Chapter

Economic Crisis, Decentralisation and Health Inequalities: The Case of Italy

Stefano Neri

Abstract

The chapter describes the recent evolution of the Italian National Health Service (NHS), highlighting the potential and effective consequences of the economic and financial crisis on social and territorial inequalities, especially in terms of service access and quality. First, it analyses the cost-containment and austerity policies in the NHS, which brought to a relevant underfunding of the public healthcare system, comparing public expenditure trends in Italy with those of other Western European countries. Then, it stresses the increasing role played by private expenditure, emphasizing the risks in terms of health inequalities connected to the high level of out-of-pocket payments and to the spread of the occupational funds. Finally, a reconstruction and analysis of the current changes in the NHS governance is carried out, explaining in details how the reassertion of the role of the Central State in health policy entails different consequences for different areas of Italy, widening the territorial inequalities and increasing the North-South divide. So far, these changes have taken place without any structural reform, in an imperceptible but progressive way, which does not help to develop an appropriate and necessary debate on the future of the healthcare system.

Keywords: healthcare, decentralisation, national health service, health inequalities, economic crisis

1. Introduction

Since the Italian unification (1861), the Italian healthcare system has fully changed its institutional model at least three times. From being substantially 'residual' during the liberal era (1861–1921) and also the fascist decades (1922–1943), with a gradual spread of corporate health funds and some compulsory insurance schemes targeted on specific illnesses [1], it shifted to a social health insurance system at the end of the fascism, which was developed after the end of the Second World War, during the first 30 years of the Republic (1945–1977); finally, an universalist National Health Service (NHS) was instituted in 1978 (Law no. 833). Structural changes were then adopted in 1992–1993 (Legislative Decrees no. 502/1992 and no. 517/1993), introducing managerialisation and managed competition, which was softened in 1999 (Legislative Decree no. 229/1999), while Constitutional Law no. 3/2001 recognised, at constitutional level, and strengthened the regionalisation of the healthcare system carried out during the 1990s [2].

As a result, the NHS is structured on three levels: a national level, constituted mainly by the Ministry of Health; an intermediate level represented by the Regions and their Regional Ministers and health departments and a local operational level, directly accountable to the Regional one, made up of about 70–75 *Aziende sanitarie ospedaliere* (hospital trusts, henceforth HTs) and about 135–140 *Aziende sanitarie locali* (local health authorities, henceforth LHAs).

Since 2001, no major reforms have been introduced into the NHS. However, important changes have almost imperceptibly taken place, connected the economic and financial crisis, which are weakening the universalist nature of the NHS.

This chapter will analyse the evolution of the NHS in Italy during the last decade, hence in the years of the crisis, focusing on some trajectories of change underway, mainly in the health expenditure and in the NHS institutional framework governance. These trends might have important consequences in terms of service access and quality, increasing the traditional social and territorial inequalities and hence weakening the universalistic nature of the NHS.

2. What universalism? NHS performance between North and South

According to international and national literature, the Italian NHS system performs relatively well in comparative terms, among both European and OECD countries, although it is questionable whether and to what extent some of the results reported in the adopted indicators are attributable to the healthcare system in itself. The OECD report *Health at a Glance* [3], which represents a systematic evaluation of the healthcare systems in 35 OECD countries, based on 76 indicators gathered in 9 categories or areas (health status, risk factors, access to care, quality of care and health outcomes, health expenditure, staff, care provision, pharmaceuticals, ageing and long-term care), the OECD *Health profile* on Italy [4] and the OECD/EU report *Health at a Glance: Europe 2018* all agree attributing, by and large, good results in terms of prevention, access and quality of care, mortality and survival rates as well as in terms of health expenditure and efficiency, with improvements in many areas compared with the beginning of the 2000s. However, as emerged not only by OECD reports but also by other literature, social inequalities are significant in many indicators related to dimensions such as health status, risk factors, access and quality of care [3–9].

