', interview in *Il Sole 24 Ore*, 27 December 1992.

[37] Dr Milillo has explained that FIMMG has been always supportive of the public national integrated system and traditionally opposed to the introduction of private insurance, interview with author, Rome, 31 July 2003.

care system from the introduction of private insurance.[38] More recently, FIMMG demonstrated against the Berlusconi government on 26 April and 4 June 2004 for much the same reasons. [39]

With reference to the assistant doctors in public hospitals, their public sector employment was not at risk. The problem was rather the exclusion of this category of younger doctors and new entrants from the level of *dirigenza*,[40] with its associated economic and legal privileges. Promotion to the higher level of the hierarchy of the medical profession within hospitals, that is to heads of divisions, has been always rigidly determined by the bureaucratic rule of seniority rather than meritocracy.[41] The Minister of Health, Garavaglia, suggested that the Department of Public Services was trying to end the seniority principle, which is the automatic promotion due to length of service.[42] For example, seniority was proposed in the legislative amendment of the Senate's Health Care Committee, which sought to promote all doctors with 10 years of service to heads of divisions.[43] Yet, in practice, partisan appointment to the highest level of the hospital hierarchy has been very common,[44] undermining the career prospects of many young doctors. Mr Poggiolini, Member of Parliament and also then Secretary of FNOM, attributed partisan appointment of heads of hospital divisions to the composition of selection panels, which were made

[38] For the policy position of FIMMG see the paper presented by its General Secretary, Dr Falconi, to the annual congress in 1998, available at www.fimmg.org.
[39] On 26 April 2004, 30,000 doctors took the streets of Rome in the most important episode of direct action since 1992. The rate of participation of FIMMG members was 90%. See: press release on 26 April and 4 June available at www.fimmg.org.
[40] Article 18, Legislative Decree no. 502/1992 eliminates the functional level of hospital assistants (previously XII), leaving in great uncertainty the jobs of 40,000 assistants.
[41] The Amato decree established that, after five years of employment, doctors could be promoted to heads of hospital divisions. As one Senator reminded, 'this method is entirely unacceptable, that is the possibility to be promoted to head of division without the necessary qualifications, only on the basis of seniority' (Senator Garaffa, Partito Repubblicano Italiano, Health Committee, Senate, 20 October 1993).
[42] Minister of Health, Maria Pia Garavaglia, Lower Chamber, 7 July 1993.
[43] Health Care Committee, Senate, 21 October 1993.
[44] Dr Botti, Interview with author, Milan, 24 July 2003.

up of members chosen by political parties, frequently not using any ranking system--appointment was not based on how candidates performed.[45] For this reason, ANAAO, participated in the strike on 16 December 1992.[46]

Besides these most combative independent interest groups, the FNOM, the compulsory top-level association of the medical profession, challenged its marginal formal role in the various levels of decision-making.[47] FNOM demanded the right to participation in collective bargaining around employment contracts, the establishment of fees for services, and to be consulted in decisions over the organisational structure of private hospitals[48]. Regarding the introduction of general management, FNOM was against 'an authoritarian conception of management'.[49] It expressed its objections to any financial constraints imposed on doctors, whose medical freedom and professional autonomy were unconditional. Accordingly, FNOM was also against rewards to doctors who successfully remained within their budget limits because it was strongly against any evaluation of doctors' performance'.[50] Despite this criticism of the autocratic figure of the general manager and his control over medical autonomy, FNOM welcomed the creation of this new post in so far as it could depoliticise the health care system. In fact, this association was critical of the partisan appointment of the higher level of hospital doctors. FNOM, however, was concerned that the method of appointment of the general

[45] Poggiolini, Partito Repubblicano Italiano, Social Affairs Committee, Lower Chamber, 21 October 1993.
[46] 'Al via il referendum contro la riforma sanitaria; I medici di famiglia minacciano il blocco' in *Il Sole 24 Ore*, 30 December 1992.
[47] FNOM, 'Proposte e Suggerimenti Decreto Legislativo di Attuazione della Legge Delega 23 Ottobre 1992, n. 421', Lower Chamber, Hearing, 3 February 1993.
[48] *Il Sole 24 Ore*, 27 December 1992.
[49] FNOM (1993).
[50] FNOM (1993).

manager could lead to politicisation because there was no ranking system in the national list of candidates. [51]

The introduction of general management and the regionalisation of health care were secondary concerns for the medical profession.[52] By contrast, trade unions focused their opposition not only on the material effect on members, but also on ideological issues and defending the national and universalistic health care system and opposing measures that might create greater inequality.[53] Accordingly, CGIL, *Confederazione Generale Italiana Lavoratori*, objected to the exclusion of large strata of the population from the national health care service[54] as an incentive to enter the private insurance funds market. This would form the basis of a two-tier health care system.[55] Yet, CGIL was internally divided on the issue of establishing supplementary health care funds to the public provision of services, which would play the role of brokers. The General Secretary of CGIL was in favour of health care funds, whereas CGIL-Funzione Pubblica, representing the public administration sector, was strongly opposed to this provision. More generally the position of CGIL-Funzione Pubblica was of unconditional rejection of the 1992 reform.[56]

As far as the introduction of general management and the enterprise formula was concerned, CGIL opposed neither the introduction of the new post of general

[51] FNOM (1993).
[52] The analysis of the reports and proposals of medical associations prepared for the parliamentary hearings in January and February 1993 does not mention any particular requests regarding the introduction of general management or regionalisation.
[53] 'Decalogo della Nuova Sanità', Congresso Annuale UIL Sanità, February 1993.
[54] The original Amato plan was to exclude from the national health care service all citizens with an income above 20,000Euros.
[55] *Nuova Rassegna Sindacale della CGIL*, no. 7, 1 March 1993.
[56] *Il Sole 24 Ore*, 29 December 1992.

manager nor the abolition of the local management committees.[57] It supported the infusion of greater flexibility and competitiveness, claiming that bridging private and public sector employment had always been its own priority. One official emphasised the need at the beginning of the 1990s to contain soaring budget deficits and health care costs by introducing new management systems and transforming LHAs and hospitals into public enterprises.[58] However, CGIL remained in favour of the introduction of general management as long as this was not an organisational model and remained only a cost management system. As Betty Leone, Health Care Policy Director, CGIL, claimed: 'the organisational model reflects one's professionalism. At present instead, the entrepreneurial culture of the administration is changing everything.' [59]

The opposition to the introduction of voluntary private insurance and health care funds, as designed by Amato and embodied in Article 9 of the executive decree, was shared by all the three major trade unions, CGIL, CISL, and UIL.[60] CISL claimed that the government had violated the principles of the delegating law in three ways: by introducing voluntary private insurance; by introducing the opt-out clause for those on high incomes; and the introduction of co-payments.[61] FISOS-CISL, the health care category within CISL, supported without the reservations of CGIL the introduction of management by objectives, performance evaluation, quality evaluation, and performance related pay. It declared itself in favour of the review of employment contracts to infuse flexibility into health care administration.[62]

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[57] All three of the top-level associations of trade unions, CGIL, CISL and UIL, were in favour of abolishing the local management committees as a means of cleaning up local health authorities from distorted behaviour which led to corruption.
[58] Betty Leone, interview with author, Rome, 24 September 2002.
[59] Betty Leone, interview with author, Rome, 24 September 2002.
[60] Betty Leone, interview with author, Rome, 24 September 2002.
[61] Co-payments had increased by 500% from 1987 to 1993. See: *La Stampa*, 22 November 1992.
[62] FISOS-Cisl, 'Il Riordino della Sanità e la Nuova Disciplina del Rapporto di Lavoro', January 1993.

Groups' Strategy and Influence on the Parliamentary Process

The substantial and legislative changes to the Amato reform, following the work of the parliamentary committees, provide the background for systematic comparison between the groups' requests and the extent to which they were accepted and included in the parliamentary amendments to the draft executive decree. Accordingly, it is possible to assess the degree of influence of the medical associations in the policy making process and the outcome of their attempts to block the reform. The core of this second part of the chapter deals with issues related to doctors' terms and conditions of employment, as they represented the predominant concern of groups: from recruitment procedures and access to promotion to the *primari* level, and from renewal of employment contracts to institutional representation of the medical association in selection and evaluation committees. The last part of this section aims to shift the discussion from public employment issues to further changes introduced by the new Ciampi government with regard to general management, the enterprise formula and regionalisation. I investigate how far the 1993 reform of health care represented an innovation or if it was consistent with the Amato reform.

Groups' Strategy: the Referendum

From the issuing of the Amato decree in December 1992, the predominant strategy of groups was public protest, such as mass demonstrations and strikes,[63] as well as

[63] On 16 December 1992, approximately 150,000 doctors went on strike and on the same day 30,000 doctors demonstrated on the streets of Rome. See: 'Al via il referendum contro la riforma sanitaria; I medici di famiglia minacciano il blocco' in *Il Sole 24 Ore*, 30 December 1992.

more disruptive measures, such as the petition for a referendum to abrogate the decree. This was launched by FIMMG and supported by CIMO and SUMAI. The parties in opposition, namely the Communist Party, the Social Democrats, the Democrats of the Left, the Greens, and the Republican Party, supported the referendum and contributed to a nationwide collection of signatures.[64] In February 1992 two referendum proposals were presented to the *Corte di Cassazione*:[65] one seeking to repeal the entire executive decree, the other only selected parts of it, including Article 3, introducing the enterprise formula and general management, and Article 9 on the introduction of private health care insurance.

The referendum to stop the Amato reform and the associated mobilisation of public opinion created real pressure on the government during the legislative process of amending the decree in Parliament, as acknowledged by the Minister of Health herself, Pia Garavaglia.[66] This instrument remained highly destructive, as it would scrap the entire decree, permanently. For this reason, the threat of the referendum to abolish the reform as whole and thus to bring a halt to the modernisation of the health care system was one that the government could not ignore. The purpose of the referendum was not only to block the reform but also to gain public support. During the campaign, issues were broadened to include protest against administrative problems that citizens were experiencing with the introduction of a new system of

[64] Approximately 774,000 signatures were collected up to July 1993.
[65] The so-called 'abrogative referendum' is regulated by article 75 of the Italian Constitution. There are three stages in the process. First, a proposal to abrogate either partially or totally an existing law must be put forward by 500,000 people or five regional councils. Secondly, the Constitutional Court examines whether the proposals can be accepted. If they are, the third stage is putting the proposal to popular vote.
[66] On 25 May 1993, Pia Garavaglia, newly appointed Minister of Health of the Ciampi Government, presented to the Social Affairs Committee in the Lower Chamber of Parliament her proposal to change the 1992 executive decree. She defined the existing policy context as 'a window of opportunity' for changing the Amato reform, given the petition for the referendum and direct action.

exemption.[67] The main thrust of the Amato reform -- new managerialism and regionalisation -- was far from being debated in public.

Citizens were more readily mobilised on those issues which affected them and their health immediately. The administrative burden of the Amato reform's early implementation was painful for many.[68] Trade unions were particularly responsive to citizens' dramatic experiences with health care administration in the aftermath of the reform.[69] In many cases, the administrative forms to complete for exemption were not available. Public employees were not able to handle 14 million requests for exemption under the new system.[70]

Those groups which petitioned for the referendum were excluded from consultation with the Amato government.[71] Access was granted only to those which were expected to be more cooperative, such as FNOM, the peak association of consultants, though not necessarily the most representative one.[72] This reflects a political culture which does not expect the public interest to emerge from the competitive and pluralist interaction of private interests. The Ministry of Health did not consult the medical profession until after the Amato reform was enacted. The authoritarian style

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[67] In order to be exempted from paying for prescribed drugs, patients had to claim so-called *bollini*, literally stickers, from the local health authority. They could not use more than 16 per year, corresponding to 16 prescriptions only. This was a way to control the demand for drugs, but it did not take into account different age groups or chronic disease. This system of exemption was based on personal income. The elderly were particularly adversely affected by the sticker system. The Democrats of the Left asked for the abolishment of this system ('La tassa sul medico', *La Stampa*, 4 August 1993).

[68] The situation was described as a very painful process because patients had to wait days in line to claim their stickers. Public employees were insulted and overwhelmed by protest and complaints. It was the 'war of stickers'. See: 'Usl, dopo i bollini un altro calvario, *La Stampa*, 17 February 1993.

[69] 'Costa, oggi il vertice decisivo per avviare la sua rivoluzione. Polemica: la guerra dei ticket', *La Stampa*, 30 March 1993.

[70] 'Le Usl temono il caos: entro il 28 in arrivo 14 milioni di domande', *Il Sole 24 Ore*, 12 February 1993.

[71] Poggiolini, MP, Social Affairs Committee, Lower Chamber, 10 March 1993.

[72] FNOM was not representative because it was so internally highly fragmented that its president had to resign in June 1993. ANAAO, the biggest association of hospital doctors, did mount an attack on then on FNOM. See: 'Si dimettono i vertici FNOM divisi tra sigle e correnti', June 15, 1993.

of the government can be explained not only as seizing the opportunity to introduce change in the context of weakened parties and political legitimacy, but also as the legacy of a public authority tradition of the state, much stronger than expected.

In contrast to the medical associations, an adversarial strategy against the government was not pursued as systematically and as intensively by the trade unions. On the contrary, Cazzola, Secretary General of CGIL, criticised vehemently the use of the referendum to oppose the reform as 'criminal in its declared objectives' [73] because it mobilised public opinion against the reform on the basis of the current administrative difficulties in implementing the policy of co-payments and exemption rather than the more needed structural changes. Also CISL opposed the head-on opposition to the government 'by the separate unions that are only keen on preserving their privileges'.[74] This organisation criticized the Democrats of the Left for cultivating a populist and demagogic position putting at risk the reform of the health care system. It claimed that the consequence of a strategy of adversarial conflict was the isolation of interest groups from policy making. CISL proposed to use more constructive instruments of interest intermediation, despite the acknowledgement that the government was not that flexible during the negotiation.[75]

As far as more constructive instruments were concerned, the trade unions favoured the popular bill,[76] which was approved by the management of CGIL on 20 April 1993, then sent to the Corte di Cassazione, and followed by the sign-in. CGIL and

[73] *La Stampa*, 17 February 1992.
[74] FISOS-CISL, 'Il Riordino della Sanità e la Nuova Disciplina del Rapporto di Lavoro', 1993.
[75] FISOS-CISL (1993).
[76] Article 71 section 2 of the Italian Constitution gives the power to initiate legislation to the people. In order for the Parliament to consider a popular bill, 50,000 signatures of voters must be collected, and a bill divided in articles must be proposed. The Parliament has the prerogative to accept or refuse the discussion and examination of the popular bill.

the UIL launched separate popular bills, despite the attempt more generally to achieve unity of action. CISL complained about the other two unions for playing demagogic politics only. CGIL in particular was blamed for breaking the unity with the initiative of the popular bill for the reform of health care.[77] According to Trentin, leader of CGIL, 'we cannot unite three trade unions in a single association, but we need to build one organisation which negotiates for all workers'.[78]

Contrary to any scholarly expectation about the endemic conflict of Italian trade unions (Ross, Lange et al. 1982), they pursued a concerted strategy. Most coalition governments at the end of the 1980s and beginning of the 1990s needed the support of trade unions to survive. They could certainly not risk compromising this favourable situation by supporting the case of recalcitrant professional groups. To become involved in someone else's battle was politically too costly for CGIL, the largest trade union, and the benefits in return very limited, given their low representation in the health care sector.[79]

CGIL, CISL and UIL had a limited membership in the health care sector. Nonetheless, all three unions played an active role in the policy-making process of health care reform, due to the formal arrangements for consultation with the executive.[80] They did so in a very constructive way, deploring the professional groups' petition for a referendum, even though the Democrats of the Left and

[77] 'Sull'unità sindacale gelata dei tre segretari', *Il Sole 24 Ore*, 30 April 1993.
[78] 'Sull'unità sindacale gelata dei tre segretari', *Il Sole 24 Ore*, 30 April 1993.
[79] CGIL Funzione Pubblica has a section for the health care sector, but only 5% of total employees in the national health care system are members, compared with 30% who are members of CIMO (Betty Leone, interview with author, Rome, 24 September 2002).
[80] The trade unions appreciated the greater openness of Minister Costa. See : 'Dal 22 Marzo un tavolo a quattro con il Governo', *Il Sole 24 Ore*, 10 March 1993.

Communists supported it.[81] The unions were formally consulted by the Amato government[82] and thus did not have to resort to direct action as extensively as the medical profession. Moreover, the unions all supported the need to infuse the public sector with private sector management systems, albeit with different levels of commitment.[83] In fact, the original initiative of bridging public and private sector employment contracts came from CGIL.

Therefore, there were two simultaneous systems of intermediation corresponding to two different groups' modes of action, in turn determined by the governmental strategy, structure of the state and politico-administrative system. The intermediation between the government and the trade unions was one of 'concerted' politics, which characterised the more 'private' arena of negotiation. The parliamentary focus on public employment issues alone at the expense of others, which the executive considered more central, did end up serving the government's interests as well, not only those of the groups. In fact, this ensured that some issues were politicised and publicly debated, whereas others were not brought to public attention to avoid dissent.[84] The two themes of managerialism and regionalisation were purposively kept within the frame of concertation,[85] which did not extend to

[81] This is a remarkable illustration of political autonomy for CGIL, which was linked to the Communist party and still represents the leftist union.
[82] Falcitelli confirmed that Amato and the unions had a profitable relationship (interview with author, Rome, 23 September 2002).
[83] CISL was the more inclined towards this move.
[84] For instance, the problem of regionalisation was only occasionally addressed by the parliamentary debate, although seven regions had appealed against the Constitutional Court in 1993. Similarly, the trade unions mobilised public opinion on the administrative problem of handling stickers, but much less on the introduction of general management. The politically sensitive issues for the people were neither regionalisation nor general management. For instance, CGIL launched the initiative of a popular bill on 21 April 1993, campaigning on the abolition of the stickers system and the abolishment of the fee of 40 Euros for GPs. UIL also did not seem to mobilise citizens on regionalisation or general management. See: 'Costa, oggi il vertice decisivo per avviare la sua rivoluzione', 30 March 1993, *La Stampa*. Also see: 'Depositate in Cassazione due richieste abrogative; per la riforma sanitaria è già aria di referendum, 16 February 1993.
[85] Nicola Falcitelli, interview with author, Rome, 23 September 2002. He was responsible for drafting the Amato reform. He suggested that trade unions did not oppose the reform and that agreement was

any professional groups, not even the powerful top-level association of doctors, FNOM.[86] On the other hand, the 'public' arena was occupied primarily by professional groups, supported by public opinion and parliamentary committees. The relation between the state and these groups was remarkably different from the tendency for corporatist arrangement of doctors in many European countries.[87]

Despite the parliamentary opposition's attempt to focus attention also on other aspects of welfare policy, such as the high level of co-payments,[88] or the pharmaceutical policy,[89] professional groups were successful at narrowing the scope of the parliamentary debate on those employment issues which affected them directly. Although the priorities of the government and the groups differed significantly, their strategy of appreciating the role of parliamentary committees in the drafting of the legislative decree was remarkably similar, serving their different interests. The centrality of Parliament in the policy making process was key to the effective influence of groups. Although the governmental priority areas were distinct from the groups' ones and one could presume that parliamentary debate would primarily address the core of the government's priorities, the parliamentary committees' legislative work concentrated instead on the changes affecting employment conditions of the medical staff.[90]

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reached on the introduction of general management with them. Similarly, Betty Leone, Director of the Welfare Department, CGIL, confirmed that the unions accepted the need to make the health care administration more efficient (interview with author, Rome, 24 September 2002).

[86] For a discussion on concertation, see: Giugni (2003).

[87] For a discussion of the challenges that the medical profession is facing to respond to government's increasing concern for costs and quality of health care service, see Johnson, Larkin & Saks (1995); Freddi and Bjorkman (1989).

[88] Giannotti, MP, Social Affairs Committee, 13 October 1993.

[89] Trupia Abate, MP, Social Affairs Committee, 12 October 1993.

[90] If one analyses the final amendments of the Social Affairs Committee in the Lower Chamber and the Health Care Committee in the Senate, one can extrapolate that the greatest number of amendments refers to changes of articles 15 and 18, regarding public employment. For instance, in the Senate, article 18, dealing with assistant doctors, had in total 10 proposals for amendments, whereas article 1, on the national health care plan, received only three. The full text of amendments can be found in the parliamentary acts: 26 October 1993, Senate and 4 November, Lower Chamber.

Direct action of the medical profession was eventually replaced on 22 February 1993 by more frequent and open consultation of medical associations with the government,[91] when, after the resignation of De Lorenzo because of corruption scandals, a new Minister of Health, Raffaele Costa, took office.[92] Quadripartite arrangements[93] were established for the negotiation of co-payments and citizens' participation in health care expenditure in general and involved the government, the regions, the trade unions and the employer's association, Confindustria. Also the professional groups were relatively more involved in the negotiation,[94] though in a less institutionalised and formal way. Despite the seemingly greater openness of the government,[95] the medical profession continued to focus its lobbying activity on the Social Affairs Committee in the Lower Chamber,[96] who had already expressed serious reservations on the Amato executive decree in December 1992.[97] According

[91] On the same day that the new Minister of Health, Mr Raffaele Costa, took office, an administrative act was approved by the Council of Ministers that established for assistant doctors a gradual move to the level of *dirigenza*. This was 'the gift De Lorenzo left to the medical profession before leaving and the greatest headache for the coming Minister'. See: 'L'accordo con i medici per modificare in modo rilevante la riforma;da Costa la prima bozza sulla pax nella Sanita', *Il Sole 24 Ore*, 23 February 1993.
[92] On 22 February 1993, Raffaele Costa replaced De Lorenzo as Minister of Health in the Amato Government.
[93] On 22 April 1993, the minister of Health, Costa, agreed with the medical profession the so-called *pax sanitaria*, literally health care peace. Yet, the fragmentation between groups threatened the stability of the *pax*. The most important aspects of the agreement were: granting *dirigenza* status to assistant doctors by public competition; granting *dirigenza* status to *aiuti* doctors, literally aides, after three years of seniority; for ambulatory care specialists a move to self-employment; possibility of inclusion in public sector employment for emergency doctors. See: *Il Sole 24 Ore*, 23 April 1993.
[94] On 20 April 1993 the minister of Health Costa met with the FNOM; on 23 April he met with all medical associations. See: 'Ministro della Sanità e medici cercano l' accordo sulla riforma', 21 April 1993, *Il Sole 24 Ore.*
[95] The trade unions appreciated the greater openness of Minister Costa. See : 'Dal 22 Marzo un tavolo a quattro con il Governo', 10 March, 1993, *Il Sole 24 Ore.*
[96] The Social Affairs Committee in the Lower Chamber launched extensive consultation with the groups for four days. For the medical association hearings in Parliament, see: 'Audizioni del 28.1.1993 and del 3.2.1993, del 4.2.1993 and 17.2.1993,' Camera dei Deputati.
[97] As we investigated in Chapter II, the parliamentary committees in both Lower Chamber and Senate had expressed their opposition to the Amato legislative decree. They had proposed amendments which were not accepted by the government.

to the MP Bicocchi, the political group of the Christian Democrats 'declared war on the Amato executive decree'.[98]

Direct action affected public opinion and contributed to raising the issue of health care reforms up the Ciampi government agenda. Groups also shaped the earlier stages of the implementation of the Amato reform, which was halted by the new legislative process of amendment under examination. The opportunity for civil society's more constructive contribution to the policy making process came with the new Ciampi government's decision in May 1993 to amend the Amato executive decree and to engage more fully with parliamentary committees, as strongly requested by Parliament and by the Christian Democrats. The positional strategies of the medical profession changed, between December 1993 and March 1994, from initial adversarial politics to negotiation and bargaining during the parliamentary process of approval of Legislative Decree no. 517, which took place from September to November 1994.[99] Hence, another significant effect of groups on the policy making process was evident as parliamentary committees regained their lost centrality, after the Amato government had largely ignored their activities.

The 1993 Legislative Process of Amendment

The most evident impact of the medical groups' active shaping of the parliamentary process was on the substantive drafting of the parliamentary opinion on legislative decree no. 517. The process of legislative amendment of an executive decree can be at least as cumbersome and intricate as that of the original decree, especially if it is

[98] Social Affairs Committee, Lower Chamber, 17 March 1993.
[99] Wide consultation was reported in the press: see *Il Sole 24 Ore*, 8 October 1993, and 29 October 1993.

not the product of consensus and negotiation, as we have illustrated in Chapter II. What follows is an examination of the substantial changes to the original Amato executive decree as they were discussed and drafted in the relevant parliamentary committees in both houses of the Italian Parliament before the final enactment of the amended executive decree no. 517 in December 1993. The major purpose of this section is to understand how far groups' demands, investigated earlier, have shaped the parliamentary process and final legislative output.

The amending powers of parliamentary committees presented groups with an opportunity to influence the executive draft of the decree. As far as the medical profession's request for greater institutionalised representation was concerned, the government did not accept most parliamentary amendments. The demands for an institutional and representational role for the medical profession[100] were met by the parliamentary 'rescue' of all those categories of doctors that had been excluded from public sector employment by the 1992 Amato reform. For instance, on the issue of exclusion of the category of ambulatory care practitioners from the public sector, the Lower Chamber's Social Affairs Committee proposed not only to reintroduce this category, but to do it in the first level of *dirigenza*, according to the detailed

[100] For instance, the Health Care Committee in the Senate, on 27 October 1993, proposed that 'regions can identify areas of activities for ambulatory specialists who require a public sector employment contract, after having consulted the major interest groups affected'. The government did adopt this amendment partially, maintaining the possibility for regional governments to identity new areas of health care services as necessary (Article 8, Legislative Decree, no. 517/1992), but the consultation of interest groups was not formalised in the final executive decree. Similarly, the Senate proposed an amendment to Article 15, regarding the *dirigenza* in the health care sector, for including an official member of FNOM in the Committee recruiting the higher level of doctors, but this was not accepted. Another illustration of the governmental rejection of professional organisations' demands for greater institutional representation was the refusal to adopt the Lower Chamber Social Affairs Committee's amendment for the inclusion of FNOM at the negotiating table for bargaining employment contracts. The new decree allowed only trade unions to be present at the bargaining table, thus excluding professional associations.

application process.[101] The government adopted this parliamentary recommendation by adding a new section to Article 8 stating:

> LHAs can employ ambulatory care specialists as established by already existing contracts[...]regions can identify areas of health care services which require the adoption of a public sector employment contract with ambulatory care specialists; for this purpose, those ambulatory specialists who on 31 December 1992 had been working for five years as independent contractors may apply to the first level of *dirigenza*, prior to an evaluation of the necessary requirements.

In this respect the new decree adopted the parliamentary committees' amendments, which reflected the professional groups' proposals, with the exception of those issues which involved the representation of interest groups at collective negotiations.

Minister Garavaglia, intended the same solution for emergency doctors, had the Council of Ministers not blocked her amendment.[102] According to the amendment proposed by the Ministry of Health, in accordance with the opinion of the parliamentary committees, LHAs could employ emergency doctors for existing vacancies.[103] The amended decree also reflected the Minister of Health's position that 'it is not admissible that there is no scope for bargaining the inclusion of emergency practitioners in the public sector employment'.[104] She suggested that regions would be able to include these doctors in their health care planning and organisation. This was in clear contradiction with the announcement by the Treasury that in 1994 cost containment would primarily have to affect personnel costs.[105] Her position, however, was not entirely convincing, but rather ambivalent. In fact, on a different occasion,[106] she criticised the Parliament for 'making every doctor by

[101] Article 8, Section 8, Decree no.517/1993.
[102] *La Stampa*, 25 Novembre 1993.
[103] Article 8, Section 1-bis, Decree no.517/1993.
[104] Speech of the Minister of Health, Maria Pia Garavaglia, Lower Chamber, Social Affairs Committee, 25 May 1993.
[105] In 1992 personnel cost was 40% of total health care expenditure and amounted to 19.8 billion Euros.
[106] The Minister of Health, Garavaglia, addressed the Lower Chamber on 7 July 1993. She, then, admitted the difficult relationship with the Department of Public Services.

definition a *dirigente*', in contrast with the concurrent reform of the *dirigenza* proposed by the Department of Public Services.[107]

Article 15 of the executive decree regulated the roles and functions of doctors, as well as their access to the higher levels of the medical profession in the public sector. In this it followed the delegating law's provision to identify the different levels of *dirigenza* according to efficiency criteria, namely without increasing staff allocation plans and establishing fixed-term contracts, renewable on the basis of performance evaluation. The Amato reform, as we have illustrated in Chapter II, identified two levels which differed in their functions and methods of access.[108] As far as the latter was concerned, the first level, the lower one, was recruited by public competition, and the second one formally by appointment by the local health authority's general manager on the basis of an opinion formulated by an Expert Committee.

There were two highly significant differences between the original and the amended decree. First, the ranking system required to appoint the second level of doctors, the higher one, was abolished. Poggiolini, MP and President of FNOM, lamented that the appointment of *primari* would remain highly politicised because the Expert Committee's members were chosen by political parties, without the meritocratic ranking system.[109] Many MPs realised that political parties in fact controlled the

[107] Executive Decree no.29 of 1993 reforming the Italian civil service.
[108] Prior to the 1992 reform there were three levels of *dirigenza* of the medical profession, as established by Law no.761 of 1979: the first level included assistant doctors (*assistenti*); the second one was composed of junior doctors (*aiuto*); and the third and higher one was made of heads of hospital divisions (*primari*). The reduction from three to two levels, established by the 1992 executive decree, meant in practice the exclusion of the first level, namely the assistant doctors, from *dirigenza*.
[109] Poggiolini, MP, Republican Party, Lower Chamber, Social Affairs Committee, 13 October 1993.

appointment of *primari*.[110] The marginal role of the general manager in appointing the second level of *dirigenza* was deplored by MP Petrini: 'the general manager does not have any power to appoint public managers, nor can he alter the staff allocation plans; he can effectively only disinvest to contain costs'.[111] As far as the appointment of *primari* was concerned, SIDIRSS, *Sindacato Dirigenti Servizio Sanitario,* the Health Care Public Managers Union, also noted that the general manager is not a member of the Expert Committee selecting the *primari* and more generally that his power is constrained.[112] The second change to the original decree was that the amended decree incorporated the provision for results-oriented management, introduced by the reform of the civil service.[113] Arguing against this, the Lower Chamber Social Affairs Committee called for an opt out of the health care sector from the general framework of civil service reform.

With respect to the particularly controversial and sensitive issue of hospital assistant doctors, medical groups were also able to influence the parliamentary process and push their demands through. The reduction from three to two levels of *dirigenti*, as established by the original decree, would have excluded the entire category of assistant doctors[114] from the legal and economic category of *dirigenti*. This was widely deplored both in the Senate and in the Lower Chamber as a response to stringent financial requirements with no consideration for the real needs of patients. The government was criticised for attempting to flatten the different levels of

[110] Senators Perina and Garaffa lamented the continuation of clientelistic practice in the appointment procedures, Health Care Committee, Senate, 19 October 1993. The amendments to the Amato legislative decree were discussed in the Senate from 19 to 28 October 1993.
[111] Petrini, MP, Lower Chamber, Social Affairs Committee, 7 July 1993.
[112] S.I.Dir.S.S., "Considerazioni e proposte sui decreti legislativi di attuazione della legge di delega 23.10.1992, n. 421 in materia di Sanità e di Pubblico Impiego limitatamente alla Dirigenza del S.S.N.", Lower Chamber, Hearing, 3 February 1993.
[113] Article 20 of the Executive Decree no.29/1992 establishes that public managers (dirigenti) are responsible for the results of their activities, for which they must present a yearly report.
[114] The 'assistant doctors', so-called *assistenti*, were approximately 40,000 in 1993.

dirigenti, according to an approach typical of the 1970s, when unions hindered the process of establishing the senior civil service.[115] In response to these critics, the Minister of Health Garavaglia reported her battle with the Department of Public Services, which was strongly against any reservation of public competition quotas for insiders based on a rigid hierarchical sequence.[116] She informed the committee of her intention to propose to the Public Services that regions could review their staff working plans so that assistant doctors could retain their position.[117] Despite the resistance of other relevant ministries, Article 18 of the amended decree established that, during the implementation, the first level of doctors be articulated in two economic, not legal, sub-levels, (a) and (b). The lower of these two economic levels, (b), included the assistant doctors, who maintained their existing pay. However, after five years of service, depending on open applications, job vacancies, and an evaluation by an *ad hoc* committee, assistant doctors could be promoted to the higher level, namely economic treatment (a). The Health Care Committee in the Senate proposed to leave the matter of transfer from (b) to (a) to collective bargaining rather than legislation. This was not accepted. The same Committee also suggested that, after ten years of service, assistant doctors could even access the second and higher level of dirigenza, but again the government did not accept this amendment. In the Lower Chamber, the Social Affairs Committee suggested unsuccessfully an automatic transfer of all doctors to level (b) after five years of service.

The legislative work of the parliamentary committees had thus been influenced by the demands of the medical profession in such a way that endemic conflict was

[115] Perina, Health Care Committee, Senate, 19 October 1993.
[116] Speech of the Minister of Health, Garavaglia to Lower Chamber, Social Affairs Committee, 7 July 1993.
[117] Speech of the Minister of Health, Garavaglia to Lower Chamber, Social Affairs Committee, 7 July 1993.

significantly reduced and accommodation temporarily replaced confrontation between interest groups and the government. Despite the general cross-party support for the requests of the professional groups, the parliamentary Opposition in the Lower Chamber voted against the final opinion of the Social Affairs Committee. Also the Communists and the Northern League voted against it. The rejection by the Democrats of the Left of the legislative text proposed by the Committee was in marked contrast to their earlier abstention during the committee's resolution on the Amato decree.[118] During the parliamentary debate in October and November 1993 on the health care reforms, the Democrats of the Left were dissatisfied with the government's maintenance of high co-payments as instruments to finance health care rather than only as a means of controlling demand. The party also opposed the definition of the minimum levels of health care entitlements on the basis of financial availability instead of health care needs. Moreover, criticisms were raised over the government's obfuscation about the financial resources available for the implementation of the new executive decree. Since regions were not given the authority to levy regional taxes, it was not clear how they were going to finance their budget deficits, especially if the old practice of underestimating costs continued.[119]

The success of groups was particularly noteworthy in view of their fragmentation and the differing strategies of medical associations and trade unions. The effects of their lack of a monopoly on representation within the policy-making process, *ceteris paribus*, did not appear to diminish groups' effectiveness. The very limited concerted action between independent unions representing different categories of doctors and

[118] Vasco Giannotti, MP, explained to the author that the Democrats of the Left had a difficult time in justifying why they voted against the Garavaglia reform, in light of their earlier abstention on the Amato reform (interview with author, Rome, 16 July 2003).
[119] Trupia Abate, PDS, and Giannotti, PDS, Lower Chamber, Social Affairs Committee, 13 October 1993.

the peak associations enhanced the autonomy of professional groups in bargaining. The autonomy of an interest group is a key factor in assessing its influence because it implies the ability to retreat from negotiation, to threaten to retreat from negotiation, and to mobilise those members who are against symbiotic relationships with the institutions. Autonomy is a favourable condition for increasing the militancy of an interest group, especially against the peak association. In contrast with much scholarly literature about Italian interest groups and their relations with the bureaucracy and political parties (La Palombara 1964),[120] the way groups shaped the parliamentary process suggests also that professional groups are relatively autonomous from political parties, which, unable to aggregate demands themselves, become instruments of the demands made by groups.

As far as the reform of the *dirigenza* of doctors and the inclusion of specific categories within public sector employment were concerned, professional groups' influence on the process determined the final parliamentary output. Their influence was most remarkable in light of the high level of fragmentation of the representation of the medical profession and their unpredictable access to the government. As for the former, the fragmentation was exacerbated by the conflict between FNOM, the peak organisation of doctors, and the independent groups representing specific

[120] The major contribution of La Palombara in the analysis of the relationship between interest groups and the bureaucracy is the assessment of the key role played by political parties, such as the Christian Democracts in the 1970s (La Palombara 1964). From empirical research he derives two main types of interactions between groups and the bureaucracy in Italy: *clientela* and *parentela*. In the first case an interest group succeeds in becoming the natural and exclusive representative of a given social sector. These variables constitute the conditions that affect whether and to what extent a *clientela* relationship can be established: a *technical* need for information from the groups; a *political* need to control the object of administrative regulation; a *value orientation* implying that the administrative agency exists in part to help or assist the object regulated; *structural deficiencies* in the administrative agency that make it impossible or unlikely that it can secure information on its own; and finally the *socio-psychological* need of maintaining an orderly and reasonably predictive relationship between the agency and the groups affected by its actions. The second type of relationship is *parentela*, which involves a relatively close and integral relationship between certain associational groups and the politically dominant parties. Pressure groups gain access and legitimacy through their attachment to that particular party rather than through their ability to represent effectively a sector of the society.

categories.[121] Paradoxically, the diffuse and fragmented representation of the medical profession did not affect the legislative fulfilment of their demands. On the contrary, despite the attempt of the government to divide the groups, their particularistic and highly technical demands were accepted.

