Health Care Regionalization in Italy

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ABSTRACT
This work aims at bringing into focus the main change that the Italian National Health Service has been undergoing over the past twenty years, namely the gradual transfer of jurisdiction from the central government to the regions. Starting with the 1992-1993 reform the regions were indeed granted broad latitude in organizing health care services in their own territories. The individual regions have thus been able to choose among various organization models, differing from each other in a variety of aspects. During the past years, frictions between central government and regions have been frequent. The central government has often accused the regions of being financially irresponsible and overrunning systematically the spending levels assigned to them; for their part, the regions have regularly accused the central government of allocating an inadequate amount of resources to the National Health Service.
Introduction

The National Health Service (Servizio Sanitario Nazionale, SSN) in Italy was established in 1978 and is mainly financed through general taxation. The SSN is committed to guaranteeing people resident in Italy (not only Italian citizens but also foreigners who hold a permit to stay in the country) a broad range of health services. The benefits package provided by the SSN includes preventive services, hospital care, family doctors and specialist services. Dental care, rehabilitation and vision care are – on the contrary – largely excluded. Two thirds of the healthcare funded by the SSN is issued by public suppliers (belonging to the SSN), while one third is provided by private suppliers holding special agreements with the public service.

During the last two decades, Italy, along with other European countries (Saltman et al. 2007; Adolph et al. 2012; Costa-i-Font and Greer 2012), has been experiencing a progressive transfer of competencies in the health sector from the centre to the regions. Since the early 1990s, every Italian regional government has autonomously planned and organized the healthcare services in its own territory. The autonomy enjoyed by Italian regions is such that some consider it no longer appropriate to talk of a single national health service, but rather of a federation of twenty different regional systems (Mapelli 2012).

The aim of this paper is to offer a rough description of the regionalization of the health service underway in Italy. We start from the reconstruction of the regulatory framework, focusing specifically on the dynamics triggered by this process. The individual regional governments are making different use of the independence granted to them. As a result, significant differences are emerging between one region and another, and the gap between the north and south of the country is particularly worrying.

The ‘regionalized’ arrangement of the Italian SSN is also generating constant friction between central and regional governments. The former is required to guarantee a certain uniformity of the services throughout the whole country. It must also ensure that the regional governments do not exceed the budget assigned to them. The regional governments, on the other hand, accuse the central government of failing to allocate sufficient resources to funding the SSN. The breakdown of the healthcare budget is also generating disagreements from region to region. Regional governments that manage to stay within their allocated budgets have no desire to take on the debts of those regions that are financially less disciplined, and they argue for criteria for the breakdown of the national health fund that reward the better managed regional systems.

The regionalized arrangement of the Italian National Health Service

Italy is divided into twenty regions. One of these, Trentino Alto-Adige, is made up of two ‘autonomous provinces’ (Bolzano and Trento), each of which manages its own healthcare system independently. The Italian Constitution, which came into force in 1948, assigns five regions (Friuli-Venezia Giulia, Sardegna, Sicilia, Trentino-Alto Adige and Valle d’Aosta) the status of ‘special statute region’. Compared with ‘ordinary statute regions,’ special statute regions enjoy

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1 In this work, the Italian regions are grouped as follows: Centre-North (Valle d’Aosta, Piemonte, Lombardia, Veneto, Friuli-Venezia Giulia, the autonomous provinces of Trento and Bolzano, Liguria, Emilia-Romagna, Toscana, Umbria, and Marche), and Centre-South (Lazio, Campania, Molise, Abruzzo, Puglia, Basilicata, Calabria, Sicilia, and Sardegna).

2 These regions obtained special conditions of autonomy because of their geographic isolation (this is the case of Sicilia and Sardegna) and their linguistic-cultural peculiarities (linguistic minorities are present in Trentino-Alto Adige, Valle d’Aosta, and Friuli-Venezia Giulia).
greater legislative and financial independence. The special statute regions were the first to be established, during the late 1940s (with the only exception of Friuli-Venezia Giulia, established in 1963). The remaining fifteen regions, on the other hand, came into being only in 1970 (Cotta and Verzichelli 2007).

The law 833 of 1978, which established the SSN, should have involved – at least on paper – a substantial transfer of responsibilities to regions. However, during the 1980s, the regionalization process advanced slowly. In fact, the regions still depended entirely on transfers from the central government and had administrative structures still weak and in a build-up phase (Mosca 2006; Helderman et al. 2012): they ended up, therefore, exercising only in part their prerogatives, limiting themselves to a role substantially subordinate to the central government.

The health care reform of 1992-1993 proceeded to change the balance. This reform granted broad discretion to the regions in planning, organizing, and financing health care services in their own territory. The regional governments acquired the control – earlier a concern of municipalities – over the local health agencies, whose general managers they could appoint. All things considered, the 1992-1993 reform had the effect of increasing considerably the powers of the regions, which became thus the level of government having the largest responsibilities in the health care context (Tediosi et al. 2009).

