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# DEVOLUTION AND FISCAL FEDERALISM IN THE HEALTH CARE SYSTEM: JURIDICAL OBSERVATIONS

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***Abstract:*** *The recent approval of the law made under delegate powers on the subject of fiscal federalism, which implements article 119 of the Constitution, raises a number of questions such as in what way and by how much the health care sector will be influenced by it. The aim of this article is to go over the legal manoeuvres that are at the base of devolution in the health care system and to analyze the institutional conditions on which fiscal federalism is grafted so as to outline the future scenario on which the judiciary will have to reason and intervene.*

***Key words:*** *fiscal federalism, regional health finance, limited autonomy, financial responsibility.*

## 1. Introduction. The Possible Role of Fiscal Federalism in the Health Care System

The day after the issuing of the first law (2000) that would concretely introduce mechanisms of fiscal federalism in the Italian system – that is a system of financial decentralization on separate government levels – in a study most of the citizens considered that a larger regional autonomy (compared to the one already attained) in the health care system would have produced non-positive results. As such, there was a loud request for guaranteeing homogeneity of services [18] offered throughout the land. In order to provide major resources to the health care system, so as to reach the average European level, new measures have been taken since 2001. These measures are meant to make the Regions more responsible towards their spending and as such, the process of "health care federalism" that has finally attained constitutional coverage. Spending on health care system has become a crucial subject in all industrialized countries, and it is even more so in those systems that have redesigned (or looked towards) the distribution of functions in a federal way. However, for some time now, the doctrine, supported by comparative studies in some federal countries, has pointed out the paradox rooted in *the federal organization of the health care system*: that is, trying to manage a sector that wants to guarantee equality by giving value to the local diversities of the country. In Italy today, more than ever, it is fair to ask whether fiscal federalism in the health care system means progress or a step backwards compared to the National Health Service (NHS) planned during the 90s and

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fossilized in the new model of distribution of competences as provided for by the 2001 constitutional reform (*devolved* NHS*)*. [9] In other words, we should ask what eventual opportunities can a financial scheme offer as the one stated in Law n. 42/2009 that gives voice to the art. 119 of the reformed Constitution and to the provisions of the art. 117 that, in the health care context, entrusts the fixing of the basic level of assistance ("*livelli essenziali delle prestazioni*", Lep) to the exclusive legislative powers of the State. In fact, it should be remembered that by following the footprints of the old art. 117 Const. that entrusted the Regions with health and hospital assistance, the legislator, in one decade, has moved the reference axes the NHS from national level to regional level, transforming it into a *group of regional health services*, with a considerable share of organizational, managerial and entrepreneurial autonomy. Obviously, one can immediately say that this would mean regression if, following the process of devolution and of the introduction of fiscal federalism, there will be greater inequality in the population in terms of access to and quality of services offered in the past.

## 2. A Close Scrutiny of the Regulations: Rationalization, Regionalization, *Federalism*

The present NHS setup makes fundamental reference to Law n. 833/1978 that set it up. This law finally marked the end of the previous mutualistic-hospital system structured around a multitude of bodies that were quite different from each other and which did not have any connection between outpatient and home assistance and hospital assistance (with inevitable and consequent duplication of operations and waste of resources) in addition to the absence of an all-embracing idea of health. The organizational plan of 1978 followed up by the legislator carried out, as required by art.32 of the Constitution, an almost total "pubblicizzazione" (rendering facilities under public law) of those facilities that offered health services. And it was, above all, a plan inspired by the principle of universality of safeguarding health care guaranteed to everybody, of equality for all people who receive health services, of entirety of services/performances (based on a synergic system of assistance and sociality for which all services not only comprehend health care but also prevention and control). According to Law n. 833, there are two decisional poles in the health care system: one at the central level (the ministry) and the other one at the peripheral level (*Unità sanitarie locali*/Local health services). At the top level, health policy decisions are taken care of and at the second level, decisions regarding day-to-day management of the objectives defined at ministerial level are focused on. The Regions are handed over the job to program and coordinate facilities offering health services which operate territorially. This system is based on a financial model characterized by the National health fund (Fsn) which gets its contribution from general taxation and follows a cascade model that starts from the State and descends towards the bodies operating locally.