The Introduction of General Management and Regionalisation: Change and Continuity

The amendments to the Amato executive decree clearly brought about big changes as far as employment terms and conditions are concerned, but they had less obvious effects on the move to general management and regionalisation. With the provisions related to the general manager, three changes are most visible. First, in the original decree, the general managers of LHAs and hospitals were to be appointed by the President of the Region. As amended, the legislation established more generally that general managers be appointed by the Region, without specifying by whom.[122] Secondly, the Permanent Conference for State-Regions Relations acquired a consultative role in shaping the employment contract of the general manager. Thirdly, the office of the general manager was made incompatible with any type of existing employment or consulting contract with the relevant LHA,[123] so that internal candidates were excluded from eligibility. In the original legislation the incompatibility existed only for independent contractors with the LHA, but not for its public sector employees. In its final resolution, the Health Care Committee in the Senate proposed to the government that an appointment to the post of general

[121] Due to the internal conflict between rival independent unions representing different categories of doctors, the management board of FNOM, the peak association of doctors, resigned on 15 June 1993.
[122] Article 3, Section 6, Executive Decree no.517/1993.
[123] Article 3, Section 9, Executive Decree no.517/1993

manager should remain compatible with already being a public employee of the LHA concerned.[124]

The ambiguities in the original legislation regarding the politicisation of the general manager remained unresolved. Some Senators suggested the reintroduction of management committees as a way of overcoming the risk of directly politicising the appointment of the general manager, who would be otherwise controlled by political parties.[125] Minister Costa assured them that the committee at the Ministry in charge of drawing up the list of potential candidates would also establish specific requirements for guaranteeing meritocracy and expertise.[126] By contrast, some MPs emphasised the need to maintain political control over technocratic decision-making.[127] The final decree maintained the autocratic management figure of the general manager and abolished management committees.

Regarding the second major theme that I analysed in Chapter II, the regionalisation of health care, the Minister of Health, Pia Garavaglia, on various occasions reiterated the new government's continuity with the Amato government's plan to regionalise health care.[128] The new legislation emphasised the legislative functions of the regions in the determination of the organisation of local health care services. The amended Article 2 of the Decree indeed set out the legislative power of the regions. However, the Democrats of the Left complained no progress had been made in giving regions the financial autonomy to cover budget deficits. The system of health care finance

[124] Health Care Committee, Senate, 27 October 1993.
[125] Garaffa, and Zappasodi, Health Care Committee, Senate, 19 October 1993.
[126] Speech of the Minister of Health, Raffaele Costa, Lower Chamber, Social Affairs Committee, 17 March 1993.
[127] Saretta, DC, Lower Chamber, Social Affairs Committee, 10 June 1993.
[128] Speech of Minister of Health Garavaglia to the Committee for Regional Affairs, Senate, 10 June 1993 and 26 May 1993; speech of Minister of Health Garavaglia to the Committee for Social Affairs, Lower Chamber, 25 May 1993 and 7 July 1993.

was not altered by the transfer of the National Health Care Fund based on population from the centre to the regions.

Despite the cross-party agreement for a greater role for the regions and for the Permanent Conference for State-Regions relations, the amended decree diminished the control of regional government over LHAs by changing the definition of the LHA from 'a regional public body' to 'public body', as requested by the National Association of Municipalities, ANCI.[129] This implied that LHAs were freed from regional control, at least in formal terms. The Socialist MP Renzulli expressed his serious concern over the implications of this provision for the prospects of the enterprise formula. He claimed that 'this amended decree creates a relationship between the LHA and the region which is not coherent because it abolishes the provision that the LHA is a regional public body'.[130] In practice, though, regions retained a firm grip on the LHAs. For instance, regions had to establish the procedures to determine the allocation of staff before 31 March 1994.

Other provisions in the amended decree revealed the government's unconvincing commitment to regionalisation. In addition to the rephrasing of the definition of LHAs, Article 1 of the amended decree granted the authority to the central administration to include in the National Health Care Plan, the so-called *Piano Sanitario Nazionale* (PSN), specific indicators to monitor costs and measure targets of the health care services provided by the state.[131] Article 10 of the amended decree provided for an administrative act to be issued by the Ministry of Health setting out quality indicators and how to use them. The regions strongly objected to the

[129] ANCI, 'Prime valutazioni sul decreto legislativo 502/1992 in materia di sanità, attuativo della legge delega 421/1992', Lower Chamber, Social Affairs Committee, Hearing, 28 January 1993.
[130] Renzulli, PSI, Lower Chamber, Social Affairs Committee, 4 November 1993.
[131] Article 1, Section 4, Executive Decree no.517/1993.

definition of indicators of efficiency and quality designed by the central administration. Moreover, a new section was added to Article 1 establishing the possibility that the Ministry of Health could promote forms of collaboration between regions and provide policy guidelines to ensure the 'co-ordinated application of the regional health care plans'.[132] This suggested a strengthened policy-coordination role for the central administration.

Regions objected by appealing to the Constitutional Court, which ultimately upheld the government decision. [133] They contended that the legislative decree was too detailed with regard to the organisation of local health authorities and hospitals.[134] As the local health authority was defined as a 'regional public body', they complained that the central government had encroached upon regional administrative competencies. For instance, the decision to grant 'trust' status to public hospitals rested with the Ministry of Health. Yet, the most problematic issue was that the decree obliged the regions to pay for the financial deficits of local health authorities.[135] The regions raised various objections: that they would not have any control over public employment contracts or national agreements with self-employed specialists and that they were also denied participation in the definition of uniform levels of health care provision; that the central government would calculate the share of the national health care fund to be divided among regions on abstract models not

[132] Article 1, Section 7, Executive Decree no.517/1993.

[133] 'Sentenza no. 355 della Corte Costituzionale', 28 July 1993. The attached report to the Court's judgement refers to the constitutional appeals of some Italian regions. Eight regions (Toscana, Lombardia, Liguria, Umbria, Veneto, Campania, Emilia Romagna, Valle d'Aosta) appealed to the Constitutional Court against article 1 (national health care plan), article 3 (organisation and management of local health authority), article 4 (hospitals and trusts), article 6 (Universities and health care), article 8 (service delivery), article 9 (introduction of insurances), article 10 (quality control), articles 12 and 13 (financing health care), and article 14 (citizens' rights and participation) of the executive decree no.502/1992.

[134] Report attached to 'Sentenza no. 355 della Corte Costituzionale', 28 July 1993.

[135] Probably the most significant decision of the Court was the recommendation to opt for a gradual approach to the transfer of all financial responsibilities to pay for local health authorities' deficits. The Court supported the concern of regions that they would not be able to pay for the huge accumulated deficits, even with the additional revenue of their own resources.

taking into account the different quality of health care services in different regions. There would be a gap between the resources necessary to maintain the uniform levels of health care and the resources transferred from the centre to the regions.

As far as the national health care plan was concerned, the parliamentary Opposition expressed dissatisfaction that the PSN did not include a three-year budget or any specific indication of the annual health care budget. Also some separate hospital doctors unions went on strike against the lack of financial coverage for the renewal of their employment contract.[136] The 1994-96 PSN, which was being discussed in Parliament at the same time as the amendments to the Amato reform, did not contain any indication of financial resources because these were to be set out by the 1994 Financial Law instead.[137] Without the budgeting provisions, the PSN became an instrument without concrete planning potential. The disjointing of the process of establishing health care priorities from their finance risked underestimating the financial resources needed to cover expenditure. These would then be incurred in the form of high budget deficits, for which regions had become accountable. Despite the request of the parliamentary Opposition to include in the last part of the 1994-96 PSN the financial resources available,[138] the government enacted it without legislative and administrative co-ordination with the provisions made in the 1994 Financial Law, which only months later established the health care budget.[139] Since

[136] See: 'Medici, anche nella Sanità comincia l'autunno caldo', *Il Sole 24 Ore*, 15 October 1993.
[137] Piano Sanitario Nazionale, 1994-96.
[138] Trupia Abate, PDS, Lower Chamber, Social Affairs Committee, 13 October 1993.
[139] The so-called Finanziaria, literally 'Financial Law', is the group of laws aimed to realise the national budget according to the long term objectives of the economic policy. It was introduced in the Italian system by Law no. 468 in 1978 in order to overcome the excessive rigidity of the budget procedures. The *Finanziaria* establishes, among other things, the financial resources of special funds intended to cover the financial requirements of bills to be approved within the year. The Financial Bill must be presented together with the Budget Bill and must be approved by 31 December. The *Finanziaria* had always encountered procedural difficulties in Parliament deriving from the inclusion in the bill of heterogeneous provisions not closely related to the yearly budget. In 1983 a major reform

there were no financial provisions with the enactment of the 1994-96 national health care plan, Trupia Abate noted that there is 'great distance between the Minister of Health's national health care plan and the one of the government, which ultimately decides without her'.[140] However, as the Undersecretary for the Treasury explained, the PSN provisions are financed by the National Health Care Fund, which amounted to approximately 42 billion Euros in 1993.[141] Hence, the purpose of the PSN was not to provide for additional resources to be given to the National Health Care Fund. The PSN was not designed to set out additional expenditure, but was an instrument of planning the already allocated public resources.[142]

On the one hand, the Minister of Health Garavaglia suggested to the Lower Chamber's Social Affairs Committee on 25 May 1993 that she intended to re-establish the centrality of the role of the mayor, as indicated in the delegating law. She expressed dissatisfaction that there was no intermediate level of decision-making between the general manager of LHAs and the regional minister of health. On the other hand, delivering a speech to the same parliamentary committee on 7 July 1993, she defended the enterprise formula from the interference of local politics. She argued that: 'we cannot have a plethora of bodies made of 140 mayors to take decisions. The LHAs will be very large after merging.'[143] Despite the contradiction in her speeches, it was the latter argument which prevailed in the final decree. The mayor's role in local health care policy continued to be extremely marginal and negligible. Both parliamentary committees in the Senate and in the Lower Chamber

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tried to improve the parliamentary procedures for examining the financial bill by the end of the year and to avoid the overloading of the bill.

[140] Trupia Abate, MP, Social Affairs Committee, Lower Chamber, 12 October 1993.

[141] Speech of the Undersecretary of Treasury, Malvestio, to the Lower Chamber, Social Affairs Committee, 13 October 1993. He provides the following figures for the 1993 health care financial requirements: 42 billion Euros for the National Health Care Fund; 500 million Euros for general medicine; 1.6 billion Euros for co-payments; 2.36 billion Euros for LHAs own resources.

[142] Fronza Crepaz, MP, Lower Chamber, Social Affairs Committee, 13 October 1993.

[143] Minister of Health, Garavaglia, Social Affairs Committee, Lower Chamber, 7 July 1993.

proposed amendments against the marginalisation of mayor in order to accept the demands of ANCI (National Association of Italian Communes). ANCI was concerned that the municipalities should retain control over LHAs and general managers.[144] This organisation demanded a central role for the municipalities in redrawing the geographical boundaries of LHAs as they were merged. It also suggested the creation of a new body, which could dismiss the general manager as a last resort and would also provide compulsory and binding decisions over the municipalities. The Lower Chamber's Social Affairs Committee proposed that Article 3 be modified so that the mayor had policy, planning and monitoring control over the LHAs. The government did not accept it. The Senate Health Care Committee proposed a similar amendment which was also rejected. Moreover, the Senate proposed that municipalities should be able to request that LHAs provide health care services not originally planned by the regional health care plan. This was also not accepted by the government.

Although we have focused on the two themes of the health care reform that have most affected the administration of health care, it is worth noticing briefly that one significant change to the 1992 reform was the abolition of the introduction of private insurance and private health care funds.[145] The major criticism against it, levelled primarily by the trade unions,[146] was the financing of private insurance with public resources. It has been also noted that the Italian private insurance market was not sufficiently developed to support the demand.[147] In order to remedy this, CNEL, the

[144] ANCI, Lower Chamber Hearing, 28 January 1993. See also: 'In una audizione in commissione alla Camera anche l'ANCI dice no a De Lorenzo', *Il Sole 24 Ore*, 29 January 1993.
[145] Artiche 9, Forme integrative di assistenza sanitaria, Legislative Decree no. 517/1993.
[146] Betty Leone, interview with author, Rome, 24 September 2002. She suggested that the issue of private insurance was one of the most acrimonious in the negotiation between trade unions and the Prime Minister, especially because Amato was very keen on it and not ready to compromise.
[147] Maurizio Ferrera, 'Welfare state più all'europea ma sanità senza paracadute, interview in *Mondo Economico*, 10 October 1992.

National Economic and Labour Council, suggested that the amount of resources redirected towards voluntary private health insurance be clearly specified. [148] The new minister of Health Garavaglia stated that she was against the health care funds as planned by Amato because they were distortedly absorbing public resources in order to compete with the public sector. She was against the privatisation of health care, although she declared herself in support of introducing greater 'competitiveness' in the sector.[149] Accordingly, the amended executive decree pursued the differentiation of the provision of health care services in order to break the state monopoly by transforming 'substitute' heath care funds into 'supplementary' ones. Article 9 established that health care funds could be created by collective agreements and managed by trade unions, by employees or the self-employed, and non-profit organisations and charities. The decree envisaged additional administrative acts to regulate the creation, organisation, composition, financial contribution, and control of these supplementary health care funds. [150]

To conclude, the professional representation of consultants was highly fragmented into different independent unions representing specific categories. Yet, most of the groups focused their lobbying activity narrowly on the part of the reform dealing with personnel policy, namely the type of employment contract within the public sector, the recruitment and promotion of hospital doctors, the structure and access of the *dirigenza*, and so on. The peak association of the medical profession, FNOM, was also actively involved in policy making but in a rather more constructive way, compared with the independent unions, such as SUMAI, which petitioned for a referendum to abrogate the reform and organised strikes and street demonstrations.

[148] CNEL, 'Parere sullo schema di decreto legislativo di attuazione della legge delega 23 Ottobre 1992 sulla sanità', Lower Chamber, January 1993.
[149] Speech of Minister Garavaglia, Lower Chamber, Social Affairs Committee, 7 July 1993.
[150] Artiche 9, 'Forme integrative di assistenza sanitaria', Legislative Decree no. 517/1993.

FNOM was not merely concerned with particularistic demands about terms and conditions of employment, but broadened its lobbying to issues such as the power of the medical profession after the introduction of general management and the problem of politicised appointments at the top level of the medical hierarchy. Not only the medical profession but also the trade unions participated in the process of health care reforms. The three confederations of trade unions supported the Amato reforms, with the exception of the introduction of private insurance, which was scrapped by the amended decree no. 517. In response to these professional groups' demands and lobbying, the parliamentary committees transmitted to the government their final opinion proposing legislative amendments to the reform which reflected almost entirely the medical profession's interests. The Social Affairs Committee expressed its favourable opinion on 4 November 1993[151] after one month of debate.[152]

The Ciampi Government Strategy to Avoid Policy Reversal

In contrast with the conflict which characterised the system of interest groups' intermediation under the Amato reform, the most significant innovations in the policy-making process under the Ciampi government were wide and open consultation with the medical profession, including peak associations and the majority of separate unions and full participation of parliamentary committees in the drafting process of the amended legislative decree. This new approach reflected the governmental strategy to re-establish a productive working relationship with the

[151] Among the amendments proposed by the parliamentary committees to the executive: increasing public funding for the national health care system up to 6.5 per cent of GDP; mayors' involvement in the identification of public hospitals to be granted autonomy; and strengthening the opportunities of engagement in providing health care services for charities and non-profit organisations. The parliamentary opinion was passed with the support of the majority. The Democrats of the Left voted against. See: 'Riforma Garavaglia: favorevole con riserve il parere della Camera', *Il Sole 24 Ore*, 5 November 1993.

[152] The executive draft of the Garavaglia reform was transmitted to Parliament on 30 September 1993.

medical profession, indispensable for the implementation of the reforms.[153] The Ciampi government was also favourably disposed towards the parliamentary control functions of executive decrees. The Minister of Health, Garavaglia, was seeking parliamentary support against the Amato reform, which she had firmly opposed when she was a member herself of the Social Affairs Committee in the Lower Chamber in 1992.[154] The Ciampi government ultimately accepted the changes proposed by the parliamentary committees as far as public employment was concerned, and incorporated them in the new amended decree.[155] The government decided to renew the ambulatory care specialists' public contract[156] and provided assistant doctors with the option of accessing *dirigenza,* albeit only juridically and not financially.[157]

Despite these many attempts at widely consulting the groups and engaging them in the drafting process,[158] and ultimately making concessions, the end of 1993 showed a renewal of direct action and groups' dissatisfaction.[159] The allocation of financial resources for the employment amendments accepted by the government remained a

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[153] 'La responsabile della Sanità punta al ritorno allo Stato sociale abbandonando del tutto le logiche dell'assistenzialismo', *Il Sole 24 Ore*, 5 May 1993.

[154] Ms Garavaglia declared her most convinced opposition against the Amato reform, in particular against the introduction of private insurance. She also despised the Amato government for ignoring the amendments proposed by the parliamentary committees in 1992. See: 'Il ministro Garavaglia dichiara guerra alla riforma De Lorenzo', *La Stampa*, 10 May 1993.

[155] 'Modifica al decreto legislativo 30 dicembre 1992 n. 502 "Riordino della disciplina in materia sanitaria, a norma dell'articolo 1 della legge 23 ottobre 1992 n. 421", approved by the Council of Ministers on 24 November 1993.

[156] Ambulatory health care specialists became *dirigenti* and as such remained in the public sector. See: Legislative Decree no.517/1993.

[157] The final decree established that the assistant doctors could become *dirigenti*, at first only juridically, awaiting economic promotion on the basis of vacancies. See: 'Il Governo rilancia la scommessa della riforma-bis della sanità; per le Usl e gli ospedali il rimedio è l'impresa', *Il Sole 24 Ore*, 25 November 1993.

[158] The press coverage mentions 'hundreds of meetings with the medical associations'. See: 'Importanti provvedimenti all'esame del Consiglio dei Ministri; la riforma sanitaria bis al varo di Palazzo Chigi', *Il Sole 24 Ore*, 24 November 1993.

[159] There was a general strike of the entire health care sector on 30 November 1993 against the 1994 Financial law budget cuts. *Il Sole 24 Ore*, 30 November 1993.

problematic and controversial issue among interest groups.[160] Trade unions declared that they were not sufficiently satisfied with the changes made to the Amato reform, and the association of hospital doctors, CIMO, was also highly sceptical.[161] The civil servants at the Ministry of Health and at the Department of Public Services were working together at an agreement with the medical associations until the very last minute.[162] The problem was the uncertainty that the 1994 Financial Law could allocate sufficient funding to the employment provisions in the Garavaglia executive draft, given the absolute necessity to contain personnel costs and the disastrous financial situation of LHAs presented by the Court of Accounts in 1992.[163] Not only the Treasury but also the Minister of Public Services, Cassese, had many reservations about the *dirigenza* in the health care sector and 'wanted to be more strict than the final legislative decree drafted by the Ministry of Health Care'.[164] Ultimately the 1994 Financial Law cut approximately 2.3 billion Euros from the health care budget,[165] against the anticipated 1.2 billion Euros. The Financial Law also blocked the filling of 50 percent of vacancies to save 400 million Euros.[166]

As we have noticed in the discussion of the influence of groups on the parliamentary process, the executive under the Ciampi government demonstrated a different type of institutional collaboration with parliamentary committees than had been displayed by the Amato government. This has been documented by the approval of an ample

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[160] On 29 October 1993, FIMMG and FIMP, *Federazione italiana medici pediatri*, went on strike to protest against the 1994 Financial Law. See: 'Si fermano medici e pediatri', 29 October 1993.
[161] 'Il testo dello schema di decreto legislativo di modifica del D.Lgs 502/1992 approvato dal Consiglio dei Ministri; riforma bis per le Usl-azienda', *Il Sole 24 Ore*, 8 October 1993.
[162] 'Il Governo rilancia la scommessa della riforma-bis della sanità; per le Usl e gli ospedali il rimedio è l'impresa', *Il Sole 24 Ore*, 25 November 1993.
[163] In 1991, for instance, the total budget deficit for local health care authorities was 6 billion Euros, almost double than in 1989 (3.9 billion). See: Corte dei Conti, Decisione e Relazione sul Rendiconto Generale dello Stato per l'esercizio finanziario 1992, Volume II, Tomo II.
[164] 'Importanti provvedimenti all'esame del Consiglio dei Ministri; la riforma sanitaria bis al varo di Palazzo Chigi', *Il Sole 24 Ore*, 24 November 1993.
[165] Minister of Health, Garavaglia, interview in *La Stampa*, 11 September 1993.
[166] *La Stampa*, 23 July 1993.

range of parliamentary amendments, the willingness of the executive not to push the process by calling for emergency measures, such as debate timing restrictions or the question of confidence, as was the case under the legislative episode discussed in Chapter II. Overall, the Ciampi government showed a greater degree of compliance with constitutionally established parliamentary prerogatives in the case of legislative control of delegated legislation.[167] The text of the parliamentary opinion on Garavaglia's legislative draft began by acknowledging the successful attempt of the Ciampi government to re-establish a collaborative institutional relationship between the executive and parliamentary committees.[168]

The greater executive openness to parliamentary co-legislation reflected the governmental strategy to secure political legitimacy for health care reform for which there was little political consensus. The referendum initiative to abrogate articles 8 and 9 of the Amato reform was still under way when Minister Garavaglia was working at the amended text. The referendum was fully supported by the major parliamentary opposition party, the Democrats of the Left. Public opinion was also turning bitterly against the government for its anticipated health care cuts and higher co-payments.[169] As D'Alema claimed: 'health care is the sector in which we have the most serious fracture between citizens and the State. It is not a welfare question, but

[167] During the parliamentary discussion of the Garavaglia reform, many MP admitted that the executive had adopted a radically different relationship with parliament than under De Lorenzo. Mr Giannotti, PDS, acknowledged the 'innovative approach of Garavaglia compared to De Lorenzo', Lower Chamber, 10 March 1993. Another MP, Poggiolini, PLI, admired the executive for the collaboration with parliament, although he disagreed on substantive matters, Lower Chamber, 10 March 1993.

[168] 'Parere sul testo di modifica al Decreto Legislativo n. 502/1992', Lower Chamber, 21 October 1993.

[169] *La Stampa*, 18 June 2004.

most of all a moral question'.[170] In this context of public dissatisfaction, the minister of Health attempted to gain the political support of parliament to overcome it.

Therefore, the executive under the Ciampi government tried to rehabilitate the role of parliamentary committees in an attempt to secure wider political consensus in support of the Amato reform. However, the legislative concessions to groups' demands regarding public employment amounted to rather nominal and legalistic changes with a meagre concrete possibility of being implemented. On the one hand, the government was willing to grant concessions on aspects of public employment because these would not alter the new organisational structure of the national health care system, the major thrust of the 1992 reform. On the other, it is not entirely convincing that the Minister of Health, Garavaglia, expected to overcome the Department of Public Services' reservations about the medical staff reforms. Not even the Amato government was able to overcome the Department of Public Services' resistance.[171] Moreover, the Financial Law of 1994 forced a budgetary squeeze on the employment pay of doctors.[172] The second wave of direct action,[173] after the enactment of the amended decree in November 1993, confirmed that the government's adoption of most of the parliamentary committees' amendments regarding personnel was not convincing enough.

[170] 'Il PDS presenterà due mozioni alle Camere; riforma sanitaria: cure a confronto, *Il Sole 24 Ore,* 15 July 1993.
[171] The Department of Public Services would not make an exception for the health care sector and forced the Ministry of Health to subsume the health care sector's employment contract into the general framework of public sector employment.
[172] The 1994 Financial Law provided: approximately 516 million Euros for the whole civil service; a freeze on new appointments; a new tax of 25% on social security funds of doctors.
[173] *Il Sole 24 Ore*, 30 November 1993.

Conclusions

The resistance of the medical profession to the 1992 health care reform posed a credible threat to the further development of the governmental programme to modernise the health care administration. Not only were the instruments chosen to pursue the strategy of outright opposition of the most destructive type, such as an abrogative referendum, but also the legislative process was characterised by a firm coalition between the professional groups and the parliamentary committees to block the Amato reform. This activism triggered the enactment of a new executive decree which amended significantly the original one as far as medical employment was concerned. Thus, professional groups exerted such an influence on the policy making process as to trigger a new legislative process which eventually resulted in a new legislative act. However, this change was not sufficiently prominent to reverse structural innovation to the organisation and management of the health care system.

The analysis of the policy making process of the legislative episode of amendment to the 1992 reform has revealed that the Italian Parliament was a formidable source of access to groups, with the parliamentary committees contributing to repoliticising and reopening the political debate after the issuing in December 1992 of the Amato decree. Rather than being independent mediating arenas, committees were 'pressured' institutions, highly permeable to groups' demands and incapable of politicisation of the macro level issues involved in the health care reforms. This, however, favourably served the strategy of the government of avoiding lengthy debate in parliament about the core changes affecting regionalisation and management arrangements.

As the change introduced by the new Ciampi government with executive decree no.517/1993 was neither radical nor substantially innovative, compared with the 1992 reform, the amendments amounted to nothing more than a legislative sophistication with legal technicalities. With regards to the introduction of general management, the enterprise formula, and regionalisation, the 1992 and 1993 reforms represented two distinct episodes of the same reform programme. Furthermore, we have also argued that the concessions of the government to the professional groups on their terms and conditions of employment were not convincing because hardly sustainable in the long run. The financial constraints placed on the 1994 Financial Law curtailed the possibility of groups successfully blocking the 1992 and 1993 reforms. Despite much work and effort on the part of the departmental administration, the radical change introduced in 1992 remained almost intact. Policy activism resulted in 'conservatism', but in this particular case, it implied the consolidation and continuity of far reaching change.

At the end of November 1993, after a convoluted legislative process, another reform of the national health care system survived groups' blockages and consolidated the move towards a long-awaited modernisation of the Italian health care services and administration. Legislative Decree no. 517/1993 was a legislation providing the broad institutional, financial and organisational design. The formulation of the operational details was left to regional implementation legislation, enacted by regional councils. Regions were granted considerable discretion in designing their own local health care systems. The next two chapters of the thesis, Chapters IV and V, investigate respectively the emergence of regional managers and the opportunities offered by the regionalisation process to regional elites.

Chapter IV

The Rise of General Managers and the Challenge to Local Political Elites

The introduction of general management and the transformation of local health care authorities into autonomous public enterprises have challenged the Italian way of mobilising political consensus at the local level. Local elites have traditionally based their political support on the firm control of administrative channels of distribution of welfare services (Dente 1990). The peculiarity of Italian local government, compared with the highly integrated French administrative system, is widely believed to be its diffuse administrative integration and the central role played by the 'political entrepreneurialism' of local elites -- mayors in particular -- and party channels in facilitating the intergovernmental relationship between centre and periphery (Tarrow 1977). Scholars characterised Italian local government as a form of 'political localism', compared with northern European countries, in which clientelistic patterns of centre-periphery relations do not exist, or are much less relevant to the national network of political power (Page and Goldsmith 1987). The reorganisation of administrative structures and management arrangements represents a potential challenge for local elites, who find it increasingly difficult to preserve the traditional use of local health care authorities. Clientelism is significantly diminished by the increasing influence that managers have acquired in the local policy making process.

Political elites have responded to the rise of managers and technical expertise by re-establishing political control with different instruments and mechanisms. This

chapter investigates the tension between technical decision-making in public administration and political consensus. The problematic relationship between rising regional technocrats and local political elites, such as mayors, is of primary interest. The significance of the relationship between managers and politicians ultimately depends on their relative influence in shaping local decisions regarding the organisation, delivery, and management of health care services. This chapter concentrates first on the creation of opportunities for managers to become key policy makers in health care policy, and then on the instruments and solutions which have been adopted to reinstate the primacy of politics over technocracy, as far as regional legislative compliance with health care reforms is concerned. The 1999 attempt at policy reversal is examined as a remarkable illustration of how national political elites have supported local ones in their resistance to emerging powerful regional bureaucrats.

The resistance of political elites to the emergence of powerful regional technocrats is characterised by the production of new legal acts and institutional experimentation. This chapter draws attention to regional legislative activism regarding two aspects of implementation of the 1992 reform: the merger of local health authorities and the establishment of the enterprise formula. The aim is to understand the effects of these changes on the relationship between general managers and local political elites, rather than to assess the new organisation of regional health care delivery arrangements *per se*. The second section of this chapter analyses the recovery of the role of the mayors in health care policy, restored to prominence by national executive decree no. 229 of 1999 -- the so-called Bindi reform, named after the Minister of Health of the centre-left Prodi Government (April 1996-October 1998). After a discussion of the general national framework for reappraising the role of mayors in

health care policy, the regions of Tuscany, Emilia Romagna and Lombardy are compared with regard to the differences between participation by mayors in the regional health care planning process and evaluation of general managers.

The Rise of General Managers

Regional implementation legislation offered managers opportunities to build up administrative power and a central position in local health care policy. Two aspects were of primary interest: the territorial regrouping of local health authorities and the introduction of 'bureaucratic autonomy', due to introducing the enterprise formula into all local health care authorities and selected public hospitals. First, the impact of regional implementation legislation in Emilia Romagna, Tuscany and Lombardy from 1994 to 1996 is analysed, with regard to the territorial reorganisation of local health authorities and the problematic relationship between political consensus and technocratic management. These regions have been selected as cases because, as in the health care sector, change is being introduced. There is no sufficiently prominent evidence of change in other regions, which belong to Putnam's category of low institutional performance (Putnam 1993). Furthermore, case selection depends also on the purpose of the case study. In order to infer hypotheses from the empirical data, a heuristic or hypothesis-generating case is more useful. This is the usefulness of 'outliers', cases that cannot be explained by other alternative theories, especially those discussed in Chapter I of this thesis, which focus on immobilisme.[1] The

[1] It could be argued that the selection of these cases does not allow for a sufficient variation of socio-economic conditions and 'institutional performance'. Certainly the selection of regions which are less administratively and institutionally efficient, such as Calabria or Sicily, would have offered greater variation and minimised the effect of intervening variables. Conversely, available theories reviewed in Chapter 1 for the difficulties of the modernisation of the Italian state cannot explain change in the regions we have selected, that is Emilia Romagna, Lombardy and Tuscany. Such atypical cases teach us the most, and explaining change is theoretically more demanding. Regions have been selected on the basis of the 'most different method': they have similar background conditions such as homogeneous institutional performance, economic and political structures, but sharply different values of the study variables, i.e. the outcome of adopting the 1992 reform. See Lijphart (1975).

second section of this part of the chapter focuses on the enterprise formula and the scope for concrete implementation of the formal autonomy granted by law to local health care authorities as 'public enterprises'. The discussion of the different role of local health authorities in different regional health care systems reveals the character of the relationship between the autonomous local authorities, their general managers, and the regional bureaucracy.

Territorial Mergers of Local Health Authorities

The first wave of regional laws implementing the 1992 reform addressed the problem of redrawing the territorial areas of local health authorities. The national legislation had indicated that regions ought to comply with the merger's provision by law and not by administrative regulation. This issue was debated by regional councils and proved to be highly controversial, for it affected the scope of political control over local health authorities exercised by municipalities. In some cases, *ad hoc* laws were enacted by regional councils; in others, this specific issue was subsumed in more general regional laws -- *leggi di riordino* or laws of reorganisation -- regarding the organisation of the regional health care system.[2] In Lombardy, for instance, an *ad hoc* regional law regarding the 'Ridefinizione degli ambiti territoriali delle Unità sociosanitarie locali' was enacted as early as 15 September 1993.[3] Lombardy was one of the first regions to implement the national provision of redefinition of the boundaries of local health authorities. However, the broader reform of general reorganisation of the health care system was passed only in 1997.[4] This can be

[2] 'Legge di riordino' refers to regional general framework law aimed to define the organisational arrangements of regional health care systems.
[3] Regional Law no. 28, Regione Lombardia, 15 September 1993.
[4] Regional Law no. 31, Regione Lombardia, 11 July 1997, 'Norme per il riordino del Servizio Sanitario regionale e sua integrazione con le attività dei servizi sociali'.

attributed in part to scandals affecting the regional administration -- from 1994 to 1995 the regional *Giunta* was accused of '*abuso d'ufficio*', literally 'abuse of office', for the appointment of general managers.[5] Fifteen of the 59 appointments made by the then-President of the *Giunta*, Paolo Arrigoni, were annulled by the Administrative Court. In 1995 the centre-right, led by Formigoni, won the regional elections and introduced a bill to reform the regional health care system taking into account the internal market and competition. Moreover, the legislative process introducing this law was protracted for two years before being finally enacted in 1997. This contrasts with Tuscany and Emilia Romagna, where a 'legge di riordino' was enacted as early as 1994.[6] These laws formed a comprehensive framework for implementation of the 1992 reform and, as such, included the enlargement of the local health authorities.

In most Italian regions the merger of local health authorities was taken up by regional councils and administrations fairly soon after the enactment of the 1992 reform and the 1993 amendment. Table 4.1 shows the decrease in the total number of local health authorities after the 1992 reform.

[5] For the scandals affecting Lombardy, see 'Nei giorni scorsi uguali ricorsi hanno fatto scattare otto dirigenti', *Il Sole 24 Ore*, 22 July 1995; 'La lottizzazione è reato. Chiesto il processo per il Presidente della Giunta e 11 Assessori', *La Stampa*, 26 February 1995.

[6] Tuscany enacted Regional Law no. 49 on 26th June 1994, 'Norme per il riordino del Servizio sanitario regionale'. This law was abrogated by Art.139 of Regional Law no. 22 in 2000. In Emilia-Romagna, two implementing laws were passed: Regional Law no. 19 of 12th May 1994, 'Norme per il riordino del Servizio sanitario regionale', and Regional Law no. 50 of 20th December 1994, 'Norme in materia di programmazione, contabilità, contratti e controllo delle Aziende sanitarie locali e delle Aziende ospedaliere'.

Table 4.1 Regional distribution of LHAs after the 1992 reform

Regions	Pre-1992 LHAs	After-1992 LHAs	Number of Provinces and Municipalities per Region	Difference pre- and after-1992 LHAs	% of pre-1992 of total LHAs	Difference after-1992 LHAs and no. of Provinces
Piemonte	63	22	6 (1209)	41	65.07	16
Valle d'Aosta	1	1	1 (74)	0	0	0
Lombardia	84	44	9 (1546)	40	47.61	35
Provincia Autonoma Bolzano	4	4	1 (116)	0	0	3
Provincia Autonoma Trento	11	1	1 (223)	10	90.9	0
Veneto	36	22	7 (582)	14	38.88	15
Friuli Venezia Giulia	12	6	4 (219)	6	50	2
Liguria	20	5	4 (235)	15	75	1
Emilia Romagna	41	13	8 (341)	28	68.29	5
Toscana	40	12	9 (287)	28	70	3
Umbria	12	5	2 (92)	7	58.3	3
Marche	24	13	4 (246)	11	45.8	9
Lazio	51	12	5 (375)	39	76.4	7
Abruzzo	15	6	4 (305)	9	60	2
Molise	7	4	2 (136)	3	42.8	2
Campania	61	13	5 (549)	48	78.6	8
Puglia	55	12	5 (257)	43	78.1	7
Basilicata	7	5	2 (131)	2	28.5	3
Calabria	31	11	3 (409)	20	64.5	8
Sicilia	62	9	9 (388)	53	85.4	0
Sardegna	22	8	4 (366)	14	63.6	4
TOTAL	**659**	**228**	**95 (8086)**	**431**	**65.4**	**133**

Author's elaboration from 'Compendio del Servizio Sanitario Nazionale, Anni 1991-95', Ufficio Statistica, Ministero Salute

The enlargement in the size of local health authorities reveals a remarkably high degree of regional compliance, in terms of promptness and legislative activism.[7] This

[7] Regional laws usually contain an appendix with the newly regrouped local health authorities with evidence of enlargement. For example see: Regional Law no. 19, 12 May 1994, Emilia Romagna;

becomes even more evident when compared with other national provisions contained in the 1992 reform, such as the accreditation procedures of private providers, and the implementation of the nationally set fees-for-services. For instance, as regards the latter, regional compliance was so poor that the national administration had to intervene by enacting a decree-law in 1995. According to a senior civil servant, 'regions had the administrative and technical capacity but they did not want to implement the national policy on fees-for-service'.[8]

The variation in timing of implementation of different aspects of the 1992 reform suggests that, overall, regions were particularly inclined to remove local health authorities from the jurisdiction and supervision of municipalities. On the one hand, the financial contingencies were a triggering factor. The 1992 reform had given regions financial responsibility to cover the local health authorities' budget deficits. For instance, mergers aim to cut costs and rationalise the network of health care providers by rationalising the hospital network.[9] Yet the closure of small hospitals raises public objections.[10] For example, a seven-months pregnant woman announced: 'I have promised my child that it will be born in my home town. If they close the hospital I will give birth in the office of the municipal council.'[11] On the other hand, the increase in size of local health authorities also reflects a political strategy as it allows regional political elites to build consensus through the delivery of health care

Regional law no. 2, 2 February 1994, Campania; Regional Law no. 39, 22 September 1994, Piemonte; Regional Law no. 22 of 28 June 1994, 'Ridelimitazione degli ambienti territoriali e norme per la gestione transitoria delle USL'; Regional Law no. 42 of 1994, Liguria; Regional Law no. 38, 30 December 1994, Puglia.

