Master Thesis

Is Devolution the Solution?

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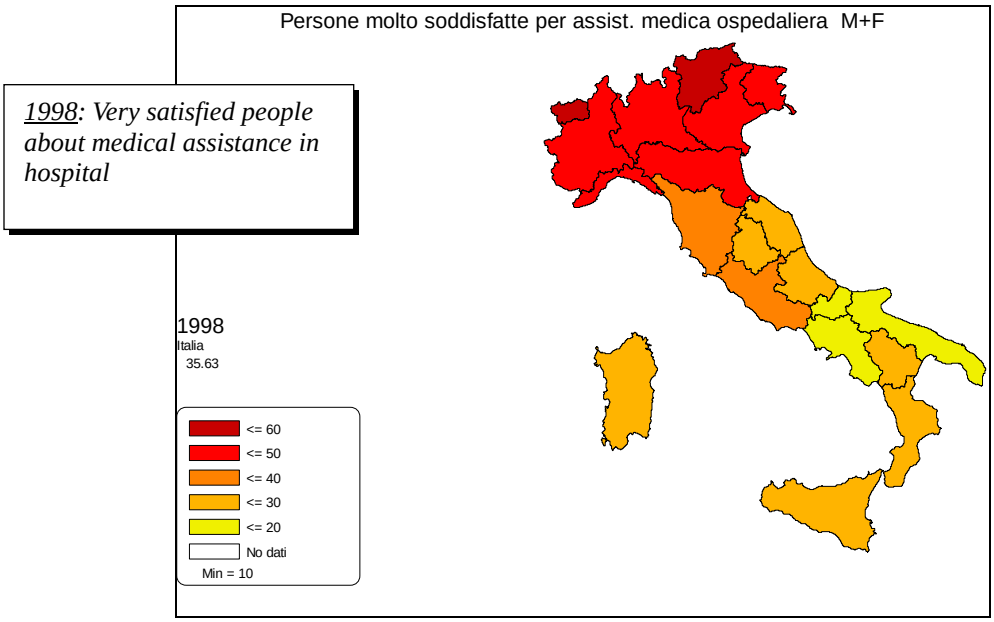
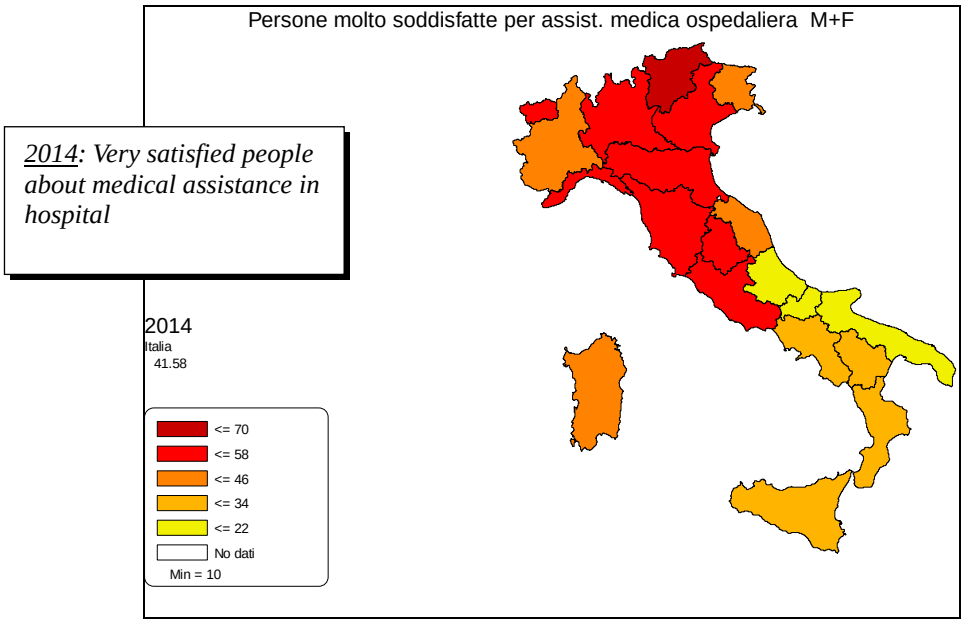
Preface: This is a study on the effects of devolution on the Italian healthcare and on a deeply divided country, still undecided whether to be properly federalist and in turn come back to centralization. This thesis would like to propose a reflection on such situation, on its limits and open contradictions.





(Source: ISTAT – "Health For All")

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Chapter One: The Introduction

1.1 Introduction

This thesis seeks to shed light on the Italian devolution and federalism's effects on the regional healthcare system and budgets, which are also dependent on strong differences that exist between the more developed North of the country and the less efficient South.

As a matter of fact, devolution in Italy is inserted in this thesis against the background of the North/South divide of the country, while analyzing the domain of healthcare and the consequences on budget. The divide has economic, political and social consequences, and so does devolution. To see what these consequences are, two regions, one of the more efficient North (Lombardy) and one of the less functioning South (Calabria) have been chosen to analyze devolution's outcomes within the domain of healthcare. In the chapter dedicated to the case the divide will be better inquired upon. However, the national healthcare system will be evaluated too, and for that purpose data from international and national institutions will be used. The North/South divide is our independent variable, devolution our intervening and the Regional Healthcare System’s budget our dependent variable.

1.2 Research Questions

To reach our goal of understanding the consequences of the devolution's reform on budgeting and healthcare, a general research questions plus three more sub-questions are going to be proposed in the following chapters.

The general research question is: *To what extent and how did devolution enhance governmental ability in the domain of healthcare between the North and the South and make it more governable?*

Subquestions:

- *What is the of North-South divide that in Italy?*;

- *What can we learn from the theory on fiscal federalism and devolution about potential consequences of the devolution reforms for the Italian case?*;
- *How did the devolution reforms impact upon Italy's healthcare?*.

The sub-questions will introduce each relevant chapter, to be answered in its end. In the conclusions of the master thesis, they will be once again reported together with an answer on the general research question.

1.3 Definition of Concepts

In this section, the most important concepts that will be found in the thesis will be briefly defined. The first one is devolution, which is intended in this paper as a governmental strategy that permits institutions like cities, metropolities, and regions to run certain policy areas previously in the hands of the State. More precisely, in this paper devolution regards the domain of healthcare, used to involve the public sector as service provider for the citizens/clients (Metho Jr., 2015). This strategy is sometimes termed as third-party government (ibid.).

The second important concept explored in this paper is federalism: the shift of power from the State to the periphery. Strictly connected to federalism is fiscal federalism, also known as budgeting, which refers to allowing the local political institutions to use the taxes' funds they collected.

1.4 The Domain of Healthcare

The domain of public management that this thesis has chosen to investigate is the healthcare. The choice has been made because, on the general level, such sector is typically one of the most important both at the State level for its strategic importance, and on the specific level, because healthcare is one of the biggest machines in the country, guaranteeing employment and decisive services to the population.

It should also be said that the specific nature of the topic makes this subject particularly suitable to be treated in the reflection on federalism. It is a matter of technical and institutional elements. Typical issues of personal services (proximity to the population, territorial diversity of needs, democratic control) cross the equally important sources of funding in exchange for resources and the management of the public budget, creating a stimulating set of "federalist" and "centralist" themes. It is no coincidence that the word "coordination" often appears in this thesis, as a fundamental organizational imperative, perceived as important but not easy to implement.

The relevance of the subject matter itself and the considerable historical and qualitative data series are the basis for drawing enough information. On this empirical basis, it is possible to make a confrontation with the concepts identified during the theoretical analysis of federalism in general and its version as "devolution".

1.5 Academic Relevance of the Thesis

The academic relevance of the thesis to the master course of Public Administration (COMPASS) lays firstly in the choice of analyzing devolution. Public administration identifies the need and capacity of the governmental institutions to run the *res publica* directly and indirectly, in this last case by allowing other societal actors (especially market ones) to substitute themselves to the State, provided that the latter works as warrant. Secondly, devolution's effects are investigated within one important domains, which is often considered in in public administration's field studies: healthcare budgeting.

Finally, this thesis has also a societal relevance, as it will insert the previously-named domains and the theory into a specific context, that of present Italy. Second-hand data that is already available will be analyzed for both the chosen case and the theory to better comprehend the current context and outcomes of the Italian healthcare system.

1.6 Outline of the Thesis

Chapters 2, 3 and 5 will be preceded by a research question each we desire answering in the thesis. The first chapter introduced the themes and structure of this thesis. The next chapter explores the contextual part where the N/S divide, the constitutional structure of federalism and the devolution reform will be unraveled. In the third chapter theories over federalism, devolution, and budgeting will be explored. In this chapter, the general theory compared to the chosen case will thus be paired. The fourth chapter will be the methodological one of this master thesis, since it will contain the explanations on the choice and use of the second-hand data that will be later used in the fifth chapter to analyze the outcomes of the paper. As previously said, the data will be qualitative and of second-hand, provided by both Italian and international official institutions, and will be as recent as possible. The fifth chapter, as said, will be the first part of the empirical part of the thesis, where the Italian set prior the devolution reforms will be investigated; followed by chapter six, the second part of the major empirical section, where the consequences of devolution on the country will be seen. Finally, chapter seven will be the conclusion of the paper, in the hope to summarize it and propose further research.

Chapter Two: The North/South Divide in Italy

2.1 Introduction

We start the core part of the thesis with the contextual chapter about the Italian situation, where the reader will be introduced to the N/S divide, our independent variable, and the devolution reforms, our intervening variable. Our main interest here is to report important information regarding the origins, potential reasons and current state of the North/South divide in Italy, together with the description of the progressive introduction process of federalist-like reforms.

Moreover, the sub-question we aim explaining in the end of this chapter is: *What is the North-South divide in Italy?*

2.2 The North/South Divide in Italy

Italy is a very heterogenous country with many and important differences between the regions and especially the North-South divide. This last bit is recognized and the literature covering it is immense, hence it is impossible to mention it adequately (Lepore, 2012). A second important thing to note is that this regional heterogeneity takes the form of a set of unbalanced advantages and disadvantages, of wealth and poverty, development and backwardness: in the North, the most positive elements in the South, the most negative ones – a gap. It is reflected in social, economic and institutional areas, structural and with deep historical roots.

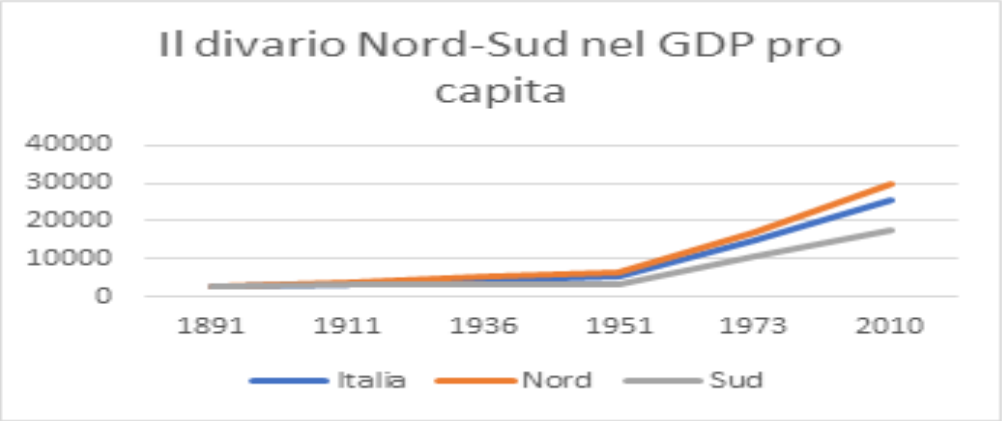
The differences in development and conditions between the North and South of the country were part of the cultural debate topic since the birth of the Italian State (1861). The issue is summarized under the name "Southern question" as the South has long been at a severe disadvantage, unique in its dimension.

Below some significant data on the long historical period are exposed. The Centre is in this case ignored as inappropriate. The differences between the two areas result in a clear gap also in the

resident population. It is strengthened by internal migration, as presented in another graph.

