

# Devolution in the Italian Healthcare System. The Role of Regions in Organizing Healthcare after 2001

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## Abstract

*A very important act reforming healthcare in Italy was the Act of 23 December 1978, which initiated devolution of competence in the matter of healthcare, with the transfer of administrative and legislative functions in this field to regions. As a result of this reform, Italy underwent a transfer from the insurance model of healthcare financing to the model of national healthcare service. Other changes concerning, first of all, the form of the regional state and broadening regional autonomy were introduced by the Constitutional Act No. 3 of 18 October 2001, amending Title V of the Constitution and concerning the status of regions, provinces and communes. As a result of these reforms, it is regions that currently represent the most important level of administration between the central government and communes. The main result of the process of federalism is how the regions were granted authority to allocate owned funds in the healthcare system in the manner that they consider most appropriate for funding basic levels of services (LEA) in their territory, as well as the management of the organization of healthcare in their local area in the way that meets the requirements of the population living there.*

**Keywords:** Italy, constitution, devolution, healthcare

The Constitution of the Italian Republic adopted on 22 December 1947 introduced regulations in the field of social security, in particular, including those relating to the right to healthcare. The starting point for further discussion on the role of regions in organizing healthcare in their local area should be Art. 32 of the Constitution, proclaiming the right to healthcare. According to this Article, “The Republic provides health protection as a fundamental right of the individual and of the collective interest and guarantees free care to the poor.” The right to healthcare is of an absolute nature and, in principle, cannot be violated, except for situations, where essential interests of the collective body take primacy (Urbaniak 2009, 59).

Very important and far-reaching changes in the Constitution, concerning, first of all, the form of the regional state and broadening regional autonomy, were introduced by the Constitutional Act No. 3 of 18 October 2001,<sup>1</sup> amending Title V of the Constitution and concerning the status of regions, provinces and communes.<sup>2</sup> Changes introduced in 2001 highlighted the urgent need for a redistribution of roles between traditional local territorial structures (Contini 2009, 55). Amendments to Title V of the Constitution develop the principle of institutional pluralism and shape the state based on self-governmental and regional autonomy in both political and legislative, administrative and financial range (Bokszczanin 2007, 124).

In the context of constitutional reform, one should not forget the reform initiated in the 1990s, named after the minister of public functions—the reform of Francesco Bassanini. These acts introduced administrative decentralization. The reform of 2001 is a natural complement to the process initiated by the decentralization of the administration introduced by Bassanini’s regulations, which constitute the necessary basis for financial decentralization, which is an instrument of the managerial autonomy of expenditure and revenue of local entities (D’Auro 2002). Under the Act

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1. See: Constitutional Act of 18 October 2001, n 3, Gazz. Uff. del 24 October 2001, n. 248.

2. In Italian literature, the process initiated by the change of the Title V is called devolution.

of 15 March 1997,<sup>3</sup> the Italian government was authorized to pass the functions and responsibilities of the central government to regions and local entities in order to carry out an administrative reform and to simplify the functioning of administration. As a result of this Act, a number of state administrative functions were transferred to the regional and communal level. Moreover, the central and local state administration and the office of the Prime Minister underwent reforms. Finally, administrative procedures were simplified and schools were granted administrative autonomy (Nosewicz 2009, 86).