A further step forward in the process of regionalization was represented by the constitutional reform of 2001. On the basis of this amendment, health care has become the object of ‘concurrent’ legislation between State and regions: this means that the regions have full autonomy in organizing and managing health care services in their own territories, while the State must confine itself to formulating general principles. The constitutional reform of 2001 represents then the final stage of an intense process of regionalization that in less than ten years has transformed the SSN from a substantially centralized system into a highly regionalized one (Fiorentini et al. 2008).

Organization of the SSN on three levels
The Italian National Health Service is currently structured on three levels: the national level consists of the Ministry of Health, the intermediate level is represented by the regional governments, and the healthcare agencies provide service at local level. Each of these three levels is assigned specific functions.

At the national level, despite the fact that reforms over the past twenty years were intended to promote accentuated decentralization, the Ministry of Health still plays a central role in the coordination of the SSN. Firstly, the Ministry of Health is responsible for determining the overall budget for the SSN. Despite years of talks about fiscal federalism, the purse strings are still held by the central government (Ferrario and Zanardi 2011). A second strategic task assigned to the Ministry of Health regards the definition of the so-called ‘essential levels of assistance’ (Livelli essenziali di assistenza – LEA). LEAs are the services that the public health system undertakes to provide for everyone in the country, on a uniform basis. In other words, LEAs correspond to the ‘package’ of services guaranteed by the SSN to all those assisted free of charge or in exchange for a prescription

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3 The LEAs are defined on the basis of two schedules: a positive schedule of services that each region must supply to its residents; and a negative schedule listing the services considered ‘non-essential’ following criteria of efficacy, efficiency, and clinical advisability (Torbica and Fattore 2005; Fiorentini et al. 2008). The list of essential services is very long and currently comprises over 5,700 types of service.
charge. The definition and update of the list of LEAs is a crucial activity in the relationship between central and regional governments, in that the amount of resources allocated by the State to fund the SSN should be based on the determination of the essential levels of assistance (Torbica and Fattore 2005).

Now we are going to move on to the regional level. As mentioned earlier, the Italian Constitution places healthcare among the matters of ‘concurrent’ legislation between State and regions. Basically, this means that the autonomous provinces and regions – while observing the general principles laid out by the national government – can establish the priorities and the objectives to pursue in the healthcare sector, and decide how to divide resources among the various spheres of assistance. The regions are able to implement the most diverse strategies and models, arranging their regional healthcare system in the way they see fit. This means that the individual regional government is responsible for identifying hospitals to turn into hospital agencies and deciding how many local healthcare agencies to divide their territory into. The appointment of the general managers of the healthcare agencies is also the responsibility of the regional council and it is at regional level that the criteria for crediting and remunerating both public and private suppliers are established.

Last, but by no means least, is the local level. The healthcare agencies, set up following the 1992-93 reform, operate at this level. They are split into two categories: local healthcare agencies (aziende sanitarie locali – ASL) and hospital. The local healthcare agencies are required to guarantee that people receive all the services included in the essential levels of assistance (LEA). In saying that the ASL have to ‘guarantee’ specific services does not mean that they necessarily have to be provided directly by the ASL, which can assign the provision of part of their services to independent suppliers. The whole Italian territory is currently divided into just over 140 ASL, with an average number of about 412,000 people served by each agency.

Some hospitals have been separated from the respective ASL and transformed into independent hospital agencies (aziende ospedaliere - AO). In most cases, it is the larger and most specialized hospitals that have been transformed into AO. There are currently about eighty AO throughout Italy. Public hospitals that are not independent agencies continue to be productive establishments within the respective ASL; they enjoy limited independence compared to the hospital agencies. Every healthcare agency is headed by a general manager who is appointed by the regional government.

Budget restrictions and the future sustainability of the SSN
For several years now, the Italian government has been committed to reducing the public debt, partly in order to fulfill the obligations undertaken at the European level. The budget restrictions imposed upon the countries belonging to the Eurozone became even stricter with the entry into force, from 1 January 2013, of the Fiscal Stability Treaty (the so-called ‘Fiscal compact’). This imposes upon countries in severe debt, like Italy, the obligation not only to keep the public deficit below 3 per cent (as already envisaged by the Stability and Growth Pact signed in 1997), but also to reduce the public debt by 5 per cent every year.