In graph:

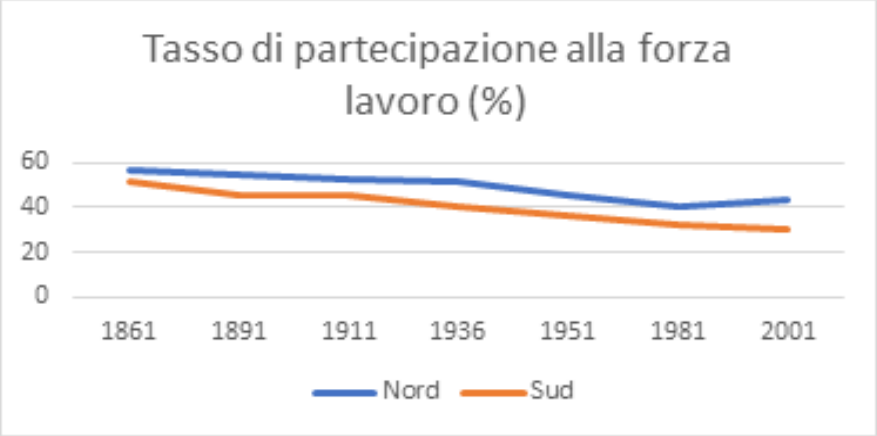
Graph 2.0



With the economic boom of the 70s the wealth increases and consequently so does the gap between the North and South.

The score of participation to the workforce (percentage of the population):

Graph 2.1: Employment Rate.

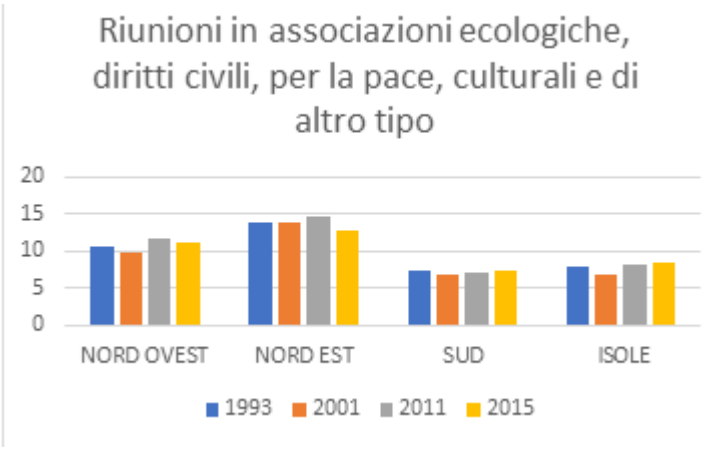


Source: Daniele and Malanima, "Il divario Nord-Sud in Italia", ibid., pg. 121.

In the context of uniform decrease of this score, the North still is at a higher level than the South and in turn inverts the trend in the last years, whereas the South always stoops lower.

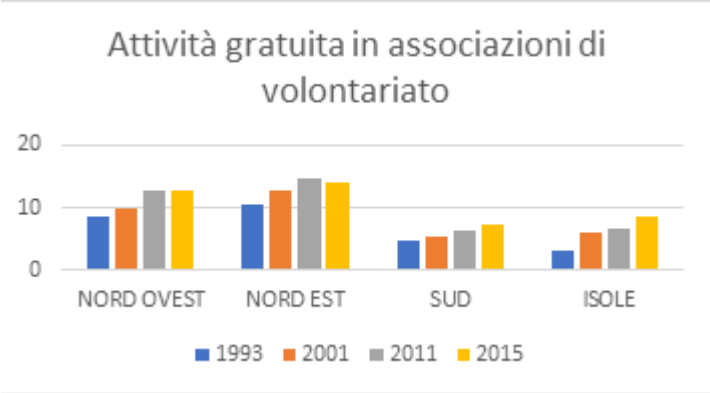
Social partecipation:

Graph 2.2: Civic participation in pro- environment, human rights, peace, culture and other sectors pressure groups.



Source: Istat, Serie storiche – People of 14 years on per involvement in social partecipation activities and peple of 6 years on per religious locations' attendancy rate, per gender and geographical area. With edits.

Graph 2.3.: Volunteereing.



Source: Istat, Serie storiche – People of 14 years on per involvement in social partecipation activities and peple of 6 years on per religious locations' attendancy rate, per gender and geographical area. Years 1993-2015 (per 100 people of the same gender and geographical area). With edits.

In this and in the last graph the huge gap in the partecipation to the social life is to be seen. The South has lower social capital levels than the North.

It is important to highlight the historic inner Italian heterogeneity and that between the North-South whithin this thesis, as this difference makes up a good argument in favor of a somewhat decentralized management of the public administration; and at the same time, it may be or it is a context condition which leads to a reform having negative outcomes if such reform shifts the power from the centre to the periphery. At the same time, the regionalization of the country happened too, achieved through legislative decrees.

In the years after the World War II, with a very strong economic growth and an equally strong growth of the N / S gap, the "Cassa per il Mezzogiorno" (Fund for the South) was an attempt, through a system of extraordinary intervention to remedy to the lack of industry in the South, growing there thanks to huge financing programs an industry that did not develop itself spontaneously. This extraordinary intervention still managed to produce some positive incomes, for instance a strong development in the South and a temporary reduction of the gap with the North (Lepore, 2012.). The limits of this policy were highlighted in the 1970s, with the birth of the Regions, and again a little later with the explosion of the first major energy crisis.

2.3 Explaining the North/South Divide

The Italian storiografy is not united on the North-South divide. A part of it maintain that the differences were already relevent at the time of the unification of the country in 1861 (Cafagna, 1989). Another one, more recent, states in turn that at the time of the unification of Italy in 1861 there was still no N/S divide issue (Daniele and Malanima, 2011). There were differences but not big enough to frame an issue of this type and importance (ibid.). In fact, some areas of the South were better developed than the North regarding wealth and living standards. According to this point of view, the story of the gap begins with the industrialization of the country and its relative economic growth, but it is also important to remember that geography played a role too, with the North being closer to the more industrialized zones of Europe. In a country that was geographically diversified and with a flawed network of incoherent communication, it was the North to benefit from its proximity to the large industrial companies in Central Europe, while the South suffered from being too distant and poorly connected. The economic and geographical relocation of the country has triggered the formation and growth of the N/S gap (ibid.). Imbalances are common in most countries, so the peculiarity of the Italian case lays in the lasting of the gap over time (Daniele and Malanima, 2011).

One can explain the gap with the central role played by the factors of production. There was indeed an important difference in productivity labor and employment rate. The South was less able to accumulate the factors influencing productivity and leading to wealth creation and added value (Daniele and Malanima, 2011). In general, it is agreed that the different degree of industrialization led in a decisive way to the different development and gaps between the North and the South (Lepore, 2012).

Putnam's most famous concept is about the “civic or social capital”, which measures the level of social networks, activities and the livelihood of citizens (Putnam, 1974). In the Italy of the 1970s, Putnam saw that social capital was mostly present in the North, much more than in the South. Regional traditions of social capital account for contemporary differences in the levels of regional development (ibid.).

Research on the economic causes of the gap, comprehensively the management of public resources, seems to provide the structural basis and concrete soil on which they can then engage in other "cultural" considerations.

2.4 Consequences of the North/South Divide

To be sure the Southern structural dependence by State transfers had grown remarkably over time (Daniele and Malanima, 2011). There were for sure important transfers of money and increased consumption, but without a true and solid increase in the production base, and without the independent ability to produce wealth surplus to match the received financing (ibid.). A mechanism that, once it got started, fed on itself to become even stronger: expenditure without reporting it.

In addition to the followed industrial policy, a big role was also given to the Italian welfare. Uniform delivery of public services was sought, in the face of very different tax revenue capacities from region to region and from North to South. It followed a redistributive result of the transfers to the South necessarily funded by the Northerner’s tax revenue. The South's development

(consumption, income, services) had no real autonomy on the revenue side.

As for the quality of public administration, it certainly seems important to get a "good" federalism (Marcantoni and Baldi, 2013). The southern elites - the political and bureaucratic ones - seem inadequate to their tasks and this, among other things, makes them particularly permeable to pressures from local lobbies (Mazzola, 2009). Also, the North South divide has produced in time a progressive occupation of the public administration by southern employees and leaders: if the economy was weaker, the State had become the largest employer (Cassese, 2014).

In 2013-2015, a research was conducted on in 206 European regions on the quality of relationship between citizens and public institutions (ANTICORRP, 2015). It turned out that the regions of Southern Italy were placed at the bottom. It does not go that well for the northern regions either, still the gap between the two halves of Italy is huge (CGIA Mestre, 2013). The quality of public institutions appears to be important in determining the level of economic and social development of a local or national community: in Italy, the regions of the South are characterized by the institutional quality levels clearly lower than the rest (Nifo and Vecchione, 2015).

2.5 Conclusions

The description of the N/S divide has not been a mere introduction as it describes almost two different countries. There are more explanations to the gap, but here we are more concerned to its structural aspect: the gap is radical and difficult to solve. For this thesis, the gap's consequences are important especially for institutional and political reasons regarding the devolution project.

The "federalist issue" has opened under the influence of various pressures, of political and cultural order. The project of unified and unifying federalism has been dropped on a very divided country at the regional level. A federalist process of this type creates the risk to increase the already serious territorial gaps, instead of limiting them. For the moment, it is confirmed that the comparison with the N/S divides as an independent variable proves crucial and essential for an assessment of Italian

federalism.

Currently, it’s not easy to tell if the Italian N/S gap will allow a real attempt to federalism or whether it is more correct to think about a form of regionalism which just remains something alike an explicit devolution.

Chapter Three: The Theoretical Framework

Now that we have introduced the context by reporting on the N/S divide in Italy, we need to theorize the concepts of federalism, fiscal federalism and devolution *per se* in this order.
While doing this, we will try answering our sub-question concerning the theory, which asks: *What can we learn from the theory on fiscal federalism and devolution about potential consequences of the devolution reforms for the Italian case?*

3.1 Federalism

The word "federalism" is well suited to the political debate because its vagueness allows alluding to very different institutional situations between them, summarizing all under a single entry thanks to some common basic characteristics. The crucial question on federalism (in its top-down version) we want to answer is to see why would it be more convenient to entrust functions and decisions to the sub-state entities, rather than centralize all the powers.
Using an economic approach, it can be said that the argument in favor of federalism is based on at least two assumptions. One considers the diversity of citizens' preferences: individuals residing in several local authorities have different preferences, like on supply of goods or on public services. These preferences can affect both the quality and quantity of that good or service. The other states that local bodies have an information advantage over the central government: they know better the preferences of citizens within their territory.

3.2 Pros of Federalism

Supporters of federalism (Dafflon & Madiès, 2012; Fabbrini, 2011; Elazar, 1995; Nuti and Vainieri, 2011) argue that it is primarily the best solution to increase the autonomy and efficiency and this is because:

- It adapts the offer of public services to the different preferences of citizens, thanks to the increased information that it has the local authority;
- it may decide the quality and quantity of public spending and taxation according to the preferences of local citizens;
- it increases administrative efficiency thanks to the "chain of command" shorter and with less loss of information from the base to the apex;
- allows more opportunities for experimentation and innovation in the policies implemented and the provision of public services, due to the greater flexibility of the administrative action;
- it allows to stem the separatist political pressure.

Also, federalism increases the level of responsibility in the management of public affairs, because it better connects citizens to public power.

In summary, a federalist approach has the advantage of better aligning public choices to the citizens/voters' preferences and to empower local administrators in their management decisions (Dafflon & Madiès, 2012; Fabbrini, 2011; Elazar, 1995; Nuti and Vainieri, 2011). Moreover, the accountability of local governments makes it comparable their choices, by allowing citizens to express opinions on their work (ibid.). Lastly, the territorial mobility of economic factors, both of resources and of people will tend to reward the most virtuous and local governments to warn the least efficient (ibid.). It is supposed that competition is stimulating for the improvement of public services.

3.3 Cons of Federalism

But federalism may also have limitations and drawbacks. An important point in this respect is that it can accentuate territorial inequalities: in countries with strong regional differences in the distribution of wealth, federalism could weaken the redistributive action of the central government and can get to introduce such strong inequalities in the provision of public services to undermine the rights of citizenship.

This means that careful equalizing activities by the central government are always required. The idea of belonging should remain central in the concept of federalism, otherwise it will not work and the very belief of being a nation will consequently fall (Elazar, 1995). In addition, the tax competition among local governments can reach excessive levels and counterproductive to the proper functioning of the system.