The solution adopted in the new regulations introduced the elements of federalism (Nosewicz 2009, 123) to the Constitution and allowed for redesigning powers between different levels of governance: central (of the state) and regional (Cuocolo 2004, 57). Changing Title V enabled abolition of the old division of competence between the state and the regions, in which the role of the former was limited to specifying the state provisions in order to clarify the division of powers reserved for state, competitive legislation of state and regions and so-called other legislation, which is a matter not mentioned in the Constitution, within the exclusive powers of the regions (Lorencka 2005). As a result of these changes, comparing present solutions to regulations previously applicable, greater freedom was given to regions and measurable limitations of their standard-creating activity were outlined (Bojek 2007). The competition between the state act and the regional act concerns only part of the norm-creating matter, because the state was granted the opportunity to legislate basic regulations, while regions were granted development rights with accordance to particular interests in the community living in them. State legislation expressed in the so-called *leggi cornice* (framework laws) constitutes the border of compliance with the legality of the regional law (di Arcidiacono, Carullo, and Rizza 2005, 150). From the financial point of view, the consequence of the reforms introduced by Title V is the existing obligation of regions to spend funds on services, included in the basic levels of services—LEA, carried out on the basis of their own revenues, funds from complicity of regions in tax revenue, and in the case of regions with lower income—funds coming from the equalization fund (Maino 2003, 103).

As the result of these reforms, it is regions that currently represent the most important level of administration between the central government and communes. The main result of the process of federalism is the granting to regions the authority to allocate owned funds in the healthcare system in the manner that they consider most appropriate for funding basic levels of services (LEA) in their territory, as well as the management of the organization of healthcare in their local area in the way that meets the requirements of the population living there. In its verdict of 4 December 2002, No. 510,<sup>4</sup> the Constitutional Court stated that as a result of the reform of Title V, the competence of the regions was deeply changed and currently they can exercise their powers, to which they are entitled, and which also replaces the state power, while respecting the principle expressed in Art. 127 of the Constitution, according to which, if the government claims that the regional law exceeds the powers of the region, it may apply to the Constitutional Court with the verification of its compatibility.

A very important act reforming healthcare in Italy was the Act of 23 December 1978,<sup>5</sup> which initiated devolution of competence in the matter of healthcare, with the transfer of administrative and legislative functions in this field to regions (Vaccaro 2004, 8). As a result of this reform, Italy underwent a transfer from the insurance model of healthcare financing to the model of national healthcare service (Brożyniak et al. 2008, 359). One of the basic characteristics of this system is the responsibility of the state for universal access to healthcare, which is performed by the national health service, and at the central or local level of governance, it determines health needs and plans their implementation (Kolwitz 2010, 133).

Act 1978/833 was the first comprehensive attempt to regulate issues related to financing healthcare. The adoption of subsequent acts reforming provisions of constitutional and statutory regulations and constituting the next phase of the reform of the healthcare system in Italy are: the legisla-

3. See: Legge of 15 March 1997 n. 59, Gazz. Uff. of 17 March 1997.

4. See: Corte Cost. of 4 December 2002 p. 510.

5. See: Legge of 23 December 1978, n. 833, Gazz. Uff. of 28 December 1978 n. 360.

tive decree of 30 December 1992, No. 502<sup>(6)</sup> and the legislative decree of 17 August 1999 No. 299<sup>(7)</sup> (these acts are also called the bis reform and the ter reform) and constituted their development and fulfillment. These reforms introduced the concept of the basic level of services, defining what was needed to determine funds necessary for financing healthcare. There were three principles introduced: patients' freedom to choose the provider, parity of treatment of private and public accredited providers and a system based on the service per unit and funding per case (Fattore and Torbica 2006, 252). The aim of the reforms carried out in 1992 and 1993 was also to continue to decentralize administrative and organizational competences of the state and to shift them to regions as well as to limit state aid for regional spending allocated to healthcare. The aim of such a solution was to introduce a clear division of roles between the various levels of administrations and to eliminate a strong imbalance, which existed since 1978, between expenditures of regions and their involvement in fundraising, as well as to promote efficiency in the use of resources and increase the quality of services offered (Maino 1999, 583–584). Starting in 1992, the regions were obliged to deliver uniform levels of care, while the regions are mandated to use their resources to provide services above what is guaranteed by national laws and are obliged to cover any deficit which is required to provide the LEAs (Torbica and Fattore 2005, 46). The reform of the healthcare system introduced by Act 1978/833 referred to the fundamental principles expressed in Art. 3, Art. 32 and Art. 38 of the Italian Constitution (Jorio 2005, 27). This Act updated the constitutional principles and introduced a system in which the activities of healthcare can be classified as a public function, because it realized a subjective right of universal entities and adopted a method of forecasting expenditures on healthcare (Mattioni 2012, 47). The basic principles applied by the NHS, which aim to ensure social equality and a better control over expenditure on health are:

- the principle of universal access to healthcare,
- the principle of equality in access to services,
- the principle of spreading financial risk (Silano 2004).