[8] Nicola Falcitelli, interview with author, Rome, 23 September 2002.

[9] Small hospitals represented the greatest proportion of the total number of hospitals: 31 per cent of total hospitals had fewer than 120 beds, 28 per cent had from 121 to 200 beds, and only 11 per cent of all the hospitals had more beds than 600. See: Pennazza (1996). The rationalisation of the hospital networks has met strong public dissent, also more recently. The regional plans to reduce hospital beds are most likely to affect small hospitals. See: 'Piccoli ospedali, cresce la protesta', *La Repubblica*, 28 August 2002.

[10] 'Fitto: 'Sono il Berlusconi del Sud, mi dicono buffone ma non mollo', *La Repubblica*, 30 August 2002.

[11] 'Domodossola, 8000 in piazza per difendere l'ospedale', *La Repubblica*, 28 August 2002.

services, and carve out a sphere of influence in health care policy making. This theme will be discussed thoroughly in Chapter 5 of this thesis.

Despite the rapid enactment of regional laws concerned with redrawing geographical boundaries, these were not generally accompanied by mergers to reduce the size of local health authorities to that of the province. The 1992 reform had established that the geographical area corresponding to the territory of the local health authority should be that of the province.[12] The area of the province was characterised by the existence of a large public hospital in the main provincial city, with the capacity to deliver the widest range of medical specialities. The enlargement in size of local health authorities originally decreased the total number in Lombardy from 84 to 44, when Arrigoni was President of the *Giunta* in 1994. Later, under the Formigoni presidency, the number of local health authorities was further reduced to 14, after two years of heated political debate and opposition by the association of municipalities. In Tuscany the number of local health authorities was cut from 40 to 12. In Emilia Romagna the original 41 local health authorities were merged into 13.[13] In practice, the outcome of the regrouping process was that, in most regions, the number of local health authorities was doubled compared to that of provinces, as Table 4.2 shows. In Veneto, for instance, there are seven provinces compared with 21 newly regrouped local health authorities.

[12] Article 3, Section 4, Comma a), Legislative Decree no. 502 of 30 December 1992.
[13] Regional Law, Emilia Romagna no. 19/1994.

Table 4.2 Regrouping of local health authorities

	Emilia Romagna	Tuscany	Lombardy	Veneto
No. of Provinces	8	9	9	7
Pre-1992 no. of LHAs	48	40	84	42
Post-1992 no. of LHAs	18	12	14	21
Post 1992 no. of Districts	40	56	62	43

Source: Regional Law Emilia Romagna no. 19/1994, Regional Law Tuscany no. 49/1994, Regional Law Lombardy no. 31/1997, and Regional Law Piemonte no.39/1994.

The increase in size of local health authorities has many implications for service delivery arrangements, organisational design and infrastructure, and impact on local demand, but here we are primarily concerned with the effects on the relationship between general managers and local political elites. The first effect of mergers is the dilution of *individual* mayors' influence in determining local health care policy and decisions affecting the local communities. This is a consequence of the much larger number of mayors in the representative bodies of local health care authorities. As shown in Table 4.3, the average number of municipalities, and respective mayors, in each individual health care authority in Lombardy rose from 18 before 1992 to 110 after the merger. In Tuscany the average number of municipalities increased from seven to 23, and in Emilia Romagna from eight to 26. The increase in the number of municipalities within each health authority creates higher fragmentation of territorial representation. This is compensated for by strengthened associational forms of municipalities only in exceptional cases. Dilution and heightened fragmentation have not been as detrimental to mayors of large cities as to small and peripheral communes. Most often the mayor of a big city, where the local health authority or

major public hospital is located, enjoys a 'direct access' relationship (Page and Goldsmith 1987) to the general manager.[14]

Table 4.3 Concentration of municipalities per local health authority after the 1992 reform

Average no. of Municipalities per LHA	Emilia Romagna	Lombardy	Tuscany
Pre-1992	8	18	7
Post-1992	26	110	23

Source: Regional Law Emilia Romagna no. 19/1994, Regional Law Tuscany no. 49/1994, Regional Law Lombardy no. 31/1997, and Regional Law Piemonte no.39/1994.

The second implication of the merger of local health authorities for the relationship between general managers and local elites is a greater co-ordination role for general managers. This derives from the heightened need for co-ordination between the smaller units of each health care authority, such as health clinics, prevention centres, local out-patients' departments and districts. The risk that local health authorities might remain internally fragmented into multiple units was addressed by centralised managerial functions.[15] Territorial services, *servizi territoriali*, are locally rooted and give political legitimacy to local elites because of their visibility. As one interviewee suggested: 'every mayor wants his own health care centre for providing public health and social services, like family planning clinics. They are very small, and very inefficient.'[16] It became increasingly urgent to integrate health and social services because of the duplication of services provided by different administrative units in the same local health authority, owing to the responsibility of communes for the provision of social but not health care.

[14] Gianni Giorgi, interview with author, Milan, 24 July 2003.
[15] Aldo Taroni, interview with author, Bologna, 22 July 2003.
[16] Gianni Giorgi, interview with author, Milan, 24 July 2003.

The tension between territorial demands and functional centralised management was mitigated by the division of local health authorities into the *distretti*. These are organisational, functional and territorial units reporting to their parent local health authorities. They are primarily aimed at providing general medicine services and out-patient local care. [17] In the case of Emilia Romagna, the *distretti* have managerial and technical autonomy, although they remain under the supervision and control of the parent local health authority. [18] Democratic and political representation is displaced to the *distretto*. Regional laws established institutional channels of representation for mayors at this level, such as committees or collegial bodies. For instance, in Emilia Romagna the establishment of the *distretti*[19] was accompanied by the creation of a '*Comitato di Distretto*', a consultative body made up of mayors of the area of the *distretto*. This committee is involved in formulating proposals to the general manager and monitors the planning activities of the *distretto*, its budget and resource allocations, performance assessment, and organisational structure. In particular, the territorial distribution of the delivery of services in the area of the competent *distretto* must be approved by the *Comitato di Distretto*.[20]

The territorial representation in Tuscany was safeguarded from the merger of local health authorities by being split into smaller administrative and relatively autonomous units, so-called *zona*. These zones are subdivided into *distretti*, the smallest administrative and operational units for the delivery of health care services. The size of the *distretti* is potentially much smaller in Tuscany than in Emilia Romagna. In terms of population, the size of a *distretto* in Tuscany can by law be

[17] Article 3, Section 5, Letter b), Legislative Decree no 502/1992.
[18] Deliberation of Region, no. 39 of 1 March 2000, Emilia Romagna, 'Linee guida per l'assistenza distrettuale'.
[19] Regional Law no.19, 12 May 1994, Regione Emilia Romagna.
[20] Article 9, Section Five (d), Regional Law no.19, 1994, Regione Emilia Romagna.

anything over 15,000 inhabitants,[21] whereas in Emilia Romagna a *distretto* must have a population of at least 60,000 inhabitants.[22] In Lombardy, the minimum number of inhabitants required in a *distretto* is generally 40,000, and 100,000 in metropolitan areas.[23] The management arrangements and organisation of a *distretto* are established by the parent local health authority. Managers in the *distretto* are appointed directly to their posts by the general manager of the local health authority, who determines the responsibilities and resources of each individual unit. [24]

In Tuscany, managerial responsibilities are devolved to smaller administrative units, such as the zone, more than in other regions. In compliance with the 1992 reform and in order to minimise the effects of mergers on territorial and political representation, Tuscany has created this intermediate level between the local health authorities and the smaller *distretti*. As Table 4.4 shows, the total number of zones is 33, only slightly fewer than the number of local health authorities before the 1992 reform. As far as the relationship between managers and local political elites is concerned, the *zona* in Tuscany give the conference of mayors and individual mayors an opportunity to influence the delivery of health care services and shape local decisions. The Regional Law no. 49 of 1994, in establishing the organisation and functioning of the regional health care system, separated management and support functions from the delivery and production of health care services. The *zona* was in charge of these latter responsibilities, being the operational branch of the local health authority at street level. The general manager of the local health authority delegates managerial authority to the 'co-ordinator of the *zona*'. Given the duplication of services between the 56 *distretti* and the thirty three *zona*, Tuscany's regional health

[21] Article 3, Section 2, Regional Law no. 49 of 1994, Regione Toscana.
[22] Article 9, Section 2, Regional Law no.19 of 1994, Regione Emilia Romagna.
[23] Article 9, Regional Law no. 31 of 1997, Regione Lombardia.
[24] For example, see Article 36, Section 3, Letter a), Regional Law, Toscana, no. 22 /2000.

care plan 2002-2004 has established that the area of the *distretto* must be enlarged to correspond to that of the *zona*, significantly further reducing the number of *distretti*.[25]

Table 4.4 Local health authorities and 'zone' in Tuscany

LHAs	No. of Zona per LHA	Number of Municipalities per LHA
USL Massa Carrara	2	17
USL Lucca	3	35
USL Pistoia	2	22
USL Prato	1	7
USL Pisa	4	32
USL Livorno	4	27
USL Siena	4	36
USL Arezzo	5	39
USL Grosseto	4	28
USL Firenze	3	33
USL Empoli	1	11
Total	**33**	**287**

Source: Regional Law no.22 /2000, Regione Toscana

Whereas local political elites were marginalised from the management of local health authorities at the macro level, they continued to influence the planning activities of the *distretti*, and zones. For instance, a 'Comitato di Distretto', literally 'District's Committee', was established in Emilia Romagna, Lombardy and Tuscany. The Comitato was formed by elected members from local political elites and representatives of interest groups (Salvadori 2004). Moreover, regional law in

[25] The deliberation of the regional Giunta of Tuscany no. 155 of 18 March 1992 had established that a *distretto* be of the size of a municipality. Regional Law no. 49/1994 had established that the size of a *distretto* should not be smaller than 15,000 inhabitants. This value has been increased to 45,000 by the most recent regional health care plan 2002-2004 (Section 6).

Tuscany established that the manager of the *zona* was responsible for handling 'contacts' with mayors.[26] In Lombardy, the 'Assemblea dei Sindaci del Distretto', literally Assembly of District's Mayors, has representational and planning functions.[27]

The Enterprise Formula: Planner and Third Party Payer Models

Managerial autonomy is inextricably linked with the institutional autonomy conferred to local health care authorities since the change in their legal status from public bodies, controlled by the municipal administration, to self-managing, independent public enterprises, so-called *azienda di diritto pubblico.* Accordingly, the local health care enterprise is a new institutional player with exclusive management responsibilities for health care services in its area of competence.[28] The local health authority's formally defined autonomy creates a framework, which enables general managers to resist pressure from local political elites more effectively. The institutional autonomy of local health authorities allows general managers to use greater discretion in decisions regarding the use and allocation of resources and administrative supervision of other institutions. *Ex ante* controls on administrative acts are recommended only for budget planning and three-year planning activities of local health care authorities.[29]

[26] Regional Law no. 22/2000, Regione Toscana. In general, the role of the manager of the *zona* was strengthened by this law. It gives the manager budget autonomy, co-ordinating responsibilities of all health care services of the *zona*, including hospitals, appointment of people in charge of local services and units.
[27] Regional Law, no. 31/1997, Regione Lombardia, Article 9, Il Distretto.
[28] Article 3, Section 1, Legislative Decree no. 502/1992.
[29] 'Orientamenti per il nuovo assetto organizzativo e gestionale delle strutture sanitarie', 8 June 1995, Ministero della Sanità, p. 46.

Administrative formalism has also been challenged by the extensive use of instruments typical of the private sector, such as the *atto aziendale* which belongs to the jurisdiction of private law (Balma 2000). This has been legally introduced by the 1999 Bindi reform as a new instrument of governance for local health authorities.[30] The *atto aziendale* is used by general managers of local health care authorities to define their internal organisation and functions. It is also used to regulate public procurement (Balma 2000). Its significance rests in the scope for greater discretion it offers to general managers, since they can take action under it without consultation (Perrella, Cicchetti et al. 2002). The *atto aziendale* does not need formal approval from the regions. It can be adopted unilaterally by the general manager and cannot be referred to an administrative court.

According to the guidelines of the Ministry of Health, the local health care enterprises, *Aziende Sanitarie Locali*, enjoy *ex lege* organisational, accounting and managerial autonomy from all other institutions of both the municipal and regional administration.[31] As far as managerial autonomy is concerned, ministerial guidelines suggest that the general manager should establish the objectives of the enterprise, plan activities, define the means to achieve the objectives, decide on the allocation of human and financial resources, determine the organisation of the administrative units and staff allocation, and monitor the results achieved. In particular, the ministerial paper emphasises the importance of organisational autonomy for the full development of managerial autonomy.[32]

[30] Article 3, comma 1 bis, Legislative Decree no. 229/99.
[31] 'Orientamenti per il nuovo assetto organizzativo e gestionale delle strutture sanitarie', Ministero della Sanità, 8 June 1995, p.14.
[32] Ministero della Sanità (1995:55-57).

But the regional interpretation of this juridical autonomy contributed to define in practice the scope for general managers to take autonomous action. The 1995 ministerial guidelines for the implementation of the 1992 legislation seemed to acknowledge the risk of regions encroaching directly on the management of local health authorities, rather than confining their activities only to overall planning functions. Regions should determine only the 'general principles' of local health authorities' bureaucratic autonomy.[33] In particular, the guidelines emphasised the exclusive responsibility of general managers with regard to human resources, such as establishing staffing levels, allocation, and organisational plans: 'it should not be the region's responsibility to define the allocation of staff'.[34]

The scope for managerial autonomy depends on how regions have defined the role of local health authorities in the broader framework of the regional health care system. This affects the opportunities of general managers for exercising their influence. In Emilia Romagna, where regional health care plans have emphasised the regulatory and planning activities of local health authorities, the general manager is more able to influence health care policy locally than in Lombardy, where local health authorities were given a passive third-party payer responsibility. In the former type of local health authority, the 'planner', general managers have greater opportunities to determine priorities, activities and the allocation of resources.[35] They enjoy relatively more independence in negotiating contracts with external providers and bargaining on the prices, quantity and quality of services produced by public

[33] 'Orientamenti per il nuovo assetto organizzativo e gestionale delle strutture sanitarie', Ministero della Sanità', 8 June 1995, p. 43.
[34] 'Orientamenti per il nuovo assetto organizzativo e gestionale delle strutture sanitarie', Ministero della Sanità', 8 June 1995, p.47.
[35] The instrument of planning of the local health authority is called 'Piano delle Attività Locale', literally 'Local Plan of Activities'. The PAL is formulated by the general management of the local health authority but inputs are received by the Conference of Mayors and the regional administration.

hospitals or private providers of health care services. They negotiate annual service agreements with the internal units of LHAs, such as hospitals or health care centres or clinics. This type of local health authority, the planner, is engaged in greater regulatory and administrative activities than the 'insurer type' (Mapelli 1999; Reviglio 1999). The planner local health authority has highly integrated production and purchasing functions within its own structure. These give the general managers greater power over the different units of the organisation.

Conversely, where regional health care plans and legislation have opted for a third-party payer responsibility, the local health authorities' role in planning and controlling demand is severely curtailed and fulfilled instead by the regional administration. For instance, it is clearly stated in Regional Law no. 31 of 1997, Regione Lombardia, that 'the autonomy of local health care enterprises must be exercised within the constraints posed by regional planning'. [36] In regions such as Lombardy the stated priority of the regional health care system is to give unlimited freedom to patients to choose between private and public providers.[37] Unlike the 'planner' type, the possibility of collusion between the local health authority and its own hospitals is very much reduced, because this third-party payer model entails the separation of purchasers and providers. Regardless of the different models chosen, in the period 1995-1999[38] regions significantly tightened their financial grip on local health authorities because these were running huge deficits.[39]

[36] Article 7, 'Natura ed organi delle ASL', Regional Law no. 31 of 1997, Regione Lombardia.
[37] The problem with this system is that local health authorities find it problematic to remain within the budget constraints of their *per capita* financial grant.
[38] The year 1995 is considered a 'new beginning' of the Italian health care system because the central state levelled off all local health authorities budget deficits. Thus one could argue that the implementation of the 1992 reform in practice started in 1995, although as we have noted regional legislation has been enacted since the beginning of 1994.
[39] 'Health Care systems in transition: Italy', European Observatory on Health Care Systems, 5 December 2001.

To recap, the regrouping of local health authorities, combined with the opportunities offered to general managers by the institutional predominance of the planner model, created the conditions for the emergence of powerful general managers as key policy makers in the definition of local priorities and decisions affecting these localities, which were previously dominated by local political elites. This tendency was consolidated by a widespread and consistent pattern of introduction of outcome and performance measurement, which has largely replaced formal controls on legal and administrative acts (Del Vecchio 2002). In addition to these primarily economic indicators of local health care authorities, there has been a consistent tendency from 1995 onwards towards strengthening the introduction of quality indicators, for instance, of delivered health care services. In 1996 a ministerial decree introduced 159 qualitative indicators for the level of personalisation, humanisation, access to information and prevention activities. Self-evaluation mechanisms have been introduced more recently to monitor the performance of medical teams within hospitals.[40]

The relative power of regional managers and political elites is not a zero sum game. Most of the public managers interviewed acknowledged the opportunities given to them by legislation, and described concrete cases in which they had used them, but had also witnessed the interference of political elites and regional administrative officials in their management.[41] One of these managers, for example, said: 'The situation has deteriorated. The general manager has to follow his political master, who is not necessarily the regional minister of health, but the party who has sponsored him. The general manager is not free to appoint senior consultants and

[40] 'Le Carte di Controllo. Strumenti per il governo clinico', Collana Dossier, no. 66, 2003, Regione Emilia Romagna.
[41] 'Manifesto per la rinascita della sanità', *Corriere della Sera*, 8 February 2004.

heads of departments.'[42] Another public manager who had been working for ten years as general manager of Parma's local health care authority openly expressed his resentment of 'the diminishing power of general managers'.[43] He continued by suggesting that: 'it is not true that mayors have been marginalised. The mayor still has a lot of power against the general manager. A weak bureaucracy serves partisan interests much better than a strong one and the real problem in Italy is the weakness of the bureaucracy, unable to resist partisan pressure.' But he also admitted that: 'when I was general manager in Parma I fired many senior consultants -- one was even an MP'.

To conclude, the regional implementation legislation introducing general management has shown a high degree of efficiency as regards the timing of its implementation, but has been slightly more cautious regarding the merger of local health authorities. The size of local health authorities was increased overall and this led to a dilution of the representation of individual municipalities and mayors in the organisation of the local health care authorities. Another consequence associated with the merger was the subsequent territorial and administrative articulation of local health authorities into districts, the smallest units. Democratic mechanisms of representation were introduced at this level, but their management was firmly controlled by the general manager. Overall, general managers have gained power at the expense of local elites, with reference also to the new planning role of local health care authorities. The extent to which regional managers influence health care strategy depends on the type of local health care authority chosen by regional governments. The planner model offers managers greater impact. Therefore, the

[42] Renato Botti, interview with author, Milan, 24 July 2003.
[43] Gianni Giorgi, interview with author, Milan, 24 July 2003.

administrative and functional reorganisation which followed the 1992 reform has offered managers a great opportunity to have a pervasive influence in local decisions.

The Recovery of Mayors: the 1999 Reform and National Elites Political Strategy

Towards the end of the 1990s, general managers came under fierce attack by professionals and elected officials for their autocratic management of local health care authorities and hospitals.[44] The introduction of fee-for-service led some managers to increase consumption of the most profitable services in order to pay for budget deficits. Managers were severely criticised for their excessive financial concern for the budget and cost-effectiveness, while paying only secondary attention to clinical management and quality of services.[45] They were also criticised for their excessive power over consultants. As one official of the largest hospital doctors' association said, 'the general manager is very powerful in relation to doctors, including senior consultants, whom he can dismiss without any performance assessment. Doctors in hospitals have never been so frustrated because they are stressed by citizens, by the public manager and by economic performance targets.'[46]

The professionals' objection is combined with that of politicians, who realise that differently from them -- as most local elected officials are professional politicians in Italy and are recruited through political parties (Randelli 2000) -- public managers have acquired technical expertise and knowledge. Excessive technocracy was despised by political elites in particular. As one politician suggested, 'we need to

[44] R. Bindi, interview with author, Oxford, 25 October 2002, and Vasco Giannotti, interview with author, Rome, 16 July 2003 and Serafino Zucchelli, interview with author, Rome, 18 July 2003.
[45] This criticism is partially unjustified because public managers' performance is evaluated primarily on the basis of the achievement of an annual balanced budget, which is a justified requirement given the recurrent situation of budget deficits and the regional responsibility for covering them.
[46] Serafino Zucchelli, interview with author, Rome, 18 July 2003.

reintroduce the management board because the management system of local health authorities is excessively monocratic and technocratic. This runs against the democratic governance of the system. We need to restore the role of the mayors in organising health care services.'[47] Very recently, the present Minister of Health has attacked private sector management in the health care system.[48]

This second section of the chapter presents the legal context created by the 1999 Bindi reform, leading to the re-establishment of the centrality of Italian mayors in the health care sector,[49] a measure primarily defined as a 'political counterbalance' to the allegedly excessive technical power of general managers. National executive decree no. 229 of 1999, known as the Bindi reform, formalised the participation of mayors in the regional planning process and in the performance evaluation of general managers. This decree was preceded by the parliamentary enactment of the Delegating Law no. 419 of 1998, by which the Italian Parliament delegated legislative power to the executive and set out the general principles to follow in order

[47] Vasco Giannotti, interview with author, Rome, 16 July 2003.
[48] Girolamo Sirchia, 'Concorrenza e qualità, così guarirò Asl e ospedali,' *Il Sole 24 Ore*, 8 January 2003.
[49] Italian mayors have been mainly political entrepreneurs, unlike their French counterparts, who have been more integrated within the administrative system (Tarrow 1977) . The channel of recruitment of mayors has primarily been partisan involvement or militancy in interest groups such as the trade unions. Political entrepreneurialism refers to the fact that the Italian mayor is forced to cultivate political contacts at the centre to capture resources for the community (Tarrow 1977). Consequently, the most frequent contacts are those with national politicians rather than bureaucrats, and integration between centre and periphery occurs more readily at the bottom of the system than at the top of the administration. However, this system is time and energy consuming for Italian mayors who tend to despise their role. The combination of partisanship and entrepreneurialism determined a high level of frustration until the beginning of the 1990s, when local government reforms introduced significant changes aimed at transforming the role of the mayor from a partisan agent to 'administrator' (Law no. 81 of 1993). The introduction of the direct election of Italian mayors, combined with a different pattern of recruitment which extended to candidates from civil society, created a new generation of mayors more careful about service delivery. Nevertheless, the frustrations of mayors are compared to Sisyphus (Vandelli 1997). The Budget Law 2003 and 2004 has reduced further the financial resources granted to municipalities (3% in the 2004 Budget Law, see 'Dalla Finanziaria sempre meno soldi', *IL Sole 24 Ore*, 6 October 2003). Mayors are most recently enthusiastic about the strengthened legislative powers transferred with the constitutional reform no. 3/2001: most mayors (90%) say they are in favour of using the legislative power to enact ad hoc rules and regulation, whenever needed (see 'Il sindaco vota sì al cambiamento', *Il Sole 24 Ore*, 6 October 2003).

to amend the 1992 Amato legislation.[50] After examining how the recovery of mayors was set out by the delegating law in 1999, different regional experiments in redefining the balance between political representation and functional needs are analysed.

The Mayor's Participation in Regional Plans and in the Evaluation of General Managers

Two important reforms in 1999 helped the recovery of the mayor's role in health care policy: the reform of participation in regional planning activities, and the rules governing performance evaluation and dismissal of appointed general managers. Letter l) of Article 2 of Law no. 419/1998, as approved by the Lower Chamber, states that 'in the legislative activities, delegated by this Parliament, the executive must strengthen the role of municipalities and of their *representative institutions* in the planning procedures at regional and local levels and in the evaluation of performance of local health authorities and hospitals [...] although they must remain excluded from functions and responsibility of direct management of health care'.[51] The Senate amended this text substantially by suggesting the creation of a new institution of policy co-ordination at regional level to ensure the participation of municipalities in the planning process.[52] When the bill returned to the Lower House of Parliament for final enactment, this amendment was fiercely criticised, mainly for

[50] The government bill, regarding 'Delega al governo per la razionalizzazione del Servizio Sanitario Nazionale e per l'adozione di un testo unico in materia di organizzazione e funzionamento del Servizio sanitario nazionale. Modifiche al decreto legislativo 30 December 1992, no. 502', was approved by the Lower Chamber on 26 May 1998, then amended by the Senate on 22 September 1998, and finally enacted after the final revision of the Lower Chamber on 10 November 1998.

[51] Dossier Provvedimento, 'Delega per il riordino del Servizio sanitario nazionale', Iter alla Camera, A.C. 4230-B-, no. 612/2, XIII Legislatura, November 1998, Camera dei Deputati, Servizio Studi.

[52] The problem of co-ordination and integration between regions and municipalities has been acknowledged as the key variable of future development by President Ghigo, President of Piemonte, in 'Le regioni in difesa sui fondi non erogati', *Il Sole 24 Ore*, 29 September 2003.

two reasons. First, new institutions would be a burden on regional public finance.[53] Secondly, the participation of municipalities in regional planning could, as some MPs claimed, adversely accentuate the conflict between mayors and regional elites, with the risk of creating a stalemate rather than improving effective planning activities.[54]

New institutional and formal channels for the participation of mayors were set up by regional legislation. The delegating law, which was enacted as amended by the Senate, and the executive decree, issued by the Ministry of Health in June 1999,[55] provided that a Permanent Conference for Health Care and Social Services Planning be established by regional law, to ensure co-ordination between different local actors and levels of government. Members of this Conference are the mayors of the competent municipalities, in cases where the area covered by the local health authority overlaps with the municipality, or the President of the Conference of Mayors in all other cases, along with representatives of regional associations of local government.[56] The responsibilities of the Conference are to approve the regional health care plan and to control implementation of hospitals' local implementation plans, according to the procedures established by regional law.[57]

As far as the formal mechanisms of policy co-ordination are concerned, Emilia Romagna, in compliance with the national framework, introduced permanent

[53] The bill majority rapporteur in the Budget Committee of the Lower House, Mr Sergio Chiamparino, Democrats of the Left, raised some concerns about the new financial burden resulting from the creation of the new regional co-ordinating institution. (See Meeting of the V Permanent Budget Committee in the Lower House, 29 September 1998).
[54] Domenico Gramazio, MP, Plenary Session of the Lower House of Parliament, 2 October 1998, A.C. 417.
[55] Decreto Legislativo 19 Giugno 1999, no. 229, regarding 'Norme per la razionalizzazione del Servizio Sanitario nazionale, a norma dell'articolo 1 della legge 30 Novembre 1998, no. 419'.
[56] Article 2, 2-bis, Executive Decree no. 229/1999.
[57] Article 2, 2-ter, Executive Decree no. 229/1999.

conferences with Regional Law no. 3 of 21 April 1999. These conferences are given policy co-ordination and planning functions at local level, often corresponding to the area of the local health authority. The participation of mayors, who are members of the conferences, is also emphasised in the 1999-2001 Regional Health Care Plan.[58] Similarly, regional law in Tuscany has created a permanent Conference for Health Care and Social Services Planning in 2000.[59] Regional Law no. 31 of 1997 had already introduced this institution in Lombardy,[60] but the definition of functions and composition is established by administrative regulation and not specified by regional law. The latest 2002-2004 Regional Health Care Plan of Regione Lombardia contains no reference to the participation of mayors and municipalities in regional planning activities, or to the co-ordinating institutions of conferences.[61] Arguably, the role of these formal conferences was primarily consultative and implemented at the discretion of the regional executive. As one MP has claimed: 'Conferences do not count much and municipalities are left out because they do not have financial resources. Their role is only of consultation ex post.'[62] The scope of mayors' participation in the process of regional planning thus remains more formal and legal than substantial.

[58] Section 2, 'Le politiche della Regione', 1999-2001 Regional Health Care Plan, Emilia Romagna, states: 'regional laws emphasise a strong orientation towards making more valuable the role of local government, not only as regards functions of control, but also general policy and evaluation of the activities of local health authorities'.

[59] Article 15 of Regional Law no. 22 of 2000, Regione Toscana, establishes that the Permanent Conference of Health and Social Services Planning is a consultative body of the regional executive. It expresses an opinion on the proposal of the regional health care plan, on all bills regarding health care, on acts of concerted action between local health authorities, on guidelines produced by the regional Giunta for the formulation of implementing hospital plans and local plans.

[60] Article 6, comma 9-bis of Regional Law no. 31 of 1997, Regione Lombardia, introduced the Permanent Conference as first established by the 1992 reform, which did not specify the functions and centrality of this institution. The 1997 regional law provides that the Conference's functions and composition be set out in deliberations of the Giunta.

[61] Regional Health Care Plan, 2002-2004, Regione Lombardia.

[62] Maria Grazia Labate, interview with author, Rome, 21 July 2003.

The second most important aspect of mayors' reappraisal is the evaluation of the activities of local health authorities and the performance of general managers, resulting in the renewal or annulment of their appointment. According to one interviewee, 'Minister Bindi decided that the mayor had to control the general managers'.[63] Another elected official in Tuscany suggested that 'the general manager is crucified by the mayor'.[64] He also revealed the political significance and fundamental unresolved problem of mayors' participation in health care policy: 'the problem of mayors' participation is an open wound, also considering that the 1999 reform did not give them back substantial powers'.

Delegating Law no. 419 of 1998 established that 'regions have to ensure that municipalities and their representative institutions are involved in the procedures of annulment of the appointment and performance evaluation of general managers, as far as the general performance of local health authorities and hospitals are concerned, in relation to the targets set out by regional planning'.[65] It is interesting to note that the original bill[66] presented by the executive to Parliament on 9 October 1997 had emphasised that the performance evaluation be based on the broad health care policy objectives set out by regions, and not exclusively on the economic goal of balanced budget. The text adopted by the Lower Chamber did not foresee the evaluation of performance on the basis of regional objectives and seemed to favour evaluation *ad*

[63] Renato Botti, interview with author, Milan, 21 June 2001.
[64] Enrico Rossi, interview with author, Florence, 28 July 2003.
[65] Article 2, letter u), Law no. 419 of 1998.
[66] Article 2 comma a) of the original bill (A.C. 4230) proposed 'to strengthen the role of municipalities, in particular referring to regional health care planning activities, in the evaluation of the activities of general managers of local health care authorities, and also their dismissal'. Article 3 of the same bill proposed 'regions to establish general criteria for the performance evaluation of general managers of local health care enterprises, with particular attention to the achievement of targets of regional planning'.

personam.[67] However, the Senate amended the text, which then conformed more closely to Minister Bindi's original bill. Eighteen months after the appointment of general managers, regional governments assess their performance in order to confirm their appointment, prior to consultation with the mayors or the conference of mayors, and, in the case of hospitals, with the Permanent Conference for Social and Health Care Planning.[68] Mayors or the conference of mayors must also be consulted if regions decide to dismiss general managers.[69] In the case of poor management, in particular the lack of implementation of the Local Implementing Plans or '*Piani attuativi locali*', the mayors or the conference of mayors can request annulment of the appointment and the dismissal of the general manager by the regional government. The direct and personal participation of the mayor becomes even more tangible in the case of public hospitals, where the dismissal and confirmation procedures for general managers must involve the mayor of the city -- often capital of the province -- in which the hospital is located. The centrality of individual mayors of cities which are capitals of the provincial area, where the local health authority is usually located, is confirmed by an interviewee who reveals that 'the President of Mantova Province, who is incidentally a senior consultant, has great influence, even on the President of the Region, Formigoni'.[70]

To sum up, the 1999 reform restores the role of the mayors in health care policy, a role which was severely curtailed in 1992 so as to isolate partisan politics from public management. National law strengthens the participation of mayors or their

[67] Social Affairs Committee, Lower Chamber, meetings of 29 and 30 September 1998. Also Plenary Sessions, Lower Chamber, 1, 2, 4 and 5 October 1998.
[68] Art 3-bis, comma 6, 'Direttore generale, direttore amministrativo e direttore sanitario', Executive Decree no. 229 of 1999.
[69] Art 3-bis, comma 7, 'Direttore generale, direttore amministrativo e direttore sanitario', Executive Decree no. 229 of 1999.
[70] Gianni Giorgi, interview with author, Milan, 24 July 2003.

associations during the regional planning process to ensure 'better co-ordination between inter-institutional levels'[71] and their political control over the activities of local health care authorities and evaluation of general managers to 'reintroduce political control of health care which cannot merely be reduced to an economic and financial problem'.[72] However, Bindi's arguments in favour of more coherent planning functions, democratic accountability of mayors to compensate for non-elected general managers, and increased territorial representation within an otherwise functionally dominated regional centralisation, are not empirically convincing for two reasons.

First, public finance obligations implemented by the 1998 Budget Law made the 'participation' of municipalities unrealistic because they did not have own resources. For instance, the legal possibility that municipalities could provide services which exceeded minimum national standards was not an actual possibility unless communes received additional grants from the centre or from regions.[73] The second major consideration regarding Bindi's strategy is that its real objective, beyond rhetorical statements, was not only to foster local democracy and the democratic governance of health care authorities, but also to preserve key access points of partisan competition offered by 'direct access' (Page and Goldsmith 1987).

The results of local elections and the recovery of the centre-right, which had been consistently defeated since 1993, corroborate this argument. The centre-left coalition, due to its greater internal cohesion, defeated 70 per cent of Italian mayors

[71] Minister Bindi, speech to the XII Committee of Social Affairs, Lower Chamber, 30 September 1998.
[72] Rosy Bindi, interview with author, 1 August 2003.
[73] This point is made by many Senators of the opposition, such as Tomassini, Pardini, Bruni, XII Committee of Health Care, Senate, 16 June, 17 June, 23 June, 24 June, and 7 July, 1998.

in the first direct elections (Baldini and Legnante 2003). Given the collapse of old parties such as the Christian Democrats, and considering that Forza Italia had still to consolidate its presence, the centre-left coalition found few obstacles in its way. The 1995 regional elections confirmed this trend (Di Virgilio 1996). However, after 1997, the year in which the first directly elected mayors were subject to electoral scrutiny of their performance, the party system had restructured itself and new parties had emerged, most noticeably Forza Italia (Baldini and Legnante 1998).

In 1997 most mayors in the big cities were confirmed in their positions, but in 1998 the centre-right did win more than 12 mayors' positions from the centre-left (Baldini and Legnante 2000). The centre-right was gaining electoral support at local level, a traditional bastion of the centre-left. This situation could have become more alarming if directly elected centre-right presidents of regions and appointed regional ministers of health care had controlled this sector, which the centre-left has traditionally found difficult to penetrate.[74] The personalisation of politics at the regional level, combined with functional regional centralising measures justified by efficient planning, was conducive to a one-party, or better one-coalition, regional political system, which Bindi tried to undermine by restoring the mayors' role as the most effective channel of political representation at local level.

Bindi has effectively defined the problem as follows: 'the real question, as far as the return of politics to the health care sector is concerned, is that regions have a conflict of interest when they appoint and simultaneously control the appointed public managers and when regions pretend to manage health care instead of only confining

[74] Chiara Rinaldini, interview with author, Rome, 17 July 2003.

their activities to planning'.[75] Rather than curtailing the power of public managers *per se*, Bindi was primarily concerned with the possibility of region creating a decisional space removed from national political competition, which would undermine opposing political parties at the centre and reduce the access points for political competition. In her strategy to restore the role of mayors, she was legitimised by the electoral success of the *partito dei sindaci*, literally 'party of the mayors', represented by the mayors of big cities. These became political figures of national relevance, such as Cacciari in Venice, Rutelli in Rome, Bassolino in Naples, Orlando in Palermo and Bianco in Catania (Baldini and Legnante 1998). The *partito dei sindaci* emerged as a response to the public's disenchantment with party government. It was the only political institution capable of gaining citizens' trust and approval, as confirmed by the high number of winning incumbents.[76] Bindi argues that mayors are the only legitimate and democratically elected actors in local government.[77] She makes the case for 'democratic' governance of health care as the necessary underpinning principle of combining efficiency and equity. But she ignores the fact that regional presidents enjoy the same direct accountability and democratic legitimacy as mayors. Thus, the argument of democracy does not appear to be sufficient reason for restoring the role of mayors.

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[75] Rosy Bindi, interview with author, Rome, 16 July 2003.

[76] 70 per cent of incumbents was confirmed in 1997 and 1999 local elections (Baldini and Legnante 2000).