The discussion on the trade-off between equity and efficiency is central in federalism, especially in its version of "fiscal federalism". Other problematic aspects of federalism can be:

- Stronger institutional conflicts between different levels of government;
- problems of coordination between levels of government in the interventions of spending and taxation, as well as in law-making;
- the easing or even blocking of national reforms still necessary and appropriate, because of the opposition of the peripheral entities;
- a sharp increase of lawmaking and of little use if not harmful;
- exposure, with less defenses, to the pressure of interest groups;
- no exploitation of economies of scale in the provision of public services;
- territorial externalities (spillover effects): the actions of local governments can have negative externalities on other neighboring areas, damaging the services;
- harmful tax competition: decentralization can push local governments to excessively reduce tax rates to attract citizens and businesses, leading to an too low levels of public spending;
- weakening of the extent of redistribution and stabilization: the strong decentralization can lead to weakening of the coordination implemented by the State through its redistributive policies and macroeconomic stabilization.

3.4 Fiscal Federalism

Fiscal federalism is concerned with the determination and distribution of responsibilities, functions and funding arrangements between the various levels of government; it is assumed that the powers, responsibilities and resources do not rightfully belong to the only central level (Fabbrini, 2011).

The traditional theory of fiscal federalism is heavily in debt with the economic approach. But the

reasons to "decentralize" can be different and not all implied by economic theory. Other criteria are linked to the managerial and operational capacity of local governments, and others to the socio-demographic characteristics and historical policies of the territories.

Following a generally-accepted scheme, a state organization may be: Unitarian/centralized, decentralized, federal, confederal (Dafflon and Maidès, 2012; Bognetti, 2016).

It is probably the case to thank the confederal part for the original meaning of the word "federalism", when refers to the combination of previously separate entities, either a top-down or a bottom-up approach. History tells us that the first one is preferred, which moves from centralism to go towards a gradual strengthening of the peripheral and local community organizations. The second and opposite path is rather typical of the so-called "confederal" States (Elazar, 1995).

In an ideal scheme, in the centralized state all decisions are taken centrally. This does not mean that local public services are delivered to offices that can also be highly decentralized, but they respond hierarchically to the central government. In this case, the devolved administrations act as peripheral central offices. As indicators (approximately) of the degree of centralization, we can use the share of central government spending to total government spending, or the proportion of central government tax revenues total.

The "top-down" path as mentioned earlier is certainly what concerns the topic of this thesis.

The approach of which we speak is indeed the "descending" type: the strategic advantage is, at least initially, in preferences and priorities decided by the central government, with a gradual transfer of powers and responsibilities to the suburbs, until it get to a (possible) turning point where the decentralization becomes true federalism. Some basic characteristics are required:

- the need of a constitutional provision;
- the budget constraint is moved to the local government, and therefore it is expected a transfer of expenses but also the transfer of skills;
- purpose of the welfare growth with better adhesion to citizens' needs;
- at the same time, minimum parameters of fairness and uniformity indispensable for the entire national territory, to safeguard the rights of citizenship;

- allocative efficiency growth;
- all the public actors would enforce the objectives of the centre (Dafflon and Madiès, 2012).

As for the features on the expenditure side, fiscal federalism must also pose the problem of the collection of resources on the revenues side, eg. taxes and debt by the local governments.

Local governments typically derive an important part of their income from transfers from higher-level government, from general taxation. This situation derives from the centralized tax advantages and difficulties of the local; these difficulties prevent an amount of tax resources able to fully finance local spending. On the side of the collection of tax revenue, the central government still appears to be the subject stronger and knowledgeable, as well as stronger is its power to sanction illegal tax behavior.

Moreover, budget transfers from central to local communities are never entirely absent, because it is necessary to: compensate the local level when it must perform a function "agency" on behalf of the central government, such as the provision of an essential service base throughout the country;

integrate local tax revenues to ensure the performance of the core functions;

correct imbalances (horizontal). The latter is where there are serious imbalances between the various local communities, for diversity of income, wealth and available services ("equalization") (Dafflon and Madiès, 2012).

3.5 Federalism and State Capacities

In relation to the political and administrative decentralization processes, the theoretical reflection has also exerted on the government's ability to characterize the action of the state or its sub-level. The drive towards decentralization comes from seeking the best information and the best way to use them: a good knowledge of the situations on which exerts the action of the government is crucial (Rueschemeyer and Evans, 1985). It is favored by the proximity with the people and with problems that are on the territory. In addition, decentralized administrations shorten the hierarchical chain of

command, reducing the risk of distortion or misunderstanding on the given instructions. But decentralized organization also requires coordination between the various levels of government. Otherwise, there would be a high risk of fragmentation of the government.

One of the fundamental tasks of a state apparatus is to ensure a level of relative autonomy and internal cohesion to develop its own line of action, and to be relatively independent of pressure groups. At any level, an action of efficient and effective government requires the presence of a professional bureaucracy, well trained in the technical aspect, capable of internal cohesion and coordination (Rueschemeyer and Evans, 1985). Another interesting reflection applied to a multi-level governance situation, essentially federalist, is related to the specific field of healthcare (White, 2011). It is concluded that it is the central government entity that is more likely to succeed in changing the healthcare system (ibid.).

For this, there are three great and fundamental needs to be met, which translated into "capacity" mean: knowledge (which leads to the "technical capability" to solve problems), power (which is the "institutional capacity" to intervene), and the political will (the "political capacity" to identify problems and purposes and to aggregate coalitions of interest to translate will into practice).

Technical capacity implies the need to make reliable predictions about what are the trends over time, such as the probability that a certain type of intervention changes in this situation in the hoped sense, such as appropriate technical means for this, namely: the means for the purpose. This capacity applies to different fields of healthcare, which is an area in which the technical aspect (and technological) is clearly very important. In general, we can ask what is the technical ability of an institution with regards to its accounting organizational apparatus, the professional quality of its administrative leaders and its service providers (doctors and other staff, in our case), of the management methodologies used, the administrative and technological equipment available, the information system and control of the organization and so on.

Institutional capacity is distributed to different levels of government. First, the fiscal capacity, i.e. the collected revenues. And then the coercive power to impose obligations and especially sanctions.

For these issues prevalence of central power may be preferable. But the central government has also characteristic weaknesses: strong procedural constraints are used to limit the otherwise too much power; the great organizational distance between the center and the final effects of the administrative action; the difficulty in dealing with increasingly complex problems that are "delivered" to the State by the various "market failures" in meeting the needs of citizens.

As for institutional capacity, if the competence to produce laws belongs to local entities, it will probably prevail the strength of the latter with respect to the central power. Another essential aspect of the institutional power is in determining the big choices in economic and financial policy. Here there is no doubt that power is in the hands of central government.

However, the government has limited ability to change behavior, especially when it comes to obtaining improvements in quality: it needs going through the work of the very people whose behavior should change.

Political capacity: in theory, the problems on which a government can exercise its action are many. It is the political choice of capacity the decision on what to tackle and the objectives to be pursued. The policy capacity therefore becomes important in determining the direction of “travel”. If the prevailing political sentiment pushes in one direction, and if this coincides with the government's intentions, it is easier to grasp the results.

On the difficulties of a central government policy capacity it affects both the division of powers between the various actors involved, both the magnitude and the internal differentiation of a company. The company has become more and more complex, interest groups are ubiquitous, and this increases the complexity and the level of bargaining. But one group is more likely to influence on those topics that attract less attention from other interest groups. Politicians need to be convinced that there is a legitimate problem to be solved, that the time is ripe for it and that there are practical ways. The selection of solutions depends more on the elite activity by other factors.

An important aspect of the problem definition is to see if and how a certain theme can be traced to another. It happened so that the issue of the cost control in healthcare has often been attributed to

budgetary problems rather than those of healthcare policy in the strict sense, and in these terms, has occupied the political agenda.

In the field of control of expenditure policy, the key condition to impose it is to demonstrate that it is necessary to balance the state budget; lacking this condition means that organized interests may also counteract the laws already officially operational.

3.6 State Capacities and Devolution

Devolution is such when considering the most extreme form of decentralization, i.e. when there is a transfer of powers and responsibilities to public bodies that are elected by the citizens (Dafflon and Madiès, 2012). It involves on the one hand the decision-making autonomy on costs (budgetary autonomy) and the resource collection inbox (financial autonomy); and on the other hand, the empowerment of local authorities towards their voters. This "political" element determines a qualitative difference from other more moderate forms of decentralization (Elazar, 1995). This aspect seems strengthened by its financial autonomy., provided there is accountability.

It remains to ask what forms assume the capacity of government in a devolution situation. It is easy to see the connections between concepts and statements used by these authors, who seem to complement each other. The crucial importance of the bureaucratic machine expresses both the strategic role played by the technical and professional knowledge, and the ability to collect and process reliable and updated information when you administer close to government territories. Here it is expressed the technical ability to a public system. In a situation of devolution, the technical capacity must be owned by the levels of government and entities that enjoy political and financial autonomy. It therefore requires that they be present in every actor of devolution: a professional bureaucracy, administrative organization and a technological device can handle in practice the theoretical areas of decision-making autonomy.

These issues lead to considering the institutional capacity, that is, the power of action that should

characterize a public entity entered a devolution situation. We have seen that the power to collect tax revenues makes it necessary. This power must be clearly attributed to the local government, not only by the Constitution but also by a coherent system of laws and implementing regulations. Moreover, from what has been said it should be clear that decentralization, especially in the extreme form of devolution, we also expect a simplification of government action. By acting locally, it expects a decrease in complexity that characterizes very large territories, a better ability to solve problems, a greater influence on the behavior of other organizations and individuals. In devolution, government objectives can be expressed in the most practical form because the decision-making level is much closer to the territory and much shorter chain of command. This should involve, among other things, a reduced need for abstract and general legislative output - limited to a few major strategic laws - and a focus on immediate operational standards. We can say that devolution is the system in which the abstract content of the laws is as close as possible to its implementation in practice. The institutional capacity of a body invested by devolution should be characterized: a regulatory apparatus relatively sober and able to produce real results in the short and medium term without the need for lengthy procedural paths; by a clear fiscal competence and the consequent ability to sanction transgressive behavior in relation to taxes; from effective chance of affecting the behavior of the local area actors.

3.7 Conclusions

In this chapter, we considered mainly federalism and one of its branches, fiscal federalism.

The concept of federalism also contains the awareness of its limitations and its potential flaws: we described them when we have listed the "pros" and "cons" of federalism. We also noted that the capacities that a state apparatus must have to carry out its basic functions do not because of federalist choices, but have different connotations depending on the new institutional situations.

Decentralization, federalism and devolution are not so absolute technical or political imperatives,

but reform processes and ways of governing with virtues and defects that require requirements and conditions to be implemented with a certain probability of success. They intervene on given situations, which are the result of history and social and economic vicissitudes; the interaction between the given socio-historical and the experiment of decentralization can produce results very different from those expected in theory.

All this will serve in the next chapters for an assessment of the Italian case. We will do this in the specific field of health, because it is matter delegated to the regions and why this matter is investing the most resources and regional policies.

Chapter Four: The Methodology

4.1 Introduction

In this chapter, our *modus operandi* will be reported and explained. We recall that this thesis confronts with an attempt to build devolution in Italy, who for a long time had a centralized public management. The general context in which this reflection is inserted is the Italian gap between the North and South considered as an independent variable with which the federalist variable intervening process, was necessarily confronted as an objective fact. Public healthcare has been chosen, as a matter of deepening devolution, because it is the most important and most funded institutional framework, among those that are in the Italian regions' competence in their autonomy.

Legal texts, expert contributions, research results, and statistical databases have provided the material that has been used to describe the evolution of public healthcare under the federalist push and the present situation. Italian healthcare is therefore the dependent variable on which the federalist experiment has exercised its influence; it is about analysing its problems, its way of government and its current outcomes.

With the theoretical concepts set out in Chapter 3, we try to understand the characteristics and results of what has happened during a process of progressive regionalization that had its fundamental transition in the constitutional reform of 2001. A key role of analysis and comparison is played by the three "governance skills" described in that chapter, supplemented by other reflections presented there.

4.2 The Selected Case

The Italian case is of great importance, and of specific interest, for at least two reasons. First, Italy in the end of the 1970s implemented perhaps the most ambitious healthcare reform in Europe, following the British NHS, but leading to the extreme the principles of universality and gratuity of

care, with the prominent role of public spending and with, at the origin, a proclaimed prevalence of needs on budget imperatives. Secondly, since the 1970s and then with a growing transfer of powers and resources throughout the 1990s and beyond 2001, Italy was attempting to implement a process of strong regionalization of public functions, until explicitly speaking of federalism in public documents. The country has moved from a situation of strong centralization and then began a process of progressive delegation of powers.

