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Federalism and Health Care: A Comparative Policy Analysis of Canada and Italy

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ABSTRACT *Canada and Italy do not share many of the features associated with modern welfare state development, yet both countries have experienced changes in the way health care programs are administered and funded, and in the shift in fiscal responsibility between center and sub-national governments. This article explores the relationship between federalism, decentralization and health reform in Canada and Italy. It investigates how the two countries – one federal, the other "regionalized" – have designed and adapted their health care systems to respond to similar issues of equity, cost containment and organization.*

Keywords: health care; comparative policy analysis; federalism; Canada; Italy

1. Introduction

Canada and Italy do not share many of the features associated with modern welfare state development, as they do not generally fall within the same categorization in terms of the configuration of social programs or indeed the institutional structures known to affect social protection. Yet both countries have experienced changes in the way social programs are shaped and funded, and in the shift in fiscal responsibility between center and sub-national governments. Nowhere is this more evident than in the health sector, where

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decentralization has had an impact on the way health care is financed and administered in both polities.

In effect, the experiences of health reform in Canada and Italy demonstrate how two different health care sectors, institutionalized in distinct welfare state settings, can adopt mechanisms to adapt to evolving challenges and pressures. In Italy, a formally unitary polity with long-standing regional tensions, the constitutionally mandated decentralization of the health care system has set the stage for a new model of devolved governance. In fact, rapid decentralization in the health care sector has opened the political and economic space for "federalization" in major policy sectors, notwithstanding the absence of formal federal institutions. In Canada, meanwhile, federalism gave rise to a health care system that is decentralized in a formal sense, in which sub-national units are responsible for the financing and administration of their individual plans. However, the central government can hold sway through the levers of fiscal federalism, which have changed significantly over the years, within an ongoing debate about the institutional relationship between the federal and provincial governments in matters of social policy-making.

Our article will attempt to explore the relationship between federalism, decentralization and health reform in Canada and Italy. We are interested in how the two countries, one formally federal, one formally unitary, have designed and adapted their health care systems to respond to similar issues of equity, cost containment and organization. How can a health care system in a formally federal country like Canada look so similar across sub-national boundaries with respect to norms and standards – single-payer mechanisms for payment, bans on not allowing doctors to extra-bill, basket of services – while an ostensibly "unitary" country like Italy allows for greater differences in terms of access to care and payments to providers. We argue that the answer lies in both the development of jurisdictional responsibilities and the levers of fiscal federalism.

The article proceeds as follows. We begin with an overview of the two health care systems with regard to how they are classified in terms of their insurance systems. We then turn to an examination of how these two health systems developed with regard to "federalism" – that is, both "constitutional" jurisdiction and "fiscal federalism" instruments. In so doing, we attempt to trace the relative "decentralization" of health care in these two ostensibly different institutional settings: Canada, a formally federal polity, and Italy, a formally unitary state. This leads us to offer some comparative reflections that attempt to trace the sources of similarities and differences between the two countries, and that can contribute to a more nuanced understanding of the role of federalism and decentralization in welfare state development.

2. Comparing Health Systems in Canada and Italy

The logic of comparison between Canada and Italy derives from the literature on welfare states in industrialized democracies that has attempted to cluster countries on the basis of their social policies – for example, as different "worlds" based on their labor market "regimes" (Esping-Andersen 1990); or as "families of nations" in terms of their social rights (Castles 1993); or as models with specific policy "traits" (Ferrera 1996a, 2012). In these types of comparison, Canada and Italy have been assigned to different clusters. Canada is seen as a "liberal" welfare regime, with an emphasis on means-tested social assistance, within a group of countries that share Anglo-American histories; Italy,

meanwhile, is considered a continental European model, with social insurance dominated by family-based benefits, although with significant gaps in the "Southern" model of such policies (Ferrera 1996a). In the case of health care, however, there are areas in which the two countries have certain similar characteristics that have an impact on health care policy and provision.

National Health Insurance in Canada and Italy

As Béland et al. (2020) have pointed out that, despite being classified as a "liberal" welfare state, Canada has developed a "universal" health care system, which allows all citizens to access the same services through their provincial or territorial plans. In Italy, meanwhile, the National Health Service diverges from occupational-based benefits in other "continental" welfare states in that health care is considered a constitutional right,[1] delivered via standardized services according to regions (Ferrera 1996a; Maino 2001). Its name suggests the inspiration, as the Italian system is often referred to as a "Beveridge model" in contrast to "Bismarckian" social insurance models. Moreover, in such a binary classification, even though Canada is more the former than the latter, neither Italy nor Canada could be said to be true embodiments of a national health system (Toth 2016). Indeed, both Canada and Italy can be classified as "national health insurance" types, where state regulation and tax financing coexist with some patient choice and autonomy for providers of services (Bohm et al. 2013). This is to differentiate from a "national health service", despite the nomenclature used in Italy to identify its public system. Bohm et al. (2013, p. 265) also conjecture that political systems in Canada and Italy are more affected by institutional "veto points": federalism in Canada and "unstable