Healthcare in the National Health Service was significantly decentralized and transferred to the regions, which now have total autonomy in the administration and organization of healthcare in their own territory (France and Taroni 2005, 170). Due to the high degree of decentralization, the Italian healthcare system is relatively efficient (Reviglio 2000, 3). In accordance with Art. 11 of Act 1978/833 regions complete statutory tasks in the field of healthcare and hospital care with respect for the fundamental principles determined by state acts, as well as perform their own or administrative functions entrusted to them. The legislature in Art. 11, paragraph 2 of Act 1978/833 establishes the principle according to which, regional Acts must:

- ensure coordination of provided health services with those of other economic, social and organizational sectors in the competitively appropriate territorial area of each region;
- ensure organizational consistency of health service providers basing on territorial and functional criteria, adapting regulations to the requirements arising from the specificity of the situation within each region,
- ensure an adequate relationship between the cost of services and benefits achieved in this respect.

According to Act 1978/833, the competences of the state are: epidemiological and statistical services, coordination of prevention programs, research and development programs, definition of basic service levels and all other activities coordinating prevention of diseases (Vaccaro 2004, 9).

The reform of Title V of the Constitution divided competences in the field of public health between central and peripheral authorities and the rules clearly define the division of power between the state and the regions in terms of health. The new edition of Art. 117 of the Constitution, in relation to the prior solutions, divided legislative powers between the state and the regions on the basis of other criteria, specifying exact matters in which the state has exclusive legislation rights, while the principle of the presumption of competence of the regions was introduced, which includes the “legislative power relating to any matter explicitly not reserved for the state legislation.”

6. See: Decreto legislativo of 30 December 1992 n. 502, Gazz. Uff. of 30 December 1992, n. 305.

7. See: Decreto legislativo of 17 August 1999 n. 299, Gazz. Uff. of 28 August 1999 No. 202.

(Calvetta 2005, 452) The intention of the amendments is to expand the provisions of Art. 5 of the Constitution, which establishes the principle of self-governance and decentralization, according to which, the Republic, as a unified and indivisible country, recognizes and promotes local authorities, realizes the most extensive decentralization of administration in the activities of the state services, and adapts the principles and the system of its legislation to the requirements of local authorities and of decentralization. The relationship between unitary and indivisible state and territorial autonomies is upgraded to the fundamental principle of the Constitution, the implementation of which is limited by the edition of Art. 5 and its development, which is the change in Title V of the Constitution (Mattioni 2012, 46).

By the reform introduced by changes to Title V of the Constitution, regions were appointed as the organizers of healthcare services, leaving for the national government the task of ensuring the financing of the basic level of services (*livelli essenziali di assistenza—LEA*), as well as the verification of the various regions to ensure healthcare for their population (De Negri 2011, 415). It should be noted, that the concept of basic levels of health services appeared already in the Italian healthcare system in the Act of 1978, which, in Art. 3 and 4, introduced the need to provide patients with equal levels of healthcare services throughout the country. Great emphasis was put on the concept of uniformity of benefits, enhanced by the creation of a single National Health Fund, whose task was to provide different levels of services in the whole country (Deias 2007, 9). Act 1978/833 in Art. 1, paragraph 1, introduced the principle according to which the Republic provides healthcare as a fundamental right of the individual and of the collective interest by establishing a national healthcare system and the principle of respect for the dignity and freedom of the human being in the protection of physical and mental health.