In recent years, Italy has succeeded – thanks to considerable efforts – in reducing its public deficit, which fell progressively from 2009 to 2012 from 5.5 per cent to 3.0 per cent of the GDP. The progress made in terms of the public deficit has not however made it possible to reduce the public debt, which – on the contrary – had continued to grow. In 2013, in Italy, the ratio between public debt
and gross domestic product has risen above 133 per cent. Of all the member states of the European Union, Italy has the highest public debt after that of Greece (Eurostat 2013). If we also consider that the growth forecasts relating to the Italian economy for the near future are not particularly positive (a 1.8 per cent drop in GDP has been recorded in 2013), it is easy to see how important it is for the Italian government to keep public spending under control.

This is where the healthcare sector comes into play. The Italian National Health Service accounts for over 16 per cent of Italy’s public spending, and provides jobs for over 680,000 employees, corresponding to 20.8 per cent of all public employment. The healthcare sector easily represents the main sector subject to regional intervention. If we look at the budgets of the ordinary statute regions, we can see that they allot over 80 per cent of said budgets to healthcare.

The healthcare sector cannot, however, be considered as nothing more than a public spending item. The healthcare system – which includes not only outpatients and hospital services, but also the pharmaceuticals sector and the medical device industry – plays a leading role in the Italian economy. It is worth over 11 per cent of the GDP (Confindustria 2012). Healthcare provides employment for over one and half million people and this figure rises to 2.8 million if we also consider collateral activities. In view of the data supplied by the Ministry of Economic Development (Ministero dello Sviluppo Economico 2012), healthcare is the country’s fourth most important production sector, after constructions, farming and ICT.

The debate on the future sustainability of the SSN

The public health service seems to be crushed in the grip of two opposing needs: on one hand, the need to keep public spending down and, on the other, the need to avoid holding back the development of an important productive sector. This is why the debate on the future sustainability of the Italian National Health Service has been raging for some time in Italy. The crux of the matter is basically the following: will there be sufficient resources to maintain the SSN at its current levels of intervention in the future? Concerns relating to the future sustainability of the Italian National Health Service are based upon two forecasts, both of which are quite plausible. The first is that, in future, the demand for health services by the population will tend to increase, while the second is that, in the years to come, the resources allotted to fund the SSN will probably be cut and, in any case, will not be increased in proportion to the growing needs of the people.

It is easy to predict an increase in the demand for healthcare in the near future, due not only to the continuing progress of medical techniques, but especially to the progressive ageing of the Italian population. The life-expectancy of Italians is becoming longer and longer and consequently people are being increasingly affected by chronic and degenerative illnesses. It is expected that over-65s, who currently account for 20 per cent of the population, will represent about 33 per cent of the entire Italian population in 2050 (Ministero del Lavoro e delle Politiche Sociali 2011). The demographic trend is a source of concern also because it will be accompanied, in the years ahead, by a more than likely reduction in the financial resources available to the public health service.

Let us consider the trend in state funding of the SSN, portrayed in figure 1: until 2012, the central government was able to accumulate more and more resources every year to fund the public health service. Between 2001 and 2012, the average growth rate of the national healthcare fund was 3.9 per cent per annum. Things have changed since the beginning of 2013. In 2013, for the first time, the state funding of the SSN has fallen in absolute terms compared to the previous year, from 108 to 107 billion euros.
The effects of the austerity policy are starting to become evident in Italy, too: as in other European countries, Italy is responding to the economic crisis by cutting social spending, comprising expenditure for healthcare (Mladovsky et al. 2012; Karanikolos et al. 2013).

One of the first consequences of cuts to the SSN could be the increase in spending for private healthcare. As a result of the reduction in funding of the public health service, families inevitably end up spending more for healthcare (Censis 2012). Remember that spending for healthcare in Italy is divided between the SSN, which takes on about 78 per cent, and the people, who pay the remaining 22 per cent (OECD 2013). The overall cost of the Italian healthcare system corresponds to 9.2 per cent of the GDP.

Of the total spent on private healthcare, over 82 per cent is out-of-pocket. The high incidence of private spending – particularly with regard to the out-of-pocket component – can be attributed to the fact that certain categories of healthcare services are not adequately covered by the public service and are, therefore, left largely to the private market. Today, 92 per cent of dental treatment, 64 per cent of gynaecological treatment and 57 per cent of diet-related treatment (Collicelli et al. 2012) is carried out by the private sector – without intervention by the SSN. If the State reduces its funding of the SSN, these percentages risk further increases.

The disputes between the State and the regions

In order to understand the dynamics triggered by the regionalization of healthcare and the relationships that are created between the different levels of government of the SSN, it is worth...
concentrating on the mechanisms used for the funding of the entire system. The methods via which financial resources flow in are particularly good at revealing the tension that exists between the various stakeholders.