Table 1. Structure of publicly funded health care systems in Canada and Italy

	Canada	**Italy**
Origin of the health care system	Hospital insurance (1957) Medical insurance (1966)	Social insurance (1947) National health service (1978)
Coverage of the health care system	100 % of residents (via provincial plans)	100 % of residents (via regional and local delivery)
Financing of the health care system	Taxpayers	Taxpayers
Sources of revenue in health care	Provincial revenues Canada Health Transfer Equalization payments	Regional revenues Central transfers
Norms of coverage and payment	Canada Health Act (1984) Provincial legislation	Law 833/1978 Regional legislation
Patient contribution	Free at the point of care	Co-payments may be imposed
Gaps in coverage (dependent on age, income, disability)	Dental, pharma, LT care (varies by province)	Dental, pharma, LT care (varies by region)
Supplemental insurance	Voluntary health insurance (may not cover public benefits)	Voluntary health insurance (may cover insured benefits)

Sources: Organisation for Economic Co-operation and Development (2016); OECD/European Observatory on Health Systems and Policies (2021); Toth (2021, p. 30).

Table 2. Integration and functioning of health care systems in Canada and Italy

	Canada	Italy
National legislation on quality	No	Yes
National ceiling on public health costs	No	Yes
Hospital status (usual)	Not-for-profit	Public
Physician payment (usual)	Fee-for-service Contract	Capitation/NHS
Physician status (usual)	Self-employed	Public employee
Coordination between primary	Weak	Strong

Sources: Organisation for Economic Co-operation and Development (2016); OECD/European Observatory on Health Systems and Policies (2021); Toth (2021, p. 96).

governments" in Italy. We would argue that "regionalization" in the Italian case also provides considerable room for instability and veto points as well.

Furthermore, while the two countries could be described as "single-payer" models in contrast to multi-payer insurance systems (Hussey and Anderson 2003), they also both exhibit "hybrid" tendencies in their health care benefits, combining a "universalist" model for most services with voluntary insurance for certain "ancillary" services (Toth 2021). In addition, the Italian system offers more leeway for private payment or alternative funding models than does the Canadian experience. Tables 1 and 2 summarize the essential similarities and differences between Canada and Italy with reference to health care systems.

In Canada, the five "principles" of the Canada Health Act (universality, equal access, comprehensiveness, portability and public administration)[2] are considered the conditions for the transfer of funds through fiscal federalism. In Italy, Law No. 833/1978 provides the template for health care, which sets out the provision of public funds, universal access and comprehensive health services (Maino and Razetti 2021).

While the principle of public administration exists in both countries, Italy allows for a wider array of funding arrangements that involve the private sector. This is important, because regions can "differentiate" themselves based on their funding models. In Canada, provincial governments negotiate fees or, in some cases, limited forms of capitation, but physicians can only be reimbursed through the "single payer" of the provincial health plan; they are not permitted to extra-bill patients, impose co-payments on services, or accept "private" payment while on the public payroll. These limits imposed by the Canada Health Act have meant that provincial health care systems are more constrained in allowing private payment for care. In both countries, a measure of patient mobility is allowed. Canadians who move from one province to another are covered, and immediate or emergency care is allowed when traveling, but for the most part they access care under the provincial system they are enrolled in. In Italy, the freedom of choice for hospital care allows Italians to access care in whatever region they choose.

Both countries respect the principle of universality to cover all citizens and legal immigrants or permanent residents: in Italy, this is guaranteed through the National Health Service; in Canada, through provincial statutes. A significant difference is that the Italian government retains the responsibility for national health policies and priorities and the allocation of resources, while in Canada health policy-making is based in the

provinces. Still, we see a significant decentralization in the provision of services in both: in Italy, regions have considerable autonomy in the organization of health care and are responsible for delivering services through the administration of local health enterprises (*Aziende Sanitarie Locali*, ASL), similar to the way provinces are responsible for health care administration in Canada. In addition, there is widespread use of private delivery of care, both for private and publicly funded patients in Italy, something not prevalent in Canada except in limited and specific circumstances in certain provinces. Another difference is the level of "integration" of care: the Italian system tends to have more coordination between primary and hospital care, while in Canada this is less so (Toth 2021, p. 105).