As a result of the reforms, the Italian state was left limited oversight functions over healthcare and is responsible for the activities of the National Health Service to ensure consistent levels of services at the same level throughout the country (Maio and Manzoli 2002, 302). Regions have used their autonomy to introduce different models of healthcare regulations which, in some regions, is a system with minimal regulation and a complete purchaser-provider separation and in other regions, the regional health services continued to be regulated and managed by the central-regional government (Cavaliere and Guccio 2009, 40). In reality, however, the regions are responsible for the organization and management of public health service. These regions differ in terms of demography, economic development, infrastructure and healthcare. One of the big political issues in Italy is the growing disparity in social and economic development of the regions, in particular, for the southern regions which are much poorer than the north-central regions. One should pay attention to differences in health expenditure per capita: in the northern regions in 2008 it amounted to EUR 1800 (the same as anywhere else in Italy), while in the southern regions, this amount was lower and amounted to EUR 1753. It should be noted, that the levels of expenditure on healthcare are different and depend on socio-economic conditions as well as on different models of healthcare management in the regions.

In Italy, the regions have the status of either an ordinary or a special region. The regions of Trentino—Alto Adige, Friuli Venezia—Giulia, Valle d'Aosta as well as Sardinia and Sicily, have the status of regions operating under special statutes. The remaining 35 regions have the status of ordinary regions. The regions are autonomous units granted constitutionally defined powers. They have legislative autonomy and have the right to issue acts having the force of ordinary acts, in the fields referred to in Art. 117 of the Constitution of Italy (Witkowski 2004, 414ff.). Currently, the regions do not perform activities traditionally reserved for the central government, which include among others: foreign policy, defense, public order or judiciary matters, but within their competence they have strong autonomy, and even a kind of sovereignty (Pedaci 2009, 793).

In accordance with the Constitution, four types of legislation can be distinguished: exclusive legislation, which falls within the competence of the state only or the regions only, competitive legislation and other regional legislation. In Art. 117, paragraph 3, the Constitution, in competitive legislation between the state and the regions, includes a broad matter of health protection along with certain sectors, which are research and technology and the development of innovation in the production sectors. The Constitution appoints the regions to define health policy, leaving the

legislative competence to define only the basic principles to the state (Buzzanca 2006, 26). The Constitution, in the field of providing health services, provides for close cooperation between the two entities: nation and regions. It should be stressed here that the issue of social care has not been taken into account in Art. 117 of the Constitution, which means that it falls within the competence of other regions (Cuocolo 2005, 40–41).

At the source of granting regions the possibility of legislation on healthcare was the belief that entities closest to the citizen are able to meet the needs of citizens in this matter, provided that care may differ at a territorial level, in particular, due to the organizational skills and financial resources of individual regions, which, in turn, may lead to inequalities in receiving benefits. As a consequence, in accordance with the principle of subsidiarity, expressed in Art. 117 of the Constitution, the intervention of the state in this regard will take place only in the case in which the regions and the local unit will not be able to secure an adequate level of healthcare, thereby, exposing to risk a universal system and the principle of equality in accessing services (Buzzanca 2006, 26).

Regional legislature, during the process of legislation, is obliged to adhere to the basic principles contained in the statutes of the state and do not, however, go below the minimum level of protection of civil and social rights (De Roberto 2006, 37). It is worth noting that before the change in Title V of the Constitution, the broadly defined healthcare issues fell exclusively within the national legislation. Thus, defining the fundamental principles of the system, in particular, to offer citizens universal healthcare, funded from public funds and managed by the method of programming these expenses are within the competence of the state (Mattioni 2004, 6). The solutions currently adopted in Art. 117 of the Constitution, in comparison with the previous edition of this Article, are not limited to issues related to healthcare and hospital care, but apply to all legal aspects related to healthcare, understood as the right of the community and as the right of the individual (Morana 2006, 279). In practice, this means that regional powers are wider than they were before. Despite this solution, the state maintained important spheres of regulations, which may stop and even do away with the possibility of action at other levels of territorial authorities (Cuocolo 2008, 34).