It can be said that *devolution in the health care system* came out of the need to correct practical application of Law n. 833 that was leading to economic disaster a primary service that guaranteed an absolute right, such as the right to health. The first concerns for an uncontrolled management of health services – that would soon give rise to serious consequences in terms of increased spending – started at the beginning of the 80s which made the local health services have a board of auditors and the strictest controls on resolutions. The

reason for this was to put a brake on the act of not being responsible about one's budget. Basically, since 1982, a series of corrective measures began that characterized the health regulations in the following two decades. In fact, after some time, rules related to the sharing of pharmaceutical expenditure, instrument and laboratory diagnostics and to a specific rationalization of services with an eye on those who gave orders on spending were introduced. Moreover, other provisions connected to issues on which there would be interventions many times were brought in: more specific criteria for financing the National health fund and for splitting it out among Regions; ways to even out the deficit of the local health services; revision of the therapeutic manual; quantification of health contributions. All in all, there was this first big attempt by the State to make the Regions responsible for their expenditure that exceeded the amount coming from the National health fund. This manoeuvre was however thwarted by the Constitutional court that declared some of those rules illegitimate, i.e., regulations that spoke about obligation and not the choice the Regions could make to turn to self-financing (even with taxes) in case of a deficit. [17] Nonetheless, efforts to limit spending on health care still went on. In the health plan of the second half of the 80s, a specific goal was made to rationalize health services, and the Regions, in their detailed action plan, were asked to pay attention to the organization and real demands of the health care system especially concerning hospitals as it was in this area that excessive expenditure had been noted. New measures (or rather operational plans whose implementation was left to the initiative of individual Regions) were targeted towards defining the number of beds, duration of hospitalization, unification and transformation of services in order to lower and to rationalize uncontrolled expenditure. It was at that time that concepts like "day hospital", *intramural* private practice, wards with paid hotel-like facilities, a standard for the number of hospital staff per bed and reviewing of the pharmaceutical handbook came into being. The initiatives of the public legislator did not give rise to the effects hoped for, and in the early 90s, there was a stronger determination to go further. The Regions now had to take on more decisional responsibilities in terms of planning and organization, and to this effect management boards of the local health services were abolished; [12] also the financing criteria for health expenditure for each Region were changed as they were not adequate for taking into account the differences between the Regions in the allocation of resources. [14] The new financial model essentially took into account the so-called per-head share, i.e., every Region received an amount that corresponds to a unit value (*quota*) which is multiplied by the number of residents. [13]

Finally, in the early 90s, there was an awareness of the urgency to apply the principles and models of cost-effective management, bearing in mind the validity and correctness of the decision made in 1978, i.e., that of implementing art. 32 of the Constitution by means of instituting an NHS set to safeguard the rights of all citizens in terms of uniform and appropriate standards of healthcare. And it was the very Constitutional Court that contributed to the revolution of the system and to the substantial redistribution of the functions: emblematic are the sentences in which the vision of the right to health are introduced, such as "financially conditioned right". [16] Therefore, a couple of legislative decrees started off the so-called *bis* reform of the NHS [15] that established a principle: this principle wanted uniform levels of health care to be fixed according to *the resources established by the financial law and would*

*be related to the volume of the available resources*. The Regions would face balance deficits of the local health services and hospitals *using their own resources with no financial aid from the State*, yet specifying that the Regions *have the choice* to adopt necessary *measures and procure necessary funds to cover the gap.* In addition to confirming this financial model on the basis of per-capita share, the foundations of the two-year 1992-1993 reform were based on:

a) assigning greater responsibility in terms of management, planning, organization and finances to the Regions thereby triggering the process of *regionalization* of the health care system;
b) making local health services *a corporation* (making the production facilities and health services as corporation in the twofold sense of recognizing them as patrimonial, accounting, managing, technical and organizational autonomy and of adopting corporation-style management strategies);
c) making top-level management responsible and remunerating every service provided by private or public provider by means of a pre-established amount (this is the so-called Drg system i.e., remuneration proportionate to the service provided);
d) competitiveness between public and private bodies (competitiveness aims at guaranteeing constant qualitative betterment of the services offered and the greatest freedom of choice for the patient in terms of facilities that provide those services) based on standard market regulations;
e) participation of citizens alone or in the form of an association such as trade unions, voluntary organizations etc., at the management and organizational stage of the NHS who would give proposals or gather information on the organization of services and would also see to the attainment of the goals at closing stages.

