In elections held in Italy in June 2006, the centre-left coalition headed by Romano Prodi was victorious over Silvio Berlusconi’s centre-right formation which had governed Italy since 2001. The transfer of power has been marked by some changes in health care policy, but on the whole there has been continuity. This may come as a surprise given the gulf which separates the two political groupings in most policy areas. Continuity in health policy, however, may be due to the persistence of certain structural problems in the Italian health care system.

Bipolarism in health policymaking
Italy has a constitutionally based system of regionalism. There are twenty regions with elected governors and legislative assemblies. Regional autonomy is most advanced and visible in the health care sector where responsibility is shared between central government and the regions. The State is responsible for setting health policy in broad terms and for promoting and protecting the national interest in health care. This national interest takes concrete form in the tax-financed National Health Service (Servizio Sanitario Nazionale – SSN) and in the national health care entitlement (Livelli Essenziali di Assistenza – LEA), that is services which are guaranteed to all citizens regardless of place of residence. As a result of an amendment to the Constitution in 2001, the State was required to make sure that the LEA is guaranteed to all citizens and to ensure, via equalisation grants, that all regions have the financial means to do this.

The constitutional jurisprudence has for long held that the regions have virtually complete autonomy in the organisation and administration of the regional health services. Until the early 1990s the regions were mainly concerned with the detailed design and implementation of centrally set policies such as market oriented reforms, public management, Diagnosis Related

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Grouping (DRG) based hospital financing and provider accreditation. More recently, they have become more active policy makers and less policy takers and have been innovating across the entire health policy sphere. For example, they have been active in: setting guidelines and standards (for the delivery of specific health services, accreditation of centres for assisted reproductive therapy and transplant units, etc); setting up programmes for immigrant health care, improving the diets of school children and women’s health, as well as providing additional services not specified in the LEA.

Groups of regions have agreed on procedures for regulating cross-border flows of patients. Regions have also organised schemes for centralised purchasing of services and equipment and have experimented with complex accounting systems. Finally, some regions are funding medical and health services research. The constitutional amendment of 2001 then formalised this autonomy which the regions had begun to accumulate on an ad hoc basis over the years. Health policymaking in Italy has therefore two distinct loci – the State and the region.

Asymmetry and the problem of regional accountability

In contrast with the thrust of the regions for power, the State in the second half of the 1990s seemed to be gradually withdrawing from proactive health care policy making with the important exception of health care financing and expenditure control.

The SSN has been plagued virtually from its birth by a lack of regional accountability due to asymmetry between spending and revenue raising responsibilities. Taxation had been centralised in Italy in 1971; when the SSN was set up in 1978 it was believed that the national interest in health care required central financing. The regions in consequence lacked any significant own-source revenues. At the same time, constitutional limitations on central intervention in the running of the SSN meant that the State had very limited influence over how the regions used their grants. Inevitably, the regions failed to live within the means provided to them and ran up deficits. The State tried to contain aggregate spending with a policy of deliberate under-financing, in the hope that fiscal stress would induce the regions to economise and rationalise their spending. Instead, this tended to aggravate deficits. Repeated measures to make the regions responsible for their deficits founded because of their lack of revenue raising powers. From the mid 1990s, the State granted the regions important taxes, in particular a ‘piggy-back’ tax on the national personal income tax, a regional business tax and a motor vehicle tax. A few regions have become completely self-sufficient, but most still rely to some degree on central financing, some very heavily so. This in part reflects wide disparities in regional tax bases: Using Gross Domestic Product (GDP) per capita as an appropriate measure of regional tax take, in the northern Lombardia region this was 28% higher than the national average, compared with the southern region of Calabria where it was 35% lower than the national average.

These differences in tax bases, combined in some regions with weak administrative and technical capacity and set in a context of substantial regional autonomy, meant that over time there was a growing divergence in the character of health care available in the individual regions. The fear was that the integrated SSN risked being replaced by a loose-knit federation of heterogeneous regional health systems, placing in serious jeopardy the national interest in health care. Moreover, year after year, the regions continued to report deficits, accumulating over time a mountain of debt, some of this dating back as far as 1994. Something had to be done.