In accordance with Art. 117, paragraph 2, letter m of the Constitution, “the state has the exclusive legislation in determining significant benefit levels to ensure civil rights and social rights that must be guaranteed throughout the country.” It implies that the Constitution includes the obligation to determine significant levels of benefits and basic principles in the field of healthcare to the exclusive legislation of the state. This does not mean, however, that the state has only been granted marginal powers, the competences that the Constitution grants to the central government are numerous and important, which include, in particular, determining significant levels of benefit, as referred to in Art. 117, paragraph 2, letter m (Banchemo 2008, 462). The constitutional norm expresses the principle, according to which the implementation of the subjective law cannot depend on different regional regulations, but only on the provisions of the national law, which can ensure uniformity of services to members of the community (Mattioni 2012, 50).

The Constitution prohibits the regions from determining the degree of protection of significant levels of benefits at a level lower than the level specified in state statutes (Tubertini 2008, 37). It is the state that is responsible for setting the quantitative and qualitative standards for the benefits and adequate funding to support them (Panzerà 2010, 946). The Constitutional Act No. 2001/3 granted each of the organs special responsibility, specifying that if at the regional level, it is more important to program social policy in a given territory, then, at the central level, with the respect for the principle of subsidiarity, only the results of this action are monitored (Lazzaro 2004, 134).

Art. 117, paragraph 2, letter m of the Constitution, refers to the relevant levels of services (livelli essenziali delle prestazioni), which apply to all types of services for the realization of the rights of the individual. This concept differs significantly from that of the basic levels of services (LEA), which in turn, refer to a narrower range of care services (Luciani 2002, 352). When defining standard levels of services in the healthcare system, what is indicated is the adaptation of basic levels (not just the minimums) of services, uniform across the entire country, provided on the basis of the criteria of their applicability (Stornauiuolo 2002, 42). Determination of the extent of relevant state benefit levels is a very difficult task due to existing restrictions which grant regions

exclusive competence in this field, as well as due to the fact that the Constitution, in Art. 120, paragraph 2, grants the government the right to replace the bodies of regions, metropolitan cities, provinces and communes, if, for instance, it is necessary to protect a substantial level of services in the range of civil and social rights (Celotto 2002, 37). Determining significant levels of services by the state emphasizes the possibility of taking advantage of the civil rights and upholds the duty of the Republic to remove economic and social obstacles, which in effect restrict the freedom and equality of citizens, or do not allow for the full development of the human being and the effective participation of all working people in the political, economic and social organization of the country, as referred to in Art. 3, paragraph 2 of the Constitution (Banchero 2004, 42). Basic levels of services form the basis of the National Health Service and it is the state's obligation to define them, with the commitment of the regions. Uniformity of services means equality in access to them and refers to a situation in which the recipients who have a need to be provided special services can receive them immediately, if only they fall within the scope of services guaranteed in the LEA (Stornaiuolo 2002, 42).

Art. 117, paragraph 6 of the Constitution states that the authorization to issue executive regulations belongs to the state in matters of exclusive legislation, with the exception, however, of where the regions are authorized to do so. The Constitution clearly states that the power to issue executive regulations is given to the regions in all other matters.

The provision contained in Art. 118 of the Constitution grants communes the administrative functions, with the exception of a situation where in order to ensure their uniform implementation, they will be granted to provinces, metropolitan cities, regions and the state, on the basis of the principle of subsidiarity, differentiation and proportionality. Art. 118, paragraph 4 of the Constitution, imposes upon the state, regions, metropolitan cities, provinces and communes, the duty, both singularly as well collectively, to promote independent initiatives of citizens, in order to develop activities for the public interest, based on the principle of subsidiarity. This provision also recognizes the non-profit forms of providing health services, as also referred to in Art. 1, paragraph 18 of the executive regulation 1992/502.<sup>8</sup> According to this regulation, non-profit institutions and organizations cooperate with public institutions for the implementation of the constitutional duties of solidarity, respecting the principles of ethical and cultural pluralism concerning services for the people.