This process of redistributing the functions in the health sector (*administrative decentralization*), which makes the Region take on a central role in the system, started initially with legislative decree 112/1998. It entered the complex procedure of rationalizing the central and peripheral facilities of the State and of the consequent reallocation of tasks among the territorial bodies (Regions and local bodies). Next, a new program of rationalization and reorganization was started that culminated in the issuing of the so-called *Third Health Reform*. The reform defined the NHS as a set of functions and activities of *regional health services* and of bodies and institutions at national level that are consistent with the prescriptions of legislative decree 112/1998 which confers to the Regions majority of the functions in the matter of health care. The salient features of this additional health reform consisted in giving a definitive value to the Regions, [20] in identifying the precise fees for the services provided by accredited private and public organizations [21] and in strengthening their planning efforts.

As such, the health care system seemed to have found a satisfactory set-up that was crystallized with the constitutional reform of 2001 which definitively marked a shift towards *devolved welfare* characterized by the abandonment of the exclusiveness of public role in the health care system and by a significant involvement of local regional bodies. The new expression of art. 117, regarding the distribution of functions between the State and the Regions, offers constitutional cover for this process, establishing that the *safeguarding of health* falls within the ambit of concurring legislation. This statement considerably increases the duties of Regions compared to primary constitutional article 117,

according to which the regional powers merely operated in the health and hospital sector within a well-defined programmed framework of the State. But, now the Regions would be able to establish political guidelines of the health care system, even if in the context of principles enunciated by national laws. However, the *Lep* of civil and social rights and those related to the health sector fall within the exclusive legislative powers of the State: this, as we will see, can considerably influence the application of fiscal federalism. The latter has constitutional cover with the regulations of art. 119 that guarantee financial autonomy (in both income and expenditure) to local bodies (Regions, provinces, metropolitan cities and communes), that is, they have the authority to independently establish and manage the necessary financial resources for carrying out the functions entrusted to them. The article mentioned also provides for an equalizing fund which compensates any eventual imbalances between tax revenues of the different Regions, allowing them to uniformly provide services on the entire national territory.

## 3. Evolution of Financing the National Health Service: A Federalism Already Put Down on Paper?

Financing health services is a subject that is related to both the qualification of the right to health and to the functioning of the health care system. In other words, there is no aspect in the modern public health care system that does not have a financial connection and as such to the identification of necessary resources. In Italy, the system of financing the NHS underwent a big change towards the end of the 90s. The evolution of this mechanism reveals a *federalist tendency*: Regions are progressively given the possibility to apply taxes for financing services replacing the old system – *cascade model* outlined by Law n. 833/1978 before, and, in some way, maintained by the legislative decree 502/1992 later.

We can divide NHS financing into four phases. The first phase (1982 – 1992) was characterized by an almost total coverage of the spending by the National health fund. The second phase (1993 – 1997) consisted of a mixed financing mechanism, or rather the National health fund became "supplementary" along with the revenue guaranteed by health care contributions that weighed on non self-employed work. The third phase (1998 – 2001) was marked out by health care contributions being substituted by regional taxes. And, the fourth phase is still in progress (2001 – to date). In this phase there was an *introduction* of fiscal federalism by law which was later constitutionalized: *the devolved organization* of the NHS is being consolidated in a federal way with the aim to concretize a strong financial autonomy of the Regions in matters of health care.

More precisely, the financial system before the reform of the 90s was more or less exclusively based on a national fund, i.e. the National health fund. This Fund, whose amount was established annually by the financial law, came from health taxes (contributions regionalized in 1992) and from the Regions' own revenues, but supplemented by a substantial amount of national contributions. As from 1997, the health taxes of workers were replaced by the regional tax on production activities (IRAP). [11] The Regions also had the possibility to apply further tax rates on the income of physical persons (*additional income tax*, IRPEF). Later, the system was completely redesigned. As a result of Law n. 133/1999 and of subsequent delegated decree n. 56/2000 [22] (so-called decree on fiscal federalism) the National health fund was abolished and was substituted for a variety of financial resources represented