[77] Before the 1993 reform of local government, mayors were selected by local councils elected by a pure proportional representation electoral system. They were appointed after long and convoluted distribution of offices among political parties. In the same way the local members of the *Giunta*, the executive structure of the municipality, represented different factions and delegations of political parties. The collegiality of the *Giunta* and cohesion was extremely low. Most of the local political class was recruited through political parties and local councillors were professional politicians. This system was highly unstable and came under attack during the general crisis of the political system in 1992. In order to provide greater stability and governability to local politics, in 1993 Law no. 81 introduced the direct election of the mayor and the president of the province. Concurrently the Law introduced majoritarian elements in the municipal elections. The mayor has the power to appoint the members of the *Giunta* and annul their appointment. For larger municipalities, members of the executive *Giunta* must renounce their office as councillors (no dual mandate is possible). As argued by Baldini and Legnante, the direct election of mayors has contributed, among other things, to the isolation of mayors from partisan politics in the local council (Baldini and Legnante 2000). The personalisation of political leadership has caused greater autonomy of mayors from partisan politics.

Regional Variations in Neutralising Strategies

The objective of this third section is to analyse the degree of resistance of political elites in three regions, Emilia Romagna, Tuscany and Lombardy, to implementing general management introduced by the 1992 Amato reform as a remedy against *partitocrazia* and in order to reshape the state.[78] Each of these regions has responded differently to the national elites' strategy of curbing the emerging influence of general managers, but in general the role of the mayor has been a critical issue. Each has devised its own organisational and administrative solutions to the mayor's participation in formulating health care policy decisions, ranging from nominal participation to real management functions. Regions are analysed in turn, highlighting the ways in which power was restored to the local political elites.

Emilia-Romagna: Piani per la Salute

In Emilia Romagna, the mayors' greatest opportunity to participate in the decision-making process affecting their local communities is represented by the '*Piani per la Salute*', literally Health Care Plans, which are the products of a negotiation process between institutions and actors involved in the provision of local health care services. One of the main purposes of this method of negotiation is to open up horizontally the otherwise centralised planning process to local organisations and citizens.[79] The general guidelines issued by the regional *Giunta* as regards the *Piani per la Salute*

[78] G. Amato makes the case for radically reforming the entire underpinning norms of the public administration to resuscitate it from the condition of 'atrophy', as cited in Ginsborg (2001).

[79] This methodology of negotiated planning is defined as 'networking' by official documents, see 'Ricerca-intervento: I Piani per la salute come contesti di partecipazione alle decisioni locali,' Azienda Sanitaria Regionale, Regione Emilia-Romagna, March 2003. For comprehensive information also see: www.regione.emilia-romagna.it/agenziasan/pps/index.htm.

establish that such local networks must be 'owned by local institutions, must cope with health care problems in a cross-sectoral way, and must encourage informed participation by citizens'.[80] The *Piano* is defined as 'the three-year collaborative action plan, co-ordinated by local government. The constituting members provide human and material resources in order to improve the welfare of local communities.'[81] The co-ordinating institution of this network is the *Conferenza Socio-Sanitaria Territoriale*, literally the Local Social and Health Care Conference, headed by a mayor. It puts together and enacts the *Piani per la Salute* and is delegated by the region with policy and planning powers.[82]

The *Piano per la Salute* has administrative and political implications for the municipalities' competencies in welfare services. This policy instrument responds to the 1998-2000 National Health Care Plan's request that co-ordination and collaboration be accepted as an alternative to competition between those involved in the provision of health care services.[83] The aim is to avoid the fragmentation which can result from competition between local health care authorities. These are instead encouraged to use their technical expertise to support the municipalities because 'one of the greatest limitations of mayors' power is the lack of information and technical expertise'.[84] However, the *Piano* has political significance as well, namely institutional identification of the level of government which corresponds to municipalities as the central co-ordinating mechanism of cross-sectoral policy

[80] Deliberation no. 321 issued by the Regional Giunta, Regione Emilia Romagna, 1 March 2000, 'Linee guida ai Piani per la Salute'.
[81] Deliberation no. 321 issued by the Regional Giunta, Regione Emilia Romagna, 1 March 2000, 'Linee guida ai Piani per la Salute'
[82] Regional Law no. 419 and no. 153 of 1998 delegated policy and planning power from regions to the local social and health care conferences.
[83] The 1998-2000 National Health Care Plan proposed the elaboration of 'Patto di Solidarietà della Salute', literally 'Solidarity Pact for Health Care'
[84] Enrico Rossi, interview with author, Florence, 28 July 2003.

actions, including housing, transport, environment and leisure, all of which have a direct bearing on local welfare.

The introduction of general management and pro-market reform ideas in 1992 was accused of increasing the 'democratic deficit' in the health care sector (Stefanini and Zanichelli 2002). This needs to be assessed in the light of evidence of the municipalities' participation in the elaboration of the *Piani per la Salute*. For instance, one interviewee confirmed the centrality of the local council of the city of Modena in developing the *Piano* in that local area.[85] The Local Health Care Conference of Parma has created a management board, the *Gruppo di Direzione*, which consists of representatives of municipalities, universities and local health care authorities, charged with the responsibility to 'promote the information and participation of citizens in the elaboration of the *Piano*, to create a network of exchange of information between participants, to foster collaboration between public and private citizens, to monitor the stages of each individual project'.[86] But the technical and operational content of the *Piani* is often sacrificed to the priority of reaching consensus and concerted actions for political reasons. One interviewee explained the political salience of this process: 'the *Piani per la Salute* are only a way of achieving political consensus between the actors involved in health care. They are

[85] Aldo Taroni, interview with author, Bologna, 22 July 2003. Modena is a province of 650,000 inhabitants, which comprises 47 municipalities and two health care public enterprises – one is the local heath authority and the other is the hospital. Since 1993 intersectoral plans and actions existed to foster local welfare, such as the 'Tavolo di lavoro per la Sicurezza sulla strada' (1993), or 'Campagna per lo Screening dei Tumori femminili' (1996). The hospital network consists of nine local hospitals, and other private hospitals for a total of 10,000 hospital consultants. The voluntary sector is represented by 230 associations. The local social and health care conference has adopted a methodology of decision-making based on 'shared values' among actors, such as equity, efficiency, sustainability, decentralisation, and based on negotiated plans and intersectoral investments. Among the players we find the province, municipalities, local health care authorities, university, high schools, non-profit organisations, trade unions, private providers, and individual citizens. Citizens participate in the smallest health care administrative unit of the *Distretto*. For more detailed information on the experience of Modena and other cities in Emilia Romagna see: 'Insieme per la salute. Un nuovo modo di programmare le politiche sanitarie. I Piani per la salute nel 2002', Bologna, Regione Emilia Romagna.

[86] Aldo Taroni, interview with author, Bologna, 22 July 2003.

political propaganda.'[87]

Tuscany: Società della Salute

A comparable instrument of negotiated planning has recently been devised by the Regione Toscana with the *Società della Salute*, literally Welfare Societies, created by the 2002-2004 Regional Health Care Plan.[88] According to the executive proposal approved by the Regional Council,[89] the *Società della Salute* has fully fledged organisational, managerial and financial responsibilities for the provision of all health and social services in the local area except hospital services. They are charged with the management of social care, health care, primary care, specialist medicine, ambulatory care, and general medicine. As regards administrative instruments, they must adopt a service contract which establishes the relationship between the *Società della Salute* and stakeholders; a *Piano integrato di Salute*, literally local integrated plan; an annual report on the state of welfare in the local community; an annual budget; and a virtual budget for controlling demand and allocating resources. Therefore, compared with the institutional solution of Emilia Romagna, the welfare societies do have financial resources[90] and direct management functions. The *Piani per la Salute* in Emilia Romagna do not have additional own financial resources and also depend heavily on the local health authority for human resources. The lack of

[87] Gianni Giorgi, interview with author, Milan, 24 July 2003.
[88] Deliberation of the Regional Council, no. 6 of 9 April 2002, Regione Toscana, 'Piano sanitario regionale 2002-04 – Linee Guida per la formazione del Piano integrato sociale 2002-2004', Section 3.2.
[89] 'Atto di indirizzo regionale per l'avvio della sperimentazione delle società della salute', Dipartimento alla Salute e delle politiche di solidarietà, Regione Toscana, 19 June 2003.
[90] The budget of the Società is made of the resources provided by the members. An important source of income will be provided by the Region during the initial stage only. The Società is responsible for the elaboration of a virtual budget ('virtual' because financial resources are individually owned by the constituting members). The budget is based upon historical expenditure on health care activities. In the case of budget deficits, the Società should commit to correct it in the following year. There is also a virtual budget regarding the cost of hospital services used by the local community.

clear financial own resources is listed as one of the major reasons for the lack of interest demonstrated in this policy tool as against others (Biocca 2003).

The emphasis on citizens' participation and involvement of the voluntary sector is a similarity between the *Società della Salute* and the *Piani per la Salute*.[91] The *Società della Salute* is an instrument for mobilising political support and consolidating political parties' local power base. The regional *Giunta* in Tuscany has proposed the creation of two consultative committees in each *Società*.[92] The *Consulta del Terzo Settore*, consisting of representatives from the voluntary sector only, comments on the integrated health care plans before their final approval.[93] Participating in planning activities does not exclude voluntary organisations from being direct service providers, because this function is safeguarded by autonomous quality and efficiency indicators. The second consultative committee, *Comitato di Partecipazione*, is composed of members appointed by the *Giunta*, including representatives of the local communities, patients and ordinary citizens. Members are not allowed to be health care service providers. The *Comitato* may evaluate the quantity and quality of services, and formulate proposals on the effectiveness of patient information, the integration of social and health care services, and the dignity and rights of patients. The *Comitato* is obliged to express an opinion on the local integrated plans and on the annual report of the *Società*. It has access to statistical information and may commission research projects to the director of the *Società*. It formulates its own

[91] In both regions there is a very well developed and active civil society. Associations providing charities and health care services abound. For instance in Tuscany ambulance services are mostly run by voluntary associations, so-called Misericordie.

[92] 'Atto di indirizzo regionale per l'avvio della sperimentazione delle società della salute', Dipartimento alla Salute e delle politiche di solidarietà, Regione Toscana, 19 June 2003.

[93] These plans set out the health care and general welfare objectives, establishing quantitative targets and the instruments to achieve them. In this way, representatives of the non-profit sector (*terzo settore*) participate during the planning exercise.

report on the implementation of the integrated plans and on the state of local services.[94]

Lombardy has devised similar forms of participation for the voluntary sector, emphasising the principle of 'horizontal subsidiarity'. In the political debate about recent constitutional reforms, the President of Lombardy has commented that 'horizontal subsidiarity is one of the key features of innovation. Co-operation with private actors is a traditional feature of the Lombard health care and educational system. Since 1997 we have encouraged the entry of private providers and ensured freedom of choice for patients.'[95] The introduction of this principle in the Italian Constitution[96] is also praised by the President of the Association of Italian Communes, for different reasons and with a different strategy: 'the constitutional principle introduced with Article 118 of the Constitution is an opportunity for local government because municipalities have been the innovative engine of the administrative system'.[97] 'Horizontal subsidiarity' in the case of Lombardy is less geared towards grassroots politics and more towards opening up the health care market to private providers, compared with other regions. The marginalisation of representative institutions of local communities, such as mayors, is consistent with the objective of a different relationship between the State and private sector.[98]

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[94] 'Atto di indirizzo regionale per l'avvio della sperimentazione delle società della salute', Dipartimento alla Salute e delle politiche di solidarietà, Regione Toscana, 19 June 2003, p.7-9.

[95] 'Inizia l'era del cittadino protagonista', *Il Sole 24 Ore*, Enti Locali &PA, 14 July 2003.

[96] The amended Article 18 of the Italian Constitution establishes: 'The State, Regions, Metropolitan Areas, and Municipalities, encourage the autonomous initiative of citizens, individual or associated, for activities of general interest, on the basis of the principle of subsidiarity'.

[97] Leonardo Domenici, Mayor of Florence and President of ANCI, interviewed in *Il Sole 24 Ore*, Enti Locali &PA, 14 July 2003.

[98] According to the study 'Toscana e Lombardia: due sistemi sanitari a confronto', Osservatorio di Economia Sanitaria, Agenzia Regionale di Sanità, Toscana, October 2001, the percentage of private hospital beds was 27% of the total number of hospital beds in Lombardy, compared to 14% in Tuscany; the percentage of hospitalisation in private hospitals was 22% in Lombardy compared to 7% in Tuscany; total private expenditure as percentage of total regional health care expenditure was 11% in Lombardy and 7% in Tuscany. It is clear that the Lombardy health care system has expanded the

Tuscany stands out from the other regions because it is the only one in which the commune wins back a substantive policy, decision-making and managerial role, beyond formal consultation and planning influence. The management function of the *Società della Salute* is carried out by a *Giunta*, or management board, consisting of the mayors of the local communes, or their delegated elected officials, and the general manager of the Local Health Authority.[99] Most of the board's members come from representative institutions. The *Giunta* appoints the general manager of the *Società della Salute*,[100] who is not appointed by the regional Minister of Health. Therefore, the role of mayors and individual communes is not only institutionally and organisationally strengthened in relation to management functions, but also safeguarded against a highly monopolistic political trust relationship between the regional Minister of Health and general managers. The regional Health Care Minister confirmed that 'with the *Società della Salute* I am decentralising a lot of power to mayors and I am reining myself in. The regional council, however, does not understand that I am limiting my power significantly and on the contrary insists that I am concentrating power for myself.'[101]

development of private providers in health care provision. For further details see Table 4.5. and 4.6. later in this chapter.

[99] The *Giunta* must: approve the budget of the Società; vote on the 'Organo di Controllo'; appoint the general manager; approve service agreements; define the guidelines for the elaboration of the Integrated Health Plans (Piani integrati di Salute); approve the Piani Integrati di Salute and virtual budget; approve the annual report; approve all arrangements regarding the internal organisational, management, trade unions relations, participation and consultation mechanisms; deliberate as regards contracts with GPs and paediatricians, data protection and privacy, quality standards and cost-performance indicators.

[100] Managers must have a university first degree and at least five years of managerial experience acquired in the public or private sectors. They participate in the meetings of the Giunta without voting rights. Their responsibilities are to elaborate the Piani Integrati di salute, literally Local Integrated Plans, to elaborate the annual report, to elaborate all acts to be approved by the Giunta, and to implement all the decisions regarding the management of the Società.

[101] Enrico Rossi, interview with author, Florence, 28 July 2003.

The experiment of the *Società della Salute* has been praised because 'it is the only example in the country of a real attempt to revive local communities and local government's involvement in the provision of welfare services'.[102] This new structure provides 'a strong institutional role for municipalities and mayors'.[103] Moreover, 'the manager of the *Società* is appointed by mayors. We wanted to weaken the technocratic power of the local health care authority in relation to the municipalities.'[104] Many approve the attempt to extend participation to non-profit organisations and voluntary associations.

However, despite the democratic and participatory mechanisms built into the *Società della Salute*, and the institutional recovery of mayors and communes, there has been criticism of fragmented planning and of the diminishing size of territorial units,[105] which runs counter to the increase in the size of administrative and planning units necessary to achieve economies of scale and efficient functional planning.[106] Another criticism, raised by the opposition in the regional council, has been the insufficient commitment to general management in the *Società della Salute*.[107] The purpose of this has been primarily political, as the Minister of Health Care acknowledged when he pointed out that:

> Next year we have municipal elections (2004) and I hope that the *Società della Salute* will pay off. Health care has become a key sector in electoral politics. In the past political parties did not worry about health care because it is a sector which requires expertise and is highly difficult for professional politicians to understand. But at present health care is a key sector and I hope that the regional council will be able to legislate on this policy area, as it is really technical for regional councillors. We need to reintroduce politics, "good politics" because it is important to govern health care policy democratically. The national health care system is

[102] Maria Grazia Labate, interview with author, Rome, 21 July 2003.
[103] Aldo Ancona, Co-ordinatore, Dipartimento del Diritto alla Salute, interview with author, Florence, 29 July 2003.
[104] Aldo Ancona, interview with author, Florence, 29 July 2003.
[105] Rosy Bindi, interview with author, Rome, 18 July 2003.
[106] In practice the Società della Salute represents a return to the size of the old local health authority before mergers, as prescribed by the 1992 reform.
[107] Enrico Rossi, interview with author, Florence, 28 July 2003.

unfortunately seen by the ruling majority of the centre-right as an evil eye, a bad legacy of the First Republic.[108]

Lombardy: Regional Centralisation

Given that Lombardy has the highest rate of municipal fragmentation and the largest health care system in the country -- as shown in Tables 4.5 and 4.6, which compare Lombardy with Tuscany -- it would be an ideal candidate for greater decentralisation of administrative responsibilities from the regional government to the municipalities and, thus, for higher mayoral representation. However, compared with other regions, the tension between regional planning and local government has reached a problematic level and is clearly confirmed by the most recent 2002-2004 Regional Health Care Plan: 'until now the size of communes, especially in regions such as Lombardy, with one of the highest levels of municipal fragmentation in the country, has hindered the integration of services across sectors, triggering three types of solutions: delegation of responsibility by the smallest communes to the local health authority which includes them; the desperate search for autonomous municipal government by cities; and confused overlapping and duplication of services'.[109] Despite official acknowledgement of this problematic relationship, the role of mayors and local government remains extremely peripheral, with no health care specific institutional or organisational instruments, such as those found in Emilia Romagna and Tuscany, for policy co-ordination. An institutional arena, *Tavolo delle Autonomie*, started to operate in 1998 but was not specific to any sector.[110] The output of its monthly meetings are non-binding *Dichiarazioni di Intesa*, literally

[108] Enrico Rossi, interview with author, Florence, 28 July 2003.
[109] Section 7.2. of Piano Socio-Sanitario Regionale 2002-04,'Libertà e innovazione al servizio della salute', Regione Lombardia.
[110] The Tavolo delle Autonomie is made by the President of the *Giunta*, the mayors of big cities only, the presidents of provinces, and representative of the associations of local government.

declarations of agreements. Despite this occasional attention to local government, the region of Lombardy has used full-blown strong 'legislative, planning, co-ordinating, controlling powers in relation to local health care authorities'.[111] Whereas Tuscany and Emilia Romagna have framed the issue of territorial representation and the return of politics in an institutional way, so that the territorial question has been addressed through the *Società della Salute* and *Piani della Salute* respectively, Lombardy has opted for a centralised regional system which delegates residual administrative responsibilities only to local health care authorities instead of municipalities.

[111] Article 1, comma 3, Regional Law no. 31 of 1997,'Norme per il riordino del Servizio Sanitario Regionale e sua integrazione con le attività dei servizi sociali'.

Table 4.5 Regional health care size: compared supply between Tuscany and Lombardy

	Tuscany	Lombardy			Italy
			Ratio	*Difference*	
Public hospital beds and % on total beds					
1996	15.720 (86%)	37.510 (78%)	0,419	-0,819	----
1997	14.586 (85%)	36.177 (74%)	0,403	-0,851	----
1998	13.902 (86%)	34.517 (74%)	0,403	-0,852	----
1999	13.567 (86%)	34.234 (73%)	0,396	-0,865	----
Private hospital beds and % on total beds					
1996	2.603 (14%)	10.374 (22%)	0,251	-1,98	----
1997	2.574 (15%)	12.616 (26%)	0,204	-1,322	----
1998	2.227 (14%)	12.323 (26%)	0,181	-1,388	----
1999	2.175 (14%)	12.799 (27%)	0,170	-1,419	----
Total number of hospitals					
Public	39	135	0,289	-1,103	906
Private	30	55	0,545	-0,588	537
Hospital beds of 1.000 inab. 1999					
Public	3,84	3,78	1,02	0,016	—
Private	0,62	1,41	0,44	-0,778	—
Total	4,46	5,19	0,86	-0,151	—
Public and private outpatients' clinics					
Total for 100.000 inhab.	27,0	9,9	2,73	0,927	16,2
Public for 100.000 inhab.	17,6	5,6	3,14	1,034	7,4
Private for 100.000 inhab.	9,4	4,3	2,19	0,745	8,8
% public out-patients' clinics	65,1%	56,8%	1,15	0,136	45,7 %
Emergency departments					
Departments	185	234	0,79	0,234	3.036
Departments for 100,000 inhab.	5,25	2,61	2,01	0,672	5,28
Emergency doctors	780	1.353	0,57	0,537	15.375
Emergency doctors for 100,000 inab.	22,13	15,10	1,47	0,378	26,76

Source: Annual Report, 2000, Office of Statistics, Regione Lombardia

Table 4.6 Regional health care size: compared personnel between Tuscany and Lombardy

Employees of the National Health Care System	Tuscany	Lombardy	*Ratio and Difference*		Italy
General practitioners and paediatricians					
General practitioners	3.109	7.451	0,417	-0,822	47.490
Number for 10,000 inhab.	8,82	8,32	0,1060	0,058	8,26
Paediatricians	385	855	0,450	-0,758	6.664
Number for 10,000 inhab <14 years old	9,50	7,33	1,296	0,258	7,85
Personnel in public hospitals					
Total for 100 beds	213,8	226,9	0,942	-0,059	214,3
Doctors and dental surgeons for 100 beds	39,0	35,8	1,089	0,086	37,5
Nurses for 100 beds	101,9	91,5	1,114	0,108	91,7
Health care technicians for 100 beds	15,1	13,4	1,127	0,119	12,6
Rehabilitation personnel for 100 beds	2,7	6,1	0,443	-0,773	4,2
Other for 100 beds	54,9	80,1	0,685	-0,373	68,3
Total personnel in public and private hospitals					
Total for 10,000 inhab.	104,0	121,9	0,853	-0,158	109,0
Total per 100 beds	196,4	211,3	0,929	-0,073	195,6
Doctors and dental surgeons for 10.000inhab.	19,2	19,8	0,970	-0,031	19,5
Doctors and dental surgeons for 100 beds	36,3	34,4	1,055	0,054	35,0
Nurses for 10,000 inhab.	48,6	48,2	1,008	0,008	45,6
Nurses for 100 beds	91,8	83,5	1,099	0,095	81,9
Health care technicians 10,000 inhab.	7,0	7,0	1,000	0,000	6,1
Health care technicians 100 beds	13,3	12,1	1,099	0,094	11,0
Rehabilitation personnel for 10,000 inhab.	1,5	3,3	0,455	-0,750	2,3
Rehabilitation personnel for 100 beds	2,8	5,8	0,483	-0,698	4,1

Source: Annual Report, 2000, Office of Statistics, Regione Lombardia

Although the most recent regional health care plan in Lombardy calls for 'the need to strengthen the planning, purchasing and controlling functions of local health authorities, by contracting out direct service provision',[112] the region tends in practice to negotiate most contracts and agreements with private providers through *accreditamento*, the highly centralised accreditation process, and through the definition of supply ceilings for each individual public and private provider. As one general manager of a private hospital suggested, 'the local health authority does not have any power, which is concentrated in the regional administration. The only power that local health authorities have is to delay times of authorisation or to delay

[112] 'Il ruolo delle ASL', Piano Socio-Sanitario Regionale 2002-04,'Libertà e innovazione al servizio della salute', Regione Lombardia.

reimbursement and payments to providers, but they do not have any contractual weight.'[113]

Contrary to national legislation, Lombardy has excluded mayors from the performance review of general managers and has made this function one of its exclusive prerogatives in the 2002-2004 regional health care plan. Hence, the performance evaluation of local health authorities becomes one of the key strategic regional activities.[114] Whereas in Emilia Romagna and Tuscany, in accordance with the Bindi reform, mayors or their associations are involved in the evaluation of public managers, in Lombardy not only do indicators of performance seem to relate primarily to economic and financial variables, but the region has also proposed the creation of an external and independent body, completely outside the national health care system, to evaluate 'individual public managers'. This provision runs counter to the Bindi reform's indication that evaluation should include the achievement of macro policy welfare objectives rather than purely financial and economic figures. The region has also demanded new competences, such as employment negotiations with employees of the national health care system, with general practitioners and with all independent contractors, pharmaceutical policy, training and continuing education, and the allocation of resources for covering the national minimum standards.[115]

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[113] Gianni Giorgi, interview with author, Milan, 24 July 2003.

[114] A new unit will be created in collaboration with universities in Milan and owned by the region, the 'Centro Studi per la valutazione dei sistemi sanitari e socio sanitari', to monitor continuously the performance of the health care system. Among the indicators: compliance with standards for authorisation as set out by regions; quality indicators of activities, based on customer satisfaction; waiting lists indicators; economic and financial indicators referred to average cost of patient for each local health authority and cost-benefits analysis. (See 'La valutazione del sistema e delle aziende,' Piano Socio-Sanitario Regionale 2002-2004, 'Libertà e innovazione al servizio della salute', Regione Lombardia).

[115] 'Devoluzione', Piano Socio-Sanitario Regionale 2002-2004,'Libertà e innovazione al servizio della salute', Regione Lombardia.

The higher degree of political heterogeneity between regional and local elites in Lombardy, compared with the other two regions, is key among the factors which discourage decentralisation to local political elites.[116] Centralisation is favoured by the uninterrupted political leadership exercised since 1995 by a directly elected President of the region, Roberto Formigoni, Forza Italia, who has succeeded in becoming a nationally relevant political figure and whose personal conflict with Minister Bindi brought him unprecedented electoral support.[117] Formigoni has used health care as a means of pioneering the process of region building, for it amounts to approximately 75 per cent of the regional budget.[118] Despite this strategy of differentiation from the centre and the 'decentralising' political rhetoric, the Northern League, Forza Italia's major coalition partner, has never been publicly and directly involved in health care policy and does not have a distinct programme -- unlike Forza Italia, whose electoral campaign for the 2001 national elections included a fierce attack on the, allegedly, 'centrist and excessively statist Bindi reform'.[119] When in opposition, Berlusconi had defined the Bindi reform as 'a tragedy for the nation, an attack against individual choice and freedom'.[120] In similar tones, President Formigoni said: 'Rosy Bindi is a disgrace for Italy, for democracy, for the centre-left coalition in government'.[121]

[116] In the most recent local elections on 25-26 May 2003 (total electorate 11 million, 12 provinces and 500 municipalities) the centre-left gained the majority of municipalities of over 15,000 inhabitants. posing a challenge to the centre-right regional coalition. For instance, in Brescia the centre-left incumbent, Paolo Corsini, won at the second ballot. See: 'I primi risultati nei Comuni con oltre 15,000 abitanti', *La Stampa*, 27 May 2003.
[117] Formigoni won 65% of votes in the 2000 regional elections.
[118] According to the most recent data on the regional budget for Lombardy, health care amounts to 18.109 billion Euros, 'Bilancio della Regione Lombardia 2002-2004'.
[119] Antonio Tomassini, interview with author, 26 September 2002.
[120] *La Stampa*, 22 June 1999.
[121] *La Stampa*, 31 May 1998.

Conclusions

The three regional cases differ in their strategy of using mayors as 'political counterweight' against rising managers. There is a regional variation in the degree of political resistance to technocracy, and the degree of mayors' participation in planning activities and reviewing the performance of general managers. Regions vary from Emilia Romagna, where consultation through formal and institutional channels is predominant, to Tuscany, where the recovery of the role of mayor is most noticeable, to Lombardy, where the tension between the regional and municipal levels of government remains unresolved. Regional elites in Tuscany and Emilia Romagna are more willing to use the role of the mayor as a way to counteract general managers, whereas in Lombardy the regional executive is more concerned with centralising power at the expense of mayors. The different strategies for technocratic decision making are consistent with the different types of centralised functional planning at the regional level. Of the three, Lombardy is the region in which regional centralisation at the expense of mayors and territorial representation has been most evident. By contrast, Tuscany has emerged as the case in which mayors were effectively given back management functions.

The resistance of local political elites to the emergence of a fully-fledged, autonomous, technically- oriented health care administration has been the key factor impeding a concrete departure from the predominance of partisanship to functionally defined welfare administration. However, the position of general managers of local health authorities within the local network of policy actors has changed throughout the 1990s, as a result of their relative influence granted by regional implementation legislation in fulfilment of the 1992 reform. Managers have gained policy influence

at the expense of local political elites, who have been marginalised from a regionally centralised planning and policy making system.

Regions complied rather promptly with those aspects of the 1992 reform which contributed to creating the conditions in which general managers could exercise their autonomous functions, not without also devising viable solutions to maintain the democratic participation of local interests, such as the *distretti*. The central role that mayors used to play in shaping local decisions was inevitably diminished by the merger of local health authorities. Another important contributory factor to facilitate the rise of managers was the enterprise formula -- the juridical transformation of local health authorities into public enterprises, with the subsequent provision of private law instruments for the adoption of strategic plans. Given a technocracy-averse administrative tradition, the emergence of powerful regional bureaucrats has been a remarkable achievement and a noticeable departure from a pattern of inertia.

The creation of opportunities for general managers to fulfil their newly acquired powers was partially reversed at the end of the 1990s by strategies such as the reappraisal of the central role of mayors in local health care services' organisation, planning, and evaluation. This was a neutralising strategy, pursued primarily by national political elites, to reaffirm their centrality by supporting the 'rivals' of managers, namely mayors. In this respect there is a high degree of variation between regions. Overall, the managerial responsibilities of mayors have been re-established only in Tuscany. In Emilia Romagna and Tuscany the attempt to curb regional managers with such a strategy did not produce the intended results.

I have suggested that the introduction of instruments and solutions to curtail managerial autonomy was only partly justified by the direct challenge posed by rising general managers to democratic participation and collegial decision-making style. National elites were mostly concerned with having local access points to political control. The national elites' primary objective in reappraising the role of mayors in health care policy at the end of the 1990s was not to curtail the power of general managers *per se*, nor to abolish the enterprise formula,[122] nor solely to improve intergovernmental co-ordination. Bindi was increasingly concerned with the political opportunities offered to regional ministers of health care and presidents of regions to control the health care sector, ensuring political consensus by the system of appointing general managers. She claims that: 'the political control of health care is a way to mobilise political consensus. The health care regional ministers control the general managers in order ultimately to control the appointment of senior consultants in hospitals. This is to mobilise political support. In Lombardy it is the President of the Region who controls everything.'[123] With such a centralised political system controlling the top level of the administration, political parties, in particular those in opposition, need to ensure that other access points are preserved in the system. I argue that this is the fundamental motivation for reappraising the role of mayors.

So far I have concentrated on the concerns of local and national political elites. The next chapter analyses how regional elites in particular have established political control over general managers of local health authorities and, as such, have entered into direct conflict with national elites. The introduction of general management has

[122] The enterprise formula was quite clearly confirmed and improved by the provision that local public enterprises could use instruments of the private sector, such as the *atto aziendale di diritto privato*, literally acts of private law (Article 3 comma 1-bis of Executive Decree no. 229/1999).
[123] Rosy Bindi, interview with author, Oxford, 25 October 2002.

increased conflict in the relationship between national and regional political elites. Chapter 5 concentrates on the power struggle between them as a way of understanding the wider implications of the 1992 health care reform on the reform of the state, in the direction of greater administrative and political decentralisation.

Chapter V

The Territorial Struggle for Political Representation and Control of the Administration: Regions and Resistance from the Centre

The decentralisation of administrative responsibilities to the regions has resulted in increased regional administrative capacity. How has this affected the relationship between national and regional elites? In the context of welfare services, it has given regional elected officials and leaders crucial resources when bargaining and negotiating with the central administration and national elites. Emerging technocracy, combined with the regional centralisation of health care policy-making and co-ordination, has led to changes in the traditional form of territorial political representation. Between 1992 and 1999, regional elites, and particularly regional executive leaders, used their administrative responsibilities to gain political legitimacy because of their commitment to creating an autonomous regional political space. They used a variety of instruments and resources to pursue this objective; most prominent among which was political control over local health care authorities and public hospitals, which they exercised through their power to appoint general managers. But this has caused regional elites to come into conflict with national and local elites over the control of administrative resources.

This chapter examines the characteristics of the regional executives' new role and functions by analysing their opportunities. It also investigates the response, at the end of the 1990s, of central elites to the increased ability of regional elites to use their administrative role to gain local political legitimacy for themselves and the institutions they represent. The 1999 Bindi reform represented an attempt to redefine

the health care system by regulating competition, and also to reorganise the system of territorial politics which there had been pressure to change radically since the 1992 reform. This chapter analyses the 'recentralisation' of the Bindi reform, aimed at blocking the regionalisation process, in the context of understanding the centrality and prominence of political control of health care administration as the single most important resource for establishing political legitimacy and consensus at the regional level. Accordingly, it concentrates on aspects of the 1999 legislation and issues emerging from the parliamentary debate that most affected the political struggle between the centre and the regions.

The intention here is to analyse politics *about* territorial representation by understanding politics about health care issues that are fought *across* territory and different institutional levels of government. After looking at the resources available to regional leaders to exercise their political control, the second section focuses on the issues at stake in the power struggle between national and regional elites. An analysis of the parliamentary debate associated with the Bindi policy reversal reveals the neutralising strategies and instruments against the regionalisation of welfare services. A detailed and selective investigation of the legislation also offers invaluable insights into the instruments used to curb the emerging regional administrative autonomy, such as centralisation of control functions and hierarchical administrative arrangements. The final outcome of this process of neutralising regional autonomous capacity is also discussed, although the purpose here is to assess the ways in which those actors threatened by change responded to it.

Regional Political Capacity

Competition between political parties has never been based in the regions – which were created in the 1970s – as the party system is nationally based (Dente 1985). Consequently, regional elected officials have been subject to the decisions of national party secretariats regarding the composition of electoral lists and coalition strategies. Like the local elites, regional elites had few incentives to pursue policies of modernisation and economic growth because of the predominant system of clientelistic networks (Tarrow 1974). Scholarly expectation, based mainly on empirical research before the end of *partitocrazia*, is that the emergence of regional government in Italy should be characterised by the survival of clientelistic networks, 'since their dissolution would undermine the role of elites in attracting and distributing resources from central government and free their clients from dependence' (Keating 1998). However, regional experimentation in the health care sector in the 1990s has required and produced increasing administrative and 'political capacity'.[1] A regionally based autonomous political space – which enhances the role of politics in shaping public policy– is emerging, in part owing to the 1995 electoral changes intended to favour strong majorities and stable coalitions. Regional political elites are growing in influence and are increasingly carving out a visible and autonomous space to shape health care policy. The nature and scope of their power are discussed, and the sources of – and constraints on – their political opportunities explored.

[1] 'Political capacity' is a feature of regional government defined by M. Keating as 'the ability of regions to mobilise support for their policy initiatives, and to take decisions on policies and priorities'. (Keating 1998, p. 120).

Policy Influence of the Regional Executive

A regional minister of health asserted: 'I have spent all my energies and personal commitment on this regional health care plan. It is my own creation and I have conceived it'.[2] Regional ministers have a high degree of personal involvement in the process of drafting and elaborating the regional health care plan, which sets out the operational details of regional planning. There are two reasons for this. First, the regional council does not have the technical expertise to deal with the content of health care legislation. One official has expressed concern in relation to the pending approval by the regional council of the *Atti di Concertazione* (concerted planning acts) of Tuscany's Aree Vaste because, 'this is the first time that the regional council has been called upon to analyse technical aspects of health care policy'.[3] Secondly, regional health care plans have been used as political manifestos by the regional coalition. Consequently, they help the regional executive to mobilise political consensus. For instance, the regional health care plan in Lombardy[4] emphasises freedom of choice for patients, in accordance with the underpinning neo-liberal ideology of the centre-right coalition led by Forza Italia. The plan features the main programmes on which Forza Italia campaigned in the general elections of 2001. As

[2] Enrico Rossi, interview with author, Florence, 28 July 2003.
[3] Aldo Ancona, interview with author, Florence, 29 July 2003.
[4] The Regional Health Plan 2002-04 of Regione Lombardia contains the following elements:

- ordinary citizen at the centre of the regional health care system, thus making public administration increasingly more flexible and user-friendly and abandoning formal, bureaucratic management;
- identification of health care priorities;
- combination of integration with competition in a 'network' logic;
- experiments with various management models seeking to achieve compatibility between needs and resources, thus leading to sustainable development; and
- promotion of projects with a considerable innovative institutional and organisational content, aimed at pursuing further devolution in the health and social care.

one interviewee said: 'regional health care plans are only political propaganda and rhetoric for differentiating regional from central policies or from other regions'.[5]

As well as shaping public policy by personal involvement in and commitment to the development and enactment of regional health care plans, regional ministers exercise their power by interfering in the daily management of health care activities and the decision-making of public enterprises. For instance, as one minister admitted: 'The mayor of Grosseto asked me for a vascular surgery division and I gave it to him.'[6] A technical decision to install new equipment, which one would expect to be taken by the general manager of a public hospital or local health authority, was the result of informal negotiations between the minister and the mayor of the city. It could be argued that regional leaders intervene on a personal basis and that this type of behaviour confirms the continuation of clientelistic practices. But apart from the fact that clientelism is based on systemic political exchange rather than occasional personal favours, this episode exemplifies 'the tendency of regions to *manage* the health care sector instead of merely *planning* health care activities'.[7]

The management power of regional leaders and their scope to shape public policy is a result of the regional centralisation of functional planning activities. But their power to appoint public managers of local health authorities and public hospitals is exclusive, legally established, and direct. The original procedure, as established by Executive Decree no. 502 /1992, indicates the selection of general managers from a list drawn up by an experts committee, delegated by the Ministry of Health to assess the qualifications of candidates. The entire procedure was simplified and transferred

[5] Gianni Giorgi, interview with author, Milan, 24 July 2003.
[6] Enrico Rossi, interview with author, Florence, 28 July 2003.
[7] Maria Grazia Labate, interview with author, Rome, 21 July 2003.

to the subnational level by law no. 590 of 17 October 1994. Article 1 establishes that, after public invitation to apply, regions appoint general managers with the necessary prerequisites from 'among those who have applied'. The appointment is subject to confirmation after 18 months. The public notice for application appears to temper the personal relationship, forcing the region to choose from a larger supply of candidates. The great discretion left to the regions has led to the issue of 'motivating regional appointment' being taken up by some administrative courts.[8] The Council of State has decided that 'there is no need to motivate administrative acts of appointment, nor to explain comparative criteria between candidates'.[9] This judgement is highly controversial (Gallo 1999) because it legitimises the direct relationship between regional government and general managers. However, the Council of State has legitimated a *de facto* direct subordination of the top level of health care administration to regional leaders.