It is therefore possible to say that healthcare is really one of the main trial of Italian "regionalism", that is, that version of federalism that Italy has been experiencing for about twenty years. Regions spend most of the resources at their disposal (own and transferred) in healthcare. In addition, in healthcare, the Italian regions have accumulated a long experience of autonomous management responsibilities (at least since the early 1990s), even before the federalist reform of 2001. Therefore, in the Italian case, the federalist experiment crosses an ambitious healthcare reform and this crossroads makes Italy a very interesting country in this regard and further justifies the theme chosen for this thesis. To this, other important considerations are added.

Concerning the context, the fundamental independent variable is the North/South divide: a historical and consolidated figure, rich in economic, social, institutional and cultural implications. Given that federalism tends to highlight regional differences, pursuing a federalist process in a country so deeply marked by territorial diversity opens the way for many questions about the feasibility and outcome of that path. This argument raises interest in research, but at the same time exposes it to many problematic questions.

Another major problematic aspect is the historical phase experienced by the Italian State, in the aspects of budget management and public finances. Italy has long lived with major public debt problems and with periodic internal financial crises, like the 2008 one. It must therefore be noted that the Italian State has embarked upon crucial processes of healthcare reform and radical institutional innovation in a context marked by the serious difficulties of public finances

4.3 The Two Regions

Strictly speaking of the healthcare domain, the two regions, Lombardy and Calabria, have been chosen because they perfectly show the Italian contradiction and its crossroads path. On one hand, some Italian regions are successfully going to a more decentralized system, possibly but not at all costs liberal (Lombardy), while others are still struggling and are dependent on public support (Calabria); and on the other, some regions score in line with other European regions in the healthcare services' quality (Lombardy), while others are either negative or worse (Calabria).

Thus, in the general context of the North/South divide, two regions have been chosen as more concrete evidence of the gap. We will justify their choice in the following lines.

Lombardy was chosen precisely because of its identity. It is not just one of the richest areas in Italy (and Europe). It is also the region where the effort to use the space of autonomy and potential innovation created by the federalist reform has been more intense and coherent, giving rise to a quasi-market, managerial and subsidiary model. If the autonomy of action that characterizes devolution should serve to emphasize the peculiarities of individual territories, Lombardy has been an expression of this freedom of choice and of institutional experimentation. That's why it seemed right to consider it in this thesis. The importance of Lombard experience has made it relatively easy to obtain quantitative and qualitative information from databases and from specific studies and research.

Calabria is one of the poorest areas in Italy. It is afflicted by rooted problems, organized crime, immigration to the North and abroad. But for this reason, it makes sense to wonder whether devolution in the specific field of healthcare has yielded some positive results in this region, in the direction of progressively overcoming the historical distance from the living conditions of the northern regions. It is therefore legitimate to ask that use has made Calabria of federalism, however the search for information and data on healthcare conditions in this region was more difficult than initially envisaged. We believe that this very difficulty is a testimony to the shortcomings and

inefficiencies of a regional information system that is still too backward and incomplete with respect to the needs of good management.

4.4 The Sources of the Data

Financial data have their main source in the MEF, the Ministry of Economy and Finance. And this is directly when data taken from documents or official reports of that ministry are reported indirectly when quoting study and research data using the sources of that ministry. In bibliographic the references section this aspect is specified.

Data describing the health indicators of the population and the financial aspects of the Italian healthcare system come mainly from the ISTAT National Statistical Institute, both at national and regional level. On paper media instead, the Italy-Raising Standards report provided a good basis for describing the Italian healthcare service as it is today. In addition, important quantitative data were taken from the OECD webpage. Other useful quantitative elements and qualitative observations come from field research conducted by public or private bodies, universities or foundations, like Agenas or Censis.

4.5 Type of Data

The type of data here used is a secondary data, instead of data collected directly on the field. This choice has been made because, on one hand, this research paper is short-timed, hence the use of pre-existing data instead of fetching it by ourselves; and because there is as much data needed on the subject, provided free of charge by mostly statistic and institutional sources. Moreover, the importance attached to the "health" topic has made it easier to find materials and documents that make up the bibliography and the content of this thesis.

The theoretical concepts and theories identified in Chapter 3 are of course academic. Qualitative

and quantitative data and data have been used to describe the North/South divide, the characteristics of Italian devolution, the evolution of the health conditions of the population and the transformations suffered by the public healthcare service as a result of the federalist process.

It was first mentioned, of course, in the most classical and consolidated bibliography, consisting of books and articles, inevitably most of the time in Italian, aside from international contributions to the theory of federalism and databases at OECD. Not marginal was also the contribution of the web, where there are presentations - on specialized and trusted sites - contributions and reflections that it seemed right to include. This has also been done in the bibliographic references, trying to be as accurate as possible in the indication of the source.

Regarding quantitative sources, they are primarily the databases of the OECD and the Italian Institute of Statistics, Istat. In other important cases, reference was made to the data published by the Ministry of the Economy and Finance, the Court of Audit reports, the databases of public health institutes, the researches carried out by well-known and prestigious institutions. In some specific cases, the data deriving from the afore-mentioned sources has been slightly edited juxtaposition purposes.

4.6 The concepts and the indicators

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Table 4.0

CONCEPTS	**INDICATORS**	
	Quantitative	**Qualitative**
The N / S divide in general (the independent variable)	Inhabitants	Public administration's quality
	Social partecipation	Presence of social capital
	GDP pro capita	
	Participation to the workforce	
	Education level	
	Internal migration	
The N / S divide in the healthcare domain	Financial deficits	Presence / absence of programming tools
	Healthcare expenditure	
	Presence of private operators	
	Rate of use of beds in public and private hospitals	
	Users' satisfaction rate	

	Healthcare mobility between regions	
	Users' health conditions	
	Life expectancy hope	
	Infant mortality	
	Number of doctors	
	Total / Public healthcare expenditure	
	Rate of bedstock of ordinary hospitals	
Devolution (the intervening variable)		The State's norm production over time
Technical capacity	The trend of efficiency indices such as hospital bedding, average stays, and bed use rate	Presence or absence of an adequate regional information system
		Presence of technical and scientific institutions in health
		The professionalism of the public bureaucracy
		Presence or absence of healthcare plans and legislative products of strategic nature
		Stability of healthcare management
		The ability to control the budget
Institutional capacity	Production of regulations in the healthcare sector: their number	Production of regulations in the healthcare sector: their quality, prevalence of fragmented norms or presence of strategic and innovative ones
		Financial and tax autonomy
Political capacity		Stability of the regional government. Continuity over time even under the ideological aspect.
		Influence of doctors and private entrepreneurs over the healthcare policy
The second intervening variable: the international financial crisis and the influence of central state power		Crucial role attributed to the Ministry of Economy and Finance
		Policy of transfer with prizes and sanctions
		The role of the regional "return plans"

In the context of this thesis, not all factors and concepts are translated into quantitative indicators. Where it was necessary, elements and information of a qualitative nature have been used, extracted from research and studies from time to time indicated.

In Chapter 2, the general North/South divide as a contextual and independent variable has been presented with tables and graphs useful to describe the existence and scope of the gap, not forgetting its temporal dimension and hence its evolution over the years. Different indicators were considered to express the concept of a multidimensional and rooted division: demographic data and internal migration, GDP measurement and trend, occupied labour force, education level, social capital in terms of participation in associations and volunteering.

An analogous approach is used in Chapter 5, dedicated to describing the history and timing of the healthcare service and the North/South gap in the specific healthcare area. The time dimension is important because it also involves the years in which the devolution process takes place to ascertain any differences between "before" and "after".

The technical capacity of government is perhaps the richest variable of reference indicators. To recognize its presence, we considered: the presence or absence of an adequate regional information system; the presence of technical and scientific institutions in health; the professionalism of the public bureaucracy; the presence of healthcare plans and legislative products of a strategic nature; the stability of healthcare management; the ability to control the budget; the trend of efficiency indices such as hospital bedding, average stays, and bed use rate.

Institutional capacity of government has been sought primarily in the production of regulations regulating the healthcare sector: their number and quality, the latter being read as the prevalence of fragmented norms or the presence of strategic and innovative breathing standards. On this point, as with others that follow, it is plain to weave with the technical ability to produce programs and schedules. The expression of institutional capacity was also considered as financial and tax autonomy, with the demonstration of the autonomous power of the regions to raise taxes to finance

themselves. Moreover, and in general, the text of the thesis highlights the qualitative testimonies of that "regional centralism" that characterizes the current season of Italian devolution.

The political capacity of government is one that leaves less to be described quantitatively. We felt that we found its tracks in the stability of the regional government, and in its continuity over time even under the ideological aspect. The importance of stakeholder weight is also important, which the thesis essentially identifies in doctors and private entrepreneurs. In this case, the text offers some numerical indexes and some qualitative information that allow comments about their possible influence on regional systems.

How much validity can be attributed to the research method used in this thesis? In this regard, Chapter 6 sets out the overall reflections on the path and outcomes of sanitary devolution in Italy, in relation to the theory of federalism. This is also done with the help of two very recent and qualified researches, produced by two distinct university research centres. The substantially convergent conclusions reached by these two distinct reports and the actual applicability of the theory of federalism to the Italian case analysis suggest that the methodological approach used in this thesis is of sufficient validity.

Chapter Five: Italian Healthcare before and after devolution

5.1 Introduction

This chapter and chapter 6, cover the empirical part of our research. This first part starts by reporting on the pre-existing Italian healthcare domain before the major devolution reforms in the country; then, afterwards till current days. The information will be presented both in qualitatively and quantitatively ways and will cover the entire national territory at the beginning. The conclusion of this first part of the chapter will be in the description of the Italian healthcare system as it now appears, at the present state of the federalist path. Subsequently, in the following chapter, the elements that make up the North/South healthcare differences will be presented. By the same method, the next chapter considers the situation in the two selected regions, Lombardy and Calabria, as a further testimony to these differences. Chapters 5 and 6 therefore mainly descriptive, and it will mirror the concepts and arguments contained in Chapter 3 on the theoretical structure of federalism.

Therefore, the new sub-question is: *How did the devolution reforms impact upon Italy's healthcare?* Its answer will be provided in the end of chapter 6.

5.2 Italian Healthcare before devolution

Prior to 1978 the citizens were referring to different healthcare entities with different performance levels, forced by their employment status. The law establishing the National Health Service, n. 833 of 1978, represented the first attempt in Italy to give an organic form to public healthcare, as well as in its funding. Italy was the first country in continental Europe to fully legislate the principle of universalism in access to healthcare services, acting with the law establishing the National Health Service, hence the three goals that are the "international standards of health systems", i.e. universal coverage, contributions related to income and not risk or consumption, and centralized control of

resources (Taroni, 1995).

The guiding principles were those of a universalist and egalitarian vision of health protection, according to which the resources for healthcare spending had to be subordinated to the needs of the clients and with a uniform level of quality throughout the country. The performance of healthcare service delivery was based essentially on tax-funded state appropriations. The resources for healthcare were laid into the National Health Fund, approved each year in the budget. To calculate the total amount to be mainly used demographic criteria were chosen, based on the number and age of the national population, and from which the spending needs of each region were drawn. The allocation of resources to the regions also considered the "historical spending", considering the usual budgetary needs of the administrations.

Ultimately, the funding of public healthcare was governed by the principles of "financial derivative" or "transfer", with a strong centralization at the State level of spending choices, with the collection of the financial resources, and with the stated purpose of ensuring consistent service. This approach essentially characterized the entire period of the '80s.

Since this system stemmed a low sense of responsibility of regional and local governments, as it was always ensured coverage of healthcare deficit through budget, the consequence was that a widespread strong need for rationalization of healthcare expenditure emerged. The reform of law 833/78 was introduced with the two major legislative decrees of that period (n. 502/1992 and no. 517/1993) that moved from an acknowledgment of the failure of certain conditions contained in the law establishing the NHS. It proved especially difficult to ensure, through such a centralized and rigid model, the adequate levels of empowerment and responsibility of regional and local actors (Tanese, 2011). The maximum financial control body on the Italian public administration, this “second reform” of the National Health System was stimulated by the failure of the 1978 model reform (Court of Audit, 1999). The goal of the early 90's reform was then to come to a business management of healthcare, with a shift from the bureaucratic logic to the managerial one, and overcoming the rigidity of the previous centralized system (ibid.).

The beginning of the intense regionalization of the healthcare service process can be placed in these years. "The 1992-1993 healthcare reform acts (Legislative Decrees No. 502/1992 and No. 517/1993) started the actual regionalization of the NHS, concentrating the powers of organization and management of the healthcare services in the 20 regions and in the Autonomous Provinces of Bolzano and Trento, which had to adapt to their specific situations and implement the principles by national law" (Neri, 2011).