by IRAP, *additional tax*, increased involvement of the Regions in VAT revenue, their own revenues and integrated incomes paid by the State. Moreover, restrictions related to the earmarking of the resources for financing health care were dropped and for aligning the differences among the Regions, an *equalization fund* was established. The fund took account of the different fiscal capacities per inhabitant and the health requirements of the different regional areas. It would then act in favour of the Regions that turned out to be financially non self-sufficient on the basis of their fiscal capacity. These regulations should have come into force the following year. However, there were series of delays in their application justifiable though with the same transitional phase envisaged by the decree and in which the coexistence of the different regimes had been provided for. It was only in 2004 that every improvement or worsening in the efficiency of the system will be under the responsibility of the Regions. Essentially, legislative decree n. 56/2000 seems to have been postponed (a kind of legal lethargy) and substituted for State-Region negotiations regarding the total amount of financing for health services and its division among the Regions, exactly as it used to happen with the old National health fund. The new mechanisms, operating only partially, have caused consequently constant tensions between the regional territorial bodies (that presently manage and spend almost autonomously) and the State that still has the authority to define the incomes and the total amount of funds for the NHS. A decisive role in handling NHS financing was therefore played from time to time by measures of substantive-organizational nature or of strictly financial kind that are contained in the annual financial laws and in the regulations related to them. Therefore, even if the National health fund has been abolished, the financial health care system continues to be managed – in many ways – at the central level, also owing to reasons connected to the respect for the community stability pact. Indeed, it is the State's responsibility to make an evaluation of the resources that are necessary for making the NHS work. It is also the State's responsibility to normatively define its financial resources and the relative measures connected to the primary level of its services.

As such, currently, the Regions do not seem to be enjoying any income autonomy, i.e. they still cannot raise and plan the resources that are necessary to fund their personal expenditure. Even though, legislative decree 56/2000 gives the Regions a substantial amount of their own resources, the revenues do not fall within their direct control. They are actually managed, checked, collected and later allocated to them by State administration. Thus, the only autonomy that the Regions enjoy is that in spending, once the amount has been allocated to them: they can decide on how to invest it in the health policies they consider best, without any restrictions in destination. However, the spending we are talking about here is quite limited (*restricted autonomy*), as the amount that the Regions receive (resulting from the financial mechanisms currently in force) does not indistinctly flow into their budget. It has to be used primarily and necessarily for health care and for covering essential health care needs. We can also say that there is a sort of making the Regions *partially responsible financially* if we take into account the fact that, on the one hand, it is impossible to attribute the responsibility of financing *public health corporation* deficits to the State [10] but, on the other, it is the State's responsibility to provide ways to settle public health corporation deficits. This situation is quite

complicated as the deficit of public health corporations, due to the constant underestimation of financial resources and to the delay with which the State's share is allocated to the Regions, seems to be quite normal. The result is that a series of stopgap measures at regional level have begun in order to guarantee fluidity of funds necessary for the normal functioning of the Regions, such as consistent operations of divesting real property or those of securitization of claimed credit from the State. However, if these operations are carried out in a wrong way or inadequately, they could lead to a further load on the financial affairs.

## 4. Fiscal Federalism and the Health Care System: New Rules and Old Problems

After a long parliamentary procedure, the rules and regulations on fiscal federalism have come into force. [8] It is a law made under delegate powers whose fundamental principles on the one hand are to coordinate the *spending centers with drawing centers* so as to give almost "automatically" greater responsibility to all the bodies involved in managing the resources. On the other, there is substitution of *historic* expenditure (based on keeping up the spending levels of the year before) with *standard* expenditure. In other words, there is a focus on making the spending centers as responsible as possible, increasing the transparency of the financial mechanisms, increasing the citizens' democratic control with the elected members and overcoming the system of regional and local finance marked by mechanisms of cascade transfer. As envisaged by art.119, there will be an equalizing fund with no limitations in favour of the Regions with lower fiscal capacity. This kind of fiscal federalism aims at introducing a *rewarding system* for those bodies that ensure high quality services and a fiscal pressure level lower than the other bodies of the same governing level. On the contrary, for the less virtuous bodies there is a *sanctioning system* that consists in neither allowing staff recruitment nor discretionary spending. These bodies will then have to balance their accounts also by transferring part of their personal and real property and by activating *taxation power* at the maximum level. There are other automatic sanctioning mechanisms of the government and administrative bodies in case of failure to respect this stability and economic-financial objectives assigned to the Regions and to the local bodies: there will be cases of ineligibility (which would be valid only for exponential local bodies of territorial communities) against administrators responsible for local bodies for which a bad financial state will be declared. The activation of fiscal federalism must finally be compatible with the financial responsibilities that were taken on in the *growth and stability pact* and must also confirm a system of fundamental functions assigned to the Regions. As regards the health care system, the basic levels of services (Lep) have to be financed and equalized at 100% on the basis of "standard costs" and "objectives of service" (which is something new). [7] Today, the transfer of funds from the State to the Regions for financing the health sector (but also social care and education) still takes place on the basis of the old mechanisms (historic expenditure with incremental criteria), which can result in strong inequalities towards the less virtuous Regions. With the application of the regulations of law n. 42, the transfer of funds by the State will be cancelled. In their place, the Regions will have a mix of their own taxes and their co-sharing with which to finance the *Lep* entirely, under the standard costs' rule.