Administrative and Political Resources

As far as the power resources of regional elites are concerned, the form of government and the electoral system have implications for the legitimacy of a political control which is based on the direct appointment of general managers. In Italy, given the traditional legacy of clientelism, this has always been viewed with suspicion as a threat to democratic government. As Endrici argues, political control which reflects the principle of political responsibility (Endrici 2000) should be the most vigorous antidote to the distorted use of the power of appointment.[10] The direct

[8] Administrative Court of Lombardy, Decision no. 1095, 5 September 1995 and Administrative Court of Piedmont no. 427, 27 July 1995.
[9] Council of State, Section IV, Decision no. 1139, 1 September 1998.
[10] In January 1995, the Minister of Health Costa had to annul the appointment of 59 general managers by the Regional Giunta of Lombardy. The entire regional executive received notification of impending judicial investigation. The recording of a telephone call proved partisan negotiation in the

election of the President of the Region, and the introduction of majority elements into the electoral system, have both increased the stability of regional coalitions and given regional government the same direct accountability as municipalities and provinces, where the executive has been directly elected since the 1993 reform. Despite regional differences in the exercise of political leadership, direct election of the regional executive has increased the scope and legitimacy of the appointment system and political control over the top level of health care administration. In the case of Tuscany, the Minister of Health is free to appoint general managers, as he confirmed: 'The President of the Region does not interfere in my decisions and appointments. I am also jealous of my prerogative to appoint general managers, although the Council always puts pressure on me to appoint this and that person.'[11] In Lombardy it is the President of the Region himself who intervenes in the appointments. One interviewee said that 'the Minister of Health in Lombardy does not count much. It is the President who has total control over public managers in order to mobilise political consensus.'[12]

Regional ministers' power derives from increased administrative capacity as well as the effects of the new form of regional government and electoral system. As one interviewee suggested: 'the weakness of mayors is that they do not have information, whereas at a regional level we are supported by the administration'.[13] For example,

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appointment of general managers. Some of the excluded managers appealed to the administrative court because the regional executive did not justify its decision. Apparently the regional executive had commissioned a private consulting firm, Russell Reynolds, with the task of ranking candidates. The three best candidates happened to be the ones sponsored later by political parties. For detailed coverage of the appointment scandals see *Il Sole 24 Ore*, 12 January 1995 and 26 January 1995, and *Mondo Economico*, 23 January 1995. At that time Lombardy was not the only region affected by this problem. In Piemonte the judiciary was investigating the appointment procedures for general managers, which were influenced by a private consulting firm (see 'Nomine Usl. Inchiesta anche a Torino; scelta dei managers', *La Stampa*, 10 January 1995).

[11] Enrico Rossi, interview with author, Florence, 28 July 2003.

[12] Rosy Bindi, interview with author, Oxford, 25 October 2002.

[13] Enrico Rossi, interview with author, Florence, 28 July 2003.

in 1995 Emilia Romagna created a Regional Agency for Health Care, the *Agenzia Sanitaria Regionale*, which has a crucial role in providing technical advice to the regional minister.[14] The *Agenzia* provides health care authorities with the management tools they need, reports annually to the regional Department of Health Care on their economic and financial state, and monitors the costs and revenues of public enterprises. The *Agenzia*, which is directed by a general manager appointed by the President of the Region, has expertise in organisation and planning. There are no comparable agencies in Lombardy or in Tuscany since this expertise tends to be provided by the departments of health. In Lombardy, a regional bill in 1993 proposed the creation of a regional agency, but was rejected by the regional council. As the civil servant who was leading the initiative reported: 'We did not want an agency which was merely a research unit of the administration, but an agency which would be responsible for managing health care finances and for managing the entire sector independently. Politicians did not want such an agency and I was defeated in my attempts.'[15]

Regional executive leaders derive their power from the increasing relevance of regional health care in the national political debate, as well as from institutional and administrative sources. In the context of the political debate about 'federalism',[16]

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[14] Regional Law no. 50 of 1994 has created the *Agenzia Sanitaria Regionale*, Emilia Romagna. See Article no. 39 for detailed functions and structure of the *Agenzia*.

[15] Gianni Giorgi, interview with author, Milan, 24 July 2003.

[16] The political debate about 'federalism' in Italy from the end of the 1990s refers to the effects of the constitutional reform, as defined in Law no. 3/2001, on the relationship between the central state and regional government. Law no. 3/2001 has reconfigured the legislative responsibilities between the state and regions in such a way that health care is included in those areas of 'shared responsibility'. Regions retain their legislative functions but minimum service standards are defined by the central state (Maino, F. (2003). "La sanità fra Stato e regioni." Il Mulino 1: 100-107. For a constitutional debate about the new interpretation of regional legislative functions, see Balduzzi and Di Gaspare (2002), Falcon (1998). For the relationship between constitutional reform and the risk of challenging universal health care, see Mario Pirani, 'Quell'incrocio perverso tra sanità e federalismo', *La Repubblica*, 23 June 2002. Bills of constitutional reforms, which confer on regional government exclusive legislative responsibilities for education and local police have recently been discussed in

health care has played a crucial role in differentiating regional from central policies and has offered the pioneering opportunity for the transformation of the Italian state into one which is highly decentralised.[17] For instance, the policy process which led to the enactment of Regional Law no. 31 in 1997,[18] which introduced equal conditions between public and private providers in Lombardy,[19] became part of a highly partisan and ideological national political debate[20] between the centre-right Formigoni regional *Giunta* and the national centre-left government coalition. Regional differentiation from the centre has offered a political incentive for regional elites to carve out a central role in national as well as regional politics. This increases the visibility which is necessary for a national career, but it also puts them

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Italy. See for a very recent debate about federalism: M.Pera, 'La buona devolution', *Il Sole 24 Ore*, 11 September 2004; 'Riforme, premierato meno forte', *Il Sole 24 Ore*, 10 September 2004.

[17] The regionalisation of health care introduced in 1992 has been pursued throughout the 1990s by different governments. The Berlusconi Government, which took office in 2001, has consolidated health care decentralisation by empowering regional governments with control over pharmaceutical expenditure. Law no. 405/2001 conferred responsibilities for controlling pharmaceutical expenditure to regions and established a ceiling of 13%. See Roberto Turno, 'La dura prova del federalismo', *Il Sole 24 Ore*, 7 December 2001.

[18] The major characteristics of this regional law, which differentiated Lombardy from other Italian regions, were: clear-cut division between purchasers and providers; equality between public and private providers in order to ensure freedom of choice of patients; the local health authority with a minor role of planning and the role of third payer only; mergers of public hospitals into very large agglomerates.

[19] Article 2, Regional Law no. 31/1997, Regione Lombardia. Equal conditions between public and private providers is the condition for the quasi-market, which J. LeGrand defines as 'the combination of free access at the point of delivery, combined with decentralised market-like competition between providers of services' (Le Grand, J. and W. Bartlett, Eds. (1993). Quasi-Markets and Social Policy. Basingstone, MacMillan.Lombardy has introduced the greatest purchaser-provider split of the Italian regions. All public hospitals have been transformed into trusts, detached from their parent local health authorities. This was aimed at levelling the playing field for competition because public hospitals managed by local health authorities would receive hidden cross-subsidies (Donatini, A. and A. Rico (2001). Health care systems in transitions: Italy, European Observatory on Health Care Systems. All accredited providers are financed by tariffs and fees-for services, established by the regional government (Mapelli, V. (1999). Il sistema sanitario italiano.

[20] The most important issue of this debate between Minister Bindi and President Formigoni was the accreditation and financing of private providers. In January 1997 the regional *Giunta* issued an executive deliberation abolishing the entry barriers to private providers in health care provision. The region's argument was that it was still awaiting national regulation of the process of authorisation of private providers. Minister Bindi sustained that the deliberation was not constitutional and would raise health care expenditure immensely. Institutional accreditation, granted by regions, is a way to the regulation of the quasi markets and ensuring quality and an instrument to carry out regular assessment of quality and evaluate the value added of the existing regional health care services. Accreditation is mandatory for contractual arrangements, negotiated between local health authorities and 'preferred providers' chosen by the region on a value for money basis among those accredited. These agreements describe the amount of services, price, quality and maximum waiting time that a provider has to respect.

into competition with national political elites, who 'should take a step back to go two steps forward and should delegate more power to regional elites'.[21]

The possibility of representing consultants or their associations, and mediating between them and the general managers, is another important source of political power for regional political elites. They have a crucial ally in the medical profession – 'consultants know very well to whom they should refer when they are unhappy about general managers'.[22] Moreover, 'senior consultants are enthusiastic about the return of politics', as one regional minister said.[23] These comments suggest that consultants use political resources and refer to politicians to prevent the direct encroachment of general managers on their medical activities. The consultants' greatest concern is the annual performance evaluation, based mainly upon economic and budgetary indicators, 'which are rather frustrating for senior consultants'.[24] Since general management was introduced in 1992, the relationship between consultants and general managers, especially in public hospitals, has become very confrontational because 'the possibility of political mediation and understanding by politicians is being curtailed. It is widely accepted that doctors, strengthened by their social influence, used to bypass managers and directly appeal to the politicians for resources' (Andrion 2003, p. 4).

Channelling consultants' demands and frustrations is an important political resource for regional elites. It derives from the organisational weakness of hospital consultants, who lack clear management functions within public hospitals. The *Collegio di Direzione* (Management Committee), established by the 1999 Bindi

[21] Enrico Rossi, interview with author, Florence, 28 July 2003.
[22] Gianni Giorgi, interview with author, Milan, 24 July 2003.
[23] Enrico Rossi, interview with author, Florence, 28 July 2003.
[24] Serafino Zucchelli, interview with author, Rome, 18 July 2003.

reform, [25] could have been used for mediating between consultants and general managers, but it was implemented in a scattered way. According to a study carried out by the ANAAO, Associazione Nazionale Aiuti e Assistenti Ospedalieri, the most representative national association of hospital doctors, in southern Italy 23.81 per cent of total public hospitals activated the *Collegio*, compared with 44.58 per cent in the north, whereas in the centre the percentage was 34.7 and in the islands even smaller, 16.67.[26]

Limitations of Regional Executive Power

Despite their relative power, regional ministers of health do face considerable limitations as far as their ability to make appointments is concerned and, more generally, in their control of health care administration. The coalition politics of the regional council are the most important constraint on their autonomy in appointing managers. Although electoral laws ensure the stability of the ruling regional coalition (Pitruzzella 2000; Tosi 2000; Endrici 2001), political parties have a tendency to defend their prerogatives to occupy institutions.[27] The regional minister's political leadership is directly related to the position of his or her party in the regional coalition. One interviewee spoke about the possibility that, in spite of the formal process, a party-sponsored candidate could be appointed: 'there is not necessarily a trust relationship between the regional Minister of Health and the general manager, because the latter responds to his political master and to his

[25] Article 17 of Executive Decree no. 229 of 1999 establishes a Collegio di Direzione which supports the general manager in the organisation and management of medical activities. The Collegio is involved in the performance evaluation of consultants and in the general strategic plan of the health authorities.

[26] 'Indagine Anaao Assomed. Dipartimenti gestionali e Collegio di direzione', April 2001.

[27] 'Manifesto per la rinascita della sanità – Fuori i partiti, malati al primo posto', *Il Corriere della Sera*, 8 February 2004; 'Tangenti a Milano, ricercato consigliere di un viceministro', *Il Corriere della Sera*, 13 February 2002; 'Con i primari di partito sanità peggio della Rai', *La Repubblica*, 10 February 2003.

political party. The regional minister appoints general managers according to partisan politics only.'[28]

Another constraint on regional leaders is rivalry with other local leaders, such as the mayors of big cities, or presidents of provinces. As far as the power of making appointments is concerned, mayors and presidents of provinces can exert pressure on regional elites. For instance, according to the general manager of the local authority of Parma, the mayor of the city intervened in the appointment of senior consultants.[29] It would be wrong to assume that these are instances of clientelism because negotiation between local and regional elites regarding the appointment of general managers is part of the legal framework. Law no.81 of 1993 gives mayors and presidents of provinces extensive powers in appointing local authorities in their area. This rivalry can turn into conflict in the case of opposing political majorities. The merger of three local health authorities in Bologna to form a single authority, covering about 850,000 citizens, has proved politically sensitive because the centre-left regional majority opposed the centre-right municipal one of Bologna.[30]

The health care reforms at the end of the 1990s revitalised the role of mayors, as discussed in Chapter IV. Regional leaders are acquiring a strong hold over health care administration and policy. Tension between local and regional elites has been increased by the recovery of the mayors and the emergence of regional leaders. For instance, early in 1997, during the legislative and political process of Law no. 31 relating to the reform of the Lombard health care system, its fiercest opponent was the Association of Municipalities and Provinces in Lombardy. The Association

[28] Renato Botti, interview with author, 24 July 2003.
[29] Gianni Giorgi, interview with author, 24 July 2003.
[30] Aldo Taroni, interview with author, Bologna, 22 July 2003.

supported central government's decision to appeal to the Constitutional Court against the juridical inadequacies of the regional law.[31] Mayors themselves participated in street demonstrations in front of the regional offices in Milan on 7 April 1997.[32] The President of the Province of Milan was particularly concerned about the huge size of local health authorities, which included an average of 1,500,000 citizens, and the fact that local government was seldom consulted on the mergers of local health authorities. The problematic relationship between newly elected mayors and other leaders of local government, even between a mayor and a regional minister of the same party, is confirmed by an empirical study by Recchi (Recchi 1996).

In the aftermath of the regionalisation of health care policy, regional governments have acquired not only administrative responsibilities but also great political capacity. Regions define their policy objectives through health care plans, which can reorganise health care systems quite differently to the national guidelines. Regional executives, strengthened by the direct election of regional presidents, have shown policy leadership and steering capacity in their control of the administration, and they have the exclusive right to appoint managers. But they also face obstacles, such as unstable coalitions, and political rivals, such as mayors. However, regional leaders have much greater administrative resources than mayors, and these outweigh any obstacles they might face. Besides, following recent electoral reforms, in many regions the executive has a clear and stable majority in the council.

[31] 'Bocciata dal Governo la riforma sanitaria della Regione Lombardia', *Il Sole 24 Ore*, 1 May 1997.
[32] 'La nuova legge sostenuta dalla maggioranza. Contrari Anci, Province e ministero; Lombardia: la riforma sanitaria al traguardo tra le polemiche', *Il Sole 24 Ore*, 8 April 1997.

Administrative Recentralisation

This section looks at how the 1999 health care reform tried to curb the emerging power of regional elites and reverse the 1992 change granting administrative autonomy to regions in the health care sector. Parliament enacted Delegating Law no. 419 on 30 November 1998. This set out the guidelines and principles for the drafting of Executive Decree no. 229, which was issued by the Prodi government on 19 June 1999, and has been labelled 'one of the more ambitious attempts in Europe to produce a detailed regulatory framework'.[33] The aim of this legislation was a structural review of key issues which had been debated since the 1992 reform, including the reform of hospital consultants' employment contracts, the reform of private providers' authorisation and accreditation procedures, the creation of new agencies and consultative committees, the rationalisation of hospital networks, and so on. The 1999 reform recognised that the internal market introduced in 1992 required careful management and assumed that this could not be left to regions, where the pace of implementation varied.[34] Our analysis focuses on those elements

[33] 'Country Report: Italy', Health European Observatory, 2001.

[34] Four regulatory measures were launched by the 1999 Bindi reform: to promote strategic planning through a hierarchical process of national, regional and public enterprise planning; to regulate competition; to assess the quality of care; and to promote co-operation. Two strategies were adopted concerning the regulation of competition in the internal market. First, in order to regulate purchasing function, comparative evaluation of quality and cost should be used in selecting the providers allowed to provide services with public funding. The 1999 reform established four steps for selecting providers: authorisation, needed to build new facilities or to modify old ones, could be granted by municipalities; authorisation, needed to deliver health care services, could be granted by regional health care departments; institutional accreditation was granted by the region upon a regular assessment of quality and after an evaluation of value added, given existing health care services. Accreditation was mandatory for contractual agreements, which were negotiated between local health care authorities and 'preferred providers' chosen by local health care authorities themselves and the region on a value-for-money basis among those accredited by the national heath care system. The second strategy adopted to regulate competition was to clarify the boundaries between public and private practice within hospitals. Bindi's personal commitment to this aspect of the reform was remarkable. Executive Decree no. 229/1999 established that managerial posts within public hospitals were to be reserved only to those physicians who chose to work exclusively for the public sector, the *esclusività*. All physicians can conduct private care within public hospitals, by paying a proportion of their extra income to the hospital. But physicians employed after 1998 cannot work in private hospitals.

which refer to the political role of different institutional levels and the role of the territory, as conceptualised by the then Minister of Health (1996–1999), Rosy Bindi. In particular, I investigate the extent to which legislative output can be considered as a way of neutralising the political power of rising regional elites.

The heavily bureaucratic recentralisation of health care policy and planning was the Opposition's strongest objection to the Delegating Bill and the draft Executive Decree, as can be seen from the parliamentary debate of both these government bills. One senator of Forza Italia declared that:

> The draft executive decree under examination is inspired by a bureaucratic and centralising principle of administrative function, which contradicts the government policy about federalism and administrative decentralisation. Moreover, the executive decree is unconstitutional when it establishes a hierarchical institutional relationship between the Ministry of Health and Regions, in violation of regional autonomy.[35]

Not only a member of the opposition, but also the majority rapporteur of the draft decree in the XII Permanent Committee of the Italian Senate on health care stated that:

> the excessive centralisation of the proposed bill is noticeable as regards the substitute powers of the Minister of Health in cases of regional lack of compliance with national legislation [...] the Committee suggests that the relationship between the state and regions be entirely revisited because it is necessary to avoid the risk of *dirigisme* that emerges from the draft executive decree proposed by the government.[36]

The 1999 bill was generally resented by the Opposition and parts of the parliamentary majority for its heavily bureaucratic interpretation of the administrative function. The decision-making process envisaged responds to a predominant planning model which pre-supposes that the state will play a strong role. This method is used widely for any strategic choice to be made in the area of

[35] Senator Tomassini (Forza Italia), XII Permanent Committee on Health Care, Senate, 26 May 1999.
[36] Senator Di Iorio, Majority Spokesman, XII Permanent Committee on Health Care, Senate, 26 May 1999.

health care policy that involves setting priorities as well as detailing operational options. In addition to national and regional health care plans, the bill proposes the adoption of local implementation plans (*piani attuativi locali*) and a local health care plan (*piano territoriale*), all of which 'are likely to be policy announcements and administrative exercises of power, when instead citizens request only efficient services'.[37] In addition to centralised planning methods, the establishment of new administrative structures, joint committees, territorial conferences and such like seems to be a response to an attempt to expand rather than streamline the public sector. According to a Member of Parliament:

> administrative confusion will increase because in addition to strong regional planning functions, two new regional institutions will be created: one for the evaluation of regional planning and another for the co-ordination and control of metropolitan areas! I believe this muddled and bureaucratic management of health care policy are only attempts to sabotage the national health care system.[38]

As far as the centralisation which derives from the changes affecting health care planning is concerned, two key issues emerge from the parliamentary debate. These are the hierarchical position in which the bill places planning acts, according to their institutional levels, and the participation of local government in planning activities, discussed in this chapter. Regional health care plans, which had become strategic instruments of regional executive power, would need to conform to the national health care plan's objectives. In addition, regions would need to make arrangements for local government, volunteer organisations, trade unions and health care associations to participate in planning activities.[39] From the Senate's attempts to amend the draft executive bill, it emerges that regional ministers of health care were extremely concerned, particularly about the participation of local government representatives in the regional health care agencies which provide technical support

[37] Senator De Anna (Forza Italia), XII Permanent Committee on Health Care, Senate, 11 May 1999.
[38] Onorevole Conti (AN), plenary session, Lower Chamber, Italian Parliament, 1 October 1998.
[39] Article 13, Executive Decree no. 229, 19 June 1999, regarding 'Norme per la razionalizzazione del Servizio Sanitario Nazionale, a norma dell'articolo 1 della legge 30 novembre 1998, no. 419'.

to the regional administration.[40] The executive decree also envisages the central administration's *imprimatur* of regional health care plans in establishing that 'regions must communicate their draft health care plans to the Ministry of Health to acquire an opinion as regards their compliance with national legislation. The Minister of Health expresses his opinion within 30 days from receipt of the drafts'.[41]

A critical issue relating to ministerial intervention in the formulation of regional health care plans was the transformation of the Agency of Regional Health Care Services (*Agenzia per i servizi sanitari regionali,* ASSR) from an institution which offered technical support to the regions, under the direct supervision of the Ministry of Health, to one fulfilling the control and policing functions of regional compliance to national legislation and general guidelines. The stated aims of the Agency are: monitoring health care expenditure; compliance with minimum standards of care; and evaluating organisational and managerial regional experimentations. However, some MPs revealed the reform's attempt to use the Agency as an instrument for directing and imposing central guidelines on supposedly autonomous regions.[42] A senator despises the transformation of the agency into 'an inquisitorial mechanism encroaching upon regional autonomy'.[43] The executive decree establishes that the Minister consults the agency upon various matters, including regions' lack of compliance with national guidelines.[44] The decree enacted does indeed suggest control functions for the Agency such as those lamented by the Parliamentary Opposition.

[40] Minister Bindi, XII Permanent Committee of Social Affairs, Lower Chamber, 30 September 1998.
[41] Article 14, Executive Decree no. 229/1999.
[42] Onorevole Cè, Plenary Session, Lower Chamber, Italian Parliament, 1 October 1998.
[43] Senator Castellani, XII Permanent Committee on Health Care, Senate, 11 May 1999.
[44] Articles 14, 15 and 17, Executive Decree no. 229/1999.

The problem of exercising the administrative control function remains ambiguous in the legislation. The Bindi reform is inspired by the principle of subsidiarity as far as administrative control is concerned; accordingly, municipalities win back a key source of influence on health care authorities. The Delegating Law establishes that, in drafting the executive decree, the Government must follow the principle that 'the Government must define guidelines to identify the instruments of control and monitoring, to be carried out according to institutional subsidiarity'.[45] This aspect remains so unclear and ambiguous that many MPs requested clarification from the Minister during the parliamentary debate about which institutional level is entitled to carry out controls.[46] It emerged that the most problematic ambiguity is whether regions or municipalities are in charge of controls. The Senate amendments favoured regions and not municipalities exercising control functions over local health authorities. However, the bill proposed by the Government suggested that municipalities should have the power to control local health care authorities. The final executive decree gave the power to exercise administrative controls over local health authorities to the regions.[47]

One of the most evident forms of centralisation is the scope for *poteri sostitutivi* (substitute powers) to be exercised by the Minister of Health Care if regional compliance with national health care plans is poor. Although these prerogatives are primarily concerned with the implementation of national legislation and are rarely exercised, they do involve the visible subordination of regions to the central state.

[45] Article 2 comma 1 letter (h), Delegatine Law no. 419, 30 November 1998, 'Delega al Governo per la razionalizzazione del Servizio Sanitario Nazionale e per l'adozione di un testo unico in materia di organizzazione e funzionamento del Servizio Sanitario nazionale. Modifiche al decreto legislativo 30 Dicembre 1992, no. 502'.
[46] Onorevole Saia (RC), Conti (AN), XII Permanent Committee on Social Affairs, Lower Chamber, 29 September 1998.
[47] Article 2, comma 2-sexies, letter (e), Executive Decree no. 229/1999.

The majority spokesman on the Social Affairs Committee of the Lower Chamber emphasises the need to 'rebalance the substitute powers of the Minister of Health Care'.[48] The executive decree establishes the possibility for the Minister of Health to appoint central government commissioners *ad acta* to put non-compliant regional administrations under temporary receivership in the case of lack of adoption of a regional health care plan.[49] Another case in which the Minister of Health appoints commissioners *ad acta* is when regional objectives to be achieved by general managers of local health authorities have not been defined. These provisions are aimed primarily at regions that will not implement the national legislation, but, as framed, they are underpinned by a more generally applicable punitive component. Sanctioning and policing elements are noticeable, for instance, in the case of lack of adoption of a regional health care plan, because these regions are banned from accrediting any further providers until they issue such plans.

As far as implementing the national legislation is concerned, the 1999 executive decree addresses the lack of regional compliance and also specifies the instruments of compliance, which are heavily prescriptive and defined by the central administration. The executive reform decree establishes the subsequent adoption by the Ministry of Health Care of *decreti ministeriali* (ministerial decrees) for the implementation of the executive decree itself.[50] This contradicts the constitutional

[48] Onorevole Buffo (DS), XII Permanent Committee on Social Affairs, Lower Chamber, 12 May 1999.

[49] Article 17, Executive Decree no. 229/1999.

[50] According to administrative law, the *decreto legislativo*, which is issued by a ministry after parliamentary discussion, belongs to primary legislation. The *decreto ministeriale* and the *atto di indirizzo e coordinamento* belong to secondary legislation. These latter instruments are considered formally as administrative acts, because they are issued by the executive, but substantially as legislation, that is having the force of law. According to constitutional law, administrative acts, such as those established by the 1999 Bindi decree, cannot regulate policy areas that the Constitution has attributed to national or regional primary legislative functions.

prerogatives of regional legislative functions.[51] As the majority rapporteur in the Lower Chamber points out: 'this parliamentary committee invites the executive to reduce the adoption of secondary legislation'.[52] Another MP suggests that the executive decree violates the constitutional prerogatives of regions because 'it is not possible for an executive decree to refer to subsequent ministerial decrees when the implementation should be left to regional legislation'.[53] Minister Bindi responds to criticism of the laborious and centralised implementation of the decree by noticing that ministerial decrees are issued with the consent of the Conference of State-Regions relationship and that their number will anyway be reduced in favour of *atti di indirizzo e coordinamento*, or policy and co-ordinating acts.[54]

The 1999 Bindi reform was followed by a complex and laborious implementation process. The Minister was aware of the upcoming regional elections in April 2000 and the relatively limited time to issue the administrative acts of implementation. For this reason she tried to put on pressure in order to issue the crucial ministerial acts without any delay before the end of December 1999.[55] But the rebellion of the medical profession regarding the negotiation of their employment contract, along with the new provision for exclusive service to the public sector,[56] complicated further the smooth implementation of the Bindi reform. A ministerial decree was issued nevertheless regarding the training and continuing education of general

[51] A recent Judgement of the Constitutional Court no. 169, 14 May 1999, has established that national secondary legislation and administrative acts cannot regulate those policy areas reserved to regional legislative powers.
[52] Onorevole Buffo (DS), XII Permanent Committee on Social Affairs, Lower Chamber, 12 May 1999.
[53] Onorevole Cè, plenary session, Lower Chamber, Italian Parliament, 1 October 1998.
[54] Rosy Bindi, Minister of Health Care, XII Permanent Committee on Social Affairs, Lower Chamber, 12 May 1999.
[55] 'Il Ministro Bindi mira ad accelerare l'attuazione; riforma ter per la sanità senza deroghe sui tempi', *Il Sole 24 Ore*, 27 November 1999.
[56] 'La Bindi bacchetta i medici: "Inutile il vostro sciopero"', *La Repubblica*, 20 January 1999.

managers, defining the guidelines and content of the courses.[57] In addition, a 'policy and co-ordinating act' was definitively issued on 20 March 2000 regarding public sector consultants' private practices.[58] Bindi was determined to pursue her objectives, and from November 1999 to March 2000 she tried to push the implementation of her reform as fast as possible.

But the 1999 Bindi reform of health care was never implemented because most of the implementing administrative acts were never issued. Minister Bindi was replaced by the new Amato government, which took office at the end of April 2000, after the resignation of Prime Minister D'Alema in the aftermath of the 16 April 2000 regional elections.[59] She was succeeded by an eminent medical researcher and oncologist, Professor Veronesi, whose curriculum vitae indicated no previous interest in politics.[60] It was not surprising that Amato decided to sack Bindi. He had defined her 1999 reform as '*etatiste* and *dirigiste*', especially for the role of the state in encroaching upon regional competencies.[61] The new Prime Minister faced a centre-left majority extremely divided as to whether to revise the Bindi reform or opt for policy continuity. The Democratici di Sinistra and Partito Popolare Italiano were against change and defended the four years' work of ex-Minister Bindi.[62] The end of the legislature drew close and the ministerial acts and decrees implementing the 1999 Bindi reform never saw the light of day.

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[57] 'Per i manager Asl arrivano 120 ore di formazione', *Il Sole 24 Ore*, 26 March 2000.
[58] 'Per la riforma della sanità tentativo di accelerazione', *Il Sole 24 Ore*, 21 March 2000.
[59] At the regional elections on 16 April 2000 the governing centre-left coalition lost dramatically, especially in northern Italy. Electoral turn over was 76.6%. The centre-right coalition in opposition, led by Berlusconi, won eight out of 15 regions. The centre-left coalition kept the traditional 'red belt' of Tuscany and Emilia Romagna. For electoral data see: cedweb.mininterno.it/ind_elez
[60] 'Italian scientists attack politicians', *Wall Street Journal*, 10 April 2001.
[61] 'Sanità, centrosinistra spaccato sulla riforma Bindi: adesso è chiaro perché mi hanno sostitutito', *La Stampa*, 12 May 2000.
[62] 'La nota romana scoperto a sinistra', *La Stampa*, 13 May 2000; 'Veronesi per la salute punta su formazione e ricerca', *Il Sole 24 Ore*, 13 May 2000.

Analysis of the parliamentary debate and legislation related to the 1999 reform has revealed an emphasis on centralising measures of health care planning, despite the rise of regional administrative and political capacity. The reform envisaged a pyramidal and hierarchal decision-making process that would clearly undermine the autonomy that the 1992 reform had granted to regions, and that regional executives had acquired in its aftermath. With regard to the regionalisation of health care services, the Bindi reform tried to reverse the change introduced in 1992, which, however, was gradually and steadily realised. Bindi tried to challenge the possibility of regional executives becoming independent of central planning, by subordinating regional health care plans to nationally set objectives and guidelines. As one MP commented:

> the reform constrains the discretion of general managers who have to report not to those who are responsible for planning activities and financial coverage, but widely to a plethora of committees [...] instead of granting managers more power we are taking it away from them.[63]

Bindi also limited the powers of general managers by reinforcing local government participation in the planning activities of local health authorities. Finally, she turned a technical institution created to support regional government, the *Agenzia per i Servizi Sanitari Regionali,* into a branch of the Ministry of Health aimed at supervising regional administrations.

Conclusions

The strategy of national political elites at the end of the 1990s was to curb the increasingly autonomous political capacity of regional governments, made possible by their newly acquired administrative resources and the regional elites' commitment

[63] Senator Bosi (CCD), XII Permanent Committee on Health Care, Senate, 16 September 1998.

to use them. The power struggle against regional autonomy was conducted from above, through instruments of administrative recentralisation, and from below, through political support for mayors. The recentralisation of health care planning and control functions would have ensured that regional programmes were supervised and co-ordinated by the newly created central agency of regional health care services, *Agenzia per i Servizi Sanitari Regionali.* The role and functions of local government, and mayors in particular, were revisited, in so far as they could oppose the effects of regional control of health care policy-making, including control of local networks and their power distribution.

This chapter has questioned the plausibility of the widely accepted and predominant argument that Bindi's response to the disturbance of traditional patterns of territorial politics was an institutional challenge to the institutional process of region building. As Bindi suggested: 'citizens do not vote on institutional models'. Instead, it is argued that political control of the health care administration was the underpinning logic of the struggle between national and regional elites. This is consistent with the findings that, among the different administrative, political and legal resources available to the regional executive, the appointment of managers is the most guarded prerogative.

Against Tarrow's argument, referring to the creation of the regions in the 1970s, that mayors would utilise their influence as well under different institutional conditions (Tarrow 1974), supported by Keating's prediction that regions would only continue old practices (Keating 1988), it is suggested here that the technocratic and bureaucratic capacity of regions is slowly increasing at the cost of partisanship. Administrators do need the expertise to be able to extract resources from the centre,

especially if the subnational level of government is increasingly organised in functional terms (Dente 1990). Towards the end of the 1990s, regional functional centralisation became predominant over the clientelistic exchange, although political control continued to be one of the key resources of expanding and consolidating political capacity. From being the aim, political control became the means of a new pragmatic way of doing politics, in which regional elites are likely to have greater resources than other subnational leaders, such as mayors. Trust appointments, aimed at political control of the top level of the administration, do not necessarily lead to a clientelistic system, nor do they represent a challenge to democracy. Analysed in the context of functional demands, political control of general managers reflected the necessity to improve ways of policy co-ordination and implementation of political strategies regarding the delivery of welfare services. Political control also becomes an indispensable resource for the definition of a new and emerging space for decision-making, which, far from reflecting only the particular distribution of welfare services, would run counter to the more ambitious project of consolidating regional political legitimacy.

Chapter VI

Italian Politics as Usual? New Administrative Resources for New Political Aims

Is the Italian state still in crisis? This question recurs constantly in the scholarly debate about contemporary administrative reforms, associated as it is with the hollowing out of the state and the new ideology of public management (Cammelli 2000; Pollitt and Bouckaert 2000; Cassese 2001). It has also long been a favourite subject of historians of Italian public administration, since, from its inception, the Italian state has lacked some of the fundamental elements of state building and development; such as expert, technically trained, and powerful administrative elites (Calandra 1978; Ferraresi 1996; Melis 1998). Significantly, the doctrine of administrative law was the only basis upon which the Italian state, while still relatively young compared with other European states, was strengthened (Giannini 1970). This doctrine was soon extended to define not only procedural, organisational, and sociological aspects of the administration, but the identity and administrative culture of public servants (Dente 1990; Dente 1999).

But recent changes studied in previous chapters seem to reveal a new tendency towards a 'technicalised' and 'technocratised' bureaucracy, especially at the top level. This is exemplified by the rise of public managers who owe their status and success to expertise in a particular sector, such as mastering techniques to evaluate the efficiency of blood supply to hospital emergency rooms, rather than to trying to explain cumbersome administrative procedures to an uninterested local politician.

The crisis in the Italian state must be reassessed and discussed with reference to the autonomy now granted to managers in the public health care administration. This new system of management exemplifies possible change, which could be applied to other sectors.

The 1992 reform of health care policy has introduced a radical change – an incredibly ambitious programme to transform the sociological, legal and doctrinal underpinning of Italian public administration. Not simply a public management reform, in the most restrictive sense of the term, the 1992 legislation aimed to provide administrative elites with new instruments to create an entrepreneurial modern state. The reform was as much about structure as administrative culture. It was intended to redirect the tradition of public authority towards one of public service, in which the efficiency of service delivery to users is predominant over legal safeguards and constitutional formalism. This intention certainly does not exemplify an 'incremental' type of change.

Although the enactment of grand changes was nothing new in the context of Italian administrative reforms, the Amato reform went through a peculiar parliamentary process and legislative stages of redrafting, rethinking and amendments. The legislative process was not linear, but marked by iterative attempts at reversal and amendments. Previous chapters have shown how obstacles persisted long after the introduction of change. These obstacles were not lifted or removed after the 1992-1993 changes had been enacted. When the reforms reached the local administrative system, it became more evident from empirical analysis that the old interests of local notables had mobilised to oppose change. The first part of this chapter addresses the question of the type of change exemplified by health care reforms. I reflect upon the

ambition of the reform programme and the challenge it claimed to pose to the rule deriving from the Weberian rational-legal authority (D'Albergo and Vaselli 1997). The legitimisation of bureaucratic activity is increasingly based on efficient service delivery rather than intrinsic legal and procedural forms of rationality.[1]

Despite the *déjà vu* aspect of ambitious administrative programmes of reforms, this one actually produced real change, as reflected in the emergence of powerful regional bureaucrats and an autonomous space for political decision making (Bogdanor 1992), namely the regional level of government. But if the reform did not sweep aside the blockages that inhibited earlier reforms, how can the real change be explained? I argue that the 1992-1993 health care reforms have much wider implications for the entire administrative system. The ultimate goal of the Amato government was to reform Italian public administration completely.