It is certain that in the new asset of the healthcare system, regions have acquired an increasingly important role, and the route taken in the ‘90s is the most meaningful one from this point of view. From the institutional point of view, this was because the structure of the local healthcare system and governance instruments were passed into the hands of the regions. From the economic point of view, because the responsible management of resources was attributed to the regions, through the definition of the funding mechanisms of providers (local health agencies and public hospitals) and with the shelf of any financial deficits. From the organizational point of view: "The control of management arises, then, as a tool that aids the management, because it allows the rationalization of corporate decisions that are the basis of decision making" (Court of Audit, 1999).

An important issue of the reform: the separation of the responsibility to ensure levels of care (exclusively entrusted to public power) and the responsibility for the production and delivery of services: this responsibility is attributed to both public and private entities. In this way, the system moves towards public-private competition, a competition which should ensure greater efficiency and quality for the citizen (ibid.). It can be said right now that Lombardy region will make extensive use of this competition since the second half of the 90s, with unique intensity and conviction compared to the other regions.

The State set with the budget law the available resources and the levels of minimal assistance from providers and distributed the funds among the regions in proportion to the resident population and other criteria. The regions have autonomy in choosing the financing model to be implemented in their territory; the State recognizes to the local healthcare authorities the choice of directly

delivering healthcare services or buy them from other entities, public or private. Each Region may, according technical and political considerations, decide whether to apply the tariffs set at the national level or to depart from them, staring at their default values (Court of Audit, 1999). In short, it was tried to start a federalist path.

Thus, in the regions there were different healthcare models. Since then, the regional governments have taken advantage of this autonomy, adopting very different strategies together (Toth, 2016). Connected with this subject, another strategic issue for regional governments is the involvement of private healthcare. Each region decides how much of the services delivered by the public structures, and how much to outsource to private parties or leave to their free initiative. In general, the regions of the South and Lombardy (North) have more use of private suppliers with respect to the Central and Northern regions (ibid.).

At last, with the Finance Act of 2001, the interest in the regions would be further strengthened by establishing the abolition of most restrictions on use of state transfers for the regional healthcare, and the cover-operating deficits through fiscal autonomy of the regions.

This radical transformation of the country's healthcare system took place under the direction of the State, and had its main stimulus in the urgent need to control public spending.

5.3 The Devolution Reforms in Brief

The history of administrative decentralization in Italy is a long one. Until the 1970s, Italy had been a typical centralized and unitary country, where as a rule the State detained all the prerogatives for itself (Putnam, 1994). This happened despite the Constitution of 1948, which provided for the creation of the regions, which however remained a simple patchwork (Elazar, 1995) until the 1970s (Sepe and Crobe, 2008).

With a first series of decrees in 1972 began the transfer of administrative functions from the State to the regions. This was followed by the DPR (Decree of the President of the Republic) n. 616 in

1977. This decree meant to trigger a major overhaul of the public administration, based on its new movement represented by the regions. The decree 616 had planned a massive transfer of administrative functions from the State to the Regions and local authorities (municipalities and provinces) and the simultaneous dissolution of many public entities declared "useless". Among the transferred functions, we find included those related to social and health services. To regions in turn was given the power to enact laws of reorganization in the areas to be transferred.

The legislative authority of the regions now included areas such as healthcare, housing, urban planning, agriculture, public works, and more. As a matter of fact, one of the organizational structure for the reform of the NHS and Welfare had been launched by some of the Italian regions. Finally, 1977 is the year of the institutionalization of the decentralization's shift (Putnam, 1994).

Twenty years later, with the so-called "Bassanini" there was another very important step towards devolution of institutional powers. The law n. 59 of 1997 was an enabling act to the subjects and the tasks reserved to the State, but it also guaranteed a remarkable degree of local autonomy. Hence, any function not explicitly reserved to the State was to be considered attributed to the competence of the regions or local authorities. This legislative output had introduced a massive and important transfer of administrative tasks, and resources from the central government to the periphery (Sepe and Crobe, 2008).

The main feature of the Bassanini reform effort was to modernize in a coherent and coordinated fashion the Italian public administration, not attacking individual pieces but reforming in an innovative and deep way all the different parts of the public apparatus.

Because of Constitutional limitations, it was necessary to change Title V of Part II of the same Constitution; in two stages: the first with the constitutional law n. 1 of 1999 (statutory recognition of the autonomy of the regions, even in the choice of the form of government; and establishment of the direct election of the president of the region); the second, with the Constitutional law n. 3 of 2001, which is the one that we are mainly interested in here and which profoundly affects the allocation of competences between State and Regions.

We wish to remember the innovative aspects of the complex constitutional reform, with particular attention to those more directly linked to the division of powers between the State and territorial autonomies; to the State, the Regions and municipalities were given "equal dignity institutions" as constituent entities of the Republic (art. 114), as well as the reversal of the allotment of policy of legislative powers between State and Regions, which entailed, in accordance with the new art. 117 Constitution:

- an initial list of materials whose discipline is left to the exclusive legislative competence of the State (Art. 117, second paragraph) that it ceases to be subject to general jurisdiction to become subject to enumerated competence;
- a second list of materials - that the same constitutional provision defines "concurrent legislation" - where "the legislative power vested in the Regions, except for the determination of the fundamental principles laid down in State legislation" (Art. 117, third paragraph);
- a closing provision, according to which the legislative authority over all matters not expressly covered by State legislation is up to the Regions ("residual" general competence: art. 117, fourth paragraph).

The legislative powers of the allotment system are completed by the principle of attribution of regulatory power, which sees a reduction in State jurisdiction, the widening of regional and local authorities: State responsibility's issue rules in matters reserved for its exclusive competence, subject to the possibility of delegation to the regions, while the Regions are statutory authority in all other matters (and therefore also in those of shared competence). To municipalities, provinces, metropolitan cities is in this way given the statutory authority for the regulation on the organization and functioning of the powers.

As with regards to the criteria for the allocation of administrative functions in art. 118 of the Constitution, the reform of Title V has in general established the allocation of administrative functions at the level of government the closest to citizens and thus, in general terms, to the public differentiation and adequacy.

A further important aspect is the new right given to regions, also to local authorities, of financial

autonomy of revenue and expenditure (art. 119 of the Constitution). Among the main new elements, the figure also states the taxing power of the local authorities, with the authority to establish and implement their own taxes; the participation in revenue taxes, explicitly based on the traceability of the revenue to the respective territory.

The new Title V had significantly reduced the scope of the legislative powers of Parliament, both with regards to matters of competence, both with regards to the legislation methods (for principles and not for details). Nevertheless, in the first steps after the entry into force of the constitutional reform, the Parliament had continued to legislate as if nothing happened (Bassanini et al., 2002). In fact, in the following years, the Constitutional Court officially demanded several times that Parliament and Government respect the new powers of the regions.

In terms of fiscal federalism, immediately before the constitutional reform, with the Legislative Decree n. 56 of 2000 there was an attempt to start a "federalist path" for the Italian tax authorities, in fact anticipating what would later be provided by the reform of Title V of the Constitution.

The purpose of Decree No. 56/2000 was the overcoming of the loan according to the criterion of "historical spending", although very gradually implementing, in the light of the principles of autonomy and responsibility for the realization of a “mature fiscal” federalism.

Later, with the approval of the law n. 42 of 2009, the discourse on (fiscal) federalism had regained momentum. This law of 2009, which contains the "delegation on fiscal federalism," was the first step towards a tax reform at the local level, providing guidance for the implementation of the new Article n. 119 of the Constitution. The new article would be precisely the constitutional basis of the next process to change Italy into the direction of a federalist State. It was wanted to eliminate the inequality in the regions and other local authorities which had been created between the recognized legislative autonomies on the one hand, and the financial autonomy deficits on the other (Minni, 2012).

We report briefly the essential contents of this important reform law, which has as its basic idea to empower the directors of regional and local authorities. Under section no. 119 of the Constitution,

such entities:

- may establish their own taxes;
- may partake in State taxes;
- they have their own heritage, even with transfer of State assets;
- are entitled to adequate resources to ensure the functions and essential services for their citizens;
- are entitled to equalization funds to meet the territorial imbalances.

In this reform, the main distinction is between the functions that are intended to fall within the "essential levels of performance" (LEP) and non-essential functions. The financing of LEP must converge on the "standard costs." It establishes the abandonment of the historical expenditure criterion, in favor of a standard cost, which represents an ideal fit with the necessary resources to ensure performance in relation to a standard requirement. Any deviations from these standards should be covered according to the funding rules of the "non-essential levels". The requirement for full funding of essential levels of performance requires a balance between the various regions. Therefore, it is possible to access the units of the "equalization fund". Regarding considered non-essential, however, it is not expected to be fully financed by the State, and so the cost derives from the regions.

The annual budget laws and budget have given the real sign of government policies, without regard to the federalist principles proclaimed in the Constitution and in the larger framework laws. The last national governments have highly centralized economic policy and drastic cuts decided to sub-national entities, and one may wonder if after all this talk about federalism remained empty (Bordignon, 2015) or the illusion of a simple return to centralism (Marcantoni and Baldi, 2013).

Even in public and cultural attitudes of opinion level the challenge of federalism was seen with less sympathy than in the '90s (Piperno, 2016). The various political majorities that have governed the country in recent years have not followed the federalist path with conviction, gradually losing contact with a strategic and long-term approach, impacting the effect of law n. 42, forcing Italian fiscal federalism to remain "halfway" – with not many possibilities of completing the work.

In addition, the LEP have not been operationally indicated and transfers equalization to the regions cannot then be coordinated with them. Finally, the coordination of public finance remains an issue of crucial importance and that also crosses individual issues of regional importance (healthcare, transport, training etc.). In the absence of a "Federal Senate" this coordination is achieved through a "Conference" system that meet the same table State, regions and local authorities. These conferences produced "agreements", "intended", "opinions" and other resolutions kind, sometimes mandatory or optional or other binding times.

5.4 Italian Healthcare after devolution

As already mentioned, the "regionalization" of the healthcare system, along with the gradual process of fiscal federalism, ended up having much more importance of the same process of "corporatization" of the Local Health Units (ASL). The regions have taken a leading, to the detriment not only of the central government but also, and perhaps above all, the autonomy of local healthcare bodies (Tanese, 2011).

This situation became even clearer after the 2001 constitutional reform. "The regionalization of the NHS has been both a decentralization process from State to Regions and a centralization process from Municipalities to the intermediate level of government. Local governments were indeed deprived of the management powers they had since 1978" (Neri, 2011). There has been talk about it to re-regional centralization, using the expression "grip-back" (Meneguzzo and Cuccurullo, 2003). From the point of view of State's institutional capacities, the regions doubtlessly become the new subject of the public healthcare.

5.5 Regional Autonomy and Financing of the Healthcare

For what concerns the financial relations between the State and the regions, the post-devolution

legislature brought some changes, the forecast of the rewarding character of State transfers, understood as measures to make it more "virtuous" regional administrations (MEF, 2016).

The State legislature has been and still is especially attentive to the need to reduce the regional healthcare deficit, and moves with the centralized interventions in relation to "recovery plans" the deficit and the increasingly widespread co-payments by the clients.

Since 2001 there is a "negotiation" between State and regions regarding the allocation of resources, practices which then became the basis of the system of so-called "Pact for Health" every three years. In the summer of 2014 the third "Healthcare Pact" became valid for the 2014/16 period. This working method sees in the State-Regions Conference the body charged with deciding, on the one hand, on the financing of the National Healthcare Service; on the other hand, for the obligations of the Regions, the requirements to be met to obtain correction of State appropriations.

Ultimately, the levers of the government healthcare expenditure are now for years in the hands of the Ministry of Economy, which is responsible for the respect of the budgetary constraints control processes, especially to the regions subjected to the deficit-reduction plans (many of which in the Centre-South). These plans mark or better formalize the entrance of the Ministry of Economy and Finance as a new dominant player in the Italian healthcare policy (OECD, 2014). Starting in 2011, finally, they wanted to also give a positive side to the supremacy of the central financial control, including the creation of a "rewarding" type mechanism in favor of the virtuous regions. So, it is indisputable that in the new constitutional framework, healthcare is a matter of regional responsibility, but there is need for a high level of control and coordination throughout the national territory; and this task belongs to the central government (Court of Audits, 2010).

The mechanisms of financing the healthcare system have yielded conflicting results: with large differences between the various parts of the country, which only partly depend on the resources invested. Regional realities present a high heterogeneity in terms of the degree of "virtuosity" in the management of healthcare expenditure and final financial results (Court of Audit, 2010).