The Regions must become completely responsible in matter of public health services and therefore there will be still more perspectives to be explored in the future.

In many aspects – and apart from the reform by the regulations under analysis - all this is not new in the health sector, whose organization has already followed an "almost federal" model. In fact, as seen before, the Regions for some time now have had considerable autonomy in terms of organization and administration. The rules of the decree on fiscal federalism can therefore be considered as the conclusive part of a process put into effect in the past decade and which has undergone substantive verification with decree n. 56/2000. Indeed, the health sector – as in other occasions – has been a forerunner both in the matter of devolution and of a different way of distribution of functions and at a later stage of fiscal federalism: in fact, for many years there has been a transfer of responsibilities at sub central level of the government and a progressive expansion in the role of the Regions; the organization and management of services are the exclusive prerogatives of the Regions: the services are largely financed by means of a regional tax on which they have wide margins of autonomy. Moreover, the health sector was the first among the important public sectors to introduce elements that aimed to recognize the value of diversity and wanted to overcome the typical limitations of mechanisms based on uniformity. In order to calculate the financial requirements of the Regions there is a meticulous system that takes account of the demographic, epidemiological, socio-economic characteristics of the different territorial situations and conditions. And, in foreseeing an equalizing fund (*constitutionalized* in 2001), the fore-mentioned decree n. 56/2000, aims not only to reduce the differences between the Regions having different fiscal capacities, but also establishes that this reduction works only 90%, as the remaining 10% is meant for pushing the less virtuous Regions to improve their taxable base. In other words, the above-mentioned decree triggers a mechanism of competitiveness that is typical of federalism and joins the other competitive stimulating measures among the providers of health services that have been introduced into the system since the 90s. The federalist system of the year 2000 could rightly constitute a driving force for those Regions that "considered to have the necessary conditions […] to continue, at least in the future, for a curb on public intervention in the health sector and, as a consequence, on a reduction in taxation pressure". [2] However, fiscal federalism provided for by decree n. 56/2000 operates only partially and, in 2009, the regional health finance appears like a *derived financial system* not only due to the effect of the mechanisms of taxation with which it can be fed but also because it is affected and limited about taxation powers by national decisions. [1]

The regulations of law n. 42/2009 could unblock the impasse in which the system finds itself right now. But at the same time they risk creating a further break-up and differentiation (compared to those registered today) in the kind and quality of the services provided if the State does not maintain the possibility to counterbalance this tendency by safeguarding and promoting the principles of solidarity by means of financial leverage. In order for this leverage to work efficaciously and for it to be used as an instrument to promote national health standards, it is absolutely fundamental that there be a concrete possibility for the State to be able to choose whether or not to distribute funds. This possibility in turn can be called concrete only if the Regions really become

capable of covering a considerable part of their spending necessary to guarantee health care with their own resources: therefore, it is easy to see that it is difficult to find and guarantee a perfect compatibility between decentralization and the ideals of the NHS, or rather, to reconcile maximum decentralization of governing the health care sector with the *universalistic principle* sanctioned in law n. 833/1978. It would not be surprising if in the issuing and activation of the implementable decrees, the Constitutional Court is called to specify in more concrete terms what it means by *national interest* and *universality* in the health sector. And then, considering the applicative obstacles that until now decree 56/2000 has gone through, special attention will have to be paid to the so-called *administrative dualism*, or rather the existence of a strong interregional differentiation in terms of technical/administrative and policy making capacities cannot be underestimated. In other words, it is the right time to combine the application of fiscal federalism with concrete measures in order to improve administrative instruments for its implementation. Otherwise, the impasse will remain.

## 5. Future Scenario: Is Right to Health Respected?

The close examination presented in the previous pages was aimed at outlining the framework within which the new regulations of law n. 42/2009 will move. We would now like to propose some further reflections regarding this analysis.