The determination and breakdown of the national healthcare fund

The SSN is funded according to a typical sequential process. First of all, the total amount of resources to be allotted to the National Health Service is determined. The budget allocated at national level is then split among the regions. In turn, every region splits its budget among the healthcare agencies and, lastly, the ASL use the resources assigned to them to pay the public and private suppliers of the health services. The first step in the funding process is the responsibility of the national government, which has to decide the extent of the resources to allot to the SSN every year. Since 2001, efforts had been made to plan the budget on a three-year basis. In negotiating the so-called ‘Health Pact - Patto per la Salute’\(^5\) with the regions, the government developed the habit of indicating the amount of resources it was going to allot to the SSN in subsequent years. This planning was, however, subject to review and the government was often forced to cut the amounts agreed to. These national government rethinks were, naturally, cause for complaint by the regional presidents.

The disputes between the State and the regions regarding the extent of the national healthcare fund go back a very long way. It is at least since the early 1990s that the regions have been accusing the government of systematically allotting insufficient resources to the SSN. Some scholars claim that the underfunding of the SSN has been a deliberate strategy by the national government pursued, also recently, with the hope of keeping the increase in spending for public health as low as possible (France et al. 2005; Mosca 2006; Mapelli 2012).

After establishing the total amount of the resources to be allotted to the SSN, the next step consists in dividing these resources among the regions. We ought to point out that the matter of splitting up the budget is very different from sourcing resources. The structure of the conflict changes dramatically depending on the matter in hand. During the phase in which the decision is made regarding the amount of resources to allot to the SSN, the regions join forces against the national government, exerting pressure on it so that as much money as possible is allotted. Then, when they move on to discussing the criteria to be applied to the division of the budget, the regions find themselves competing against one another, with each one pressuring for the criteria that will afford it the greatest benefits during the division of the available funds. The methods used to divide the healthcare budget are subject to heated debate.

In recent years, the division of the healthcare fund has taken place mainly on the basis of the number of residents in every region. In addition to the number of residents, the age of the regional population has also been taken into partial consideration (Caruso and Dirindin 2012). This means that regions with a higher average population age have been assigned more resources than those with a younger population. It is a well-known fact that consumption for healthcare rises considerably as people age. It seems, therefore, understandable that the regions with an older than average population insist on the implementation of a division formula that takes into greater account the age of its residents. Obviously those regions – mainly in the Centre-South – with a younger population have the exact opposite aim.

\(^5\) The ‘Health Pact’ is an agreement, signed by the national government and by the regions every three years, outlining the strategic orientations relating to the planning and funding of the public healthcare system.
Law n. 42 of 2009 provides that, from 2013, transfers to the regions shall be calculated on the basis of the so-called ‘standard costs’. In short, some benchmark regions that stand out from the others in terms of efficiency and appropriateness in the disbursement of healthcare services are identified. The standard cost corresponds to the spending per capita sustained by the benchmark regions to ensure that the essential levels of assistance are provided. The financial resources transferred by the central government to the single regions are calculated on the basis of these standard costs. The introduction of the standard costs should, therefore, encourage less efficient regions to fill the gap that separates them from the benchmark regions. We will see whether or not it works.

The regional deficits and the budget balance plan

On the basis of the above procedure, every region will be allotted its share of the national healthcare fund. The division has nothing to do with the fiscal capacity of the individual regions, which receive more or less the same amount per capita, with which they are required to guarantee the essential levels of assistance throughout their regional territory. Some regions manage to stay within the budget allotted to them, while others do not and spend more. For several years now, it has become standard practice – among those operating in the sector – to separate the ‘virtuous’ regions (whose accounts are in line) from the ‘vicious’ regions (whose accounts are characterized by heavy and recurrent management deficits). The operating result becomes an important criterion for assessing the ability of the regional governments to manage their own healthcare system.

As emerges from the reading of table 1, many regional healthcare systems find it difficult to reach an economic-financial balance. The third column indicates the operating result for 2012 (in euros per capita) for every region: the ‘+’ and ‘-’ signs indicate a positive or a negative balance. All the healthcare systems of the central-northern regions, with the exception of Liguria and Toscana, reach a financial breakeven. The healthcare systems of the Centre-South regions, on the other hand, with the exception of Abruzzo and Puglia, are in the red. The regions in the most severe conditions are Sardegna, Lazio and Molise.

The table also indicates the healthcare deficit accumulated, once again per capita, with reference to the period from 2001 to 2011. In this case, it being an accumulated debt, the negative sign indicates an operating asset. We ought to acknowledge that, alongside certain ‘good’ regions (particularly Friuli-Venezia Giulia), there are others (especially Lazio, Molise, Campania and Sardegna) that, in recent years, have accumulated a very large healthcare debt. Remember that, in absolute values, the deficit accrued during 2012 by all the regional healthcare systems was 1.04 billion euros. This can also be considered as positive: in 2001, the overall deficit amounted to 4.1 billion euros. This means that, from the early 2000s onwards, many (but not all) regional governments have considerably reduced their operating deficit.