5.6 Conclusions

The previous sections have tried to show that the devolution healthcare process has certainly been very important in terms of legislative production and institutional effort. This effort has perhaps been too intense, with the risk of underestimating other, not least crucial, aspects such as organizational and managerial aspects. At the same time, circumstances have pushed central government into an increasingly "invasive" role from a financial point of view. The government's administrative intervention has made a path contrary to the constitutional one.
But the comparison with empirical data cannot stop at these qualitative observations and still very focused on the national scale. In the next chapter, the focus will be on quantitative reports and the data presentation will consider the regional level: above all, the N/S divide and the two regions selected as exemplifying cases.

Chapter Six: The Impact upon Devolution on Italian Healthcare

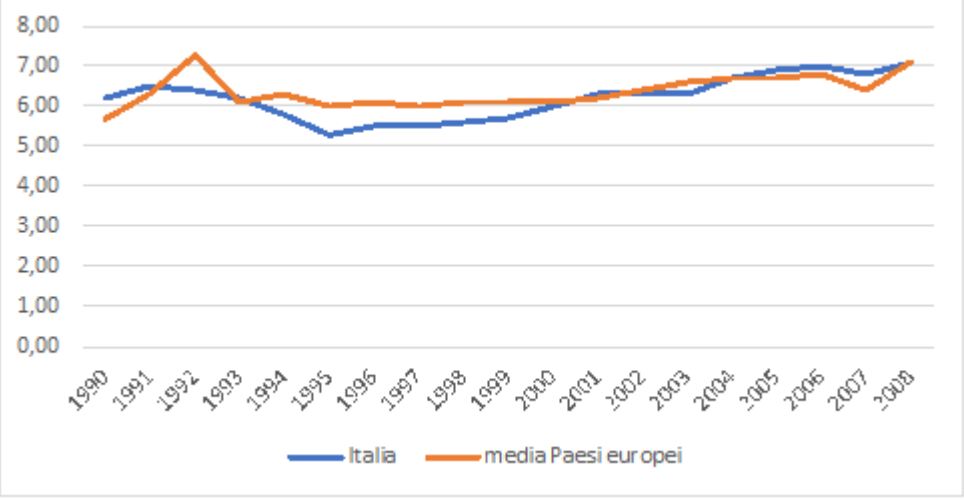
6.1 Introduction

This is the last part of our empirical chapter, where it will be analysed the situation of Italian healthcare after the devolution reforms. For this task, the theoretical chapter will be mirrored and quantitative data will be used. Moreover, a deeper analysis of the chosen regions, Lombardy and Calabria, will be provided to be exemplify the N/S gap, as thoroughly seen in Chapter 2. Lastly, we remember the last sub-question seen in chapter 5, which recited: *How did the devolution reforms impact upon Italy's healthcare?* Its answer will be provided in the end of the chapter.

6.2 Quantitative pre- and post-devolution data

For what the evolution of the national healthcare expenditure is concerned, its effect is measured in % on the GDP:

Graph 6.0.



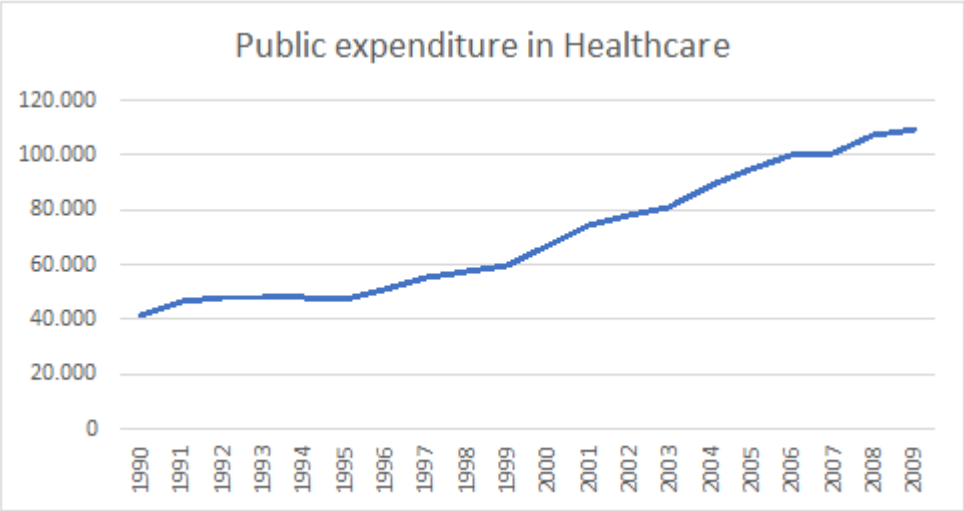
Source: MEF – Ministry of Economy and Finance.

We see that for a long time the Italian figure remained well below the European average. Only in recent years, since the devolution of 2001 and until 2008, the respective percentages tend to strongly converge. Here it is said that the Italian NHS arrived with good or excellent outcomes with

a level of expenditure in line with, or lower than, the European average. In the aspect of weight percentage, devolution seems to have aligned the Italian public to those values, higher, than the European average.

One also confirmed, about Final consumption expenditure of public administration in healthcare 1990 – 2009 (Istat, 1999):

Graph 6.1.

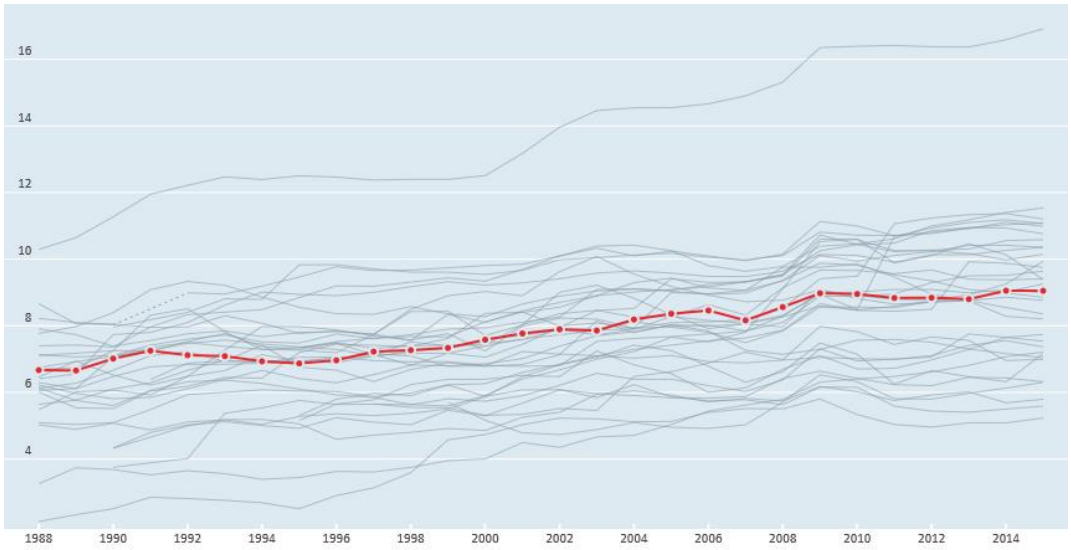


After the financial crisis of the 90s, the country continued to grow, almost regularly, up to 109560 (in millions of Euros) in 2009. The turning point of devolution (2001) does not alter the pattern of the general scheme: the regionalization process had already started by that time.

It should be said that the general indexes on the healthcare situation in Italy have always been positive and high, with an upward progression during the course of time. The indexes on spending are normal when compared to the OECD average.

Regarding the indicator "Healthcare Spending" in Italy is has been increasing regularly, but quite in line with the average performance of other countries. After many fluctuations in the past years, now Italy ranks in a middle position: In percentage of GDP:

Graph 6.2.



Source: OECD (2017), Health spending (indicator). doi: 10.1787/8643de7e-en (Accessed on 22 March 2017).

In general, however, we can say that the Italian healthcare produced, in the period considered here, excellent results in many respects, with spending levels fully in line with the average of other countries (OECD, 2014). However, the regional organization of the Italian healthcare has a major problem: it is very fragmented from a territorial point of view, with quality levels and too much differentiated performances (ibid.).

6.3 The N/S divide in the Italian healthcare.

In the aforementioned research of the Censis (Censis, 2001) the analysis of the healthcare system in the "time zero" of the federalist reform asserts that it was diversified throughout the national territory and that there were marked differences along the North-South axis: the Northern regions, operating on the basis of regional plans; regions of the Centre: some programs with serious delays, others with timely and recurrent planning; the Southern Regions: substantial absence of programming tools.

The Southern regions were also those with financial deficits generally higher than the national average. It weighs the absence of healthcare programming tools. Moreover, the same regions showed a stronger presence in percentage of privates in healthcare and, at the same time, lower

satisfaction levels in the service provided. We show now the relative tables.

In the following table: the expense of the regions (grouped) for some functions, year 1999 (in % over the total expenditure):

Table 6.0.

Regional Groups	Total expenditure for services directly managed	Specialistic performance together with privates	Hospital Services in together with privates	Total Expenditure together with privates
North-West	61,3%	2,0%	12,2%	38,2%
North-East	68,9%	1,7%	7,0	30,7%
Centre	62,6%	2,5%	11,1%	36,5%
South	58,0%	3,7%	11,2	41,3%
Italy	61,5%	2,7%	10,9%	37,8%

[Source: Censis, 2001: elaboration of the Censis om data of the Finance Ministry]

It is notable that the South is characterized in those years for the most spending for private healthcare agreement with the NHS.

The total amount of clinics and public and private accredited laboratories shows a net prevalence of the regions of the South, also thanks to the strong presence of private-nature structures than in the North:

Table 6.1.

	Total (public + private) per 100.000 inhabitants	% of public structures on the total
North	10,1	64,6
Centre	20,6	53,7
South	21,4	30,8

Source: Censis, 2001: Elaboration of the Istat on data of the Ministry of Healthcare.

But if we consider the healthcare structures of high complexity, their number was much higher in the North, where, however, it is influenced by the strong contribution in this regard of Lombardy.

As for the presence of "accredited private", the more weight was found in some regions of Central and South Italy.

The lowest rate of use of beds in public and private hospitals accredited particularly characterized the South, showing a lower efficiency rate:

Table 6.2.

Used percentage in %	
North	77,4
Centre	77,8
South	70,9

Source: Censis, 2001: Elaboration of Istat on data of the Ministry of Healthcare.

With regards to user satisfaction, some significant figures, which show the difficulties of the South (ibid.):

Table 6.3.

Satisfied people by hospital services (%):		
	Medical Assistance	Nursing Assistance
North	47,9	47,9
Centre	31,1	26,8
South	21,8	21,2

Source: Censis, 2001: Elaboration of Censis on Istat data.

Another important aspect is the healthcare mobility between regions. Again, we see an Italy split in two: Central and Northern regions show positive balances (more patients incoming than outgoing), while in the Centre-South and the Islands is the exact opposite. It must be said that the Southern hospitals show a tendency to poorly treat differentiated disease and few complex cases; to deal with such cases, it is often necessary for the citizens of the South to look elsewhere.

6.4 Lombardy

There is no shortage of research and analysis on the Lombardy region in general nor on its healthcare system. The bibliography provides the very convergent content in the overall judgment on this region. Lombardy is historically characterized by the quantitative and qualitative importance of their hospital system, public and private, capable of high performance specialty and technical complexity (Ranci Ortigosa and Ghetti, 2011). All this adds to a significant private sector. The strong presence of private healthcare is also centered on residential shelters, certainly more profitable.

A fundamental characteristic of the RHS is the clear separation between the functions of finance and production services functions: ASL (but in fact more and more the Region) have the programming tasks, purchase and control; the services are produced and provided by public hospitals (AO), and often private structures (Neri, 2011).

Politically-wise, there is an extraordinary centre-right political stability, with almost 20 years of continuous government of the regional President himself. Corresponding stability of the strategic choices and values, which resulted in a very ambitious reform program, especially in welfare and in healthcare, which is allocated a large part of the resources and expenditure. Building a completely original model into the overall characteristics of the regions, with full use of regional powers after the 1992-1993 healthcare reform. The basic lines of the regional healthcare service were defined in 1996-1997. It took place thanks to the training and continuity over time of a compact political-administrative group summit with common ideals and cultural roots (Neri, 2011).