In particular:

- From 2000 to 2015, life expectancy at birth has increased from 79.9 to 82.7 years (the second best figure in the EU after Spain), thanks mostly to the decrease of the mortality for cardiovascular diseases. However, there are relevant gender and social inequalities.

- As far as risk factors are concerned, from 2000 to 2014, the rate of smokers has decreased from 25 to 20% slightly below the EU average. Also obesity rates decreased, but they remain considerably high, especially among children, with 18% of children aged 7–8 years in condition of obesity in 2017 (the second highest level in Europe, 6 points over the EU average).

- Coverage rates for several types of immunisation are at the level of the comparable European countries, although they have slightly decreased after 2012–2013 (but it is expected to have increased again in most recent years in the case of children vaccinations). Conversely, rates of cancer screening have increased [6].

- Avoidable mortality (preventable and amenable) is one of the lowest in Europe, and also survival rates for different types of cancer and major cardio-circulatory illnesses are within the average or among the best found among Western European comparable countries.

- In terms of access, the Italian NHS provides coverage to all citizens and foreign residents with a comprehensive care based on health needs, but social and territorial inequalities are relevant.

- In 2017, health expenditure was below the EU average, both in terms of per capita expenditure (2,551 Euro, −8.1% compared with the average EU level) and of share of the GDP (8.9, −0.6% compared with EU average). Although the NHS ensures a wide package of free services, out-of-pocket expenditure (23% of total health expenditure in 2015) is much higher than the EU average (15% in 2015).

- Long-term care is still lacking, with several indicators below the level of Western European comparable countries, although there are signs of improvements in the last years.

However, as it is well known by NHS scholars, national figures reported in international statistics and comparisons hide the very relevant differences existing among different areas of countries, traditionally summarised in the North-South divide. In this respect, 1992–1993 reforms had introduced the 'Livelli Essenziali di Assistenza' (essential levels of healthcare), or LEAs, which include all the kinds of healthcare services to be provided by all the regions throughout the country. Every year Central State attributes to regions the amount of funds needed to the provision of this very wide service package, after a State-Regions negotiation based on an allocation defined according to per capita criteria, adjusted for the distribution of the population by age and epidemiological factors.

The LEAs, which were first released in 2001, are matched with a monitoring and control system based on a set of indicators which allow checking whether and to what extent regions are respecting and ensuring the LEAs in the healthcare service provision to their resident population. The indicators are grouped in three areas of healthcare (prevention; outpatient, community and home care; hospital care). For each area, a synthetic index is obtained from the relevant indicators, with scores which may vary between 0.00 and 100.0 points. The monitoring system is associated to incentives and sanctions in terms of attributed funds.

Last assessment carried out by the Ministry of Health in 2017 [10] showed the persistence of very relevant disparities among Regions, with Northern Regions nearly always having the best scores in most of the indicators of the three areas of healthcare. Moreover, differences in the scores are striking, going, in prevention, from 80.92/100.00 points by Lombardy to 48.48 by Sicily; in outpatient care, from 86.39/100.00 by Liguria to 29.05 by Campania and in hospital care, from 89.13/100.00 points by Tuscany to 25.41/100.00 points obtained by Campania. Although many indicators are focused on expenditure efficiency, they highlight also the very important territorial differences existing in terms of service access and quality, in favour of Northern and Centre-Northern Regions.

These differences are historically rooted. However, despite significant efforts especially addressed to reduce territorial differences in expenditure for health services [11], these were not translated into a correspondent reduction of the differences existing in terms of service quality and efficiency between different areas of the country. Quite the opposite, according to some studies, the North-South

gap has been widened since the 1990s, that is, in the years of NHS regionalisation, instead of being reduced [12–14].

In this context, the economic crisis started in 2008–2009 triggered a set of policies which, on the one hand, risk to deepen the existing social inequalities in terms of service access; on the other hand, they caused a substantial change in the NHS governance which could seriously increase the territorial differences.