Despite claims of comprehensive services by both countries, in reality there are gaps in public provision. In Italy, these include user fees, co-payments and the alternative use of private care; whereas in Canada these methods are not yet widespread for services provided by provincial health plans. Moreover, these plans offer only partial coverage of prescription drugs and dental care, which are usually covered by supplementary (voluntary) insurance, and gaps in the access to and coverage of long-term care and home care remain.

This is reflected in health care spending: in both countries, only three-quarters of total spending in health care flows through the public purse, making them similar with respect to their Organisation for Economic Co-operation and Development (OECD) counterparts, which range from 60 to 85 per cent.[3] Overall, pre-pandemic total expenditures in health (2019) were higher in Canada (11 per cent of GDP or Purchasing Power Parity PPP$ 5,190 per capita) than in Italy (8.7 per cent of GDP or PPP$ 3,565 per capita). Since the pandemic, government deficits have increased due to the considerable pressure of health care crisis responses.

In Canada, there are considerable differences in per capita costs for the three territories compared to the ten provinces, as they are more remote in geographical terms, more sparsely populated and both patients and providers may have to travel for some forms of health care. For example, pre-pandemic per capita costs in the Northwest Territories were CA$13,670 as compared to CA$5,428 in Alberta (Canadian Institute for Health Information 2022). Among the provinces, the magnitude of difference is much less, although there are still variations that reflect different government capacities, provider remuneration and population needs. In Italy, meanwhile, regional differences are mitigated to some extent, although there are differences in terms of northern regions, which tend to have an older population and where governments are able to offer care beyond the national minimums (Corte dei Conti 2023). Moreover, there are considerable differences in private expenditures between northern and southern regions, reflecting overall disparities in wealth and income.

The Impact of Federalism on Health Care

A significant comparative element in the study of health care is the nature of federalism and its impact on the welfare state (Obinger et al. 2009).[4] Federalism can be seen as part of the institutional "veto points" that frustrate social policy development (Immergut 1992), and has been measured as having a dampening effect on social expenditures (Evelyne et al. 1993). Shared governance can lead to strategies of "blame avoidance", although arguments

have been made about the way in which subnational units, under certain conditions, can function as "laboratories of democracy" (Weaver 1986).

Federalism can be defined as a political arrangement by which power is constitutionally distributed between central/national and regional/sub-national governments and in which the social and economic lives of citizens are affected by both domains (Smiley 1987).[5] Although an ideal type of federalism would include a division of powers in which policy sectors are "watertight compartments", in the real world of modern politics "entangled governance … has given way to more flexible and adaptable practices" (Fenna 2007, p. 301).

Canada is considered an established federation, with a constitutionally recognized division of powers between the federal and ten provincial governments, as well as the three territories. While health care is not explicitly mentioned in its Constitution, provinces are considered to hold primary responsibility in health policy. However, the federal government can contribute monetarily through its extensive taxation and spending powers, and does so in many domains. While their historical antecedents could not be more different, Italy's political structure, like Canada's, emerged from the recasting of existing political units in the 19th century.[6] A variety of fragmented polities were fashioned into a unified Italian nation-state in 1861. The 1947 Constitution formally defined Italy as a unitary republic, even with the recognition of 20 regional governments along territorial lines. Furthermore, the Constitution recognized health as a "fundamental right". This was later reinforced through the introduction of the National Health Service in 1978 (Maino and Razetti 2021). Nevertheless, and especially since subsequent constitutional reforms, Italy is said to have developed a more "quasi-federal" arrangement (Maino 2001). It has been classified in comparative terms as a "regional state which displays a clear territorial division of powers" (Requejo 2010, p. 285). More recent studies of the welfare state that eschew rigid variable-based approaches of political institutions to embrace sub-national variation include Italy in a "generous definition" of federalism (Greer et al. 2023).[7]

Although there are comparisons between federal and "quasi-federal" polities in key policy areas (e.g. for Canada and the UK, see Keating and Laforest 2018; for Italian and European examples, see Valdesalici and Palermo 2018), less has been noted between Canada and Italy, even though, beyond formal definitions, in the kinds of measures that affect health care spending and the provision of services, it is clear that both countries are decentralized in their approach. In Italy, clashes between the central government and the regions, which led to important devolution in health care spending and service provision, have allowed for the emergence of a de facto federal structure in the financing and organization of health care; in 2001, constitutional amendments recognized health as a "concurrent" responsibility between the regions, autonomous in the organization of their health care systems, and the national government, which distributes public monies based on general policy frameworks. In Canada, shared responsibility has been apparent since the origins of hospital and medical insurance in the provinces, where provinces organize their systems and services, with financial supplements from the federal government. The general conditions on federal transfers in the Canada Health Act of 1984 have constrained the provinces from widespread divergence in their health care systems, at least in terms of constraining private access and ensuring coverage (Flood and Thomas 2016).