Northern regions and Southern regions have, however, contributed differently to rebalancing the accounts. From 2001 to 2012, the central-northern regions have reduced the average deficit per capita from 46 to 0.1 euro, almost reaching a breakeven. The southern regions have progressed less than their northern counterparts. In the period from 2001 to 2012, the average deficit per capita of the Centre-South regions – most of them are all still in the red – has gone from 104 to 39 euros.
The gap between North and South emerges even more clearly if we assess the extent by which the single regions contribute to the overall deficit. If we consider the deficit accrued by all the regional systems on a scale of 100, in 2001 the northern regions accounted for 35 per cent of the total deficit, while the southern regions accounted for the remaining 65 per cent. In 2012, the northern regions are responsible for a mere 6 per cent of the total deficit, 94 per cent of which is generated by the southern regions. Campania and Lazio alone are responsible for 64 per cent of the overall deficit of all the regions put together.

To gain a better understanding of the trend in regional healthcare deficits from 2001 to the present day, we should take a look at the so-called ‘budget balance plans’. We can date the beginning of the story back to the August 2001 State-regions agreement (Tediosi et al. 2009). The agreement consisted in this: the government made additional resources available in order to settle the debts accrued up until then by the regional healthcare systems. In exchange, the regions made a commitment to cover any deficits generated from 2001 onwards using their own resources. In subsequent years, some regions respected the commitment undertaken. This was possible thanks to

Table 1 – The regional healthcare deficit (2001-2012)

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<thead>
<tr>
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<tbody>
<tr>
<td>Piemonte</td>
<td>216</td>
<td>+4</td>
</tr>
<tr>
<td>Valle d'Aosta</td>
<td>936</td>
<td>+8</td>
</tr>
<tr>
<td>Lombardia</td>
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<td>0</td>
</tr>
<tr>
<td>Bolzano</td>
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<td>+14</td>
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<tr>
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<td>+4</td>
</tr>
<tr>
<td>Veneto</td>
<td>81</td>
<td>+1</td>
</tr>
<tr>
<td>Friuli V.G.</td>
<td>-163</td>
<td>+8</td>
</tr>
<tr>
<td>Liguria</td>
<td>892</td>
<td>-19</td>
</tr>
<tr>
<td>Emilia-Romagna</td>
<td>86</td>
<td>0</td>
</tr>
<tr>
<td>Toscana</td>
<td>122</td>
<td>-13</td>
</tr>
<tr>
<td>Umbria</td>
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</tr>
<tr>
<td>Marche</td>
<td>273</td>
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</tr>
<tr>
<td>Lazio</td>
<td>2,470</td>
<td>-111</td>
</tr>
<tr>
<td>Abruzzo</td>
<td>922</td>
<td>+39</td>
</tr>
<tr>
<td>Molise</td>
<td>2,083</td>
<td>-101</td>
</tr>
<tr>
<td>Campania</td>
<td>1,500</td>
<td>-21</td>
</tr>
<tr>
<td>Puglia</td>
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<td>+3</td>
</tr>
<tr>
<td>Basilicata</td>
<td>461</td>
<td>-29</td>
</tr>
<tr>
<td>Calabria</td>
<td>723</td>
<td>-33</td>
</tr>
<tr>
<td>Sicilia</td>
<td>860</td>
<td>-3</td>
</tr>
<tr>
<td>Sardegna</td>
<td>1,120</td>
<td>-127</td>
</tr>
<tr>
<td><strong>Italy</strong></td>
<td><strong>652</strong></td>
<td><strong>-17</strong></td>
</tr>
</tbody>
</table>

Source: Ministry of the Economy and Finance, General Report on the Economic Situation in Italy (various years).
the reorganization of services and a reduction in expenditure (cutting the number of hospital beds, closing small hospitals, reorganizing territorial services, limiting the use of private suppliers and unifying purchases). Nevertheless, some regions, particularly in Southern Italy, continued to accumulate significant deficits.

Consequently, a few years after the 2001 agreement, State and regions had to negotiate a new agreement. The aim of the central government was to interrupt, once and for all, the perverse circuit according to which the less disciplined regions were always saved by the national government, which agreed to cover their debts after they had been run up. In autumn 2006, the first ‘Health Pact – Patto per la Salute’ was drawn up and the national government made a commitment to find new resources to settle previous debts. From then onwards, the financial support for regions in difficulty was to be conditional to the signing of a specific budget balance plan, aimed at settling the balance. If a region were to be unable to respect the budget balance plan, the government would have had the power to take away the regional government’s power to manage the healthcare system, entrusting it to a compulsory administrator appointed by the national government.