3. The economic crisis and austerity policies in the NHS

In Italy, the economic crisis started in 2008 was prolonged, with a fluctuating trend, characterised by two peaks (**Table 1**): the first was in 2008 and especially in 2009, when the Italian GDP declined by 1.1 and 5.5%, respectively, from the previous year. After an overall weak recovery in the following 2 years, in 2012, the crisis heightened and the GDP dropped by 2.8%, followed by a further decline of 1.7% in 2013. In 2014–2015, the GDP growth trend was very slack and became a little more sustained in 2016–2017 (respectively, 1.1 and 1.6%), but in 2018, it dropped down again below 1%, and also provisional data for 2019 indicate a further weakening of the economic recovery (Eurostat database). In all these years, the GDP growth rates were considerably lower than those of the 28 EU countries (**Table 1**). Similar differences emerge also considering only the countries within the Euro area.

The recession had a very strong impact on the relationship between the GDP and public debt. Since 1991–1992, this ratio had always been at more than 100%, one of the highest in Europe, except for 2007 (99.8%). However, since the start of the economic crisis, it has progressively increased surpassing the 130% of the GDP in 2014, with a tendency to level off over this level (**Table 2**).

Beyond the data, the crisis became particularly serious in 2011–2012, when the widespread perception, by the international markets and European institutions, that the Italian government was no longer able to bring the debt under control resulted in a sovereign debt crisis. This brought to the fall of the Berlusconi government, at the end of 2011, replaced by a 'technical' executive, headed by the economist Mario Monti. In the context of a protracted financial crisis and lack of confidence of the international environment, strict austerity measures were taken to control the budget deficit, reduce public sector expenses and increase public revenues [15]. While in policy areas such as pensions, these measures were accompanied by structural reforms; this was not the case in healthcare which was, however, object of severe cost-containment and retrenchment measures.

In the Italian highly regionalised NHS, control of health expenditure by the central government was pursued primarily through extremely limited increases, and, in some cases, reductions in the level of funding are attributed by the central government to the regions to finance the LEAs. The level of annual funding of LEAs is calculated in the budget laws, called 'stability laws', and it is negotiated between the State and the Regions within the State-Region Conference (see below) and

	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Italy	1.5	−1.1	−5.5	1.7	0.6	−2.8	−1.7	0.1	0.9	1.1	1.6	0.9
Eu 28	3.1	0.5	-4.3	2.1	1.8	−0.4	0.3	1.8	2.3	2	2.4	2.0

Source: Eurostat: National accounts and GDP online database.

Table 1.
GDP rates: percentage change on previous year.

ratified in official acts and documents such as the 'State-Region Agreements' or the 'Pacts for Health'. However, the Parliament and the central government can modify the concerted funding levels, as has always occurred in fact, after the beginning of the crisis with reductions in the originally agreed funds.

Absolute values and percentages of annual funding increases confirmed a stagnation in the central government financing from 2010 onwards, with very reduced surges but also drops compared with the previous years, in 2013 and in 2015 (**Table 3**). From 2010 to 2019, central funding increased by about 8,800,000,000 Euro, with a yearly average of about 0.9%, less than the average yearly inflation rate (about 1.1%; see [16, 17]).

Besides the containment of general central funding, austerity policies addressed the control of specific sources of expenditure arising from the acquisition of production inputs. The main cost-containment programmes started in 2009 (Law Decree No. 39/2009) and 2010 (Law Decree No. 78/2010) and intensified in the following years, culminating in the so-called spending review on public administration, promoted by the Monti government in 2012 (Law Decree No. 95/2012, converted into Law No. 131/2012). The austerity measures then continued roughly until at least 2016, albeit with less intensity, and the cost-containment in healthcare remains one of the central government priorities.