The external budget constraint

The irony is that, contrary to what the chronic deficits in the SSN might suggest, public spending on health care spending in Italy was, and continues to be, relatively low by international standards: 6.4% of GDP in 2004 compared with the OECD-Europe average of 6.6%. Expenditure per head in 2004, at purchasing power parity, was $1,828 compared with an OECD-European average of $1,942.1 The problem lies elsewhere. Italy has built up a large public debt over time, currently equivalent to 107% of GDP. This has heavily constrained spending options. To illustrate the magnitude of this debt, if this could be halved, $35 billion per annum in interest payments could be avoided.2

This opportunity costs of servicing the public debt include foregone expenditure on health care and other public services, reduced investment in infrastructure and limited scope to reduce taxes. It has meant that for public health care Italy cannot afford per capita spending levels similar, for example, to those in Germany, France or the UK, unless it cuts expenditure elsewhere or increases tax levels. In addition, as a condition of membership of the European Monetary Union, Italy had to undertake to maintain an overall balance in the public budget and to substantially reduce its public debt. Living with such a hard budget constraint means rigorous central planning of aggregate public expenditure levels; chronic divergence between planned and actual spending cannot be permitted, especially in a sector as large as health care. Meantime, economic and political considerations rule out the option of increased national taxation.

Changing the balance

The need to impose a hard budget constraint in public health care was all the greater because of the approval by referendum of the constitutional amendment in October 2001. This, among other things, consolidated the autonomy of the regions and placed an obligation on the State to guarantee that the regions had sufficient resources to deliver the LEA. The outcome of the referendum had already been anticipated by the Berlusconi government elected in May of that year. Foreseeing the need for a re-adjustment in the intergovernmental balance of power, they negotiated an accord with the regions barely three months later.3 This accord of 8 August 2001 provided for central aid to the regions to help them eliminate their accumulated deficits, but only on condition that they demonstrated concretely how they planned to avoid future deficits, including resorting to increased regional tax rates, patient co-payments, property sales and steps to reduce unnecessary and inappropriate care and labour costs. An important innovation was the imposition of rules on allocating the blame between the State and the regions for deficits and, therefore, responsibility for funding them. For example, a distinction would be drawn between increased expenditure due to a higher wage bill as a results of nationally negotiated labour contracts and new expenditure stemming from regions providing services not included in the LEA.

Seen in retrospect, the 2001 accord was a watershed in intergovernmental relations in health care. Cooperation replaced confrontation. However, the accord on its own proved insufficient to put a stop to regional deficits. Over the period
2002–2005, a total deficit of €20,851 million was accumulated. Using the new rules, almost 84% of this sum was attributable to the regions.4

On March 23 2005, another State-region accord was signed under which, in return for help in eliminating the deficits accumulated in the period 2001–2005 and any remaining debt incurred before 2001, the regions accepted considerably tougher conditions.3 As with the 2001 accord, they had to prepare detailed proposals for balancing their future budgets, plus describing how they intended to cover any deficits that should occur. The regions had also to agree to transmit detailed information to the central authorities on the operation of their health services; this information had to conform with definitions set by the New System for Health Information (NSIS) operated by the Ministry of Health. Additionally, they were required to introduce in all facilities detailed accounting systems based on cost centres. Other conditions included action being taken to rationalise the hospital sector, in particular reducing the bed stock and creating alternatives to inpatient care such as day hospitals, ambulatory surgery, domiciliary health care and extra-hospital residential and semi-residential care.

Heavy emphasis was given to the need to integrate these delivery options to secure seamless care. State financial help in tackling their budget imbalance would be granted only after external appraisal of the regions’ actions. 5% of the annual state funding to a region to finance the LEA entitlement would be withheld until the central authorities were satisfied that the conditions contained in the accord had been met.