The purpose of this chapter is twofold. First, it explores the impact of the combination of entrepreneurialism with decentralisation. Throughout this thesis I have separated these two themes for the purpose of the narrative, but in fact it is necessary to link them to produce a possible explanation of why change actually originated from the reform. Secondly, before elaborating an alternative model for explaining the possibility of escaping inertia and implementing radical change and departure from the past in Chapter VII, selected theories of policy change are briefly applied to the Italian case of health care reform so as to assess the usefulness of their

[1] Effectively, bureaucracy is, according to the Weberian ideal type, technically the most highly developed form of rule. See Weber, M. (1991). From Max Weber: Essays in Sociology. London, Routledge.. Specialisation is one of the key elements of the ideal type and does not appear to run counter to the power of experts, as emerged during the 1990s in Italy. Weber claims that bureaucracy expands its power with the weapon of technical and official knowledge. It appears that the introduction of new public management ideas in the health care sector in Italy reinforce the Weberian ideal type rather than challenging it directly.

contribution to this inquiry and examine whether the factors fundamental to change that they reveal, such as revolutionary crisis, issue expansion or analytical disjointed incrementalism, are plausible ways to explain how change became possible for the Italian state.

The Amato Reform: Implications for the Modernisation of the State

In political systems that produce a large number of attempts at reform, it may be tempting to dismiss the most radical, attributing them to fortuitous circumstances and calling them exceptions to the general rule. This would be misleading in the case of the 1992 health care reform and would detract from its remarkable significance to the reform of the Italian state. Health care policy reform has far-reaching implications which go beyond sectoral aims and include reconfiguring the basis for the legitimacy of the whole administrative and political system in Italy. From analysis of policy ideas informing the Amato government, substantive change, and political parties' response, I conclude that the 1992 health care reform is a clear and consistent attempt to modernise the Italian state, despite strategically devised legislative ambiguities and blockages which appear to detract from the merits of the reform. The government proposed to limit the scope of the state in three ways: by transforming a highly legalistic public administration into an efficient and entrepreneurial one; by decentralising administrative functions and political power to regional governments; and by introducing market type mechanisms to reduce the public-private distinction. These three different policy objectives converged on the overall determination to reconceptualise the division between politics and administration. This priority remained at the core of the 1992 health care reform and, more generally, of administrative reforms.

The 1992 Reform: Technocratic Enlightenment and Paradoxes

The challenges and changes introduced in 1992 are not without paradoxes. Entrepreneurialism and managerialism have caused a restructuring of the administration of local health authorities which undermines traditional democratic mechanisms of territorial representation. The desperate attempt to introduce the paradigm of efficiency and expertise into the public administration has resulted in an exaggerated reaction against consensual and politically driven decision-making. With regards to regionalisation, it has raised problems of administrative and political co-ordination between municipal, provincial and regional levels of government. The greatest paradox associated with the regionalisation of health care, which will be analysed in the second part of this chapter, is this. As the government is trying to modernise the state, by overcoming clientelism and the inefficient allocation of welfare services and by depoliticising the management of health care, the process of regionalisation, as set out in the decree, creates the conditions for a repoliticisation of the health care system at regional level, albeit of a different rationale.

These problematic issues are not resolved in the 1992 legislation, but rather magnified by its seemingly disaggregated nature. There appears to be no coherent and unifying policy objective, given the abundance of subtle ambiguities such as the lack of clarity about the method of appointment of managers of reformed local health care authorities. These are not the careless by-products of an ill-defined political strategy, but blockages built in to mask a radical and controversial change, for which there was little consensus and no prenegotiated agreements with interest groups. Disaggregation is not the result of the absence of a coherent government strategy or

homogeneous objectives. Rather the legislation reflects the anticipatory effects of the parliamentary debate and is a way of handling forthcoming political opposition. Therefore, the introduction of the enterprise formula and regionalisation are less empirically detached than first appears. These two reform trajectories are unified in the overall aim to restructure local government and local politics.

The reform of the state has been difficult in Italy because parties, for different reasons and to different extents, lacked full commitment to change the structure of local politics and local government (Della Porta 1999). Chapter II investigated opposition to the reform by the majority of political parties. The differences between the political parties' positions were due to their varying degrees of ideological adherence to the introduction of private sector management practice in health care, political views on the concept of the state, political support for the government coalition, use of the rhetoric of efficiency and transparency, and expectation of policy failure.

The parties' opposition is determined not only by structural factors, such as the fragmented party system, but also by policy content. The problem is not simply one of fragmented coalitions and decisional levels, but also of superficial embracement of the reform. Italian scholars have always concentrated on the party system as an element of policy ineffectiveness and lack of cohesion. However, this type of structural explanation needs to be complemented by policy-specific issues and content analysis. The structural constraint of the party system alone does not suffice in explaining why the reform was opposed by parties in Parliament. The nature of party government is not enough to explain the inertia of the Italian public administration. Political elites have interests which go against the reform of local

government. For instance, controlling the appointment of local hospital managers ensures the appointment of heads of hospital divisions friendly to partisan interests.

The Amato executive was willing to use all its legislative prerogatives to push its legislation through Parliament. The committed effort of the government corroborates the thesis that the reform was not only a rhetorical and legitimising discourse to regain citizens' trust in institutions. On the contrary, it aimed to change the administrative structure of the health care system. The government refused to compromise on the depoliticisation of local health care authorities, on the introduction of managerialism and health insurances, on the marginalisation of local administration, and on the transfer of responsibilities to regional governments. The government ignored most of the amendments by parliamentary committees and did not extensively amend the draft decree. The Amato government made a clear organisational choice, with juridical, administrative, and political implications for the modernisation of the state. An official interviewed said: 'It is now more difficult to mobilise staff in local health care authorities because the organisational change has been so deep as to change the administrative culture.'[2]

Health care is not just a sector like all others. It is at the core of the welfare state. Choosing this area to pioneer regionalisation transformed regions from mere administrative reality into a source of territorially defined political legitimacy, deriving from the provision of welfare services. With regard to regionalisation, this thesis challenges the claim that the Amato government was effectively centralising what had been formally granted to regions by Article 117 and 118 of the Italian Constitution, thus disguising the regionalisation process. On the contrary, the 1992

[2] Betty Leone, interview with author, Rome, 24 September 2002.

reform started a process of concrete functional administrative decentralisation, beyond rhetoric, and introduced some of the most propitious conditions for regions to become a new 'political locus of power' (Bogdanor 1986).

Although the government started a process of administrative and political regionalisation, the 1992 reform *per se* is not ambitious to change the form of the state in a federal dimension. There are limitations to the process of regionalisation and this is not surprising. As some scholars have argued, in non-federal states the local level of government, and this can be applied to regions, remains subordinate (Page 1991). Thus, the reform should be assessed against its sectoral aims first,[3] and only at a second stage can we assess its applicability to other sectors. The government set a new path because the reform of health care had created endogenous possibilities for further development in this direction. By the end of the 1990s, health care represented almost 80 per cent of regional budgets and regional administrations had developed full-fledged capacity. Regional demands include the transfer of similar responsibilities for other sectors, like policing, transport and environment. A ministerial official suggested that 'the Ministry of Health should not exist any more. The Presidents of the Region decide everything together.' [4] However, at the moment the debate about federalism is dominated by strong resistance from constitutional lawyers.[5]

The health care reforms are significant beyond the health sector and have implications for Italian public administration as a whole. Yet the 1992 reform

[3] M. Keating (1988) explains that decentralisation in Italy has occurred primarily through sectoral perspectives, because of the bureaucratic interest of the state in keeping the regional administration fragmented along policy areas.
[4] Claudio De Giuli, interview with author, Rome, 21 April 2001.
[5] 'Le riforme tradiscono la Carta', *La Repubblica*, 2 July 2004.

caused controversy regarding its policy instruments, among which the law was the most prominent. Academic criticism of the 1992 reform is fierce and comes mostly from economists. Some analysts have criticised the bureaucratic belief that it is necessary to introduce new administrative acts, or pass new laws, or adopt new administrative procedures to solve the problem of inefficiencies.[6] As Rebora argues, 'the Italian public administration is in a state of malaise and it is not sufficient to decentralise because we need to change the "core business" of public administration' (Rebora 1999, p. 98).[7] He argues that the abstract and framework types of legislation and government plans exclude pragmatic solutions. According to my empirical findings, the 1992 reform initially did not pay attention to operational details. The government was clearly not looking at the operational requirements necessary to its effective implementation. When asked about the policy makers' efforts to improve the feasibility of the reform, Nicola Falcitelli, considered the founding father of this decree and a national 'institution' for his expertise and life-time dedication to health care policy, admitted that 'we could not procrastinate. Amato wanted to have this decree approved as soon as possible because we could not resist one day longer against all the pressure coming from parties. Our approach was to launch some ideas and wait to see what would happen.'[8]

Despite this criticism, it is also necessary to understand the distinctiveness of the *method* by which the Italian public administration produces certain types of legislation. The administration is strongly embedded in the rational-legal framework, which emphasises organisational change and structure rather than an orientation towards output. The administrative reform activity could be called

[6] E. Borgonovi, 'La grigia burocrazia e l'utopia rinnovatrice', *Mondo Economico*, 26 December 1992.
[7] Rebora also laments civil servants' fear of discretion. He complains about the role of the Court of Accounts that should advise and guide the administration rather than being an inquisitor (1999).
[8] Nicola Falcitelli, interview with author, Rome, 23 September 2002.

'rationalistic reformism', which is embraced with commitment by civil servants.[9] The 1992 legislative decree was the product of the technocratic enlightenment of senior civil servants in the Ministry of Health, who jealously guarded their prerogatives and acted as an isolated community during the policy making process. It is well documented that the Ministry of Health became an impregnable citadel while the decree was being drafted.[10] Had interest groups been offered consultation,[11] the legislative decree could perhaps have been more operational.

To summarise, unlike many of its critics, I believe that the reform did not consist solely of a rhetorical legitimising discourse in support of the moral mission of cleaning the Italian administration of corruption and clientelistic practices. These policy decisions, formulated in isolation by an enlightened technocratic elite, profoundly changed not only the administrative structure and organisation of the Italian health care system, but also the traditional institutional pattern of relations between centre and periphery. This change was achieved by using traditional mechanisms and instruments. Consequently, the government's proposal is informed by managerial *ideas*, but the *policy instruments* available to bureaucrats to transform these ideas into legislative drafts reflect the Italian public administration's method characterised by the centrality of law and formalism, which will be elaborated in Chapter VII.

[9] Too often we overlook the fact that administrative reforms' attempts come from within the administration.
[10] *Il Sole 24 Ore*, 18 November 1992.
[11] C. Sizia, President of the Confederation of Hospital Doctors, laments that the government has not consulted professional groups during the drafting stage of the decree (*La Stampa*, 27 December 1992).

The 1993 Reform: Legislative Amendment and Substantive Continuity

The core innovations of the original Amato reform were not significantly altered by the 1993 legislative amendment, despite claims to the contrary. The organisational structure of local health authorities and public hospitals did not change. Even the ambiguities of the reform relating to the possible politicisation of their general managers remained unclear. The enterprise formula and the introduction of general management stayed unchanged.

Similarly, the regionalisation process of health care was not reverted, despite the claim that the amended legislation made the functions between intergovernmental levels of government more clear and explicit. The reform firmly maintained the region's central role in planning and organising local health care services, along with the marginalisation of mayors and municipalities. On the contrary, the new decree showed some degree of resistance to the increasingly powerful executive functions of the regions. The control of regional governments over local health authorities was indeed formally diluted by changing their status from 'public bodies of the region' to 'public bodies'. Moreover, in an attempt to reduce regional executive power, the decree stated that 'the region' appointed the chief executives, rather than the more specific 'president of the region', and it strengthened the legislative functions of regional councils. Yet this nominal changes did not prevent regional governments from controlling the volume and quality of services provided as part of their planning powers.

As far as employment contracts of the medical profession were concerned, the 1993 legislative decree showed the highest degree of discrepancy from the original. As

noted in Chapter III, the employment contract of ambulatory care specialists and assistant doctors was to be renegotiated in such a way as to include both categories in the public sector. Hospital assistant doctors were offered the possibility of access to the lowest level of the *dirigenza*, if certain seniority criteria and qualifications were met. Despite these evident changes regarding the supply of doctors, the major innovation, namely the 'privatisation' of employment contracts, was not fundamentally altered. Chief executives and the highest level of hospital doctors remained public sector employees, but were employed with a private law fixed-term contract, renewable after performance evaluation. Moreover, the process of recruitment by public competition was superseded by an interview and an evaluation of a curriculum vitae, a procedure previously incompatible with public law.

The two legislative decrees can be considered part of the same reform attempt rather than as two different reforms, both in terms of substance and in respect of the process. The legislative process of the 1992 and 1993 reforms revealed many commonalities. The relationship between the medical profession and the government remained problematic, characterised by outbursts of protest, direct action and confrontation, although it improved slightly from March to November 1993. During the Amato and Ciampi governments, the executive remained generally in control of the policy making process, despite the apparent centrality of the legislative work of the parliamentary committees.

The most remarkable similarity was the impetus and dynamism with which reforms were pursued by different actors, for different interests. Engaging in protest was the only way in which interest groups could bypass the government's exclusion. They were forced to lobby parliament, proposing legislative workable solutions in the form

of legislative amendments, and to mobilise public opinion by organising a referendum. A similar campaign was conducted by the parliamentary committees whose endless legislative work resulted in an elaborate and complex opinion being presented to the government. The legislative office of the Ministry of Health was engaged in the amendment for almost a year. The policy-making process of Decree no. 517, which maintained unchanged the core aspects of no. 502, was tremendously active, eventful, resourceful, and dynamic. However, the outcome was continuity and conservatism because the impetus and motion which sustained the process of amendment did not translate into a policy reversal.

The Combined Magnifying Effect of the Enterprise Formula and Regionalisation

As a consequence of the 1992 reform, unprecedented managerial autonomy was acquired by the higher level of the administration of local health care authorities and public hospitals. This change has affected the power relationship between the parties involved in making health care policy at local level. Autonomy has posed a challenge to the traditional system of local welfare services. But more generally, it has also threatened national political elites and parties. This section aims to establish a systematic relationship between the two separate themes of the 1992 reform, namely the introduction of general management and regionalisation. In particular, the definition of the regional level of government as merely an administrative institution (Keating 1998) is revisited and challenged in light of these empirical findings. Only when the political interests of regional elites are taken into account is it possible to understand how increased administrative capacity was turned into a political asset.

The reform of the state did not only materialise in the formal enactment of legislative decrees by the Amato and Ciampi governments in 1992 and 1993. In addition to the national reform activity, regions acted promptly and effectively upon the provisions regarding the reorganisation of the health care system, especially with respect to the increase in size of the local heath authorities and their transformation into public enterprises. As a result of the rapid implementation of those administrative opportunities, which helped general managers to achieve a prominent position at the top of the regional health care administration, concrete change was achieved by the end of the 1990s. General managers of local health authorities and of public hospitals, especially those granted enterprise status, became central actors in the network of health care policy making at the subnational level.

The emergence of managers at the top of the health care administration has been one of the most prominent departures from the traditional pattern of Italian administration, which has historically been characterised by the lack of an established senior civil service, as explained in Chapter I. The organisation of Italian administration in a pyramid without a head was one of the main obstacles to state reform. This obstacle has been partly removed by putting in place managers entrusted with real administrative resources and giving them actual responsibilities. These managers are responsible for policy decisions and initiatives at the local level, as well as administrative procedures. Managers contribute to the regional planning of service provision, such as deciding upon the volume, quality, and distribution of services across the territory of the local health authority. Findings suggest that they have also gained considerable power over hospital consultants and, more generally, human resources. Criticism of their alleged autocracy and excessive concentration of

power increased exponentially towards the end of the 1990s. There is a growing consensus among health care professionals and local political elites that perhaps a management board should be reintroduced to counterbalance this concentration of power in a single executive post. This is an indicator that managers have posed a real and concrete challenge to local political elites.

The effects of the affirmation of regional health care managers go far beyond sectoral reorganisation or an exercise in legal institutional engineering. The attribution of identifiable responsibility to a single manager was aimed at rationalising and improving the efficiency of the decision making process, previously left to a plethora of committees and collegiate bodies. At the same time, the most pervasive impact of the reform of management arrangements was the immense challenge it posed to the old Italian system of territorial politics and political localism. As discussed in Chapter I, the system of political control of the bureaucracy at local level was based on the political parties' occupation of administrative offices and related structures, such as local health care authorities. Local political elites were political entrepreneurs with an extensive network of contacts with national politicians. The distribution of resources followed this party channel of integration, as Tarrow explained. Towards the end of the 1990s, parties in general were deprived of their main instruments for mobilising political and electoral consensus at the local level. Not local elites but managers were responsible for negotiating prices and quantities with service providers, evaluating human resources, appointing heads of hospital departments and top consultants. The extensive patronage system traditionally available to local and national elites was crumbling away.

Therefore, the introduction of general management in Italy, given the traditional use of administrative structures for territorial political mobilisation and political forms of integration between the centre and periphery, has had tremendous implications for the relationship between the centre and the subnational level, both in administrative and political terms. The rise of powerful regional bureaucrats triggered a vigorous struggle between political elites at different levels of government, primarily between emerging regional ones on one hand, and national and local ones on the other. If this primary effect of rising bureaucrats is combined with the allocation of administrative competencies to regional government, the effect is magnified exponentially. Not only did the introduction of general management *per se* challenge the old system of integration between the centre and the subnational level of government, but also regionalisation of health care policy ended up consolidating and accelerating this pattern.

The interpretation proposed in this thesis counters those who emphasise the impossibility of departure from the historical path (Cassese 2001). According to Tarrow's claim, the pervasiveness of clientelism in Italian administration would constrain the government's ability and plan to re-establish the borderline between politics and administration (Tarrow 1977). The Amato government, on the other hand, supported the view that a clear-cut division between management and policy would solve the problem of corruption because, by marginalising local politicians, it would remove the possibility of creating clientelistic ties. However, as Tarrow's claim goes, this could lead to underestimation of the pervasiveness of the clientelistic system and to parties adapting to find alternative institutional channels of political patronage (Dente 2001). Recent corruption scandals suggest that the problem is far

from being resolved. In May 2002, the general manager of one of the most prestigious public hospitals in Turin, Le Molinette, was jailed for fraud and bribery.[12]

Given the structural incentives to a clientelistic relationship between civil servants and local politicians, the introduction of general management is likely to displace the clientelistic network from one level to another, thus not reducing its scope and pervasiveness. If clientelism is a systemic feature not only of local government itself but also of centre-periphery relations (Tarrow 1977), then eradicating it from local government, assuming this is possible, will only create the need to promote 'clientelistic integration' at a different level of government (Keating 1988). Most of these claims derive from the fierce criticism of the direct appointment of public managers by the regional president, which is supposedly a new effort to 'repoliticise' the health care system (Endrici 2000).

This thesis comes to a rather different conclusion, not because it overlooks the structural character of clientelism, or the remaining cases where it persists, but because in connecting the two trajectories of reform, that is general management and regionalisation, it contends that these are mutually reinforcing. Their combination and simultaneous introduction make departure from the *status quo* both possible and irreversible. First, regarding the possibility of change, it is necessary to consider the complexity underpinning the system of direct appointment of general managers by regional executive. This cannot be simply labelled as a threat to democracy or a return to clientelistic practices. By the end of the 1990s, the basis of political legitimacy had dramatically changed. Political consensus at regional level is not based on particularistic distribution of health care services, but on the efficiency of

[12] *Corriere della Sera*, 3 May 2002.

their delivery. Increasingly, citizens demand efficient services, and recent ranking of major international organisations in the Italian health care system suggests that people have good reasons not to lower their demands and standards. The Italian health care system was ranked second in the world, after the French, by a study carried out by the World Health Organisation in 2000. If political legitimacy increasingly derives from service delivery, and if regions have become major players, the clientelistic system would not seem to benefit regional governments and elites. Conversely, it is likely to increase criticism and citizens' indignation, as was the case with recent scandals.

Regional governments, very differently from what was previously argued about Italian local government (Cassese 1991), are becoming service delivery institutions. This is a tremendous departure from the traditional pattern of political mobilisation at the subnational level in Italy. The increasing centrality of health care politics to regional electoral campaigns appears to confirm this new pattern. Hence, the scope for the relay of patronage is very limited in those regions analysed where change has indeed occurred. The possibility of change does not seem to be limited only to those regions with a past record of effective implementation and good institutional performance. Policy diffusion from best practices to other regions, especially along partisan lines, is possible. For instance, the Regione Puglia tried to import the model with which Lombardy experimented, after a centre-right coalition won the regional elections.[13] The Department of Public Services has developed numerous projects and programmes for the transfer of best practice.[14]

[13] See the Regional Health Care Plan, 2002-3004, Regione Puglia, p.4. The preamble refers directly to the regional decision to follow the 1992 reform. This is defined as a 'historical change' for Puglia.
[14] See, for instance, the programme *Cantieri*, launched in 2002 by the Department of Public Services and aimed at policy diffusion of best practices. More information can be found at: www.funzionepubblica.gov.it/servizi or the web site of the programme: www.cantieripa.it.

The disturbance to territorial politics has been triggered by the consolidation of managerial autonomy and technocratic decision-making in local health authorities. The direct challenge has most directly involved local political elites. The difficult process in Lombardy of enacting the 1997 Regional Law, of reorganisation of the regional health care system, when mayors protested with direct action against the regional centralisation process has been highlighted. In other regions the tension between regional and local elites was not as disruptive, partly because new participatory tools to ensure mayors' influence in local health care policy, such as the *Piani per la Salute*, were established, as discussed in Chapter IV. Only in Tuscany, where mayors were given managerial responsibilities in the newly established *Società della Salute*, managers were not able to gain power at the expense of mayors.

The struggle between regional elites -- sponsoring the emergence of regional technocracy, including rising managers -- and local elites -- defending the old system of political localism -- was not only the result of the managerial revolution. It facilitated change. Paradoxically, the reform of the state would have been difficult without a power struggle between political and administrative elites at different levels, between those committed to use administrative resources to gain political support by means of a new legitimacy, and those engaged in resistance. For instance, political determination to differentiate the Lombard health care system from the national provisions of the 1999 Bindi reform was fuelled by the heightened territorial and political struggle between the centre-left national and centre-right regional government. This struggle was sustained by highly developed and efficient bureaucratic means, but the aim was first and foremost political. Allowing managers

to emerge and affirm their power against local government was a regional strategy to gain control and quell the rebellion of local political elites.

In short, the strategic alliance between regional elites and managers was aimed at countering the alliance between national and local elites. Both local and national political elites were resisting the change introduced by the 1992 reform, first blocking it outright during the parliamentary blockage in 1992 and then reversing it in 1999, when change was gaining ground. National political elites and parties were concerned by the emergence of a new space for political decision making at the regional level in what had been a rather centralised and nationalised arena of party competition. In particular, national elites were threatened by the ample influence enjoyed by regional ministers of health and the presidents of regions in determining policy objectives. Regional health care plans were mainly alternative and diverging organisational frames from the nationally set ones. The national health care plan has been labelled a book of dreams, whereas the regional ones represented the most serious and operational planning. National elites were also marginalised because they did not enjoy administrative structures comparable to those of regional ministers, supported by newly created regional agencies such as the *Azienda Regionale Sanitaria* in Emilia Romagna.

Points of political access were increasingly precluded to national elites by the strong trust relationship between regional executives and appointed general managers. This is a solid relationship, not strictly based on party membership, but on trust and a personalised bond. National elites found themselves marginalised in asserting their influence on and leadership over administrative structures. Although the concerns of national elites grew stronger in those regions governed by the opposition, the

narrowing of political scope for manoeuvring and reduction of possibilities of mobilising local civil society was a real and credible threat in most regions. The Bindi reform was an illustration of re-establishing political control of the health care administration from above, by centralising measures of administrative supervision, and from below, by restoring the role of mayors.

Hence the overall nature of the struggle between different levels of government, made worse by the introduction of general management, was mainly political and only secondly administrative. This is less surprising if examined in the context of the traditional relationship between centre and periphery, based on party channels with a diffuse administrative system. Because the Italian system was characterised by political localism, it was this system itself that was mostly challenged by change, rather then the supervisory and co-ordinating power of the central administration, which had always been rather ineffective. Moreover, the central administration had an interest in relieving itself from responsibility for huge public deficit and shifting the blame for soaring costs and mismanagement of welfare services.

Despite the resistance of local elites, supported by national elites, and the medical profession, change became not only possible but also irreversible. There were significant legislative attempts to reverse the underpinning pillars of the Amato reform. The 1999 Bindi reform aimed to re-establish the balance between central policy making and co-ordination and regional autonomy. This purpose was pursued primarily by administrative means, namely by recentralising administrative controls and supervision of the health care system. New centralised agencies were created for supervising and policing regional activities and discretion, such as the *Agenzia dei Servizi Sanitari Regionali* (ASSR). The policy co-ordinating function of national

planning and national standards was emphasised. This reversal exacerbated the conflict with regional governments, and never came into effect.

The policy reversal failed not just because of a cabinet reshuffle, but also because the administrative culture of public law had been slowly adjusting to new juridical categories. These included the *azienda pubblica*, or public enterprise, which did not previously exist in the doctrine or practices of administrative law, and the introduction of instruments used under private law jurisdiction, such as public procurement contracts, or the *atto aziendale*, literally enterprise act. Administrative law, contrary to any academic expectations about its incompatibility with other juridical traditions, has been self-adjusting by importing instruments from other juridical categories. This experimentation and innovation has not threatened democratic accountability, nor has it diminished procedural transparency. Managers are directly appointed by the regional executive, which is composed primarily of members of the regional council. Direct election of the president of the regional executive supports direct accountability for health care policy making. Accountability might not be self-evident in its formal and procedural implications, but it is noticeable at the level of public opinion, which is increasingly demanding about the standards and quality of services provided at regional level. This might be a different type of accountability, but it is not any less effective. In a sector such as healthcare, patients do not vote on institutional models, but when the question is a matter of life or death, the quality and delivery of efficient services is a vital source of electoral support.

Empirical findings suggest that the Italian state is changing. There is opposition and resistance, but this is not unusual for radical reforms. The interests and strategies of

national and local political elites remained unchanged throughout the 1990s. Change is not explained by the removal of this obstacle. The 1990s reform of the Italian state, at least as far as the themes analysed in this thesis are concerned, owes much to the emergence of a powerful administrative elite at the head of the administration and to the commitment of regional elites to alternative models of political mobilisation and legitimacy, based on service delivery rather than patronage. The strategies of these new regional elites, combined with the administrative tools necessary to pursue them, were essential elements of change. Whether this change was the same as that originally intended by the Amato government is a rather different question, which does not make the final outcome any less significant.

The initial aim of the Amato reform was similar to that of wider administrative reforms, namely to separate politics from administration so as to transform the entire *modus vivendi* of administration and liberate it from partisan colonisation. This has been curbed by the change analysed in this thesis, although not by virtue of the artificial separation of politics from the administration. Change was made possible by the combination of increased regional administrative capacity and the autonomy of regional managers combined with the political control of health care administration by regional elites. Administrative resources were crucial for stimulating political demands and sustaining the transformation of a local administration concerned only with its own interests into one focused on service delivery. The separation of politics and administration did not have an effect at the regional level. If it had, it would have defeated the overall reform of the state which was based on the alliance and co-operation of powerful regional technocrats and regional elites. If national and local elites had understood that separating politics and the administration was unrealistic and counterproductive, they would have used more

effective instruments to curb regional autonomy than restoring the mayor as a rival to the manager.

The tradition of central state and public authority seems to be 'in crisis', especially after the accomplishment of change which could not be imagined ten years ago. The central administration has been deprived of its responsibilities and its supervision over local authorities. Policymaking has moved away from the Department of Health to regional executives and presidents. Managers are not accountable to any central institution, only to the regional governments. Managers have ample scope for making decisions with regard to agenda setting, financial distribution, management of medical staff, and so on. Their power derives from a personal relationship of trust with the regional executive – not from legal formulae, artificially created offices, or seniority criteria. Managers are responsible for delivering high quality efficient services to citizens. They are publicly scrutinised through the system of direct election of those who appoint them.

However, the 'crisis' affects the centre, rather than the core, of the Italian state. The national administration has been severely challenged by change. The legal doctrines underpinning the concept of the state, the state's core, have not. The internal mechanisms which allow blockages to be transformed into changes, which are at the basis of the theory of dynamic conservatism, proposed in Chapter VII, owe an immense amount to the centrality of the law in the political system. The administrative culture, and the main role it assigns to the law as a mechanism for reform, are still firmly anchored at the core of the Italian state. Change does not ensue from the upheaval of a political tradition and administrative culture which have been formed throughout history. On the contrary, change would not have been

possible without the peculiar law-making activities of the Italian administrative system which will be elaborated in the next chapter, after having considered alternative explanations for policy change which could be applied to the empirical findings of the thesis.

Theories of Policy Change and the Italian Policy Reform Process: Limitations

General models taken from the existing literature on policy change can be used to determine the outcome of decision-making processes in a given political system. The problem with these models, which becomes particularly evident if they are applied to the reform of the state in Italy, is that they regard 'non-incremental' change as a marginal and non-representative feature of policy reforms in advanced democracies. Radical change is claimed to be the end result of a temporary upheaval of the political and institutional system in any given country. Incremental growth is benign and ameliorative, whereas drastic change is associated with disruptions and undesirable upheavals of the rules of the game. This could be problematic because it prevents focusing on more comprehensive and overly ambitious change as a distinct kind of change in its own right. Reformers might embrace large-scale change while simultaneously introducing blockages to limit its most disruptive elements in the process of reform-making. The Italian case of health care reforms in the 1990s illustrates that non-incremental change could be consistent with a peculiar elites' strategy, aimed not at 'revolutionary crisis' (Crozier 1970) but at conserving the *status quo* by conservatism and at changing the system by dynamism.

Administrative reforms in Italy have characteristically introduced rather ambitious and comprehensive change from the late 1970s, as discussed in Chapter I. Policy

makers embraced ground breaking reforms which would fundamentally transform the way in which the Italian public administration operated. Radical change, introduced and adopted primarily through legislation, has occurred not only at times of institutional crisis, such as during the collapse of the party system in 1992-1994, but during routine periods, such as at the end of the 1990s. No radical change has been announced without subsequent parliamentary and executive actions. The Italian Parliament has been deeply involved in discussing and enacting a large number of administrative reforms. The type of change which has occurred and the process which has produced it seem different from incremental change. Lindblom's incrementalist[15] explanation does not offer a complete understanding of why policy makers not infrequently adopt more ambitious and comprehensive reform packages.

Linblom's theory of incremental change, however, remains useful for our explanation of policy change in the context of the modernisation of the Italian state for two main reasons. Incrementalism is an analytical model which explains in particular how the process of decision making is determined by policy makers' strategy. Lindblom is not so much concerned with the question of the likely persistence of incremental change over a prolonged period as with the here-and-now choices made by decision-makers. The emphasis on elites' strategies offers the

[15] Lindblom's seminal work is concerned both with specifying incremental politics and with a specific method of analysis, namely disjointed incrementalism. See: Lindblom, C. (1979). "Still Muddling, Not Yet Through." Public Administration Review 39(6): 517-26.. Respectively, incremental change is political change by small, reversible, and serial steps over a relatively short time. As a method of analysis, disjointed incrementalism is the process of decision making characterised by limited comparison with familiar policy alternatives, not distant from the existing ones, reflecting the low understanding and incomplete analysis of policy makers who ignore the consequences of their actions. According to Lindblom's ameliorative development of the concept of incremental change and analysis, incremental politics is more likely to yield a successful outcome: 'it is because we see reason to expect such big attempts to fail that we move incrementally in politics' (Lindblom, C. (1979). "Still Muddling, Not Yet Through." Public Administration Review 39(6): 517-26.. In addition to maximising the avoidance of failure, incrementalism also minimises social conflict, for 'it helps maintain the vague general consensus on basic values (because no specific policy issue ever centrally poses a challenge to them)' (Lindblom, C. (1979). "Still Muddling, Not Yet Through." Public Administration Review 39(6): 517-26.. A larger scale of change is more likely to reshape more drastically policy networks and to determine greater and riskier political conflict.

advantage that no determinism is built into the model, with the benefit of avoiding the introduction of metaphysical 'forces' that allegedly would account for change or stability. For instance, the ambiguities built into the 1992 legislation, which were the product of a precise political strategy rather than poor drafting, have been mentioned. However, Lindblom's theory of incremental change is myopic, for it does not explain the long-term effects of incremental change on the policy system. Concern for the cumulative effect of incrementalism is sacrificed to the study of the strategy at an isolated point in time and presumably space.[16]

The second most useful feature of Lindblom's model, which can be usefully applied to the Italian case, is the dynamic character of the analysis of policy change; the scope for revision and revised trial of adopted actions, justified by the limited information and low level of knowledge available, allows for the reversibility of change and the possibility of multidirectional deviations. Serial changes do not necessarily progress on one predetermined path in the same direction, because errors can be corrected or adjustments to new issues made. To avoid the pitfalls of analysing a reform episode in isolation, subsequent amendments to the original change have also been considered. The policy process of the health care reforms in 1992-1993 was characterised by iterative attempts to adjust to the opposition of dissenting interests, such as civil society or municipalities. Rather than progressing in a linear direction, change was the result of a convoluted process of amendments, which incrementalism suggests is part of the policy makers' analytical models.

[16] Although Lindblom argues that 'a fast-moving sequence of small changes can more speedily accomplish a drastic alteration of the status quo than can only infrequent major policy change' (Lindblom, C. (1959). "The Science of Muddling Through." Public Administration Review 19: 79-88.), it remains unclear how speed and scale can be so directly related in a short time frame.

Despite these applications to the Italian case, incrementalism fails to explain blockages and failures, in reality common during the process of change and probable in the conditions that Lindblom sets of low understanding. If policymakers act under a 'veil of ignorance' regarding future consequences, it is unlikely that they will always make changes for the better and that their actions will always result in amelioration. Lindblom seems not to apply his assumption of low understanding consistently to the different stages of the policy process, but as a justification for conservatism. Low understanding and lack of knowledge cannot be considered the only conditions for the impossibility of radical change. For instance, Lindblom ignores the case of policymakers deciding upon a course of action regardless of the high political costs to be paid, in order to overcome the high threshold set by past reform failures. Lindblom's veil of ignorance assumption seriously impedes understanding of serial radical changes in advanced democracies.

The policy change brought about by the 1992 and 1993 reforms was not the result of a revolution or authoritarian regime change. It occurred within a stable and democratic framework, despite the emergence of new issues and problems related to the legitimacy of the political system itself. Hence, radical change was not the direct causal effect of an 'institutional crisis', as the managerial ideas informing change had been in circulation since 1989. According to Lindblom, large scale change would represent only a temporary interruption to the ordinary and steady series of small steps. But ambitious change could also be a persistent strategy of reforms reflecting the character of a political system and the predominant way of reform, and dealing with emerging new problems. Incrementalism remains a theory of change which can be applied more readily to old problems which persist or need readjustments rather than entirely new situations generating new political demands.

Other explanations of policy change emphasise the agenda-setting stage and the process of new issues arising rapidly and suddenly. This type of change is described as 'big' change, and seems to fit the empirical findings of health care policy reforms in Italy in the 1990s more readily than incrementalism. Political change is the result of positive feedback processes, according to the punctuated equilibrium model (Baumgartner and Jones 2002)[17]. New issues move up the political agenda and function as catalysts of media and public attention. Borrowing Simon's thesis of 'serial information processing' (Simon 1985), Baumgartner and Jones suggest that at times of change there is a shifting of attention to a few new issues or different dimensions of old ones. New ways of understanding issues and new ideas are able to break old and established policy monopolies. This is the key element of policy change, namely the destruction and creation of policy monopolies, which are more fragile than usually conceived. This type of policy change, which reflects an analysis of the process of agenda setting, excluding the discussion of any other stages of the policy process, has potentially no limits. Once it has taken a direction, deviation from the original equilibrium leads inevitably to a new equilibrium. Like the model of incremental change, positive feedback change is a story with a happy ending, which fails to account for blockages and resistance once the change has been implemented.

[17] In an attempt to defeat the criticism that the American public policy process is characterised only by immobilisme and stability, is conservative and biased around structure and established policy subsystems, Baumgartner and Jones have proposed an agenda setting model which accounts for non incremental change (Baumgartner, F. R. and B. D. Jones (1993). Agendas and Instability in American Politics. Chicago, The University of Chicago Press.. The American policy process, they argue, is characterised by long periods of policy stability, when government policies appear resistant to change and to the reshaping of powerful policy monopolies supported by legitimising ideas and deeply rooted structures, and rapid bursts when dramatic change occurs. The type of policy change that they propose is drastic, rapid, and a clear disruption from the old system: 'new problems appear on the political agenda; crises require quick government response; new programs are created and old ones are terminated' (Baumgartner, F. R. and B. D. Jones, Eds. (2002). POlicy Dynamics. Chicago, The University of Chicago Press..

But this thesis is not only concerned with explaining how and why policy change is initiated, but also examining the operational mechanisms that sustain or resist change once it has been adopted. An alternative explanation is needed which accounts for blockages and resistance in the process, rather than providing ameliorative rhetoric. Operational mechanisms are the policy instruments used to push reforms through the institutional process and implement them at different levels.