Applying the ‘Health Pact’, starting from 2007, the regions with the greatest deficits were forced to draw up strict budget balance plans in agreement with the Ministries of Health and the Economy. This happened in 2007 to Lazio, Abruzzo, Liguria, Campania, Molise, Sicilia and Sardegna, and the other regions that followed them in the signing of a budget balance plan were Calabria (2009), Piemonte and Puglia (2010). As was to be expected, some of these regions were unable to fulfil the obligations entered into in the budget balance plans. Therefore, the government had to intervene, appointing a compulsory administrator for the regions in greatest difficulty. The first to be placed under compulsory administration were Lazio and Abruzzo (in 2008), followed by Campania, Molise (2009) and Calabria (2010). Naturally, the signing of a budget balance plan (and entry into compulsory administration even more so) implicates a loss of sovereignty by the regional government. The latter has to observe the restrictions and the instructions imposed mainly by the Ministry of the Economy.

It is important to point out that profound differences among the twenty regions already existed even before the reforms of the 1990s. The Italian regions have always been different in terms of size, economic development, civic culture, and institutional performance, with a sharp cleavage between the north and the south of the country (Banfield 1958; Putnam 1993; Cotta and Verzichelli 2007). From an economic point of view, the northern regions are, in fact, traditionally more developed than the southern ones, and, still today, they have a higher per capita income: it exceeds 27,500 euros in the northern regions, while it is 18,200 euros in the southern regions. However, such a disparity at the economic level is not reflected in the public health spending of the Italian regions. In fact, an equalization fund at the central level aims at guaranteeing roughly the same resources per capita to all regional governments.

Why did the regions of the south not adopt the same strategies adopted in the north? Leaving aside the influence of organized crime and the widespread political corruption (problems that, however, affect especially the southern regions), the answer can probably be found in the fact that in Italy, the resources intended for health care have traditionally been utilized for patronage and political consensus purposes (Ferrera 1995). The creation of new jobs justifies the recruiting of personnel in excess of the real needs. Awarding rich contracts to suppliers outside the SSN responds to the wish to

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6 A budget balance plan is an agreement, which a single region that finds itself with a considerable deficit enters into with the Ministry of Health and the Ministry of the Economy. The plan, which has a duration of three years, aims to re-establish the economic and financial balance of the region concerned.
stimulate the private sector. The appointment of managers and the hiring of new employees take place often on the basis of patronage considerations or political affiliation. These conditions are shared, to some degree, through the entire country, but they flourish especially in the southern regions, economically backward and affected by unemployment rates much above the national average.

*Interregional healthcare mobility*

Besides tensions linked to the budget, another interesting phenomenon is characterizing healthcare regionalization process in Italy: the mobility of patients from one region to another. All users of the Italian National Health Service can, once in possession of a prescription from their GP, choose the hospital at which to have their treatment. They can choose from all the public structures and those private structures that have special agreements with the public service, including those outside their region of residence. This freedom of choice given to patients is responsible for what is known as interregional healthcare mobility, on the basis of which, every year, hundreds of thousands of people receive treatment in a region other than that where they are resident.

Sometimes admission to hospital outside the region is not a decision made by the patients. It may be that they find themselves in another region for work, study or pleasure and have to be admitted to hospital in an emergency. In any event, admissions considered as ‘emergencies’ represent less than 10 per cent of all admissions outside the region (*Censis* 2012). If we exclude emergency admissions and also a physiological mobility just beyond the regional boundaries, in most cases it is the patient’s deliberate choice to leave the region, in the hope of finding a better service, of reducing waiting times or of receiving treatments – such as highly specialized care – that are not available in the hospitals within their home region (Collicelli *et al.* 2012).

This is why the phenomenon of healthcare mobility can be classed as an indicator of the perceived efficiency and quality of the regional healthcare systems (*Messina* *et al.* 2008; *Glinos* *et al.* 2010). We have to assume that if people are happy with their regional healthcare service, they will not seek admission to a hospital further away from home, and that, once a patient decides to move, they will choose the region where they think they are going to receive the best care. It is particularly interesting to analyze the flows of interregional healthcare mobility, because it allows us to understand which regions’ patients ‘escape’ from and which regions are their preferred destinations (table 2).

We notice immediately how there are particularly attractive regions. This is the case of Lombardia and Emilia-Romagna. If we calculate the relationship between incoming patients (from other regions) and outgoing patients (residents in regions who go elsewhere for treatment), these two regions have been confirmed for several years now as the regions that are best able to treat their own patients and to accept many more from outside. The regions that attract the fewest patients, on the other hand – partly due to their geographic isolation – are Sicilia and Sardegna, followed by Campania and Calabria.