1. The law on the so-called fiscal federalism is a law under delegate powers that largely contains provisions, principles and directive criteria which allow the government wide margins for manoeuvring in the enforcing phase. The making of implementable decrees will therefore be decisive for the concretization (and completion) of the *federalist model* in the public health care system. For instance, it has been observed how the financial system of public health services comes from multiple sources: national and regional rules and regulations, financial interventions by the State every year for many years, contractual agreements, emergency and administrative decrees, all to the detriment of the stability and transparency of the system. Therefore, the first thing that one wishes might happen with the emanation of the above-mentioned decrees is the identification of a model which is coherent and compatible and which takes account of the fact that the evils that afflict the finances of the NHS seem to be arising from two directions. On the one hand, they are coming from the public health expenditure that - in spite of it being the most important element in the national and regional budget and is constantly increasing due to demographic reasons and to the increasing needs of the people - it still continues to be lower than the national GDP compared to what other European countries destine. [19] On the other hand, there still exists a terribly inefficient and differentiated health expenditure. [5] Quite recent studies show how the "classic" Italian dualism continues to surface: the central-northern Regions have a significantly higher level of efficiency and a better quality of expenditure compared to those of the southern Regions. Moreover, the Regions that are farther away from an efficient border turn out to be those that provide lower quality services. It seems that high expenditure and lower quality go hand in hand. Introduction of fiscal federalism (and of the consequent *total* health federalism) could, with an adequate impact analysis of the regulations by the legislator, open a new chapter in health care that is more careful with the territories and more

rewarding towards virtuous Regions, i.e. those that know how to combine quality health care with management rigors. In the last ten years, the NHS has definitely changed Italian health care services for the better, but the continuing unacceptable costs in different regional areas of the country and the thoughtless attitude of many Regions in terms of health management must not be permitted any longer. The remedy of healthcare federalism must lead to an attitude of higher responsibility by the *peripheral centers of expenditure* and to the spreading of best practices. However, it should be noted that already decree 56/2000 had the objective to make each and every Region more responsible towards their own budget restrictions and towards the efficiency of their system, but its implementation has turned out to be quite difficult.

In those same articles the regional tax resources used to be by and large connected to the locally generated income: the financial endowment of each Region turned out to be influenced by the distribution of the taxable base that at that time as in present times was unbalanced between the North and the South of the Nation. Already, the day after the issuing of decree n. 56/2000 it was pointed out that there was a risk: the Regions with higher levels of income would have received more resources for the distribution of additional public services including distribution of health services. [6] It is true that in any case a territorial readjustment by means of an equalizing fund was and is provided for, but once the fund is implemented (and comes out of the impasse for the health sector) it will not be easy to establish which Regions will be able to access it (or will have to access it). The third comma of art. 119 of the Constitution states that the equalizing fund is instituted "for those regional areas which have lower fiscal capacity per inhabitant": therefore, establishing criteria for this *lower capacity* (lower than the level of fiscal capacity in the richest Region; lower than the average national level of fiscal capacity; lower than the level of average fiscal capacity of 3, 5 or 7 richest Regions) becomes a criterion for the real redistributive possibilities of the financing mechanism. [3]

2. It is well known that Constitutions are definitely not treaties of public finance and hardly show the complete list of instruments necessary to carry out the objectives of a system based on fiscal federalism. The Italian Constitution reformed in 2001 is not an exception to this rule. Having shown that multiple objectives cannot be reached by means of only one instrument, it must be thought that it will be interpreted with the traditional and legitimate method of the balancing of rights and protective measures: consequently some objectives could be ignored and it will be necessary to integrate the list of implementable criteria and related instruments. Therefore, it must be thought that the respect for letter m) of art. 117 Const. (identification of *Lep* at national level) and the indications in comma 5 of art. 119 Const. are to be considered strong objectives; then it should also be acknowledged that these are objectives that can not be followed only with instruments provided for in commas 2 and 3 of art. 119 (equalizing fund; Regions' own taxes and incomes and their co-sharing in revenue taxes) and cited by Law n. 42. However, it must be said that - in this law - the signals for the criteria of financing based on indicators of requirements are useful integrations to the list of instruments proposed by Constitution. Once again, the importance of the provisions of the implementable decrees should be pointed out as they will not only have to work on reducing (high and excessive) segmentation of the

financial resources but will also have to operate well so that the unfulfilled delegated law since 1997 (regarding the issuing of a consolidation act on health care) will finally be implemented. This will allow to clarify a multitude of regulations and mechanisms that regard the system and will improve the efficiency of any kind of intervention.