The punctuated equilibrium explanation does not really help to explain how change became possible in the Italian case. Baumgartner and Jones offer an 'issue expansion' explanation of how issue redefinition leads to radical change. This explanation is remarkably difficult to fit into any purposive model of change which emphasises the interests and strategies of elites. Ideas seem to sweep through the American political system with such force that they have no limits.[18] The positive feedback process which sustains policy change is an exponential one by which 'seemingly random initial events can lead to a cascade of subsequent events that dramatically change the status quo' (Baumgartner and Jones 2002). Ideas do not spread in the same was as an infectious disease. I am not refuting the concept of issue expansion, but the inevitability and irreversibility of this initial 'random' trigger, in the absence of strategies and actors willing to utilise them. This reflects one of the main problems of using punctuated equilibrium to explain policy change in the Italian case.

[18] The acceleration of change, that underpins this explanation of policy change, has a bandwagon effect as new ideas take hold. Powerful ideas can potentially break policy monopolies, albeit temporarily. But I disagree with the emphasis on the independent causal effect of ideas on policy change. Ideas cannot be self-propelling mechanisms unless they are directed and transformed into decision-makers' interests. Ideas might be circulating and attractive to policy makers for a variety of reasons, but it still takes political will to use them in order to adopt them and push them through the old rules of the game.

Any explanation of drastic policy change needs to take into account power relationships and bias and whether some actors or groups control the political agenda by excluding certain ideas from the policy process. In the Italian case, the policy subsystem of the central administration defined and shaped the policy image with very limited input from other directly-affected interests. It was not necessary to restructure monopolies to produce change. Radical change was promoted and introduced in Italy by the bureaucrats themselves.

Baumgartner and Jones, however, present agenda-setting as a way in which policymakers are able to regulate or manage complexity through simplification rather than 'political control'. American subsystems are capable of processing issues by lurching from one to the other, although 'we cannot help but note that the American political systems seem more devoted to the processing of issues of interest to various factions of the middle class than those benefiting the lower classes' (Baumgartner and Jones 1993).

This framework is less plausible when applied to reform of the European welfare states. What may work as an explanation of environmental policy, or regulations relating to car safety, may be less convincing when it comes to explaining issues which involve the redistribution of resources. Although it is claimed that the punctuated model addresses the question of bias in the political system, the aim of proving that the American political system is as pluralist as possible is pursued at the expense of considering policy sectors where redistributive policies are affected by

class, power and intrinsic and structural asymmetries, such as health care reforms.[19] There are policy monopolies in these area which are far from fragile.

In addition to its lack of appreciation of the central role played by the interests of elites, their strategies and instruments, the punctuated equilibrium theory of major policy change, especially in its most recent development, emphasises the endogenous role of institutions.[20] But decision makers and others involved do not have the choice of a wide range of possible institutional venues that is claimed by Baumgartner and Jones. For instance, the parliamentary process of enacting legislative decrees is cumbersome, rigid and formalistic. The choice of policy instruments by decision makers is sometimes constrained by established customs or constitutional law, such as reserved areas in which only the law, and not another instrument, can regulate the administration. The adaptability of policy venues to policy images cannot be applied to political systems in which 'venues' have acquired a historical legacy and legitimacy beyond temporary contingencies. Therefore, the thesis that changes in institutional jurisdictions are common over time is misleading when applied to the Italian political and administrative system. Administrative law has been adjusting itself to social pressures, but it is far from losing its centrality to the administrative process. This is also because certain institutions do not change as rapidly as Baumgartner and Jones presume. The system of intermediation between the state and interest groups, for instance, does not fluctuate according to *ad hoc*

[19] Baumgartner and Jones apply their model of punctuated equilibrium to the following policy sectors: the use of civilian nuclear power, pesticides and tobacco policy, transport safety, urban affairs (1993).
[20] (Baumgartner and Jones 2002). The authors seem to argue that the definition of the issue will determine to which institutional arena it gets assigned. They suggest that 'just as images may change over time, so may policy venues', (Baumgartner, F. R. and B. D. Jones (1993). Agendas and Instability in American Politics. Chicago, The University of Chicago Press. The punctuated equilibrium model does recognise the creation of new institutions as a condition for policy change and the establishment of a new equilibrium. Policy venues represent different jurisdictions with the authority to make decisions. An issue may be assigned to an agency in the federal government, to the private market, to state or local authorities.

policy issues as much as is claimed, but is influenced by cultural traditions different from American value-laden pluralism.

An alternative explanation for the Italian case of policy reforms, which accounts for major change under the continuity of established institutions and an inertial administrative course, is put forward in Chapter VII. The most crucial question addressed is how it became possible to 'unblock' what Michel Crozier has defined in his seminal study as the *société bloquée* (Crozier 1970), which refers to the case of France. He suggests that *changement par crise* [21] is an obvious consequence and reflection of the conservatism and immobilisme pervading the French state and society in general. The study of administrative inertia is central to the work of Crozier, who suggests that the French bureaucratic phenomenon is trapped in a 'vicious cycle' (Crozier 1964).[22] He studies the resistance of the French administration to reform and ascribes it primarily to cultural and pathological traits, claiming that: 'as soon as one embarks on the study of the pathology of organisation, cultural analysis becomes an indispensable tool' (Crozier 1964).[23]

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[21] 'Change by crisis'. Author's translation.

[22] The four basic elements of a bureaucratic vicious circle are: the extent of the development of impersonal rules, the centralisation of decisions, the isolation of the different strata and the contributory group pressure on the individual, and the development of parallel power relationships. Impersonality excludes any power relationship between public managers and subordinates because everything is regulated by law. Centralisation, in Crozier's view, is the second means of eliminating discretionary personal power within the organisation because those who make and interpret rules have to be far away from the field and this runs counter to the problem of adjusting to the environment. Thirdly, strata isolation implies that each stratum ignores the organisation's wider goals and is only concerned about members' compliance and group discipline. The fourth element of the vicious circle, the parallel power of experts, indicates that the more narrowly the organisation is regulated, the greater the independence of experts, because they operate outside the rationalised system of rules and they gain their power from controlling areas of uncertainty in a system where everything is predictable. These elements are self reinforcing and result in greater bureaucratic rigidity and new dysfunctions.

[23] The cultural approach permits the bureaucracy to be analysed in relation to social and cultural system of society at large, beyond the internal logic of the system and its internal rules. Typically French traits include individual isolation, lack of communication between strata, and avoidance of face-to-face relationships. The second merits particular attention. The introverted nature of each stratum within the organisation and the coercion on its members have direct implications for resistance. Assuming that innovation comes from the top of the organisation, the higher civil servants

Crozier argues that change of the paternalistic state, and the conservatism associated with it, is possible only by *crise*, which is rupture, reversal, upheaval of the rules of the game, radical transformation of administrative and political behaviours. Real change is caused by a revolutionary moment rather than an accumulation of incremental changes, to which Crozier does not seem to attribute much potential for innovation (Crozier and Friedberg 1980). *La crise* is *the* French style and method of collective action and as such is part of a cultural tradition, namely a *tradition rèvolutionnaire*[24], which makes experimentation and negotiation problematic. The alternation of long routine periods with short crises, 'that we can observe easily in the history of public institutions is the natural consequence of this sociological mechanism'(Crozier 1970). The conservative behaviour disappears only temporarily during a crisis: 'la crise est une rupture temporaire de l'ordre bureaucratique, mais elle ne le détruit pas' [25] (Crozier 1970). In fact, the outcome of a revolutionary crisis seems not to be radical change, but the 'transposition de l'ancien à un niveau d'adaptation plus adequate'.[26] Crozier attributes an ample transformative power to a moment of crisis, but its outcome is nothing more than readjustment to the changed environment. The rupture is then an attribute of the process of change, sustained by revolutionary symbolism and rhetoric. It is a *prise de conscience,*[27] the disclosure of a hidden problem, but not necessarily a substantial departure from the *status quo* because new forms of public authority might well resemble the old ones.

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are omnipotent because they are at the top of the bureaucratic pyramid, but they are constrained because they cannot interfere with lower strata.

[24] 'Revolutionary tradition'. Author's translation.

[25] 'Crisis is a temporary upheaval of the bureaucratic system, but it does not ruin it'. Author's translation.

[26] 'Projection of the old system into a more adequate level of adaptation'. Author's translation.

[27] 'To be aware'. Author's translation.

The mechanism of change through crisis, as Crozier has formulated it, is not entirely convincing when associated with the 'extraordinaire capacité à masquer la réalité ou à la brouiller' [28](Crozier 1970). He offers a characterisation of French society which could possibly be applied to other countries with a Napoleonic bureaucratic tradition, Italy being among them. In French society, he argues, change is continually discussed, but rarely adopted, notwithstanding its revolutionary appeal. One of the most powerful weapons, he argues, is an extraordinary capacity to mask reality which ends up in blockages. Crozier illustrates the case of *complicité* [29] between the local administration and the mayors, who appear to oppose each other openly while actually accepting and sharing the same values of stability and conservatism. Opposition becomes a rhetorical tool. In reality *rien n'a changé*. [30]

The main problem with Crozier's revolutionary crisis as an explanation of change is the applicability of its type of mobilisation and collective action, peculiar to French historical tradition, to the Italian case. The mechanisms he describes as necessary to bring about a real transformation of the state are not feasible, and have not been pursued by reformers in the Italian political system. It could be argued that a great deal of 'masking' the reality and 'conflict' is endemic in most political systems, as political conflict brings risk and responsibility, especially for bureaucrats. On the other hand, political systems, including those sharing similar administrative traditions, differ profoundly in the methods and style of mobilisation of dissent that they incur. In this respect, the Italian political tradition has been characterised by *trasformismo,* which is very far from being a revolutionary practice. Social conflict between deep seated subcultures in post-war Italy has been regulated and structured

[28] 'Exceptional capability to mask the reality or confuse it'. Author's translation.
[29] 'Complicity'. Author's translation.
[30] 'Nothing changes'. Author's translation.

primarily through aiming at an enlarged parliamentary majority. Political parties have prevented the system from falling into major institutional crises by pushing the Opposition to the extremes of the political system.[31] In the absence of a social consensus, the practice of *trasformismo* was a compensatory factor for an otherwise divided civil society. For the Opposition, conceived as 'anti-system' in Italy and thus not entirely legitimate, the model of *trasformismo* has been an alternative to revolutionary crises which would have disrupted the democratic system and stability (Musella 2003). In addition to the historical legacy of *trasformismo* -- which has hindered a legitimate and open conflict between majorities and opposition, justified partially by the consolidation of a democratic system and the development of a comparatively young European state -- some general cultural traits do separate the Italians from the French. As La Palombara notices, the instinct of the Italian political elites is to avoid direct confrontation whenever possible (Palombara 1987). This reflects the deep psychological aversion of Italians to divisive confrontations and their willingness to search for consensus and negotiation. No matter how severe the conflict, political and administrative elites prefer to work out some form of mutual accommodation and distance their strategies from revolutionary crisis.

Conclusions

Italian public administration has been moving along two main trajectories of policy reform. First, a technocratic and technical *esprit,* an extraneous cultural trait for the majority of Italian civil servants, has been infused into the Weberian rational-legal

[31] The first chapter of this thesis explains in greater detail the Italian version of party government. In such a system the leaders of the opposition, mainly the Communist Party, were consulted informally and were part of the policy making process. This informal practice was aimed at the consolidation of democracy in the post-war period and the avoidance of institutional crisis, in the light of the deeply divided Italian society.

paradigm. Second, the process of administrative decentralisation -- or regionalisation -- of administrative resources and responsibilities has created new political pressure and demands which, in turn, have thrived on the development of powerful regional administrative capacity, especially the autonomisation of the top level of welfare administration. The modernisation of welfare administration in Italy has been conceived and triggered from the centre, but has become a reality at the periphery.

The emergence of managerial autonomy has challenged the traditional system of relationships between civil servants and local political elites on one hand, depriving the latter of control of administrative instruments, and between regional and national elites on the other. The struggle between political elites at different levels of government has been the single most important precipitating condition for the implementation of change, as far as the increasing managerial autonomy of top civil servants in health care administration is concerned. If the regionalisation process had not been introduced at the same time as the introduction of general management, it would have been unlikely that the reforms would have achieved the same outcome. It is improbable that the old forms of political mobilisation and control will reproduce themselves at the regional level, because regional governments have been publicly and democratically legitimised as service delivery institutions. This represents a radical change from the Italian nature of local government, namely political localism.

Reform ideas in 1992 and 1993 were inspired by managerialism and entrepreneurialism, but were introduced in a way that could be defined as 'technocratic enlightenment' owing to its poor definition of operational details and

predominance of abstract analysis, in the legal-formal sense. Yet, rather than detracting from the significance of the reforms, technocratic enlightenment leads to two main considerations. First, it was possible to achieve change even with an ill-contrived national implementation scheme. Secondly, the abstract and formalistic legal culture predominated throughout the drafting stage and introduction of legislation. This suggests that there is scope for continuity and that the administrative culture and tradition are resilient even in the face of change. The central legal method of the Italian administration is not simply a defence mechanism for bureaucrats, but is *the* predominant means of adopting change, including the case of change which has been analysed here. Against all those who point to the incompatibility of managerialism and public law, it can be argued that the centrality of the legal and formal process does not have to be dismantled in order to enact and accomplish administrative change. The next chapter will analyse in more detail how the legal process can allow for change and how blockages can be transformed into changes in the administrative process.

An alternative model is needed to understand how blockages in Italian policy reforms are handled during the process of reform and how they relate to the impetus for change. The theoretical explanations reviewed in the last part of this chapter maintain blockages and incentives for change as distinct and separate processes. Blockages are primarily conceived as 'given' so that it is their lifting that explains how change becomes possible. However, the model which is developed in the next chapter accounts for the dynamic transformation of blockages into changes during the process of reform. Paradoxically, had the blockages been lifted, change would not have been possible, or at least it would have been less likely.

The problem with applying existing theories to the Italian case of the modernisation of the state does not only rest in the distinction and separation of the processes of blockages and change. It also lies in the definition of non-incremental change as the result of either a revolutionary crisis, or an institutional disruption, or an upheaval of policy monopolies. In the case of punctuated equilibrium, major change is explained as the result of sweeping ideas which exercise a reinforcing effect on the policy process, as if no purposeful actor was directing it, or at least influencing it. The consequence of conceptualising change which is non-incremental as a 'crisis', or temporary outburst, is that its cumulative effect, that is the long term effect of serial non-incremental changes, does not receive enough academic attention. In the next and final chapter of this thesis, I propose an alternative explanation of the pattern of administrative reforms in Italy, analysing the non-incremental, recurrent, prolonged attempts to introduce change by transforming blockages and inertia conditions into factors of dynamism.

Chapter VII

Dynamic Conservatism: a Model of Change Under Inertia

In comparative terms the Italian state has been too often categorised as inevitably destined to paralysis and immobilisme. This is certainly justified given the traditional pattern of failed implementation of numerous administrative reforms. However, nothing could have more clearly illustrated the fact that the most established scholarly categories can become suddenly anachronistic than the considerably distinctive approach to managing change we have found in the course of the empirical investigation of health care reforms in the 1990s. Change is possible and has been impressive, considering the stalled institutional pattern of the reform of the Italian State. This type of change has proved to be concrete, thus moving beyond political rhetoric and the nominal introduction of novel paradigms, such as those offered by new public management ideas. The possibility of big change at the core of the welfare state leads to the hope that the Italian state is finally overcoming its traditional difficulties. A central issue we propose to explore in this chapter is related to the mechanisms by which change became possible in health care and, more generally, how the possibility of this distinctive approach to handling blockages can be generalised and applied more widely.

The relationship between policy change and exogenous factors of the type associated with the transition from the First to the Second Republic has been extensively studied. However, these attempts to emphasise the link between the financial crisis at the beginning of the 1990s and health care reforms are unsatisfactory (Mapelli 1999;

Maino 2001). Little attention has been given to the study of how political and administrative elites handle blockages strategically and intentionally, so as to help change. The introduction of big change does not need to be merely the result of an accidental logic of historical events, but can be the result of careful political considerations. If this type of intense, high risk, high cost change is purposive and not merely associated with an economic climate, we need to develop an alternative explanation for the strategy undertaken by political elites of embarking on large scale reforms in spite of the legacy of numerous failed attempts in similar directions. We need to move beyond those widely posed questions of how reforms are defeated and by what blockages.

We need to ask why policy makers adopt such radical change in the first place. Why do they pursue risky reforms under the force of inertia, when it seemingly only maximises countermobilisation and social conflict? Policy symbolism, suggesting that public policy is about 'doing something' rather than 'problem-solving' (Lasswell 1948; Edelman 1977), does not offer a satisfactory explanation here because 'words' were not sufficient in the dramatic collapse of the First Republic to legitimise the political system. Moreover, the use of policy symbols by elites to 'dissipate hostility', providing scapegoats and saviours (Lasswell 1948), does not apply to the process of health care reforms marked by a high level of public disgruntlement and opposition. The significance of the reforms of health care rests in their substantive rather than symbolic implications, as intended by the reformers from the outset.

By analysing the mechanics of the process of introducing big change and managing subsequent blockages in the case of health care, this chapter aims to elaborate a novel conceptual approach to the study of reforms in blocked societies, characterised by the

historical legacy of administrative and political inertia. Given the blockages, the first part of the chapter focuses on what the health care reforms achieved and on the features that made them possible. After highlighting the main characteristics of this change, we define this new approach to policy reform as 'dynamic conservatism' and we extract the main elements. In the second part of the chapter, after a brief discussion of the origins and conventional usage of the term, I propose to elaborate a new general model of change. Of primary importance for this approach are the role of the legislative process and the developmental way of managing blockages. Finally, the possibility of generalising this novel approach more widely is explored by turning to a discussion of the antecedent conditions that enable the operation of change and magnify the effects of dynamic conservatism on policy change.

A Distinctive Way of Handling Blockages

The health care case illustrates an impressive break with immobilisme and persistence of historically entrenched patterns of administrative reform in Italy. This section of the chapter aims to highlight how this was possible and to discuss the mechanisms that facilitated such a concrete achievement of change. Above all, the first feature of health care reforms that made their departure from traditional patterns possible was the high level of intensity and radicalness of change introduced, despite the cumulative effect of failed attempts and policy inertia. This initial reform impetus was a response to the need to overcome the historical legacy with equally forceful instruments. As much as big change triggered policy dynamism, it also set in motion a process by which blockages were built into the system in a developmental way, as the second part of the chapter will elaborate further. A second important feature of the health care case was the relative autonomy of the

public administration from pressure groups, enabling it to avoid a 'pluralistic paralysis' (Hayward 1975). This rather state-led system of intermediation created societal conflict, which was used to help change. A power struggle was a necessary condition for achieving big change. The third feature of the reform process that made change possible, besides high intensity of initial change and autonomous administration, was the distinctive way blockages were handled by political elites. The availability and distinctive usage of the paired legal instruments of an enabling law implemented by legislative decrees proved crucial. This legal aspect will be the central concern of the second part of the chapter and hereafter will be only briefly highlighted, as far as handling blockages to help change is concerned.

The investigation undertaken in Chapter I of the major administrative reforms of the Italian State from the introduction of the Giannini Report in the 1970s until the present suggested an historical Italian strategy of launching radical reforms to overcome the legacy of blockages and failures. This is most remarkable in light of the high political, economic and social costs of embarking on big policy change. A series of large scale and intense changes involves greater risk than incremental change and higher political responsibility for policymakers in terms of the implications for the stability of the institutional system and necessary administrative adjustments to take account of frequent changes. Intense reforms are also very demanding in terms of the resources necessary to push them through the implementation stage. The announcement of big change entails providing the public with great hopes and expectations, especially for promises of efficient service delivery. Citizens' frustrated expectations, in the case of policy failure, could be politically much more detrimental than the option of introducing incremental change. Furthermore, comprehensive packages of reforms require a more committed

coordinating effort, which is notoriously difficult to accomplish by the highly fragmented Italian administration. Moreover, big change is likely to mobilise civil society, especially when most groups and actors have traditionally been against reform. In spite of these various drawbacks, policymakers in the 1970s and 1980s, and in particular from the beginning of the 1990s, have consistently pursued radical administrative reforms.

This thesis has maintained that the health care reforms in the 1990s were a pioneering case illustrating the concrete possibility of transforming the Italian State. This remarkable departure from the historically entrenched administrative tradition took two main directions. First, the enterprise formula, introduced in local health authorities and public hospitals, yielded the intended results by creating at the top of the health care administration a powerful executive post taken by powerful regional bureaucrats and public managers. This change is impressive given one of the most integral features of the Italian administration, namely the lack of a firmly established senior civil service until fairly recently. General managers have emerged as the key policy actors in regional health care policy, posing a threat to the old centrality of local political elites. The significance of the change, however, does not only rest in the creation of a new post and the attribution of new formal responsibilities, but also in the consolidation of a different type of public administration: more service oriented, less anchored in the public authority tradition, increasingly infused by private sector management practice and instruments, such as the *atto aziendale,* more open to flexibility in hiring, and performance related pay. These aspects have already been discussed in Chapters II and IV.

The concrete implementation of new public management arrangements in the health care sector is most impressive when assessed against the challenge this paradigm posed to the traditional relationship between centre and periphery in Italy, based on political localism and clientelistic networks of integration. The effects of the regionalisation of the national health care system on territorial politics were dramatic, as Chapters IV and V have investigated. First, greater regional demand for management capacity has facilitated the codification and formalisation of integration arrangements between different levels of government and institutions, previously based on informal and party channels. This has resulted in the removal of strategic sources of political legitimacy and power, as local health authorities were for local political elites before the 1992 reform. Clientelism has lost its predominance as a way of characterising Italian local health care politics.

The second effect of regionalisation has been the emergence of the regions as the most important administrative and political level of government in charge of health care policy making. Few responsibilities remain allocated to the central state. Among these we find establishing minimum standards of care and monitoring overall health care expenditure. Regional political executives became over the course of the 1990s by far the most important decision makers in the overall formulation of health care policy, defining the provision of services, managing administrative structures, and mobilising political consensus. Regions have also acquired such extensive financial powers that observers have defined this process as 'fiscal federalism' (Cavicchi 2001). This change is remarkable given the failure of the 1977 regional reforms and the difficulty in changing the configuration of local government and local politics in Italy (Page 1991). The regional level is, thus, emerging effectively as

a powerful intermediate institution for the definition and provision of welfare services.

The availability at the beginning of the 1990s of a powerful and persuasive paradigm of an entrepreneurial administration, capable of revolutionising the deeply seated tradition of public authority, was one of the key contributory factors in helping the introduction of big change from the outset. This big change was facilitated by the insertion into a rational-legal administrative tradition of an external and unfamiliar model of public administration, inspired by new public management ideas. This was, for instance, echoed in the entrepreneurial formula and transformation of public sector health authorities into public enterprises. As Chapter II has considered, the then minister of health, De Lorenzo, and Prime Minister Giuliano Amato were attracted to this new *modus operandi* of public administration, which promised efficient delivery of public services and cost effectiveness. Against the claim that the 1992 reform was exclusively financial in nature, owing to the undisputable context of a severe financial crisis, we argued that the attractiveness of the entrepreneurial paradigm was paramount. In fact, a bill to introduce new public management in the health care system had been discussed in parliament as early as 1989, before the collapse of the party system and the implosion of the institutional system in 1992. Throughout the 1990s, change continued to be sustained and implemented with some success at the regional level, as Chapters IV and V analysed.

Thus, contextual factors of the financial and institutional crisis should not be exaggerated in considering why change was adopted in 1992. In 1992 a far-reaching transformation of the way the health care administration operated was adopted as a result of the conviction of political leaders and their faith in the beneficial effects

attributed to the paradigm of the 'entrepreneurial administration'. This had been attractive *per se.* Although the reforms' aim was also to resolve the institutional deficiencies of the national health care system, such as the high politicisation of the local health authorities, and address the issue of soaring budget deficits, the adoption of this powerful paradigm became an aim it itself and ceased to be a means, as interviews with key informants have confirmed throughout the thesis.[1]

The power of the paradigm of an entrepreneurial administration is not only the result of being an alternative model of public management to the traditional one, but also a highly unfamiliar mode of administrative operation. This external paradigm, developed in a different jurisdiction, and not based on public law, gave rise to political and administrative resistance, as expected. Hence, blockages did not disappear and were not removed during the health care reforms in the 1990s. The political strategy was to transform their power into instruments of additional reform impetus, so as to help change. Blockages were built into the legislation during the process of drafting the 1992 reform and the legislative process of its parliamentary approval. Chapter II showed how the 1992 legislative decree contained many ambiguities in order to build in possible breaches for later administrative manoeuvring, such as the unclear demarcation between state and regional responsibilities. The process of regionalisation was not clearly and unequivocally defined from the outset. The appeal of regions to the Constitutional Court suggested that the 1992 reform was not entirely favourable to regional discretion. By contrast, and noticeably, the reform was rather clear about the regional responsibilities for covering the huge budget deficits of local health authorities and public hospitals.

[1] Interviews with Falcitelli in Rome in September 2002 and again in July 2003 have confirmed that the paradigm of new public management became the aim in itself and not the means of change.

During the implementation of the 1992 and 1993 reforms, blockages were built in even more obviously and took the form of new administrative regulations or entirely new laws. For example, the creation of the *Società della Salute* in Tuscany illustrated the attempt to challenge the central role of the general manager by the restoration of the mayor and of territorial politics. In Emilia Romagna, the *Piani per la Salute* were designed in part to counterbalance the emerging power of general managers and give more policy responsibilities to municipalities and mayors. At the national level, the 1999 Bindi reform attempted to re-establish central administrative control over regional health care systems, though consolidating the enterprise formula. Hence, change and blockages were bounded up intrinsically in the process of reforms.[2] In the second part of the chapter, I propose to analyse conceptually change and resistance as mutually self-reinforcing parts of the same reform process. Thus, they are more usefully treated in combination than apart.

What was distinctive about the handling of blockages in the case of health care was that they were transformed into instruments of change by not bringing them into the open. They did not emerge as a result of direct opposition to general managers or to regionalisation, which conversely were largely acclaimed publicly. Blockages were not embodied in alternative administrative programmes, different policy options, or conflicting political and administrative positions. Instead, blockages were handled mainly by keeping resistance covert. For instance, empirical findings have shown

[2] As considered in Chapter II, the Legislative Decree no.502/1992 introduced regionalisation as one of the major themes of reform. However, certain provisions did not seem entirely consistent with it. For instance, the decree recuperated the role of central planning. Another blockage to the regionalisation process was the creation of a national list of candidates for the post of general manager of local health authority (article 3, section 10). Moreover, the selection of hospitals to be transformed into public enterprises rested with the national administration (article 4, section 1). Public employment was also regulated centrally (articles 15 and 17). Not only the legislation, but also the Social Affairs Committee in the Lower Chamber recognised the excessive number of ministerial decrees necessary to implement the reform (10 December 1992). These are just few examples of built in blockages. More details can be found in Chapter II.

that the process of drafting the 1992 legislative decree was a highly secretive and closed one, which offered the opportunity to build in ambiguities and contradictions to be activated later during the implementation stage.

The predominant mode of administrative opposition and dissent, characterised by mainly covert and oblique resistance, brings about the simultaneity of change and impediments to it. Blockages to reforms are not necessarily manifested by the direct opposition of affected interests, nor by direct countermobilisation, as suggested by Truman's theory of 'disturbance' (Truman 1951). Some interests might not want to be publicly associated with a conflictual strategy. In the case of administrative reforms, which promise to deliver more efficient services, few higher civil servants would be willing to bring into the open their reluctance over change, especially at times of institutional delegitimisation of the system. The more publicly advocated reforms are,[3] the greater the possibility that they might trigger covert and oblique mechanisms of resistance by those negatively affected.

Hence, the reforms of the Italian national health care system in the 1990s illustrate the distinctive decision making process of introducing incisive change into a blocked political system, not by removing obstacles or rejecting change outright, but rather by finding creative and viable ways to survive in the resulting changed environment.

[3] As the literature on the 1992 crisis of the Italian political system argues, the collapse of the First Republic was primarily driven by public rebellion against the system of corruption and clientelism which characterised it. Public advocacy for reforms was central to political change since 1991. Voters expressed their discontent over the excessive power of political parties in the 1991 national referendum by repealing the system of preferential voting. Italian voters were sending a clear message to the political elite that they were dissatisfied with the ineffectiveness of the party system. The arrogance of the two major parties, the Socialists and the Christian Democrats, led respectively by Craxi and Forlani, determining the political and institutional distribution of offices regardless of their electoral performance in the upcoming 1992 election, was clearly punished. In the 1993 referendum, once again, 82.7% of the voters decided to elect 75% of Lower Chamber seats and 25% of Senate seats by an electoral system of first-past-the-post in single member districts. See: Pasquino and McCarthy (1993).

For instance, the support of political and administrative elites for the demands of civil society, after the 1992 reform was enacted, was symbolic and dissimulated. The Ciampi government secured the consent of groups by amending the Amato reform along the lines of the suggestions made by parliamentary committees echoing doctors' demands. Political and administrative elites effectively decided to maintain radical change against the rebellion of interest groups, as we discussed in Chapter III. This is illustrated by the government's decision to make concessions to medical groups' requests, on the assumption that it would be unlikely to be able to implement them given the financial constraints set out by the 1994 Financial Law and the opposition of other ministries, such as the Department of Public Services. However, the result of this governmental strategy of handling blockages did not prevent the additional launch of a new legislative process.

It was not only the introduction of radical change but also the system of interest groups' intermediation with the State during the reform process that contributed to keeping the policy process going and helped to infuse political momentum even when blockages appeared to defeat the process of change. One of the facilitating conditions for sustaining momentum during the health care policy change was the endemic conflict between the state and the medical profession, as Chapter III has already shown. The effects of civil society's response to the process of reform were important because they triggered another legislative initiative, keeping the process of change moving and far from getting stalled again. This was facilitated by the existence of the institutional arena of the parliamentary committees, willing to channel and aggregate the opposition conveyed by civil society. Otherwise, interest groups' response could have merely contributed to the abrogation of the decree, without resulting in new legislative output, a fundamental characteristic of change in

dynamic conservatism. However, as Chapter III showed, the impact of interest groups was rather limited as far as the thrust of the reform of the national health care system was concerned. It is the effect on the process that matters most, as far as the mechanisms that allow for change in the case of health care are concerned.

A Pregnant Oxymoron: 'Dynamic Conservatism'

The empirical investigation undertaken by this thesis revealed that one of the key contributory factors to health care change and, more generally, to the reform of the Italian state, was a distinctive approach to handling blockages during the process. The distinctive approach towards change that we refer to and elaborate hereafter as *dynamic conservatism* results from the combination of two factors. The first is the introduction of big change, exemplified by the adoption of an unfamiliar administrative paradigm. This is then challenged from the outset by a more oblique type of resistance, with the strategy of overcoming blockages caused by the parliamentary process and civil society by a disguised accommodation and meeting of these groups' demands. This refers to a distinctive way in which change and blockage, impetus and immobilisme, are bound together during the policy making process.

In blocked societies, the cumulative effect of failed attempts is to raise the threshold level necessary to infuse renewed impetus for reform into the political system. Incremental change is not an alternative way of bringing about change in inertial systems because the immobilisme resulting from many attempts at reform needs to be contrasted with a process at least as incisive as resistance. As we discussed in Chapter VI, Crozier proposed that change by revolutionary crisis was needed to

unblock French society. Past failures of reforms make it necessary to adopt increasingly more incisive administrative reforms to resolve the problems that then crowd in. Intensity of change is proportionate, thus, to the effects of the legacy of resistance. Therefore, policymakers, with arguably higher understanding of the past than of the future, raise the intensity of change in order to overcome the cumulative effect of unresolved problems and achieve at least some of their intended high expectations. Consequently, they choose the most legally powerful and politically legitimising policy instruments available to them, according to the principles of administrative law.[4]

Reflecting upon Schon's conception that dynamic conservatism is self-reinforcing (Schon 1971), the threshold for change rises over time as a direct consequence of resistance to individual reformist attempts. The energy required by the system to introduce innovation and change is greater from one reform to the next in the presence of a process of dynamic conservatism because the opportunity cost of abandoning the established equilibrium increases over time. Hence, endemic conflict is *per se* an effective means of triggering motion and inducing dynamism in an otherwise inertial political system.

[4] According to the Italian administrative law doctrine, there is a formal hierarchy of legal norms based on the notion of '*fonti*', literally 'sources'. The plurality of *fonti*, from which legal norms derive, is regulated by three different types of relationship: chronological, hierarchical and competence. The chronological principle of establishing the relationship between legal norms is that *lex posterior derogat legi priori*. According to the hierarchical criteria, inferior legal norms (such as administrative regulations, ordinances, local government statutes) cannot contradict in any way superior norms, such as acts of parliament, constitutional laws, decree-law, regional laws, referenda, regional statutes, or legislative decrees. The third principle is based on a separation of competencies, according to the subject matter being regulated, or to the constitutional preference of one '*fons*' over the other.

Beyond Terminology: a Theoretical Model of Reforms in Stalled Societies

The purpose of this second and core part of the chapter is to set out an elaborated version of dynamic conservatism as an analytical framework for the institutional pattern of reforms in those blocked political systems, in industrialised countries, characterised by an historical legacy of political inertia and policy failure. In this context, the key puzzle to address is how the breaking of immobilisme becomes possible, and what operational mechanisms contribute to the triggering and development of a dynamic conservative process. Before embarking on a conceptual development of dynamic conservatism, we will briefly discuss the origins and usage of the term. The purpose is to demarcate our approach from the conventional usage of the term, which excludes the possibility of change. The operation of dynamic conservatism will be investigated by analysing first the process and then the instruments of change. A developmental study of the changing nature and differentiated effects of blockages during the legislative stages of reform will then be offered. After elaborating this, the final section discusses the significance and centrality of Law as the key instrument of change and the most important antecedent condition for reforms in blocked political systems. The evolving function of the law during the process explains how the system evolves from blockages to change. Lastly, the conditions for the operation of this transformation, such as legislative fragmentation, legal flexibility of the enabling law, and the peculiarity of executive legislative decrees are discussed.

The Conventional Usage of the Term: Limitations

'Dynamic conservatism' has been used in the literature rather loosely as an attribute of policy immobilisme and administrative resistance. The first scholar to coin this expression was Donald Schon in 1971 in his work Beyond the Stable State. There he defines dynamic conservatism in these terms: 'The resistance to change exhibited by social systems is much more nearly a form of "dynamic conservatism" – that is to say, a tendency to fight to remain the same' (Schon 1971, p.73). Social systems and organisations strive and engage in relentless activism to remain in equilibrium. They resist change with opposing energy proportional to the high intensity of the change introduced. Thus, dynamic conservatism is recognisable, as an observable phenomenon, in the course of a radical attempt at transforming the political and administrative systems. Drawing on the work of Schon, Jack Hayward suggests that political inertia contains 'an active sense of resistance to change, although common usage identifies inertia with passivity and inaction' (Hayward 1975).

In the early scholarship of Donald Schon (Schon 1967; Schon 1971), dynamic conservatism is used to indicate a universal human condition, the anguish of facing uncertainty and the need for individuals and institutions to retain acquired norms and values, which he defines as the 'theory' of an organisation. The central question Schon is addressing is how we maintain 'belief in the stable state', which is a means of maintaining the illusion of stability of organisations and social systems, when in reality they are subject to continuing transformation. The belief in the stable state is the bulwark against the threat of uncertainty generated by change and reforms. It is a pervasive condition that is only partly rational, according to Schon. Instability is indeed a disturbing factor for established human relationships, organisational roles

and rules. The problem is how we manage to maintain belief in the stable state and simultaneously respond to change. The solution to this intractable dilemma, namely the evolving character of social systems and the human inclination for stability, is 'not a passive or inertial but an active and more or less systematic resistance to change' (Schon 1971).

From Schon's elaboration of the concept, it remains unclear, however, how intentionality is built into the pattern of dynamic conservatism, if at all. He maintains that social systems have power over individuals because they provide individuals with 'a framework of theory' (Schon and Rein 1994). Yet, political systems and political mobilisation are the result of conflicts, negotiations and compromises between actors. Schon explicitly dismisses this approach because 'it would be an oversimplification to identify dynamic conservatism with vested interests' (Schon 1971). The major reason why Schon is not convinced by the element of intentionality is that it cannot explain the long-term tenacity and irreversibility of resistance to change. However, our empirical findings suggested that the opposition of interest groups was necessary to the consolidation of radical change as it helped to renew legislative impetus. Conflict was a necessary condition in the health care reforms studied here and political elites were capable of leading the policy process so as to help change take place.

The silence in his work about bias in the distribution of political power and how this affects the relationship between the state and interest groups is one of Schon's most dubious contributions to the study of dynamic conservatism as a political process. In his work he did not address the question of the effects of asymmetrical political power and conflict in organisations, owing to his conceptualisation of institutions as

a living organism. Schon suggests that 'we undertake a continuous and active program to maintain the system in which we are involved – we keep it in being in the sort of way that a living organism preserves itself by homeostasis' (Schon 1971). Excessive reliance on biology leaves the problem of exploring political strategy in dynamic conservatism under-researched.