Main policies included spending caps and reduction in the pharmaceutical expenditure; decrease in hospitalisation rates and in the number of hospital beds per

2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
99.8	102.4	112.5	115.4	116.5	123.4	129	131.8	131.6	131.4	131.2	131.4

Source: Eurostat: General government gross debt online database.

Table 2.
General government gross debt in Italy: percentage of GDP.

	Financing (in Euro)*	Change compared with previous year (in Euro)*	Change compared with previous year (%)
2007	97,600,000,000	(4,400,000,000)	(4.7)
2008	101,600,000,000	4,000,000,000	4.1
2009	104,200,000,000	2,600,000,000	2.6
2010	105,600,000,000	1,400,000,000	1.3
2011	106,900,000,000	1,300,000,000	1.2
2012	108,000,000,000	1,100,000,000	1.0
2013	107,000,000,000	–1,000,000,000	0.9
2014	109,900,000,000	2,700,000,000	2.7
2015	109,700,000,000	–200,000,000	–0.2
2016	111,000,000,000	1,300,000,000	1.2
2017	112,600,000,000	1,600,000,000	1.4
2018	113,400,000,000	800,000,000	0.7
2019	114,400,000,000	1,000,000,000	0.9

*Approximate.
Source: Ministero della Salute [16].

Table 3.
Financing of the central funding for LEAs.

1000 inhabitants; a redefinition, in a generally restrictive sense, of the criteria used to set the regional tariffs (linked to DRG-like systems), for inpatient and outpatient services provided to the NHS; general restrictions of the expenditure on purchases of goods and services; increasing revenues, mainly by increasing the copayments for citizens, although Regions have the possibility to make partially different choices.

These measures were added to those aimed at controlling staff expenditure in all public services [15], which are of particular significance due to the importance of human resources in the health sector. In the NHS there were main two types of measures addressed to public providers: measures aimed at gradually reducing the number of employees and others at containing wage and salaries.

In the first case, at the end of 2006, and thus before the start of the crisis, a cap for personnel expenditure in the NHS, which had to be equal to the 'corresponding amount of the year 2004 reduced by 1.4%', including costs for temporary employees and autonomous workers. This measure has been substantially confirmed, with some minor changes, until May 2019, when it was replaced by less restrictive constraints.

A predictable result of the cap and other similar measures was a slowdown and substantial stop in the staff hiring and turnover within the NHS healthcare organisations. Between 2008 and 2017, the staff of the NHS passed from 689,873 to 647,048 total employees, a drop of 42,825 employees (−6.2%; data taken from the Ministry of Economy and Finance online database). The decrease was highly significant, considering that the Italian healthcare service is understaffed compared with many European countries [1].

Staff hiring was reopened in 2017–2018; especially after that the new national NHS collective agreement signed in 2018 opened the possibility to hold extraordinary public competitions for the new recruitment of doctors, nurses and technical health personnel. These measures were confirmed by the stability law for 2019. However, the pace of recruitment seems inadequate to face the lack of healthcare staff within the NHS, which will become more serious in the next years considering the predictable wave of retirements connected to an ageing labour force, especially among doctors [18].

Furthermore, a second type of measures concerned the containment of wages for employees in the NHS, as well as independent professionals working for the NHS, starting from the general practitioners and paediatricians. After moderate wage increases in 2008–2009, national-level collective bargaining was suspended for 2 years, in 2010, for all 2,800,000 contractualised public employees, including NHS staff. The suspension was then extended until 2015, when a sentence of the Constitutional Court forced the government to restart the collective bargaining process in the public sector. A new national NHS collective agreement for the period of 2016–2018 was signed in May 2018, with modest pay increases. Collective negotiations at decentralised level was not frozen but was put under strict financial constraints, with the prohibition to exceed the amount of resources used in 2010. The overall effect of these provisions was to freeze the salaries of NHS employees for 8 years, substantially to the levels of 2010.