The "ideological" guidelines can be summarized as follows: refusal of state intervention, in favor of an approach based on the free choice by users, the free initiative and the "horizontal" subsidiarity; strong opening to private initiative, profit and nonprofit, with great appeal to the accreditation mechanism; and free competition between service providers (Alma Mater Studiorum, 2006), and the intense recourse to the use of vouchers in the payment system services (Marotta, 2011) because

of the principle of free choice of the structure from which to receive the performance (Court of Audit, 1999).

There was thus an attempt to bring liberal principles (free market) together with the principles of social solidarity (subsidiarity) (Bifulco, 2011). In this situation, we can speak of managed competition, in a situation of quasi-market (Alma Mater Studiorum, 2006; Bifulco, 2011). However, following this attempt has taken a step back, given the effects in increased public spending.

This was the strong initial setting, from 1996-1997 (Regional Law n. 31/1997). So, the guiding principles of the "Lombardy model" were present well before the federalist reform of 2001, confirming the choice in the sense of autonomy and innovation. The basic idea was to use the autonomy granted by the State to the regional policy to radically change the traditional public-private relationship, putting the two sectors on an equal footing. After this choice, the region has made up its interventions in the healthcare balancing the production of services to advantage of the private (Alma Mater, 2006).

The centralized programming leads to a distinctly top-down decision-making. The programming choices are made within the regional political and bureaucratic summit, in a rather narrow and one-sided area with almost no participation by local communities. The "management rules" issued by the regional summit in healthcare programs are very detailed and accurate, and must be implemented locally by ASL and AO (Neri, 2011). In this way, the local healthcare authorities have in fact been deprived of much of their theoretical programming functions-purchasing-control, move effectively towards the regional government (Bifulco, 2011).

The centralized planning has also led to heavy investments in the regional information system, converging at the regional government, which is essential for the proper conduct of the planning functions and control, considering that the establishment and enforcement of spending limits are strictly implemented. The light of attention to the management problems, the Region has made the reorganization of the Information System of Healthcare, with the strategic objective of improving the management of databases and information flows.

Fee policies are widely used by Lombardy to manage the behavior of the producers of services, to promote and to discourage. The goal was to combine the strict control of expenditure with the maintenance of high quality standards. In fact, the region's control on indicators and economic levers is easier and practicable (Neri, 2011). In this respect, the Lombardy regional policy appears to have met with success.

After the constitutional reform of 2001, the Lombardy healthcare system of the 2000s was called "generalized and generous" to the breadth and quality of performance, an universal welfare with an integrated mix of public and private. The method of financing is also different from case to case (Bertin and Cipolla, 2013).

Contextual factors: we are facing a cohesive society with relatively low social risks (ibid.). There is a fair amount of associations and high participation in the community life for citizens (Bertin, 2012). It is a social and institutional system that even after the reform has been characterized by a long political stability and a large internal administrative consistency. Lombardy has been able to move within the national legal framework in total autonomy, using the opportunities available choice (Bertin and Cipolla.). The autonomy of movement and the use of space granted by devolution have also made possible the testing and deployment of innovative services (Bertin, 2012).

As confirmation of the clearly "liberal" choice of this region is a decrease of 30.6% occurred structures directly managed by the public sector. Along these lines, the Court highlights some trends: "distributing companies of healthcare services are in private majority and in 2005-2009 their number has seen a steady increase, compared with a slight overall decrease in the number of public facilities." The number of inpatient institutions and private care has almost reached the public ones (ibid.).

We must add that over time, and especially in the two-year period 2002/2003, the emphasis on competition between suppliers and between public and private has been greatly diminished in favor of subsidiarity and therefore in favor of more cooperative and less competitive relationships. The

explanation for this change is essentially in the continued insistence of the central government on the control of public expenditure, in view of the growth of healthcare spending that was also ascertained in Lombardy. The balanced budget and strict control of costs have become so for Lombardy priority of its policies. This led to further highlight the importance of centralized regional planning and a growing net centralism regionalist (Avanzini and Ghetti, 2011).

6.5 Calabria

The collection of data and information on this region was more difficult, due to the lack of specific studies on it and the information deficit that seems to characterize its healthcare system. Despite this, we believe that the profile given below is sufficient.

First, a report from about the period before the devolution reform (Court of Audit, 2000). Faced with profound changes in the 90's which had a remarkable effect on the institutional structure of the national health care, the Court setting out its concerns about the state of healthcare in the Calabria region "A worrying combination of defaults and delays in several respects (…) and the uncertain and difficult start of the change of the organization of healthcare processes and related departments in the branch network".

The Court observes in a very critical way that is totally missing an evaluation of the company management of the local healthcare authorities, due to the top positions turn over system that causes an average duration of each Director not to exceed 18 months. This has certainly affected the capacity for monitoring and evaluation: "a situation of serious operational impairment, characterized by extreme mobility of the Companies vertices and resulting in a precarious situation where the management complexity of the issues would require stabilized and technically authoritative structures" (ibid.).

The report recognizes that Calabria has favorable data in terms of the mean length of stay, but the indexes relative to the complexity of the episodes of hospitalization and surgery show low scores.

This last observation is consistent with the high healthcare mobility moving to other regions with a stronger technological and professional equipment (ibid.).

Speaking of regional programming capabilities, the region of Calabria has operated, in the 1998-2000 period, in total absence of the Regional Healthcare Plan. So, regional action has been geared to fragmentary and sectoral interventions, without an adequate overall strategy to the needs of the Calabrian reality. The Region has failed to exercise the functions of planning, guidance and coordination necessary for the government of the relationships between healthcare authorities, hospitals, public and private facilities and professionals. It is important to stress that the regional government has in fact been unable to exercise control because it lacked an adequate information system. The absence of an efficient and comprehensive information system has heavily influenced the actual programming skills, direction and control of the regional system, which cannot be upgraded.

The model applied in Calabria follows the logic of top-down under which the region stands as the lead organization and management of healthcare. Regional guidelines annually identify healthcare goals and the strategies to be implemented in the programs of individual healthcare authorities and hospitals. It is noted that significant changes were initiated on an organizational level, with the incorporation of ASL, reduced to 5 compared to the n. 11 existing prior (Court of Audit, 2008).

After the constitutional reform of 2001, the healthcare system of Calabria can be called a "mixed" system, with a strong presence of the private sector in hospital and a mix of public and private sectors with regards to outpatient activities. But the private offering is mainly financed from public resources. Given the context, it is a welfare "minimal and high social criticality" (Bertin and Cipolla, 2012). Overall weak the presence of all the welfare actors (public and private). The total offer appears little expanded and the company is poorly cohesive, with a problematic social context characterized by high risks. Even the spread of services is reduced, both for traditional ones and for those innovative (Bertin and Cipolla 2012, Bertin, 2013). This simplification of the organization of the regional healthcare system is undoubtedly in the wake of the reorganization measures of

regional bureaucratic structures imposed by the State budget law. In the field of planning there are still delays in adopting the instruments of regional address containing the basic guidelines for the governance of healthcare organizations. There remains the problem of the Directors General of ASL and the extreme precariousness of the directors themselves and the lack of transparency in the appointment and removal procedures. These procedures do not appear related to the results achieved, but to foreign management approach political dynamics (Court of Audit, ibid.). There are critical elements in the legislative measures taken by the region for the organization of services and control of healthcare expenditure have been produced sporadic and fragmentary rules, difficult to fit into a coherent plan of the regional healthcare programming. The Region has annually introduced rules that have thwarted or delayed effects of the healthcare plan and have favored transitional measures with which they are contingent responses to problems that would have required more radical and far-reaching interventions (ibid.).

To this political instability is added. Since 1994, the regional governments of Calabria are alternately Right and Left; every political majority does not last longer than a mandate. This instability affects the political ability to produce consensus and stable reform pathways; it explains at least part of the institutional weakness that manifests itself in fragmentary, excessive, lacking strategic vision. The healthcare deficits for the years 2001-2005 are covered in part by tax revenues, partly with state additional resources, while it seems marginal weight of real measures of rationalization and containment of current health expenditure. In other words, the inefficiencies of the regional health management flow (mostly) in an aggravation of the tax burden on citizens (Court of Audit, 2008).

As for the so-called "outsourcing" (outsourcing services), the report highlights that "in most of them, for a long time the use of external suppliers is considered an operational mode rather than an administrative innovation. In very few cases, considered outsourcing processes were subject to economic and preventive organizational analysis, (...) and, finally, are almost never available information to assess the organizational effects of the interventions included in the outsourcing

phenomenon". Thus, it is clear the need for a profound change in how to manage outsourcing processes (ibid.). The analysis on the operation of internal controls in healthcare and Hospitals of the Region demonstrates the difficulties on the part of individual companies to implement adequate control systems.

There are difficulties and shortcomings in the functioning of the supervisory bodies, in contradiction with the needs of a corporate-run inspired by the programming logic and the achievement of objectives in terms of effectiveness and efficiency. It misses "a satisfactory feedback process able to build a steady flow of information" (ibid.).

In fact, the system of indicators-targets is weak, has not developed into a genuine business setting. The monitoring practiced by healthcare providers is not sufficiently refined and does not allow verification of the degree of achievement of objectives, and these shortcomings are compounded by the lack of adequate professionalism within individual facilities and IT support tools to an efficient detection system of the flows. The control systems for its individual companies are unreliable. A real management control still seems far from being achieved (ibid.).

The precedent observations paint a picture where the State capacity to govern NHS seems weak under some aspects: at the local (instability of directors) and the regional levels (lack of an adeguate informative system and inadeguate personnel formation). In conclusion: there is a need for a deep "cultural renewal", to change the way of thinking and acting of the public bureaucracy, to start real processes of renewal of health management at all levels according to the criteria of effectiveness and efficiency (ibid.).

In 2009, it was agreed with the central government the Recovery Plan. It confirms the difficulty of obtaining accurate information on the financial situation of the Calabrian healthcare: the shortcomings of accounting and information system creates uncertainty about the actual quantitative dimension of the deficits accrued in previous years. It must be built an efficient administrative organization, regional and business, consistent with the commitments related to debt settlement. The strategic objective is to deliver the essential levels of assistance (LEA). Therefore, the plan is not

just an administrative tool of finance shelf, but should also be an occasion for an overall restructuring of the regional healthcare system, because citizens and businesses of Calabria are the first to pay with tax increases the managerial errors in healthcare (Rationalization Plan and Requalification of the RHS, 2009).

6.6 Quantitative comparison between Lombardy and Calabria

Interesting quantitative data on Lombardy and Calabria are from the National Institute of Statistics, ISTAT, and precisely from the archive "Health For All". It seems appropriate to present them here in conjunction: this will enrich the description of these regions and in the meantime the differences, or the convergence points, will be clearer. The following tables of this section are all off the "Health for All" archive.

Table 6.4: People suffering from bad health (14+, M+F).

	Lombardy	Calabria
2000	5,75%	12,05%
2005	4,75%	9,10%
2013	5,41%	10,86%

Without much surprise, the recent years of crisis marked a sharp worsening of the healthcare conditions in both regions, but the difference to the detriment of Calabria is clear and constant.

Table 6.5 - Mortality rate of neonatal 1 month and beyond (M + F):

	Lombardy	Calabria
1990	19,57%	19,28%
2001	11,40%	12,25%
2014	9,51%	11,52%

There is a total equality in the trends but not yet in the scores: to be born in Calabria is a significant disadvantage.

Table 6.6 - Life expectancy 0 years, Males:

	Lombardy	Calabria
1980	68,97	72,22
2001	76,63	77,48
2014	80,84	79,65

Table 6.7 - Life expectancy 0 years, Females:

	Lombardy	Calabria
1980	77,11	77,1
2001	83,03	82,33
2014	85,54	84,55

Both values and trends strongly coincide for both genders.

Table 6.8 - Number of general practitioners:

	Lombardy	Calabria
1995	8,27%	8,46%
2001	8,11%	8,55%
2013	6,61%	8,22%

This data confirms what seen before on the North-South gap concerning the presence of practitioners. The medical class is more present in the South, and Calabria is no exception.

Calabria prevails in presenting a stable framework over time to a higher attendance rate of physicians compared to their population. The medical community in this region is quantitatively stronger, and probably has greater chance to influence healthcare policies, in the face of a public bureaucracy less prepared than necessary.

Table 6.9 - Rate of PUBLIC ordinal bedstock (number per 10000 inhabitants):

	Lombardy	Calabria
1996	51,58%	39,45%

2001	37,81%	33,84%
2013	27,74%	15,63%

The decline of bedstock in the public sector is almost “dramatic”, especially in recent years, as seen before at national level, and the trend is the same in both regions. In Calabria, this trend is stronger and is probably the effect of the hard “Plan of recovery” which the region has undergone. The differences between the two tables are derived from the presence of private facilities, most evident in Calabria.