A survey of regional health policy in 2005–2006 found that the bulk of the regions were trying hard to meet these conditions.5 In the closing months of the Berlusconi government in 2006, the financial screws were turned ever tighter on those regions still running serious deficits. The bulk of the deficits (64.4%) were run up by just seven regions.4 Eligibility for state aid to these regions was made dependent on their preparing a Budgetary Balance Plan (Piano di Rientro) which would serve as the basis for a bilateral accord between the individual region and the State. This Plan had to provide as precise an estimate as possible of the region’s indebtedness, calculated with the help of an Advisor Bank nominated by the Ministry of the Economy and Finance. Debt had to be

renegotiated with creditors; the State helped to lighten the annual burden to a region of debt repayment by making it a long term loan repayable in thirty annual instalments.

The Plan had to include measures aimed at resolving the problem of structural budgetary imbalance, including further increases in regional tax rates. These measures were to be designed by each region working closely with a team of experts nominated by, and reporting directly to, the Ministry of Economy and Finance. In addition, each region was expected to enter into a ‘partnership’ with a region in budgetary balance, with a view to facilitating the procurement of know-how and experience. The seven regions were subject to strict data reporting requirements, continuous monitoring, as well as quarterly and annual in-depth appraisals. Regions receiving aid under these terms were in effect under special surveillance.

The Prodi government, which took office in June 2006, continued this policy and set itself the target of regional budgetary balance by 2009. A State-region accord, called A Pact for Health and signed in September 2006, laid out the strategy to be followed.6 The Prodi government increased the resources going to the SSN for fiscal years 2006 (via supplementary funding) and 2007. The proportion of the state grant to be retained until the central authorities are satisfied that the conditions have been met was however reduced to 3% for 2007.

A Transition Fund has been set up to provide additional aid to the regions with serious deficits, provided of course they meet the conditions included in the various accords. Those running a deficit in 2006 equal to or more than 7% of planned spending have been classed as “regions in difficulty”. Three such regions accounted for 75% of the total national deficit in 2006 (Lazio, where Rome is located, Campania, including Naples, and Sicily), while another four (Abruzzo, Molise, Liguria, Sardinia) also meet the 7% criterion. The State signed bilateral accords with five of these regions in February 2007 and with the remaining two in July.

Wielding the spending power
Central strategies to rein in regional deficits have heavily conditioned regional options on the financial plane. The seven ‘regions in difficulty’ are in such dire financial straits that they have been prepared to accept severe limitations on their freedom of action. This exercise of central spending power represents a dramatic break with the period pre-2001 when state financing was granted virtually unconditionally. Central grants had tended to be seen as going to finance expenditure considered to be essentially rigid in the short to medium term. Moreover, these grants were intended to help finance the LEA which the State and regions were constitutionally obliged to guarantee. Finally, there was a tendency in Italy to see regional autonomy as a situation whereby there would be minimal central interference on how funds from the centre were spent. This meant that central government in Italy lacked the instruments to influence regional policy in health care to any significant degree. Italy had differed here from other countries with decentralised systems of government, such as Australia, Canada and the USA, where the federal governments have always made heavy use of the power of the purse – spending power – to condition the health policies of sub-central governments.

Now, under the State-region accords described above, the central government is trying to do just this – use its spending power to condition regional budgetary policies. And it is going further. The Berlusconi government saw a window of opportunity and used the weakened bargaining power of the regions stemming from their precarious finances to impose additional conditions aimed at influencing regional policies on the provision of health services. There seem to have been several motivations for this. First, there was concern that, with the imperative to balance their budgets, the regions might evade their constitutional obligation to provide the LEA. Second, as noted earlier, regional autonomy plus differences in tax bases and administrative capacity risked creating excessive geographical heterogeneity in the SSN and damaging the national interest in health care. Third, the central government may have been trying to re-assert the constitutional power to set the broad direction of health care policy that had been placed in question by the regions’ thrust for autonomy during the 1990s.

Thus, the 2005 accord required, as an additional condition for receiving supplementary funding and the 5% retention, that the regions design programmes to implement national plans for prevention, training and revalidating SSN staff and
Reducing waiting lists. Additional state funding was available for this, provided the regions also met part of the cost.