3. The *federalist regulations* of the reformed Constitution determine differentiations in the characteristics of the public offer, in the treatment of citizens and also in the levels of expenditure per inhabitant in the different Regions, but this characteristic is a fundamental requisite of a system based on fiscal federalism which has to necessarily provide for the existence of some kind of differentiation. In fact, without any differentiation there would not be any fiscal federalism. Diversely, the word federalism should not be used. We also need to consider that the regionalization of the health care system has already introduced a significant state of instability with differences not only at organizational level but also at the drawing up of the final accounts: or in organizing regional accounts systems, applying compensation mechanisms (carried out after the event and belatedly) etc. These circumstances have created inequalities in the distribution of services leading to repercussions on the efficacy of health services. In fact, practically, the levels of health care are essentially distributed on the basis of the organizational capacity of each Region, even if it is getting the same funds like every other Region. Law n. 42/2009 influences only the way of financing the service and does not touch, if not indirectly, the organizational and management setup; but if the organization or management is not good, or rather, the administration is not efficient, it will be difficult for federalism to have good effect. Evidence lies in what happened the day after the issuing of decree 56/2000. It is certainly true that if there are more resources, organization benefits from them and vice versa (with a more efficient organization more resources are given out). However, the renewing of the NHS will not come about solely from the need to restore the regional budget, but it will have to be associated with a reorganization and re-planning of the services. In fact, good planning and good organization will affect both budget and above all expenditure.

4. It is well-known that in a system based on fiscal federalism there is a need for rules that aim at limiting the possibility of continuous and repeated interference by the State in matters of regional legislative responsibilities. More precisely, the theory on fiscal federalism dictates that an appropriate financial structure must be defined in relation to the power of interference of the central government in the activities of decentralized bodies. Thus, there could be maximum interference for activities that are subject to the principle of uniform services for all and for interventions mentioned in comma 5 of art. 119 (*additional resources and special interventions to encourage an effective exercise of personal rights*), and there could be minimum interference for those activities that come under concurring legislation and for those governed by the regulations of the exclusive competence of the Regions. As a result, where there is a lower level of admissible interference, there will be a higher resorting to resources of regional revenue and to exercising of taxation power and there will be lower intensity of equalizing the fiscal capacity. Where there is a higher level of interference, there will be lower binding reasons for using regional taxes and for exercising tax autonomy. Resorting to regional taxation or to co-sharing cannot be excluded, but they will not be very useful as the State should finance the

differences anyway until the costs of the services that are the same throughout the national territory are completely paid off. Therefore, in such circumstances, in spite of the apparent impediment of comma 3 of art. 119 (the expression, "without restrictions of allocation"), one cannot exclude fixing restrictions of allocation on transferred resources by the State. The point is that, at present, regional taxes (instrument considered to be capable of creating virtuous behaviour among regional administrators) play a very limited role in relation to many restrictions put on financial autonomy (such as the stability Pact). The necessity which still remains and which will have to be worked on in the future is the concrete incentives to find important innovations in the context of taxation.

5. Finally, it is important to highlight that there is a need to limit the risk of placing internal management and financial restrictions before the interests of the citizen. Consider the system with which the Regions manage *passive mobility* (which means money going out of one *local health service* to another or out of one Region to another) in order to compensate supplied health services. In a country like ours where the regional frontiers are only administrative, it is easy to find patients running over or being attracted to a health service depending on what is being offered. This happens specially in border areas. The more efficient Regions with higher resources can in fact stimulate border health services to organize themselves encouraging *active mobility*. On the one hand it encourages competitive mechanisms among local health services of the most efficient Regions; on the other hand this can generate second-rate services from other Regions less efficient (bordering or not) that, when facing a more advantageous offer somewhere else (perhaps not far from home), happen to ignore the interest of the patients who have also paid taxes to support their Region's health services. So, it should be noted that some negative situations seen today will not change with the introduction of fiscal federalism because the rules of law n. 42/2009 will not affect those Regions that are incapable of structurally changing their services; those that limit themselves to implement monetary compensation mechanisms or that prefer to go for a low-profile solution neglecting to create a real health care policy, [4] sapping the effective exercise for all citizens to their right to health.