He did realise that problem solving required consensus building about the definition of problems, but how such consensus is to be created, and whether there is a role for social conflict within organisations, was only partially addressed. In this passage from The Reflective Practitioner, Schon gets as closest as possible to his interest in the political process:

> But with this emphasis on problem solving, we ignore problem setting, the process by which we define the decision to be made, the ends to be achieved, and the means that may be chosen. In real world practice, problems do not present themselves to the practitioner as given. They must be constructed from the materials of problematic situations that are puzzling, troubling and uncertain (Schon 1983, p. 65).

As will become clearer in this chapter, conflict is a central element in our conceptualisation of dynamic conservatism, drawing upon the possibility that the impetus towards political reform brings about change. As Hayward observes, 'the political problem arises when those who will sustain the central losses and those who have firm prospects of gain are pitted against each other in the decision for or against specific changes' (Hayward 1975, p. 15).

Drawing on Schon's concept of active resistance, Hayward defines dynamic conservatism as a resourceful activity of those dedicated to resistance. He suggests that the only changes tolerated are those necessary to preserve the system from crisis. The decision making process of political inertia is characterised by incrementalism. Incremental adaptations amount to a minimal compliance with the demand for

change. He claims that 'when action finally comes it has been too little and too late to be really effective' (Hayward 1975). Hayward attributes political inertia to the British propensity to compliance and to 'rule-fetishism that values institutional devices for their own sake' (Hayward 1975). Therefore, in this model of inertia, change is incremental and timid and does not proceed by grand schemes. In his approach, Hayward does not hold that dynamic conservatism is distinct from inertia, mainly because they are empirically difficult to discern (Hayward 1975). However, the study of the operation of the process of dynamic conservatism in the case of health care reforms has helped us to assess how blockages were inserted in the process and how political impetus was infused.

In contrast to this, other scholars have suggested that inertia can be studied as a distinct kind of change. This refers to 'a uniform rate of motion, that is, a predictable series of increments' (Rose and Karran 1984). This definition of inertia emphasises the cumulative effect of incremental changes. Inertia is conceptualised as a 'force in motion', which Rose describes as a 'juggernaut'. The model of inertial change is not a political strategy model, because the historical legacy sustains ongoing government commitments. Despite the legacy of past decisions, incremental changes made by governments can cumulatively produce big changes (Rose 1990). Therefore, this conceptual definition of inertia emphasises the irreversibility of a series of small changes, whereas the scholarly work of Hayward and Schon stresses the stability and conservatism produced by political inertia.

The problem with Rose's model of inertial change is that the mechanisms which produce it are not distinguishable from Lindblom's incrementalism. The final outcomes are clearly rather different, respectively big and small change, but the

process of accumulation does not seem to distinguish itself from the aggregate sum of all the small increments. This applies to the growth of public expenditure since 1951 in major Western nations (Rose and Karran 1984). Yet, there is no predictability that the final change will be of the same nature and intensity as the initial one. During the process, the elites' strategies might change in a different direction, not directly related to the original one, driven instead by factors such as new policy instruments or temporarily pursued objectives. The direction of change is neither as obvious, nor as automatically sustained by a 'juggernaut', as Rose suggests in his inertial model.

In addition to the difficulty of disentangling the mechanisms of the inertial model of change from an accumulation over a long time of incremental steps, Rose's model is not much different from the others discussed in the last part of Chapter VI in its inadequacy at explaining a series of non-incremental changes which produce change and dynamism, including change of a different nature to the original one. Although explaining persistence is as relevant as dealing with change, especially when there is empirical evidence of a cumulative effect, we still need to address the question of why radical change is adopted by governments and what strategy it responds to. Dynamic conservatism explores how breaking the path of reforms is made possible by analysing the mechanisms of its operation. In as much as accounting for the lack of a decision advances our understanding of inertial systems, how certain mechanisms, and not others, trigger the decision-making process is a key question which we must address.

The Developmental Process of Handling Blockages

Having established that blockages are built into the process, this section investigates *how* they punctuate the legislative process and how they impede change at each individual stage. Table 7.1. summarises the developmental and cumulative process of blockages discussed in this section. The dynamic conservative strategy develops along three legislative stages associated with a national framework law delegating authority to the executive to legislate, the so-called l*egge delega.* This is a general feature of the Italian policy making process, beyond health care specificities. As this law aims to provide the executive only with the general principles as they are decided in Parliament, it is at the second stage of the process, which is drafting and enacting the implementative legislative decrees, that administrative elites are able to influence more pervasively the process of reform. At the third stage of the legislative process, regional implementation legislation, enacted by regional councils, adapts the national general framework to regions' own specificities and political strategies. Regional governments have ample discretion in the so-called *leggi di riordino*, aimed to devise a new institutional and organisational framework for the regional health care systems. These three are the main stages of the reform process of legislative specification and legislative development of a national enabling law introducing big reforms. The relationship between the government and interest groups has also changed during the policy process from open conflict to more covert negotiation according to the legislative stage and the administration's strategy.

Table 7.1. Developmental Process of Blockages

Legislative Stage	Type/Nature of Blockage Introduced	Aim of Blockage	Effects on Radical Change Introduced
Delegating Law or *Legge Delega*	General principles	Limiting scope of radical change and scope of executive delegated authority	Minimal as principles are abstract and broadly defined, and executive has discretion to legislate
Legislative Decree or *Decreto Legislativo*	*Neutralising ambiguities*, that is ambivalent formulation	Create breaches and opportunities for later administrative regulations	Very Large in theory and practice
Regional Implementation Legislation or *Legge di Riordino*	Neutralising *instruments*, that is operational blockages	Activate neutralising ambiguities	Very large in theory, but in practice regional discretion creates cases of large innovation

Source: Author's Elaboration

The first stage is characterised by the parliamentary approval of an ambitious and wide reaching reform. General guidelines in the delegating law are broad and they usually contain very limited operational provisions. Resistance is minimal in light of the fact that this stage is the most exposed to public and media attention and political conflict in the public arena. Blockages to radical change can possibly be found in the limitations that parliament places on the authority delegated to the executive. Thus, blockages consist in defining the scope of the executive's power of delegation and identifying areas to be excluded from executive intervention. For example, Delegating law no. 421 of 1992 established that the post of general manager, to be introduced in the health care administration, should not remove the existing executive board as a collegial decision making structure. In this way, the majority of political parties in parliament attempted to avoid the excessive technocratisation of public management and ensure continuity of political control.[5] Another instance of potential blockage during the first stage of the process was the definition of local health care authorities and public hospitals as 'public enterprises' in such a way that it was not clear which institutions would have supervisory control over them. This

[5] Chapter II discussed the attempts of parties in parliament to maintain collegial decision-making in local health authorities.

omission was intended to avoid the possibility, which in fact became reality, of regional governments acquiring direct political control over them.[6] As we have discussed in Chapter II, the Amato government largely ignored the general principles of the delegating law. Thus, blockages had a very minimal substantive effect. Criticism of the reform, however, resurfaced later on.

The drafting process of legislative decrees takes place at the relevant ministries, most often in the legislative offices, so-called *uffici legislativi*. They coordinate the activity of civil servants involved in the process of defining the operational details of the reform. At this second stage of the legislative process the skeleton of the delegating law acquires concrete relevance. Sector specific requirements and legal technicalities necessitate the active involvement of civil servants. *Neutralising ambiguities* in the form of ambivalent clauses or definitions are introduced. This is only remotely attributable to 'bad drafting'. Rather, it reflects the legally driven logic of resistance that the administration has at its disposal. Ambiguities leave great liberty of interpretation at later stages and can be transformed into obstacles in the third stage of the dynamic conservative process.

In the third stage of the dynamic conservative strategy, when the legislative reform hits the administrative system, neutralising ambiguities become neutralising instruments, purposefully and skilfully designed to conserve the status quo ante, or to dilute the big change adopted in the first stage. For instance, the regional legislation creating the Società della Salute in Tuscany permitted the restoration of local elected elites to their original role and threatened to constrain the rising authority of the managers. Similarly, regional legislation in Emilia Romagna attempted to re-

[6] This was discussed in great detail in Chapter V.

introduce participatory and consultative methods of decision making which required a dilution of managers' authority, considering that local elites were placed at the centre of the network realised through the Piani per la Salute, analysed in Chapter IV. The blockages, thus, gained visibility at a post-decisional stage but had already been debated politically during the parliamentary adoption of the delegating law and built in during the drafting of the legislative decree. This shows that political elites and bureaucrats are equally involved in blocking change, which is thus more encompassing than a merely 'bureaucratic phenomenon' (Crozier 1964).

Professional groups became salient actors in the process, only when and how the state decided to consult them. Consultation with medical associations was limited by the decision of the administration to open up the process of reform only after the radical change had been introduced. The legislative stages in Table 7.1. do not only correspond to different developmental moments in the evolution of blockages against change, but they are also related to the predominant type of mediation between interest groups and the administrative system. Any generalisation about the relationship between the administration and interest groups has limitations because it is issue-specific. As we have investigated, the government was more willing to compromise on issues of public employment than the introduction of general management. However, empirical findings suggested that, during the drafting of Legislative Decree no. 502/1992, the mode of action of interest groups was primarily identifiable with endemic conflict and a rejection of cooperation with the government. Negotiations between the medical associations and the administration became somewhat more prominent only during the parliamentary approval stage of the decree. This suggests that conflict was 'privatised' and 'socialised', to use

Schattschneider's terms, with a remarkable degree of flexibility and rapidity, but often at the discretion of the administration.

The most significant condition permitting the administration to direct the mobilisation of political conflict during the process of reform was its relative autonomy from professional groups' pressure, in comparison with that of parliamentary committees. We can improve our understanding of the effects of the system of interest intermediation on a dynamic conservative process if we analyse the degree of *closure* and *openness* of the public administration towards groups at different developmental stages of the process rather than considering it as a fixed given structure. Rather than conceptualising administrative strategy in terms of static policy subsystems and closed policy communities with fixed interests, we need to appreciate the remarkable degree of flexibility of the Italian public administration in transforming rapidly from a closed and isolated system to one open and responsive to groups' demands. This response varies, depending on whether the strategy is one of adopting change or dissimulating it. The bureaucracy might work with a high level of isolation and closure when it drafts secondary legislation and needs to adopt radical change. Writing good quality legislation and adopting big change take priority over gaining political consensus. At later stages groups are granted consultation if gaining political legitimacy and political accommodation is necessary for the implementation of change. However, this new degree of openness from the public administration does still depend on the unilateral decision to grant groups access during the drafting stage rather than being beholden to their threatening power. The Italian state is vulnerable, but much stronger than presumed.

The Central Function of the Law: From Instrument of Reform Impetus to Substance of Administrative Activity

The strategy and process of dynamic conservatism proposed so far necessitate the activation of peculiar legal instruments and legal conditions. The centrality of the 'law' as the key instrument in enacting the reform of the state is one of the main features of the Italian policy making process. Hereafter we discuss the peculiarity of the usage of the enabling law and executive legislative decrees in the Italian system. This second part of the chapter aims to show how the transformation of the function of law during the legislative process, as explained earlier, determines the departure from the status quo and the possibility of overcoming blockages. Once parties in parliament have approved the enabling law as a political agreement, it is bound to lose its initial function and become a self-sustaining administrative activity *per se*, during the drafting of legislative decrees. Legislative proliferation, parliamentary hyperactivity, and the fragmentation of the legislative function, which is rather diffuse, owing to the dispersal of executive power in Italy, are contributory factors in keeping the legislative process progressing, and creating access points for new actors and new elites to mobilise support around their interests. Had regional elites not found a legislative process in motion already, it would have been difficult for them to be able to initiate an entirely new one without fierce opposition and possible defeat. After considering how blockages can help change, without being swept away, this section offers some brief indications of the applicability of the theory of dynamic conservatism to other sectors and countries, thereby assessing its external domain.

The primacy of Law over other policy instruments in reforming the public administration is justified by the administrative law doctrine of the *fonti.* [7] The precedence of the instruments of law over administrative regulation as the main vehicle to bring innovation reform to the state is established formally by this doctrine. The reform of the Italian state has historically been pursued by laws enacted by parliament. Alternative instruments are indeed available, such as various types of administrative regulations, so-called *regolamenti*, but these are not used for grand reforms but rather to spell out their operational details. Although there is no general legal principle, or constitutional provision, which clearly establishes how to choose in practice between law and administrative regulations in Italy according to specific policy issues (Giannini 1990), these instruments differ remarkably in their 'legal power'. According to Sandulli (Sandulli 1989), law and regulations fundamentally differ in the 'their formal power', so called *forza giuridica.* The formal power of the law refers to the potential of the legal act to promote *innovation* in the pre-existing juridical system. The power of the law is also measured in terms of its capacity to 'resist' administrative regulations, which do not have an equally forceful innovative capacity. By contrast, the power of administrative regulations is to be 'authoritative', namely it rests in their capacity to produce unilateral decisions (Sandulli 1989).

One of the most direct and concrete effects of the centrality of the law is legislative hyperproductivity. This trait distinguishes empirically dynamic conservatism from inertia. It does not only derive from the high legal productivity of the Italian Parliament (Di Palma 1977), but also from the intrinsic nature of the law, which contains provisions for the production of subsequent and related legal acts. For

[7] See note no. 4 of this chapter.

instance a delegating law already determines the number, the scope and timing of its implementation decrees. Similarly, a legislative decree contains indications with respect to adopting ministerial acts and regulations. Dynamic conservatism shares with a legal autopoietic system[8] the process of self-reproducing and self-sustaining legal norms (Teubner 1993). Law, thus, permits the policy process to be kept continually in motion, by ongoing legislative initiatives.

Another important condition for sustaining the process of dynamic conservatism, besides internal self-reproduction, is the fragmentation of the legislative function, which in Italy permits actors to use various policy venues at different stages, in an extremely flexible and polycentric system (Cotta 1994). The executive and the legislature co-legislate during the process of delegated legislation, as the case of the reform of the national health care system illustrated. The legislative process of the enactment of a delegating law and legislative decree unfolds by a unified mechanism (Manzella 1991) rather than by a separation of responsibilities. This offers an open and flexible method of making reforms, which allows for amendments, changes, and reversals, if necessary, given the amending power of parliamentary committees. The decision-making process remains in a state of fluidity that contributes towards increasing the number of access points and breaches. Then, new elites, new actors or new issues can emerge and be inserted in the ongoing legislative process.

[8] For a discussion of autopoiesis, see Luhmann (1986), Teubner (1988), Jessop (1990), Morgan (1986), Kauffman (1976). An autopoietic organisation is self-referentially closed and perceives its environment as a projection of its self-identity. It functions only to survive and regenerate its components. The aspects of autopoiesis that are most relevant to our theoretical approach are: the regeneration logic which depends on the network of interrelationship between actors in the political system which produces these mechanisms; and, the fact that autopoietic systems must produce their own components for conserving their organisation. As Kaufmann suggests, the autopoietic model can be applied to public administration to describe bureaucracy as a self-reproducing system (Kauffman 1976).

Grand schemes of reforms have been increasingly pursued by the paired policy instruments of an enabling law[9] followed by implementing executive legislative decrees.[10] The nature of enabling laws in the Italian parliamentary system offers an opportunity for ample policy change that is politically legitimated and for which political consensus has been achieved. Its necessary parliamentary enactment makes it into a suitable instrument for introducing big policy change. An enabling law is a piece of primary legislation that establishes the principles and criteria to guide the executive in the reform process. Its use by reformers in Italy is hardly symbolic. Rather than guidelines for the executive to exercise delegated legislative powers, enabling laws impose formal constraints as far as the scope of governmental intervention is concerned. This instrument offers the advantage of being sufficiently flexible to allow for adjustments at later stages but necessarily restrictive as far as compliance with constitutional principles is concerned, such as the 'right to health'. Enabling laws, thus, are adaptive instruments that offer multiple solutions in order to address political conflict arising at later stages of the process. They permit radical change, and are not fixed once and for all at the beginning of the process.

The fragmentation of delegated legislative functions in Italy and the centrality of the Italian parliament (Di Palma 1977) permit the juridification of norms to be constantly

[9] An enabling law to delegate legislative powers to the executive has the same formal status of an ordinary law enacted by parliament, namely primary legislation, whereas an executive legislative decree has a 'sub primary' position in the rigid hierarchical system, not a secondary one though, which applies only to administrative regulations.

[10] Legislative decrees, so-called *decreti legislativi*, are executive decrees having the force of law, which are issued by the government in accordance with the principles and criteria set out in their parent enabling law, enacted by parliament in the form of ordinary legislation. Law no. 400 of 1988 (article 14) has clarified further the procedures of this instrument of delegated legislation, not to be confused with decree-laws. The enabling law must formulate clearly the object, timing, principles and criteria of executive legislative authority. If the delegation of legislative authority exceeds two years, the executive must get parliamentary approval on the draft legislative decrees before they are issued. A parliamentary opinion is formulated by the relevant standing committees after 60 days of receipt of the draft document from the executive. Then, the executive must amend the text according to the recommendations of the parliamentary committees and send the draft for a second and definitive reading to the committees, which deliberate a final resolution after 30 days. There are, thus, two readings of draft legislative decrees.

infused with political conflict, power struggle, and new emerging political issues. The iterative policy process allows for the transformation of the law from a means of political agreement and consensus to being primarily an administrative activity. This is a core element of the dynamic conservative theory offered here. A policy agreement is juridified during the drafting process of an executive legislative decree, and repoliticised by being returned to the relevant parliamentary committees for approval. Legislative decrees are attractive instruments for reform because they offer the executive and legislature the possibility of co-legislating and sharing the blame for unpopular reforms. Their usage has increased significantly in the 1990s.[11] The peculiarity of the *decreto legislativo* is that it is a hybrid instrument, not as powerful as primary legislation but potentially suitable for greater innovation than administrative regulations.

The Law plays inevitably a fundamental role in the theory of dynamic conservatism because it is empirically the predominant instrument through which big change is introduced, opposed and again renewed. Neutralising and purposefully built in ambiguities at the first stage of the legislative process are transformed into means of resistance by the transformation of the Law from an *instrument* of political change and reform impetus in the first stage of the process of dynamic conservatism into the very *substance* and object of the administrative activity during the second stage. As one MP defined it, 'the legislative process responds to a contractual logic, being characterised by the need to settle conflicts and disputes so that a legal act fulfils the function of political compromise; yet, once a legal act has been created, its function

[11] In the Xth Legislature (1987-1992) the total number of legislative decrees issued by the executive was 129, and in the XIIIth (1996-2001) it increased to 425 (of which 242 derive from enabling laws not connected to the implementation of European directives). See Capano and Giuliani (2001).

is no longer useful'. [12] The transformation of the function of a legal act, from being a way to settle political disputes and achieve political agreements in parliament into a different aim is a crucial factor which explains how the legislative impetus can become self-sustaining and eventually driven by new elites, or different actors to the ones who initiated it.

The Law therefore becomes the *substance* of reforms responding to other legal acts rather than to new political impetus for change. Having lost its original function, the law becomes an administrative mechanism of operationalisation and increasing legal sophistication and specification. For instance, in the delegating law no. 412/1992 the transformation of local health authorities into public enterprises, so-called *aziendalizzazione*, was aimed at improving the efficiency of public services. Once the ministry of health became involved in implementing the reform, the *aziendalizzazione* became an end in itself, so that general managers acquired disproportionate powers of discretion against the medical profession.[13]

As emphasised earlier, the power of the law rests in its capacity to bring innovation to pre-existing systems. This should not be underestimated as a result of the normative preconception that legislative proliferation produces only paralysis. Against most scholars, who have used the term 'dynamic conservatism' as a characterisation of 'resistance' or immobilisme associated with the persistence of old rules and procedures, the process of change we have analysed here is far from being a reflection of inaction and paralysis. On the contrary, its major trait is impetus and continually sustained legislative momentum.

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[12] Interview with Giorgio Bogi in Rebuffa and Monica (1995).
[13] See Chapter IV of the thesis for an account of how managers have emerged.

The process of juridification does not coincide only with the creation of blockages. The legal 'execution' of delegating laws[14] is not merely a process of self-reproduction of old administrative customs and procedures. Drafting implementative legislation is associated with the resourceful and imaginative creation of new institutional arrangements which, though aimed at blocking immediate change, in the longer term offer the opportunity for the mobilisation of a new political process. The ongoing legislative process is fuelled by the dynamism of introducing blockages, and ultimately this impetus facilitates the creation of opportunities for change rather than fossilising the system. For instance, at the end of the 1990s, emerging regional elites and regional managers seized the opportunity created by the legislative decree no. 502/1992 to gain autonomy and create innovative regional health care systems. Yet, they have done so in the footsteps of the legislative process originally launched in 1992, and not by an entirely new policy initiative. Thus, dynamic conservatism is a continual process that evolves to exploit the powers that block the system in order to help change.

External Validity of the Theory of Dynamic Conservatism

The purpose of this last part of the chapter is to extract the elements of dynamic conservatism, as elaborated so far, and to explore the applicability of this novel approach to other cases. The discussion of the potential for generalisation is based on the consideration of its antecedent conditions. These enable its operation and magnify its effects, when they are present. As offered here, the theory of dynamic

[14] By 'execution' we do not refer to the implementation stage, but to the legal activity of detailing and operationalising a general framework enabling law enacted by parliament, so-called *legge di delega*, into an executive legislative decree, so-called *decreto legislativo*. The latter is further executed by implementation legislation, inclusive of regional legislation, or ministerial regulations.

conservatism advances our understanding of why high intensity policy change is adopted in the first place by political and administrative elites, how blockages are continually built into the process of reforms, and how eventually the operation of dynamic conservatism produces a departure from the *status quo ante*. In the case of the reform of the Italian state, the predominance of explanations for change, heavily relying on exogenous factors, has impeded the theoretical advancement of the debate about reforms.

Key Elements of Dynamic Conservatism

In our model, policy change is not by crisis, by incremental steps, by exponential issue expansion, or by an invisible hand, but by a dynamic conservative process in which political impetus and equally forceful resistance are bound up together during a three-stage legislative process. The legislative stages of the reform of the national health care system considered in this thesis, namely the enactment of the delegating law, the issuing of the legislative decrees, and regional implementation legislation, have shown different types of blockages. These were here conceptualised in their dynamic developmental evolution because their effects on the process varied according to the policy stage and institutional level in which they were built in. Against the emphasis of more static models on accounting for 'given' impediments to change (Crozier 1964), the theory of dynamic conservatism improves the understanding of the effects of blockages on the process of reform as it unfolds. Actors introduce latent impediments at an initial stage as Trojan horses. These are later activated during the implementation of the parent enabling law when executive legislative decrees are drafted. The element of the theory of dynamic conservatism that explains the relationship between initial radical change and blockages is the

'threshold effect', that is the need to overcome the cumulative effects of past failures by the introduction of very incisive change to counterbalance the historical legacy.

The second most important element of the model of dynamic conservatism is the innovative function of the Law as the main instrument in reforming the state and the key driver of policy change in Italy. The Law is defined by the process which has generated it rather than some abstract and general theory (Giannini 1990). The high degree of fragmentation of the legislative function in Italy offers a remarkable opportunity for continual amendments and provides multiple open access points for new actors, such as regional elites, to intervene in a pre-existing and already ongoing process. However, law-driven change is not only associated with new legislative initiatives enacted in parliament. It is the transformation of the law from an instrument of political change and strategy to the very substance of administrative activity that allows finally for a departure from the status quo. When the law loses its function of ensuring political agreement and becomes an aim in itself for legalistically minded civil servants, then it is possible for new actors to reorient the process according to their own new political strategy. The transformation of the function of the law from instrument to substance is at the core of the explanation of how we move from original radical change to blockages to renewed change.

Whereas the other developmental models of change primarily focus on benign growth and ameliorative change, as Table 7.2. shows, dynamic conservatism attributes to blockages a key role not only as factors of resistance but also as triggering factors of change.

Table 7. 2. Theoretical Models of Change: a Comparison with Dynamic Conservatism

Dimensions of Change	Incremental Change	Positive Feedback Change	Inertial Change	Dynamic Conservative Change
Dominant Characteristic	Small, serial, self-correcting and reversible steps	Radical change in a burst after a long period of policy stability, change is rapid, rare	Change without choice. Uniform, predictable series of small increments of institutionalised commitments	Drastic change, comprehensive reforms, breaking traditional patterns of blockages. Induced, delayed and unexpected final change originating from neutralisation of original one
Overall Purpose of Change	Ameliorative and benign change, remedial of ills, problem-solving, avoid big change doomed to fail	Break up policy monopolies with new ideas (fragile policy monopolies). Change is for the better.	Not a purposive model. Change can occur as unforeseeable consequence of past decisions.	Break the vicious cycle of cumulative failures, grand schemes of overly ambitious reforms, pitch high to obtain a small proportion
Actors' Strategy	Low understanding and low knowledge of future consequences. Keeping afloat rather than steering goals.	Limited role of choice, no group is in control of policy process. Mimicking and attention shift (centrality of media).	Not a model of choice, but of forces in motion. Past decisions sustain ongoing commitments of policymakers. Not a purposive model.	Top-down political and administrative control of policy process. Simultaneously embraces big change and keeps resistance overt and oblique to avoid head-on conflict. Dissimulation strategy in two developmental stages
Drivers of Change	Trial and error process, here-and-now elites choice	Lurching from one issue to the other, new issues on the agenda and changed policy images, 'random' trigger.	Persistence and regularity, continuity of motion and inheritance. Non-decision making of policymakers.	Iterative process: consensus-driven mobilisation of political conflict, followed by formal juridification of issues, then return to political arena. Continual, flexible, and adaptive political and legal reframing of issues.
Mechanisms of Change	Analysis of limited comparison with familiar alternative policies	Issue expansion, positive feedback process, unlimited, bandwagon effect	Accumulation, legacy, importance of non-decision making	Legal evolution and legal specification of issues: instrument of framework law and its execution. Creative power of law.
Outcome: Change	Small deviation from status quo	Institutional disruption, new institutional arrangements supporting reshaped policy monopolies. New ideas take hold and have no constraints.	Consequences are unforeseeable, unpredictable. Likely big change in long term.	High, deviation from the original equilibrium, but of lower magnitude than expected. Final change is induced rather than direct consequence of original
Outcome: Continuity	High degree of policy stability and conservatism	Very Low	High in short-term, but low in long-term for the cumulative effect	High: structures of monopolies, and system of State- interests intermediation
Time Span	Short-term: five years No cumulative effect	Long term: fifty years	Long-term	Short-medium (5-10 years)

Source: Author's Elaboration

Blockages are inserted in a dynamic and developmental process of change sustained by political strategy, self-reproducing legal activity and also societal conflict. The type of activity undertaken by interest groups contributes to renewed legislative activism, as was the result of the opposition of interest groups in 1993. Dynamic conservatism is a model that simultaneously closes and opens up possibilities. Not only a neutralising strategy, it opens up the possibility of reform as a result of the developmental and cumulative nature of the legislative process, that is, the juridification of political issues, where the law becomes the substance of reform and ceases to be its instrument. This brings about a renewed politicisation of legal acts, as interest groups bring into the open otherwise covert and oblique administrative resistance.

From Particular to General Explanation: Antecedent Conditions

The extent and limits of the applicability of the theory of dynamic conservatism depends on the existence of its facilitating conditions. These could be found in other sectors or in other countries or both. Therefore, the process of dynamic conservative change is not sector specific, but rather determined by the existence of conditions which go beyond sectoral rationale. These are linked with three variables: the developmental character of the legislative process and associated system of blockages; the level of intensity of initial change introduced; and the autonomy of the administration in relation to civil society, allowing conflict and power struggle to emerge and sustain dynamism. The case of health care reforms represents the policy area in which reforms went furthest in challenging and eventually reforming the Italian state. However, additional research could be carried out in other policy areas to investigate the different conditions that did not allow for a dynamic conservative

process to be activated. This could illuminate further the extent and limits of the theory developed in this chapter.

This thesis argues that the dynamic conservative process contributed to determining the final outcome of the 1992-93 reforms of the national health care system, which was change and innovation, mainly evident at the regional level. Education and higher education, however, were not immune from legislative initiatives introducing new public management ideas.[15] For instance, in 1996 and 1997, legislative innovations in the higher education sector attempted to devolve power to single universities, establish new decision-making processes based on articulation and networks, avoid politicisation and emphasise self-regulation.[16] These reforms were met with high resistance, making them ineffective (Capano 2003). It is widely argued that in these sectors the implementation of change has not yielded the intended result (Brachetta 2002; Leonardi and Fedele 2003).

We have emphasised how far-reaching change is a crucial condition for the activation of the dynamic conservative process. This condition has not been present in education reforms. Despite the common themes of reforms across different sectors, the change adopted in education was from the start not remotely radical, as was the case in health care.[17] For instance, the transformation of local health authorities into 'public enterprises' could not be compared to the greater administrative autonomy, broadly defined, of local schools. Collegial systems of

[15] Art 21 of Law no. 59/1997 establishes the administrative 'autonomy' of schools to be implemented by means of decrees to be issued within a period of one year. See for a comprehensive analysis of the reform of Italian education in the 1990s Ventura (1998).
[16] The higher education reforms were part of the Law n.59 and Law n.127, so-called Bassanini reforms, introduced by the Prodi Government in 1996-97.
[17] For recent literature on the reform of education in Italy see Brocca (1995), Ferroni (1997), Brachetta (2002), Brocca and Frabboni (2004), Mottinelli (2004).

decision-making were not done away with in schools, as was the case with the administration of health care services. One of the most important reasons for this different degree of legislative innovation in these two sectors was the different level of institutional deficiencies of the two administrative systems, such as the pervasiveness of clientelism, more prominent in health care than education, and consequently the differentiated intervention to eradicate the problem.

Besides the more diluted legislative innovation, the missing legislative stage of regional implementation in the case of the reform of education was another crucial factor that prevented a process of dynamic conservatism, as we have discussed earlier in the chapter. The transfer of competencies and control of local health authorities from the central state to the regional governments did not have any equivalent in education.[18] Although schools were made more autonomous, they would still be under the closed supervision of the field services of the central administration, or the Ministry of Education itself. Far from arguing that modernisation coincides only with the regional management of policy areas, I suggest that, in contradistinction to the case of health care, the legislative process associated with the reform of education was not sufficiently articulated in differentiated stages of legislative development to trigger a dynamic conservative change.

The key factor generating change in the dynamic conservative process is the existence of many breaches and access points for fostering differentiation and ample flexibility. In the case of education the reform remained quite fixed from the start

[18] In the case of higher education, for instance, Law no. 341 of 19 November 1990 and Law no.127 of 15 May 1997 (Article 17, sections 95 to 101) have devolved down autonomy to universities. However, it refers only to discretion to organise their own courses and teaching rather than managerial freedoms comparable to the process of 'aziendalizzaione' in health care.

and did not allow for regional discretion. It is outside the aims of this thesis to discuss in depth the characteristics of the reform of education, but as far as the application of dynamic conservatism is concerned, the conditions emphasised in this chapter for its activation in this case were either not present or minimal. This does not exclude the possibility that a dynamic conservative process might unfold in other policy areas, including education. Dynamic conservatism is a process helping a political strategy that can be activated under certain conditions, such as initial radical change in order to benefit from the threshold effect and an articulated and flexible developmental legislative process, offered by an enabling law, legislative decrees, and regional legislation. The more polycentric the legislative function the greater is the scope for dynamic conservative change.

Another important area of further comparative study could be the applicability of the dynamic conservative model to the process of the modernisation of public services in other countries. It is likely that similar bureaucratic blockages might be found in countries like France, for instance, although they may be handled in a different way. A dynamic conservative process is more likely to be at work in blocked societies, where blockages represent complex political and sociological processes in their own right. Crozier's work suggests that the French case might offer a promising suitable case for comparison (Crozier 1970). On the contrary, it is unlikely that dynamic conservatism could be in operation in countries where societal conflict is not part of the political culture and predominant structure of the state, such as Britain. A cultural disposition towards 'conflict'[19] might provide suitable cases for the application of dynamic conservatism. Moreover, dynamic conservatism is more likely to be found

[19] Jack Hayward characterises the British political tradition, in comparative terms with the French one, as 'relatively free from conflict, frictionless' and lacking the 'bitter clashes that precede almost every innovation'. On the contrary French society managed to escape the Third Republic's immobilisme by 'crisis' and conflict. See Hayward (1974).

in political systems where the legislative function is more dispersed and fragmented rather than structured around closed and stable policy communities. Ample flexibility of legal instruments, allowing for multiple open access points, is a crucial condition for dynamic conservatism. They are unlikely to be found in legislative systems sustaining policy processes controlled firmly by few actors or few central institutions. Political systems that show a greater dispersal of institutional and political power seem more suitable for the application of a dynamic conservative process.

Conclusions

The model of dynamic conservatism suggests that non-incremental change is not necessarily the outcome of a crisis or disruption of the institutional and political system, as it has been widely held. Our model of dynamic conservatism liberates us from explaining policy change in terms of revolutionary crisis. It responds to a specific policy process to introduce grand schemes of reform, possibly over a rather prolonged timescale, by achieving two objectives: breaking the level of threshold established by the legacy of past failures, which requires embracing path-breaking change, and simultaneously mitigating with neutralising instruments the possible disruptive effects of change on traditional institutional patterns. The latter are activated at the later stages of the developmental process of reform when new institutional arrangements and policy solutions emerge. Owing to the transformation of the function of the law from instrument of political will to self-contained administrative activity, these neutralising instruments which were devised as blockages trigger new political impetus and turn into factors of change as a result of the mobilisation of political conflict over issues previously juridified. The Law does

not ossify the state, but facilitates the flexibility of an otherwise homeostatic and conservative system.

Dynamic conservatism, as it was developed in this thesis, advances the debate on policy reforms in advanced industrial democracies by considering how blockages are transformed into triggering factors of change. Blockages and changes are bound up with each other in a blend of old and new. Blockages are not given, or exogenous, but they are built in purposefully during the process of reform by those actors who mobilise against the introduction of change. Closure is maintained by the process of resistance, but openness is also ensured by the dynamic conservative process in which neutralising instruments trigger political mobilisation when new political impetus is infused in order to bring an end to immobilisme. The infusion of impetus from groups magnifies the effect of the system of blockages and sets the system on a new policy path. The cumulative effect in the long run of this motion in spirals rather than circles remains rather unpredictable, but it does offer opportunities for departure from the *status quo ante*.

The modernisation of the welfare state is certainly not only an Italian problem, but also a European challenge. The type of resistance, the process of reform, and the instruments used for policy reform vary across countries and make any generalisation a speculative endeavour. The type of resistance that Crozier described in the French administration, that is the tendency for civil servants to mask their opposition in an oblique way, is remarkably similar to the way latent impediments were built in the 1992 case. Thus, in terms of bureaucratic behaviour there are similarities between the resistance of the Italian and French public administrations. As regards the instruments used for the modernisation of the state, decentralisation of welfare

services has been discussed in other countries for some time. The current reform of the British National Health Care System is driven by the creation of foundation hospitals with great scope for autonomy from the central administration. As for the process of reform, dynamic conservatism could be applied to countries which show similar conditions to the Italian administrative and political systems, such as a public law administrative tradition, or at least a highly legalistic administrative culture, a moderately state-led system of intermediation with pressure groups, and a polycentric policy process where power is not concentrated at any one institutional level of government or at any stage.

The Italian state has found a possible way to change. The reforms of the national health care system have introduced in the Italian public sector unfamiliar and new arrangements for the efficient management of welfare services and for the reallocation of responsibilities between different levels of government. For the first time in the republican history of Italy such a far-ranging and structural reform has produced concrete change and has challenged the traditional bureaucratic patterns entrenched in the historical development of the State. Among the various factors contributing to this pioneering change, the combined effect of the managerial autonomy of rising regional managers of health care authorities and public hospitals, and the strengthening political capacity of the regions has been crucial for countering the combined resistance of national and local elites against the rise of powerful regional bureaucrats. The opposition was primarily motivated by the demands of preserving the old system of territorial politics. Regional welfare administration has developed to represent a new and alternative form of political legitimacy, based on service delivery rather than particularistic distribution through party channels. Augmented administrative and political capacity is unlikely to permit the

reproduction of the old patterns of the Italian welfare system at this level of government.

The modernisation of the Italian State is far from being complete because blockages persist and are continually built in the process of reforms. They are rarely swept away. However, the case of health care reforms has showed *the* possible way to diffuse the reform process, now it has been launched, into other sectors. For once, Tommaso di Lampedusa's widely quoted fragment from the *Gattopardo*, 'everything changes for nothing to change', which has characterised for so long the conventional wisdom about Italian politics and captured the empirical reality of the Italian state, can be converted with some confidence into, 'nothing changes for everything to change'. Paradoxically, it is the operation of resistance and the development of blockages that has offered opportunities to reform in practice the Italian state.

As an explanation for change, dynamic conservatism could be *the* way of possible change in stalled societies. As we have shown, the unrealistic scenario of revolutionary crisis in the context of the Italian political culture of consensus building and accommodation and improbable weakening of policy communities of public lawyers makes dynamic conservative change more suitable than other types of change. The second stage of the policy process, where neutralising instruments become opportunities for change, was facilitated in the case of health care by the mobilisation of regional policymakers. At present, this possibility is still inhibited by the centralisation of other welfare sectors, such as education and pensions. If regionalisation affects also these areas, the reform of the state may become a more widespread phenomenon.

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