The regions have responded positively here. For example, all regions had announced measures to cut waiting lists by March 2007 and most had published strategies on prevention by the end of 2006. In addition, as already noted, the 2005 accord contained requirements regarding the rationalisation of the hospital sector and the integration of health care delivery options. The regions continue to have wide discretion in the design and administration of programmes, but it is a measure of the effectiveness of the centre’s spending power that they have accepted policy directives from the centre which only a few years ago would have been immediately contested in the Constitutional Court or possibly just ignored. Another likely reason for regional compliance is that the national strategies have been negotiated by the State and regions and included in the accords as annexes.

The Prodi government has continued the strategy of using central spending power to influence health care service provision by the regions. Regions are required to submit to regular appraisals and monitoring by teams attached to the Ministry of Health with the specific purpose of verifying that the regions are meeting their LEA obligations.

Over and above requiring continued regional action in the specific fields targeted by the Berlusconi government, the Prodi government has created an ad hoc fund for the co-financing of projects in other fields, for example women’s health, rare diseases and spinal units.

The new government has also continued to encourage intergovernmental cooperation and has taken it further. It called for “a new form of shared government” and urged a “cooperative and consultative approach”. One of its first initiatives was the presentation in Parliament in July 2006 of A New Deal for Health [Un New Deal della Salute]. This strategy went beyond state-regional cooperation (addressed in the Pact on Health) and covered all the stakeholders in the health care system. As part of the New Deal, the Ministry of Health is cooperating with other ministries in investment programmes in health care in southern Italy, financed in part with European Union funds, and in initiatives to promote population health. It has also signed agreements for the promotion of population health with voluntary associations, patient groups and consumer organisations. Finally, it has set up a broad swathe of ministerial commissions and working parties involving the health care professions, with briefs to make recommendations regarding, for example, AIDS policy, doping in sport, appropriateness of medical prescriptions, pain therapy and palliative care, immigrant health care, stem cell research, women’s health and vaccination policy.

Prospects
Continuity in national health care policy since the early 2000s reflects the persistence of imbalance in regional health care budgets, particularly for the ‘regions in difficulty’. It also derives from the search for compatibility between the pursuit of the national interest in health care and strong regional autonomy. Finally, continuity is the result of the need for national government to respect the hard external budget constraint accompanying membership of the European Monetary Union.

An important development has been the use of central spending power to influence regional policies, but what may prove to be equally significant is the emergence of a form of ‘cooperative regionalism’. The two are corollaries: the bitter pill for the regions of the exercise of central spending power may be made easier to swallow by intergovernmental negotiation and cooperation in policy design and implementation. This would represent a break with a past characterised by State-region conflict and mutual incomprehension regarding the adequacy of central funding.

The strategies developed over the past six years may now be producing results. The majority of the regions appear to have their financial situation under control and the ‘regions in difficulty’ are under strict surveillance. It remains to be seen if it is possible to modify markedly the structural factors contributing to large deficits, at least within the short time frame set by the Prodi government. It is also an open question as to how long the ‘regions in difficulty’, particularly those with lower than average tax bases, can sustain the higher than average tax levels which they have had to include in their Budgetary Balance Plans. The other side of the coin is that some of the ‘virtuous’ regions which have attained budgetary balance are unhappy with the special treatment given to the ‘regions in difficulty’ via the Transition Fund, complaining that this is tantamount to rewarding improvidence. Further subsidies of this kind could be opposed.

Using spending power to influence the provision of health services may also be problematical. The regions do seem to have responded positively and are setting up programmes to implement national policies for prevention, waiting lists, integrated care processes, etc., but it is one thing to prepare programmes, it is another to implement them actively. It also remains to be seen if these programmes will produce the desired results, including containing costs. In any case, it is inevitable that there will be inter-regional differences here. But at least central policymakers do seem to have learned, albeit belatedly, a basic law governing policy-making in systems of decentralised government. This is, if it is to attain its goals, a central government needs the cooperation of subcentral government just as much as subcentral government needs its funding.

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