**References and notes**

1. Cilione, G.: *Diritto sanitario*. 2005, p. 266. For instance, the Regions have only a marginal capacity to handle other aspects connected to financing services. They are often not allowed to impose additional tax rates, and can not take loans except for investment costs. This highlights the fact that total institutional responsibility with regard to financing the NHS is totally ascribable to the powers of the State.
2. Dirindin, C. N.: *Federalismo fiscale e tutela della salute. Un percorso di responsabilizzazione delle regioni o il presupposto per cambiamenti strutturali?* in Governare il federalismo, a cura di Dirindin N., Pagano E., Roma. PSE, 2001, p. 10.
3. Giarda, P.: *Competenze regionali e regole di finanziamento: qualche riflessione sul federalismo fiscale in Italia*. paper presented at the ISAE-SIEP Convention, Rome, 14 December 2005.
4. Manzi, P.: *Federalismo diseguale: la via italiana ad un servizio sanitario federale*. in Care, I, 2009, p. 24. In some federal systems there has been an attempt to adapt the need to ensure

health care services with that of containing and planning the expenditure by implementing the so-called economies of scope. In order to check the changes in expenditure, limitations are made to the citizen's choice as free services are connected only to some geographical areas, while resorting to health treatments out of one's geographical area is discouraged. The positive aspect of these measures lies in defining services based on a population of a certain area in the economies of scale, concentrating medical, technical and administrative knowledge in health facilities, in providing higher security to investments etc.

5. Pammolli, F., Papa, G., Salerno, N. C.: *La spesa sanitaria pubblica in Italia: dentro la 'scatola nera' delle differenze regionali*. Quaderno CERM 2/2009 in http://www.astrid-online.it/Politiche-/Documenti/CERM_Sanit-_26_10_09.pdf.
6. Spandonaro, F., Rafaniello, A.: *Le frontiere della sanità tra decentramento istituzionale e sperimentazioni gestionali*. AIES Convention, 2002.
7. The reference is in art.2 letter f) and in art. 2, letter m), point 1 of mentioned decree n.42/2009. *Standard costs* should/could mean "efficient costs" to which the most virtuous Region supplies services.
8. Law no. 42 of 5-10-2009 "delegates the Government in the matter of fiscal federalism to implement article 119 of the Constitution", in the official gazette of 6 May 2009. To make fiscal federalism practically operative, there is a need for a series of provisions that will take effect in a period of 7 years: 2 years for their implementation and 5 years of transitory regime.
9. Constitutional Law of 18.10.2001, no. 3.
10. As provided for by law 405 of 2001, of converting leg. Dec. 347/2001: the deficit has to be evened out by the Regions that will do so with additional "tickets", further taxation or other acts to contain expenditure.
11. Legislative decree 446 of 15.12.1997. The Regional business tax (IRAP) is a tax on the value of the net production coming from the regular running of an activity for the production or trading of goods or services.
12. The dissolution of the boards came about with l. 4-4-1991, n. 111, and the local health services were entrusted to special administrators with the task to tow them towards a new and robust NHS reform.
13. In turn, the per-head quota comes from the identification of the cost of healthcare, i.e., cost per head of each service (on the basis of organizational *standards* and activities necessary for those services). The new model introduced by the financial law for 1992 (l. no. 412 of 30-12-1991) would be better depending on the precision with which it would be possible to establish the cost of each service in every regional area.
14. L. n. 887 del 22-12-1984 (financial act of 1985).
15. Decrees of 30-12-1992 n. 502 and 5-12-1993 n. 517.
16. Cfr. Const. Corte no. 455 of 16.10.1990 and no. 356 of 23.7.1992
17. Const. Court sentence no. 245 of 1984.
18. FBM-Censis investigation, 2001 at http://www.censis.it/277/372/4974/5129/cover.asp
19. Source OCSE. Cfr. http://www.oecd.org/dataoecd/55/33/35635683.pdf
20. The Regions lay out proposals for organizing a National health plan. They adopt a Regional health plan to satisfy the specific demands of the

local population. They then define the regional territory in the local health services, establish criteria for the subdivision of local health services in districts, regulate the finances of the local health services, ways and means of supervising, control and assess the results of their activities, see to the accreditation of authorized public and private facilities that provide services on behalf of the NHS, propose forms of trial management among NHS and private facilities.

21. The new criteria of payment provided for by the decree are of two types: financing which is calculated on the basis of a standard production cost by the healthcare program. It is attributed for some specific services that are not quantifiable based on individual service (programs for long term, preventive pathologies and those that require assistance for rare diseases etc.) and payment on the basis of pre-established fees, at central level, by the Ministry and at local level by the Regions as regards admissions for severe conditions and services connected to outpatient specialized health care.
22. Until 2000, the legislator had not really got into the heart of the matter regarding *financing* the service, as he was basically concerned with the rationalization of organization and functioning. The first real and new mechanism of financing the NHS is in fact contained in legislative decree 56/2000 which implements "fiscal federalism" which, in the context of operations of rationalization of the fiscal system, introduced a series of important innovations in financing the Regions under ordinary statute.