Moving on to passive mobility (this expression is used for residents that are treated outside the region), patients exit particularly from smaller regions, like Basilicata, Valle d’Aosta and Molise, with about one patient out of five from these regions leaving to go to hospitals outside the regional

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7 Reference here is being made to the index of attraction, which consists in the percentage of non-residents admitted to hospital in the region out of the total number of patients admitted to the regional hospitals.

8 The escape index corresponds to the percentage of residents admitted to hospitals in other regions, compared to the total number of residents in the region who have been admitted to hospital during the year (both inside the region and elsewhere).
boundaries. It is, however, also true that some small regional systems, such as those in Molise and in the Autonomous Province of Bolzano, succeed in attracting more patients than those that leave. Consequently, these systems present an active mobility balance. At this point, it should be said that every regional healthcare system is required to reimburse the cost of admissions of its patients to hospitals outside the region. Outgoing mobility is, therefore, an expense borne by the regional finances. Incoming mobility, on the other hand, is a source of income for the regions. The economic balances of interregional mobility are indicated in table 2 (last column on the right).

**Table 2 – Interregional healthcare mobility (2012)**

<table>
<thead>
<tr>
<th>Region</th>
<th>Admissions of patients from outside the region</th>
<th>Residents admitted to hospital in other regions</th>
<th>Balance of mobility, in no. of admissions</th>
<th>Balance of mobility, millions of euros</th>
</tr>
</thead>
<tbody>
<tr>
<td>Piemonte</td>
<td>40,965</td>
<td>47,473</td>
<td>-6,508</td>
<td>-7,508</td>
</tr>
<tr>
<td>Valle d'Aosta</td>
<td>2,409</td>
<td>4,199</td>
<td>-1,790</td>
<td>-10,752</td>
</tr>
<tr>
<td>Lombardia</td>
<td>142,930</td>
<td>66,563</td>
<td>76,367</td>
<td>555,183</td>
</tr>
<tr>
<td>Bolzano</td>
<td>6,482</td>
<td>3,813</td>
<td>2,669</td>
<td>10,629</td>
</tr>
<tr>
<td>Trento</td>
<td>9,490</td>
<td>12,531</td>
<td>-3,041</td>
<td>-15,488</td>
</tr>
<tr>
<td>Veneto</td>
<td>54,426</td>
<td>49,306</td>
<td>5,120</td>
<td>75,790</td>
</tr>
<tr>
<td>Friuli-V.G.</td>
<td>22,979</td>
<td>12,719</td>
<td>10,260</td>
<td>30,076</td>
</tr>
<tr>
<td>Liguria</td>
<td>34,021</td>
<td>38,608</td>
<td>-4,587</td>
<td>-56,743</td>
</tr>
<tr>
<td>Emilia-R.</td>
<td>110,944</td>
<td>43,750</td>
<td>67,194</td>
<td>336,690</td>
</tr>
<tr>
<td>Toscana</td>
<td>69,869</td>
<td>35,875</td>
<td>33,994</td>
<td>132,294</td>
</tr>
<tr>
<td>Umbria</td>
<td>24,107</td>
<td>19,655</td>
<td>4,452</td>
<td>9,411</td>
</tr>
<tr>
<td>Marche</td>
<td>24,931</td>
<td>29,366</td>
<td>-4,435</td>
<td>-33,677</td>
</tr>
<tr>
<td>Lazio</td>
<td>90,000</td>
<td>68,260</td>
<td>21,740</td>
<td>32,739</td>
</tr>
<tr>
<td>Abruzzo</td>
<td>26,197</td>
<td>38,424</td>
<td>-12,227</td>
<td>-69,559</td>
</tr>
<tr>
<td>Molise</td>
<td>16,875</td>
<td>13,429</td>
<td>3,446</td>
<td>30,109</td>
</tr>
<tr>
<td>Campania</td>
<td>26,028</td>
<td>81,744</td>
<td>-55,716</td>
<td>-310,810</td>
</tr>
<tr>
<td>Puglia</td>
<td>26,281</td>
<td>58,454</td>
<td>-32,173</td>
<td>-180,058</td>
</tr>
<tr>
<td>Basilicata</td>
<td>14,146</td>
<td>22,342</td>
<td>-8,196</td>
<td>-19,111</td>
</tr>
<tr>
<td>Calabria</td>
<td>7,248</td>
<td>59,279</td>
<td>-52,031</td>
<td>-251,654</td>
</tr>
<tr>
<td>Sicilia</td>
<td>15,514</td>
<td>49,416</td>
<td>-33,902</td>
<td>-188,774</td>
</tr>
<tr>
<td>Sardegna</td>
<td>4,391</td>
<td>15,027</td>
<td>-10,636</td>
<td>-68,787</td>
</tr>
<tr>
<td><strong>Italy</strong></td>
<td><strong>770,233</strong></td>
<td><strong>770,233</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
</tr>
</tbody>
</table>