Table 6.10 - Number of ordinal PRIVATE bedstock:

	Lombardy	Calabria
1996	12,35%	16,45%
2001	9,35%	16,31%
2013	7,85%	8,84%

The comparison between two equally rich regions of private presence still sees the Calabria at higher levels (but the in the post devolution they decline net). The control of this sector is therefore more pressing in the southern region and would require a careful public administrative machinery.

Table 6.11 - Percentage of people very satisfied aboutt their last specialistic visit (M+F):

	Lombardy	Calabria
2013	78,18%	63,98%

Table 6.12 - Percentage of people very satisfied about the medical hospital assistence (M+F):

	Lombardy	Calabria
1998	49,21%	29,98%
2001	41,86%	19,08%

2014	52,66%	25,46%

The dissatisfaction of the Calabria citizens is clear and stable over the course of years. But in both the regions there has been a positive trend. We can consider the satisfaction level as an objective indicator of the received service quality; it corrects objective data that in turn show a clearer convergence trend.

Table 6.13 - Current public expenditure pro capita (euros):

	Lombardy	Calabria
1998	1024	941
2001	1273	1263
2015	1855	1725

The absolute values are naturally lower in the less populated region, but the pro spending happens is very similar in trends and values, even if these are regular lower in the southern region. It confirms that the pro capita allocation is not necessarily equal between all the various regions, depending from a set of various criteria.

Table 6.14 - Percentage of public healthcare expenditure on total expenditure:

	Lombardy	Calabria
1990	80,27%	81,46%
2001	71,95%	79,06%
2014	74,95%	78,24%

Table 6.15 – Percentage of public healthcare expenditure on the GDP level:

	Lombardy	Calabria
1990	4,45%	8,72%
2001	4,43%	9,19%

2015	5,17%	10,48%

The total sum of these tables shows that Calabria is more dependent than Lombardy on public expenditure. Here, the burden of public healthcare expenditure is higher, even concerning the GDP levels: it is no surprise. This signifies too that healthcare expenditure is crucial, not onlt for the NHS *per se*: not only for the system alone but for other external aims of healthcare, for instance occupation and the relationship income/consumes.

Table 6.16 - Number of SSN staff:

	Lombardy	Calabria
1994	112,4	104,76
2001	110,37	112,81
2013	91,47	99,1

In line with the previous consideration, in Calabria the "public sector" is also important for employment and employees. Since the region is less economically developed, public spending, even as healthcare, plays a crucial role. In this context, it becomes the centre of interest and objectives that are not strictly related to the protection of health. And the bureaucratic class has the biggest obstacles to act according to purely professional logics.

Ultimately, Lombardy and Calabria are united by a strong presence of very similar per capita private and public healthcare expenditures. But the final results are very different, as seen about the levels of satisfaction.

6.7 The Consequences of Devolution on Healthcare

The empirical data gathered here speak of two things: a) powerful progressive improvements in healthcare system performance at a global level; B) regional gaps that remain, albeit somewhat

attenuated.

In a recent interview, the Minister of Health stated that regional return plans have worked, but that the uniformity of care and essential quality of services has not yet been achieved. The differences between regions and between North and South were already existing before devolution and before the recent economic crisis. So, the reforms and difficulties may have aggravated, but not created, the inefficiencies.

Here is where we answer the sub question: *How did the devolution reforms affect Italy's healthcare?*. It should be noted that there are many common traits in today's NHS regional articulations, as well as some significant differences (OASI 2016; OsservaSalute, 2016). Common pressures affect those imposed by the state and the economic, financial and constitutional conditions to which all public powers are currently subject. These common elements invest more or less all regions, which have responded with convergent institutional and technical measures, and without significant political differences.

Regional differences, on the other hand, have specific effects on individual realities, with particular regard to context variables that describe their degree of economic and social development, and "agency" variables related to the maturity of regional political and institutional systems and their Technical equipment (RES Foundation, 2011).

From the institutional point of view, the public healthcare service is today a strongly regionalized system. The constitutional reform of 2001 further pushed forward the federalist project. Italy is today one of the few countries where public healthcare spending is almost entirely decentralized (OECD, 2014). Healthcare federalism (and federalism in general) has been designed and applied uniformly throughout the country independently from the pre-existing and strong diversity between the regions, devolution too.

The first consequence of devolution is the solid institutional legitimacy of this power.

However, there are also important aspects and common trends. For example, the financial equilibrium is a result that converges almost all regions (OASI, 2016). This is the product of very

strong stimuli from the central government. But more generally there is a general tendency of all regions to a type of approach that has been termed "institutional engineering" (OASI, 2016).
The public/private mix in the complex of services and facilities is also heterogeneous between one region and the other. The role of accredited private entrepreneurs is important in Italian healthcare (OASI 2016); it follows that the diversity of regional management skills in this sector leads to different results in the operation of the various regional systems. In regions with return plans, technical capacity is weaker. In addition, heavy cuts in public spending end up giving more weight to the private system. But elsewhere (eg in Lombardy) the robustness of the bureaucratic apparatus and the much wider freedom of spending allow the system to be governed by logics close to the quasi-market mechanisms, but with a strong central control of the spending limits reserved for entrepreneurs. In the absence of a strong unitary action from the central level, which is not limited to financial imperatives, the differences in economic development between the various regions and the various historical legacies in public services and management skills have prevailed.
In the presence of differences, devolution gives power to government centres and elites that react differently and produce different results. The literature on the subject and the data collected during this thesis suggest that these government capacities are on average lower than the North of the country (RES Foundation, 2011). These resource and resource differences trigger or widen the differences between the regions.
Civil society on which devolution exercises also has differentiated degrees of development and maturity. The data on associations show a deficit of civic participation in the South than in the North.
There is a top-down governance system in the regions, with a hierarchical approach and a clear decrease in the management autonomy space of ASLs and hospitals and their management figures. The provisions mature in the narrow circle of the political summit and the top managers of regional healthcare. The "institutional engineering" approach has thus produced institutionally strong regions, which tend to reproduce on a smaller scale the characteristics of state centralism.

However, important aspects of the institutional capacity of government remain in the hands of state power. The state has had easy access to translating the various government problems into budgetary problems, and this has often been the case for healthcare as well. The regional information system is an indispensable part of the institutional government and at the same time it is a testimony to the possible technical capacity of healthcare, but it does not work the same way across the territory. Institutional capacity and technical capacity of government have many boundaries in common and it is easy to see each other's connections. For what concerns political stability, Lombardy is a clear example of what can be the potential advantage of a regional political government that is lasting, stable, coherent as an ideological and cultural inspiration. Even better if this stability coincides with a solid technical and administrative apparatus; and a civil society largely oriented towards the same values.

6.8 Conclusions

The answer to the initial sub-question (chapter 5) is in the composite framework that has been outlined here: a portrait with aspects of strength and others of weakness, successes and failures. In addition, the major intervening variables were at least two: they complicated the interpretation of the results due to the interweaving of their action. Despite everything, today we are faced with data of well-established facts, the effect of real changes. Devolution has created regions capable of exercising significant and autonomous powers in healthcare.

The achievement of the financial stability of the NHS, on the other hand, is the result of a powerful central government action, far from the theories of fiscal federalism. But with the consolidation of regional management skills, regions play an autonomous and positive role in budgetary control. Part of the challenge was played by the possibility that healthcare devolution could contribute to the overcoming of historical differences between the various areas of Italy. We have seen that this challenge is still far from won. The context variable, the N/S gap, has so far prevailed.

Today, the consequences of sanitary devolution are ambiguous, and probably the whole federalist strategy that has ever been implemented in Italy can be said to be ambiguous. Beyond a sometimes too slow, contradictory and confused path, the bottom line is the creation of twenty healthcare systems, which are still unclear whether it is just as many realities destined to go further or retreat backwards.

Ultimately, the discourse on devolution does not erase the need for a national vision, but re-establishes the role and content of national politics in the face of the potentially large autonomous regions granted to the regions.

Chapter Seven: Conclusions

7.1 Introduction

We have now reached the end of the thesis and in this last chapter we will sum up the discoveries of the work and answer the general research question and its sub-questions. In the end of the chapter, we will consider the role of this work in the literature on devolution.

7.2 The Answers to the Sub-questions

The subquestions were:

1) What is the North-South dividein Italy?

2) *What can we learn from the theory on fiscal federalism and devolution about potential consequences of the devolution reforms for the Italian case?*

3) *How did the devolution reforms impact upon Italy's healthcare?*

Our answers are:

1) It’s not easy to tell if Italy is facing a real attempt to federalism or whether it is more correct to speak of a strong form of regionalism which just remains something alike an explicit devolution. The international economic crisis also damaged Italian federalism and the country. And of course, the N/S gap is very much alive and is negative factor as well.
2) Decentralization, federalism and devolution are reform processes and ways of governing with virtues and defects that require requirements and conditions to be implemented, and success or failure cannot be taken for granted. Case-wise, devolution and federalism contributed positively in some degree to an enhanced quality of the NHS, especially in the North, but in the South this thrust was less effective, because of previous state limitations.
3) The weight of national policy has manifested itself in the strong control of the state budget and the management of the crucial level is even more important, but the specific cases of

Lombardy and Calabria highlight the importance of ideology and executives' stability. The regional healthcare systems are now more differentiated.

7.3 The Answer to the General Research Question

The general research question was: *To what extent and how did devolution enhance governmental ability in the domain of healthcare between the North and the South and make it more governable?*
The central question that moved the thesis was to ask whether devolution was really used to make Governance more manageable and to overcome the N/S divide. Chapters 5 and 6, about the current situation and the consequences of devolution on health speak of real successes in the context of a gap that yet remains. The overall answer to the general question is however more complex than the mere comparison between theoretical expectations and real facts, because the final picture is made of potentialities and risks.
Even though the results are not what we are hoping for today, especially because of the N/S gap, the research carried out with this thesis does not authorize definitive negative conclusions on the validity of the federalist solution in managing Italian healthcare. We are faced with a story with many contradictions, where the parties involved have made mistakes and incoherences that are not to be attributed to the federalist experiment itself. It is then to identify the forms of organization and the means the state can and must exercise the support function to the regions, to help them in the path of autonomy in coherence with a national strategy. Italian experience shows that it is not about practicing hostile devolution to the state or supporting central punitive positions towards the regions: it serves a coordinated devolution between the various levels of government and a national strategic vision.
So, returning to the central question of research: in the Italian experience, the federalist approach may still be a good solution, and at least in part has proved to be so; even though it may not be the only solution. Devolution is certainly not a luxury that a country cannot afford, more than it can

afford a centralized power. But it is an approach with assumptions and imperatives that must be understood by elite leaders, politicians and technicians.

7.4 Reflections on the Thesis

We can say that this thesis has developed a naïve but obligatory analysis: summarizing the heoretical terms of the concepts of federalism and devolution, recapturing the legislative history of health devolution in Italy, collecting the empirical data as evidence of concrete results, and making comparisons. Probably, the most interesting aspect was not to discover the distance between expectations and results, but to find inconsistencies and contradictions that have left Italy's healthcare halfway between institutional reforms and new state central government policies.

A second search could then start from here to identify the paths and tools for a proper devolution. Such research would probably give less space to major institutional issues than it has been done here: we saw that the Constitution and the great reform laws lay down principles and objectives that are far from practical implementation. The policy of budget management and administrative measures can go against the great federalist principles; however, it seems to have more real weight from this point of view, and it therefore deserved more attention than was possible in this research.

It is probably normal that these final considerations also contain ideas for the future. They have appeared for hints in the thesis and it is worth mentioning here the main ones. In the NHS today there are crucial nodes that will perhaps be the engine of future changes and will push to a more consistent conclusion with federalist design but also less focused on regional centralism. With the latter, there have been some limitations of state centralism. It expresses itself along vertical command lines and tends to reduce movement autonomy to units at lower levels.

At a first question, we have pointed out several times: the radical change in the population's radiological framework, due to aging populations. In response, extra-hospital spatial assistance will need to be strongly strengthened and horizontal relationships between the various welfare services

at local, infra-regional level will have to be multiplied. It will therefore be a great national effort that will have to be expressed at the level of each individual region.

Another important organizational question arises from the general tendency, seen in the previous chapter, to ever greater ASL, hence more complex to handle.

The two previous observations are enough to say that the coming years will perhaps question regional centralism as much as the State.

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