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

4. Dynamics of public and private expenditure: out-of-pocket payments and occupational funds

The overall effect of the austerity policies and public underfinancing policies has been a recalibration in the health expenditure levels, which were already lower

than the average values recorded in comparable continental and Northern European countries, and in line with the other countries of Southern Europe (in particular Spain and Portugal). In Italy, in 2015–2016, the total health expenditure in fact amounted to 8.9–9% of the GDP (+0.7–0.8% compared with 2007), two points (or more) below than in France, Germany and Sweden, which traditionally have expenditures higher than Italy, and also nearly a point less than in the UK, which has always been a very parsimonious country. In 2017–2018, the total health expenditure amounted to 8.8% of the GDP (OECD database).

Also public (or government) health expenditure is lower than in the main continental and Northern European countries, in terms of both the share of the GDP and per capita expenditure (**Table 3**). Starting from a precrisis value of 6.3% (2007), the Italian government expenditure, GDP ratio did not grow even by half a percent in the following decade (6.6% in 2017 and 6.5% in 2018 estimation), despite the inevitable increase in demand for services with a steadily ageing population, which has the highest share of the over 60 age bracket in Europe (22.3% in 2017) and the highest median age in Europe along with Germany (45.9 in 2017, Eurostat database). Similarly, public expenditure per capita on health services increased by 18% from 2007 to 2018, a share much lower than in the main continental and Northern Europe countries reported in **Table 4**.

Italian trends in public expenditure on health are more similar to those of other Mediterranean European countries such as Portugal and Spain, although, from 2007 to 2016, the growth of expenditure per capita in Spain was certainly higher (23.3%).

At the same time, the share of private health expenditure over the total expenditure on health, while diminishing in France, Germany and Sweden, increased in the UK, Italy and other Southern European countries (**Table 5**). In Italy, from 2007 to 2018, it shifted from 22.5 to 25.8% of the total health expenditure, therefore coming to represent more than a quarter of total health expenditure. This brought the level of private health expenditure closer to that of Spain. Highest ratios of private health expenditures, which should not be typical of NHS systems, are shared by other Mediterranean countries such as Portugal and Spain (and, of course, Greece where private health expenditures represent nearly 40% of total health expenditure).

The increase in private health expenditure, traditionally high, entails serious risks of worsening in social inequalities, in an era of economic crisis, especially because in Italy it is mainly constituted by out-of-pocket payments which, as it is well-known, emphasise the role of socioeconomic inequalities in service access. Between 2007

	Share of GDP (%)			Per capita (US$PPP)			Growth of expenditure per capita (%)
	2000	2007	2018p	2000	2007	2018p	2007-2018p
France	7.6	8.0	9.3	2119	2770	4141	33.1
Germany	7.7	7.5	9.5	2260	2809	5056	44.4
Sweden	6.3	6.6	9.3	1878	2647	4570	42.1
UK	4.7	6.1	7.5	1238	2111	3139	32.7
Italy	5.5	6.3	6.5	1474	2088	2545	18.0
Portugal	5.9	6.2	6.0	1127	1548	1902	18.6
Spain	4.9	5.7	6.2	1087	1795	2341	23.3

p = provisional value. Source: OECD Health Care online database.

Table 4.
Levels of current public expenditure on healthcare.

and 2014, the share of individuals reported unmet needs for medical examinations (because they were too expensive, because care facilities were too far away or because of waiting lists) for medical examinations shifted from 4.1 to 7.0%, highly concentrated in the share of population with the lowest income (elaborations by E. Pavolini on OECD health care online database). It is quite likely that the combination between cost-containment and retrenchment policies in the public sector and the increase in the role of private expenditure played an important role in determining this result.

However, an important part of the growth of private health expenditure in Italy during the crisis was due to the insurance component. In this regard, one of the most recent transformations that has taken place in Italy in relation to private health expenditure is the spread of occupational health funds for workers and their families, introduced or reintroduced from national collective bargaining or unilateral initiatives by employers (**Table 6**).