*Source: Ministero della Salute (2013)*

All the Centre-South regions, apart from Molise and Lazio, have recorded a negative balance. The worst situation is that of Campania (-311 million), followed by Calabria (-252 million) and Sicilia (-189 million). A negative balance, albeit of a more modest entity, is also recorded in some of the
Centre-North regions: Valle d’Aosta, Piemonte, Province of Trento, Liguria and Marche. If this is the overall picture, it is interesting to make a more detailed analysis of the flows among the single regions. In this way, we discover that in central-northern Italy, most of healthcare mobility takes place between neighboring regions. About half of the residents of Marche who seek treatment outside of the region head for Emilia-Romagna. Of the Piedmontese patients that ‘emigrate’, 60 per cent go to hospitals in nearby Lombardia, and Emilia-Romagna and Lombardia also exchange several thousands of patients every year. The situation is partly different for the southern regions. When patients from most of these regions decide to move, they prefer to travel to the north. The favorite destinations of people from Sicilia, Puglia and Sardegna who decide to seek treatment outside their region are Lombardia and Emilia-Romagna. Those from Calabria head mainly for Lazio and Lombardia, and so on.

The figure that most clearly highlights the imbalance between North and South Italy, however, regards something else. In 2012, 221,000 patients residing in the southern regions headed north for treatment. Only 43,000 travelled in the opposite direction, from the north to hospitals in the southern regions. In economic terms, this means that the southern regions pay their northern counterparts about one billion euros a year\(^9\). This financial transfer from south to north has a twofold effect. On the one hand, southern regions end up paying a huge amount of money. In this way, they find it difficult to stay within the budget. On the other hand, many northern regions would hardly be able to balance their operating budgets without the additional income generated by patients mobility.

**Conclusions**

A first conclusion that emerges from the data given above is the wide gap that separates the north and south of the country. For those familiar with the Italian situation, this contrast does not come as much of a surprise. The fracture between the regions of the Centre-North and those of Southern Italy is highlighted by numerous social-economic indicators and is found in numerous policy sectors. From this point of view, healthcare is simply no exception. However, this does not make the problem less serious. It is as though a line has been drawn, cutting the peninsula in two. The regions north of Rome have a more or less balanced financial situation and attract patients from other regions (leading to the assumption that they offer better quality services, otherwise patients would not move). Conversely, the regions south of Rome, in most cases, have imbalanced accounts and offer poorer quality services (at least this is the perception of the residents of the southern regions, many of whom prefer to travel to hospitals in the north for treatment).

The disparities among the various regions are a source of concern for the national government, as the Italian Constitution assigns government the task of guaranteeing uniformity of healthcare services throughout the entire country. Particularly alarming to the national government are the operating deficits accrued at regional level. In recent years, some regional healthcare systems (especially in Southern Italy) have accumulated considerable deficits and are unable – even today – to stay within the budget assigned to them. This lack of financial discipline shown by certain regional governments naturally risks annulling the considerable efforts made by the Italian government to keep public spending down, representing a serious problem for the competitiveness of the whole country. From this point of view, certain experts in healthcare policies believe that the regionalized arrangement of the SSN is becoming an obstacle on the road to rebalancing the public accounts. It is sustained that, if

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\(^9\) With reference to year 2011, the southern regions paid those in the north 1,147 million euros, while the latter transferred just 169 million euros to those in the south.
we were to return to a more centralized system, it would be easier to keep spending for healthcare under control.

This situation is understandably generating tension among the regions. Those in the north – which not only have healthier finances but also boast a much higher income per capita – are tired of having to take on the debt deriving from the poor management of others. The ‘virtuous’ regions feel that they are being damaged and are asking for acceleration on the road to fiscal federalism and for the adoption of criteria for dividing the national budget that reward the most efficient regional healthcare systems. The introduction of the ‘standard costs’ method should take this direction. Conversely, the strategy implemented up to now by the national government has been – in contrast with the requests by some regions – to slow down the fiscal federalism process, continuing to hold the purse strings. As mentioned earlier, the national government still determines the overall entity of the national healthcare fund and the criteria used to share it among the regions. Thanks to the financial lever, the central government is able to limit the autonomy of the regional governments whose accounts are in the red. This is achieved by signing strict budget balance plans.

Today, the Italian regions can be split into two groups, which proceed at different speeds (Tediosi et al. 2009; Helderman et al. 2012). Those whose accounts are balanced continue to enjoy the autonomy acknowledged to them by the Constitution (albeit within the restrictions imposed by recent cuts to spending for healthcare). The regions with financial difficulties, on the other hand, are stripped of their full autonomy in relation to healthcare. These regions are initially kept under close observation and, if they fail to respect the budget balance plans agreed to with the government, they risk being placed under compulsory administration.

References