The amended Article 119, paragraph 1 of the Constitution, establishes the principle according to which communes, provinces, metropolitan cities and regions have financial autonomy in terms of income and expenditure. Constitutional legislation in this way granted local entities the basis of financial autonomy (Struska 2008, 169–170). According to Art 119, paragraph 4 of the Constitution, funds from sources referred to in the previous paragraphs allow communes, provinces, metropolitan cities and regions to finance the public functions entrusted to them. Services aimed at satisfying the social and civil rights of citizens fall within the functions granted to the territorial units on the basis of the revised Title V, and through the equalization fund, the legislation secures a country-wide effective implementation of these rights if their securing constitutes a standard task of communes, provinces, regions and metropolitan cities (Balboni 2001, 1108). Financial autonomy of the regions and other local units does not mean a definite loss for the state of influence on the regulations in the sphere of regional finances due to granting competitive legislative power in the harmonization of public budget and coordination of the tax system (framework laws, basic principles) (Nosewicz 2009, 96). A very important act, which modified the rules for financing the healthcare sector, prior to the entry into force of amendments to the Title V of the Constitution, was the legislative decree 2000/56, which extended the responsibility for financing healthcare also to the regions and introduced the foundation for the concept of the so-called fiscal federalism. Nevertheless, for over ten years, this concept had not been implemented and only the entry into force of Act 2009/42 and of the legislative decree 2001/68 were an attempt of its implementation.

The Constitution distinguishes two systems of financing, where this distinction is made through a regulation according to which sources granted to autonomous entities for various reasons allow them to finance the performance of functions entrusted to them (Pinelli 2006, 199). Another sys-

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8. See: Salute (diritto alla) by R. Balduzzi In (Cassese and Catenacci 2006, 5400).

tem of financing is focused on “additional sources” and “special intervention”, which are passed by the state to the individual autonomous entities, in order to “promote economic development...” (Article 119, paragraph 5 of the Constitution). In addition, Art. 120, paragraph 2 of the Constitution states that the government may replace the regional bodies of metropolitan cities, provinces and communes . . . when it is required by the protection of legal or economic uniformity and in particular, by the protection of a significant level of services in terms of civil and social rights, regardless of the borders of local authorities. This provision grants the state the right to different establishment of the limits of benefits, even though interfering with responsibilities reserved for the regions, every time when the necessity of guaranteeing their compliance is required (Luciani 2002). It should be emphasized that the new solutions introduced by Title V of the Constitution were not sufficiently used, which resulted in the failure of the introduction of the constitutional model of financial autonomy of local authorities (Scuto 2010, 70).

Summing up the above considerations, it should be acknowledged that the autonomy of local entities has been extended to many areas, including the matter of healthcare. As a consequence, the result of the changes was a greater participation of the regions in the management and regulation of the system of health services in their area. It should be recognized that the increasing autonomy of the regions is a positive phenomenon, whose main manifestation is visible in entrusting them with the legislative function in a number of important issues, including those related to healthcare, as well as the decentralization of administrative and managerial functions. In the regions, local needs and health determinants of the population are better recognized. The Italian experience shows that decentralization of the health system has influenced the increase of competition on the market of health services and has guaranteed wider access to those services.

It should also be noted that the reform of the health system, initiated by Act 1978/833, continued by changing Title V of the Constitution, has not yet been completed. The process of transformation of the healthcare system is entering a new phase, related to the financial crisis and the reduction of funding of health services. The fact that Mario Monti’s administration, as a part of austerity policy of the country, has proposed a serious constraint on the amount of funds allocated for financing the healthcare system, and which deserves, in this context, special attention.

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