Although the occupational funds were almost non-existent in the 1990s, they have increased dramatically in the past decade, especially since the mid-2000s, reaching more than 10,000,000 people, around 33–35% of the total employees, in 2017. Most of the workers registered to an occupational scheme are employees (63% of total registered people), which mostly belong to the private sector, given that occupational schemes in healthcare are still nearly absent in the public sector.

The increased role of occupational healthcare funds represents a major challenge to the universalistic nature of the Italian NHS for three main reasons [19]: (a) they are increasingly financing core healthcare provision (especially diagnostics

	2007	2018p	Diff 2018p-2007
France	22.9 (9.5)	16.6 (9.4pp)	–6.3 (–0.1pp)
Germany	24.9 (14.3)	15.5 (12.3)	–9.4 (–2.0)
Sweden	18.1 (16.9)	16.1 (14.8)	–2.0 (-2.1)
UK	18.3 (10.4)	20.5 (16.0pp)	2.2 (5.6pp)
Italy	22.5 (21.5)	25.8 (23.1)	3.3 (1.8)
Portugal	31.3 (25.7)	33.5 (27.4pp)	2.2 (1.9pp)
Spain	27.3 (21.0)	29.5 (23.6pp)	2.2 (2.6pp)

p = provisional value; pp = data referred to 2017. Source: OECD Health Care online database.

Table 5.
Private and out-of-pocket health expenditure in share of total health expenditure (%) (in brackets: out-of-pocket health expenditure as % of total health expenditure).

Categories	No. of registered people to occupational schemes	%
Employees	6,692,000	63.0
Independent workers	1,062,239	10.0
Employee relatives	1,944,634	18.3
Independent workers relatives	216,070	2.0
Pensioners and relatives	500,966	4.7
Pensioner relatives	200,386	1.9
Total	10,616,847	100.0

Source: GIMBE [17], elaborated from data by the Ministry of Health.

Table 6.
Registered people to occupational schemes: 2017.

and ambulatory care), which should be offered by the NHS, acting as a substitute for NHS services rather than completing or supplementing them; (b) access to occupational healthcare funds is profoundly affected by the employees' occupation and their position in the labour market (fixed-term vs. open-ended contracts, manual occupations vs. nonmanual occupations, unskilled occupations vs. skilled professions, etc.), and coverage is therefore rather unevenly distributed among workers and also in relation to the sector of employment; and (c) occupational schemes are concentrated among workers employed in big and medium-sized firms; this entails the creation of inequalities among those employed in firms of different sizes. Moreover, as medium and big firms are mainly located in the North of Italy, the spread of occupational funds brings serious risk to deepen the traditional differences existing in service access and quality between the North and the South of the country.

5. The evolution of the governance of the NHS between the reassertion of the role of the State and the development of a differentiated regionalism

Unlike the oldest national health services, such as those of England or Sweden, the Italian NHS has always had a decentralised structure, in line with the Italian Constitution. In a first phase (1978–1992), the powers and responsibilities were divided among the State, Regions and local government. With the reforms of 1992–1993 (Legislative Decrees No. 502/1992 and No. 517/1993), instead, the regionalisation of the NHS was introduced, together with its managerialisation [5, 20]. Regionalisation was then strengthened by the Constitutional reform introduced in 2001 and confirmed by the failures of subsequent attempts of Constitutional reforms in 2006 and 2016.

According to current regulation, legislative powers are shared between Central State and Regions. As already mentioned, the State is in charge of defining the 'essential levels of healthcare', or LEAs, and has to guarantee regions the financial resources necessary for LEA provision. Regions and the two Autonomous Provinces of Trento and Bolzano have great freedom in organisation and management of their Regional Health Services. Starting from the second half of the 1990s, different 'regional healthcare models' emerged, characterised by regulatory structures marked by hierarchical integration, cooperation or competition between purchasers and service providers [2]. NHS regionalisation includes also a certain degree of fiscal autonomy, even if very restricted (see [21]), as well as the possibility of introducing copayments for drugs and outpatient services at regional level.

