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Introduction

In the last 20 years the Italian National Health Care System (NHS) has experienced a significant process of transformation. The NHS was introduced in 1978 substituting a previous Social Health Care Insurance model (Vicarelli, 2011). While the 1980s represented a decade when governments tried to implement the new institutional design for health care, the 1990s were already a time of discernible change: at the beginning of the decade, for a series of reasons that will be explained later in this chapter, attempts were made to dismiss the NHS and shift to a more private-like system. These attempts failed but important transformations took place nevertheless (Vicarelli, 2011).

NHS reforms had to follow a difficult path between cost containment given the huge public debt of the Italian State and innovation, which though often costly, was required by an increasing exigent and aging population (and electorate).

In order to solve the dilemma of containing costs and trying to keep pace with social demand, the institutional changes in the NHS reform took different directions, three of which are of particular interest: rescaling, privatization and managerialization. Two reforms were passed in the 1990s, one at the beginning of the decade (1992–93), the other at the end (1999), setting the main aims and goals of innovation in relation to the three directions. The last decade saw neither a general NHS reform nor attempts made in this direction but only smaller and more focused regulatory changes which are having a noteworthy impact on the overall functioning of the NHS today.

As in many other European countries, rescaling largely meant a shift of power and responsibilities from the national level to sub-national (regional) governments. Following the regionalization reforms of the 1990s a good part of the regulatory public power in health care was shifted from the national State to Regions: the former essentially maintained two tasks (a substantial part of financing and setting ‘homogeneous standards of health
care provision’ over the country), the latter received all other tasks (from planning to managing health care provision). As a consequence, health care became one of the most important policy fields for the Regions, given the fact that at least 60–70 per cent of Regional spending in each Region is allocated to its provision (Pavolini, 2011).

In the same years and chiefly through the same laws, a strong attempt was made to modernize NHS administration following for the most part, a New Public Management approach: the local health care authorities (USLs – Unità sanitarie locali) created by the 1978 reform were transformed into health care agencies (ASLs – Aziende sanitarie locali) and Hospital Trusts (AOs – Aziende ospedaliere). Politicians appointed by local governments were substituted by managers (called ‘General Directors’ – Direttori generali) heading the agencies and trusts. These managers have fixed-term contracts and are appointed directly by the Regional Government. The managerialization approach not only shaped the NHS top decision making process in a new way, but also the day-to-day running of hospitals and other health care facilities: a whole new set of instruments (primarily, but not solely, referring to budgeting, costs controls, etc.) was introduced, trying to foster a shift from a traditional bureaucratic approach to a more post-Weberian one (Vicarelli et al., 2009).

In connection with managerialization, the 1990s also witnessed the introduction of competition and a broader use of private providers within the NHS. This paved the way for using ‘quasi-markets’ and replacing an increasing number of public provision with provision contracted-out to the private sector. In the 1992–93 reforms, ‘managed competition’ was considered one of the main tools in making the Italian NHS more efficient. However, in the 1999 reform, ‘managed competition’ among different providers was partially replaced, at least in national legislation, by ‘managed cooperation’, thus proposing a view of public and private providers as single component parts of a complex and integrated care network.

In comparison with the 1990s, the last decade was quite different. Apart from the Constitutional Reform of 2001 (introducing a more federalist-like institutional design of the Italian State) which could be seen as the last act in line with the wave of changes sweeping through the previous decade, no major reforms were passed by Parliament. Nonetheless, significant transformations occurred in the Italian NHS. These took a more ‘hidden’ form and yet brought, and continue to bring, profound changes to how the health care system works (Hacker, 2004).

The first decade of the new century: what’s new for the Italian NHS?

As often happens with complex policies, health care in Italy also underwent a series of processes in the last decade which were related both to medium-long term dynamics and to more recent ones.