The balance of powers between state and regions that emerged from the regionalisation introduced during the 1990s and in 2001 required a permanent mechanism of negotiation and, possibly, cooperation between the State and the Regions to define national health policy.

On the one hand, since 2001 the central government has been *de facto* unable to implement institutional and organisational reforms without the consent and the involvement of regions. On the other hand, regions must respect a national regulative framework which imposes significant constraints on their possibility to introduce institutional changes within the regional healthcare systems. Therefore, concerted policy-making has been developing since 2000–2001. It has given rise to a series of 'agreements', 'pacts' or 'ententes' signed in the 'State, Regions and Local Governments Conference' (simply called State-Regions Conference) and then converted into legislation by the Parliament.

The State-Regions Conference includes the Prime Minister as President of the Conference, the Presidents (or Governors) of the Regions or other Ministers whenever matters related to areas of their competence are discussed. Instituted in 1988 and strengthened in 1997, in the first part of the 2000s, the Conference came to play a major role in national healthcare policy-making, representing the main institutional mechanism able to ensure close cooperation among Regions and permanent negotiation between those and the central government (see [22] for more details).

Although none of the regulatory changes had modified the above-described division of powers, the economic and financial crisis as well as political responses to the crisis weakened the role of the regions in national policy-making, in favour of greater importance of the role played by the central government, the Ministry of Economy and Finance (MEF) and, indirectly, by the European institutions. State-Region Conference has partially lost its centrality in policy-making, given that concerted policy-making has been increasingly substituted by unilateral decision-making by central government and supra-national institutions.

This shift became particularly evident after the explosion of the sovereign debt crisis of 2011–2012. The need to take urgent measures able to signal to international markets and the EU the willingness and ability of the national Government to bring the public debt under control have prompted approval of measures, contained in the laws of stability and austerity packages adopted by the Central Government, which in great part had not been agreed upon and basically not even discussed with the regions, Parliament and organised interests. The minimisation of room for discussion and negotiation was motivated by the lack of time and alternatives in the face of the commitments made with the EU and the need to reassure the markets. These dynamics did not occur only in Italy but were common to all the European countries most affected by the financial crisis and sovereign debt, namely, those of Southern Europe and, in a partially different form, Ireland [23–26].

The reassertion of the role of the State was enhanced by the economic crisis, but it had already started before 2007–2008. In the mid-2000s, many Regions showed to be unable to control health expenditure growth and contain regional deficits. In order to ensure compliance with the European Stability and Growth Pact, in 2005, the central government and Regions agreed on a multistep mechanism of regional expenditure monitoring and recovery plans in the case of excessive deficits. If a Region accumulates serious deficits and misses spending targets, the agreement provides for the activation of automatic mechanisms (like an increase in regional taxes) and the close supervision of regional expenditure policies by the MEF. Central government may appoint a commissioner in charge of NHS administration in that Region and impose specific measures to reduce deficits, thereby introducing severe limitations on regional autonomy.

To date, the recovery plan mechanism has been activated in 10 (out of 20) regions, and 5 of them have been subjected to administration by a commissioner. In 2019, seven regions are subject to a recovery plan; most of them entered the mechanism between 2007 and 2010. These regions include all Southern and Southern-Central Regions except the small Basilicata, while only two Northern Regions were forced to approve a recovery plan and were never commissioned.

Despite differences between individual cases, the recovery plan mechanism was largely effective in securing a debt reduction of the regions. The success was such as to cause the Government to introduce a control mechanism of deficits of individual NHS providers, bound to the presentation of plans, in 2015.

However, experience has shown that, once the plan procedures began, it was extremely difficult to abandon them. This was due not only to the presence of particularly demanding financial targets in years of economic crisis but also to the existence of objectives beyond purely economic aspects that impacted on quality and access

to services. In many cases these objectives were not easy to meet, considering that recovery plans inevitably required retrenchment policies which entailed severe cuts and other kind of restrictions in service provision. On this respect, this monitoring mechanism might have determined a worsening in some dimensions linked to access and service quality, widening the gap between Southern Regions which entered into the recovery plans and Northern Regions free from the plans and their constraints.

From the point of view of the intergovernmental relations, the recovery plan mechanism severely restricted the autonomy of regional governments in the development of health policies. Central government and, in particular, the MEF not only exerted a penetrating supervision and monitoring of the plan implementations in the regions concerned but also, often, gained the right to exert a sort of veto, in the face of regional policies that involve increased expenditure. Although the formal division of powers between the levels of government has not changed over the past decade, regional decentralisation proved in fact to be much weakened in favour of an increase of the Central State's regulatory role, embodied by MEF rather than by the Ministry of Health [27, 28].

If Central and Southern-Central healthcare have been subjected to these strict forms of control during the years of crisis and until now, this has not been the case of the Northern and Central-Northern regions, except for two cases (Piedmont and Liguria). In most of these regions, the ability to maintain fiscal equilibrium or limited deficit has allowed them to consolidate the autonomy of regional health policies, even in the presence of nationally determined austerity policies.

Moreover, some of these regions (Emilia-Romagna, Lombardy and Veneto) have formally demanded 'further forms and conditions of autonomy' (Article 116, cl. 3, Italian Constitution), both in the health sector and in other policy sectors, which would make them more similar to the five Italian regions provided, from the 1950s, with a special autonomy for historical or ethnical reasons.

After the successful consultative referendum held in Lombardy and Veneto on 22–23 October 2017, and the formal request of the Emilia-Romagna government between August and October 2017, a negotiating table was opened with the central government, according to the procedure laid down in Art. 116 of the Constitution. Although negotiations are still underway, with serious conflicts emerged between the two parties of the current coalition government, it is quite clear that the request of more autonomy should concern not only the management of resources but also regional tax capacity, so as to take a significant step towards a more complete accountability of the regions. One of the most delicate issue concerns the possibility to retain most of fiscal revenues collected within any single region, limiting the process of central redistribution. Given the very relevant differences in fiscal capacity between the North and the South of Italy, the potential effects of this change could be highly detrimental for Southern Regions.

6. Conclusions

Economic and financial crises which severely hit Italy did not result into structural and fundamental changes in the NHS. However, it prompted or accelerated some processes which seriously risk to gradually change a universalist healthcare system into a more hybrid one. Retrenchment and austerity policies in the public, underfinanced NHS find some sort of compensation in the high level of private out-of-pocket expenditure and in the spread of occupational funds. As a consequence, traditional inequalities in access to healthcare services are deepening and seem bound to increase, exacerbating differences among socioeconomic and occupational groups.

Moreover, the trend to informal but substantial re-centralisation in national policy-making, with the reassertion of the role of the state in charge of playing the role of 'financial watchdog' of regional governments, is having different consequences for Northern and Southern Regions. The former was able to retain their autonomy, so that to develop health policies targeted to the needs of their citizens, while the ladder entered into a monitoring mechanism of their expenditure, which is giving significant results in financial terms but risk to worsen service access and quality.

So far, healthcare system 'hybridisation' [29] and the trend to 'differentiated federalism' [28] or 'differentiated autonomy' have occurred without any structural reforms, by means of imperceptible but progressive changes which, in terms of institutional change, may be qualified in terms of 'gradual transformation' [30, 31]. However, the formal request for constitutional change by three regions and related, current political conflicts, as well as the increasing complaints and also protests by doctors and healthcare experts on NHS underfinancing, emphasised by the media, might help promote an open debate on the future of the Italian NHS and health policy, which has been completely lacking so far.

Author details

Stefano Neri
Department of Social and Political Sciences, University of Milan, Italy

*Address all correspondence to: stefano.neri@unimi.it

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