In both cases, the central government wields power in health policy through the use of "fiscal federalism" – that is, in the way in which resources are allocated and choices about redistribution and financing are made (Giarda 1995). This involves the financial relationship by which a central government redistributes money to sub-national units in order to finance specific programs or add to general revenues. This can be done in three ways that span the spectrum from more to less centralized control: the use of federal transfers to fund specific programs; the transfer of a "block" of funds that may or may not be tied to conditions on how the money can be spent; and the reallocation of revenue collected by the central government destined to be added to the general revenues of provinces, states or regions with more limited fiscal capacities.

The relationship that binds together governments in the area of health policy has been profoundly affected by decentralization in both Canada and Italy. Decentralization involves the transfer of authority or diffusion of power in policy-making from central to sub-national governments (Mills 1990). In Canada decentralization is "baked in" to the constitutional division of powers in the federal polity. The wide breadth of jurisdictional powers for provinces and the spending of monies associated with these responsibilities, most notably health care, means that, in comparative terms, Canada is considerably decentralized (Marchildon and Bossert 2018). According to Requejo (2010), Canada and Italy are both classified as "federations" in terms of the division of powers and of degrees of fiscal federalism, with the former being one of the "most" decentralized.

However, in Italy, decentralization has been part of the ongoing power struggle of regional governments within a unitary framework and, more recently, the trend toward "differentiated regionalism" in certain regions. This is especially notable in the health sector, where there has been a "progressive transfer of competencies" to the regions, leading observers to label it a "federation of regional systems" (Toth 2016, p. 63).

In the following sections, we explore such decentralization through the lens of "constitutional" federalism in the division of powers and responsibilities as well as the impact of fiscal federalism on the development and reform of health care systems in Canada and Italy, taking into account the similarities and differences of their constitutional setting, political environments and fiscal pressures.

3. Canada: The Struggle for Political Space in Health Care

Federalism and the Development of the Canadian Health Care System

Canada's federal structure has had an obvious impact on the development of its welfare state, including health care provision. In contrast to Italy's 1978 Constitution, there is no constitutional "right" to health in Canada (nor is it made explicit in the Canadian Charter of Rights and Freedoms). Again in contrast to Italy, it is the provinces, not the central government, that have *de jure* responsibility for health care through the Constitution Act of 1867, which gives provincial governments exclusive jurisdiction in social matters, including hospitals (Section 92.7) and local and private matters (Section 92.16). These powers were not considered to be very important in 1867, since state intervention in citizens' lives was still limited. In effect, contingencies such as sickness, old age and poverty were considered "private" matters, to be attended to by the family. Under poor-law traditions imported to the colonies from Britain, municipalities undertook the funding of charitable institutions (such as public hospitals) or, as in the case of Quebec,

religious communities (Guest 1997). However, the Constitution also singled out specific "classes" of persons considered to be under federal responsibility, the most significant of which were Indigenous peoples; in this case, the central government intervened heavily in ways that would affect their health and social condition for decades to come.

Apart from provincial responses to public health needs and attempts by municipalities to address health concerns, government involvement in general health care provision remained limited in the first decade of the 20th century. A federal Department of Health was created in 1917, but its role was mainly to investigate population health issues. Even though the federal government's response to the economic pressures of the Great Depression was limited, the expansion of its fiscal powers during World War II led to a debate about post-war reconstruction; since Canada, unlike Italy, had not suffered material damage or witnessed the collapse of a political regime, this debate revolved around building social protection rather than rebuilding physical and institutional structures. While the "Beveridge" model – which was to be influential in Italy – captured the imagination of federal bureaucrats (by insisting on powers to tax and spend, can play a fiscal role in funding social programs), the British model seemed incompatible with Canadian federalism at the time (Maioni 1995).

In the absence of an immediate federal response, a social democratic government in Saskatchewan introduced hospital insurance in 1947 and a subsequent federal cost-sharing program encouraged all of the provinces to pass hospital insurance legislation by 1961. A similar pattern occurred in the case of medical insurance: the social democratic government of Saskatchewan introduced medical insurance in 1962 and then the federal government passed a cost-sharing arrangement in 1966 that encouraged provincial governments to provide medical insurance. By 1971, Canadian residents were thus covered for the costs of hospital and medical services through provincial health plans (Taylor 1987).

While provinces became the "single payers" for health care, reimbursing physicians and allocating hospital budgets from general revenues, the practice of medicine remained essentially "private" (Naylor 1986) – that is, unlike in the Italian NHS, the state did not employ doctors (mainly paid on a fee-for-service basis) or administer hospitals (which remained voluntary organizations, even though dependent on public monies). Although the federal government specified that provincial programs were to be public, portable, comprehensive and universal, it was not until the passage of the Canada Health Act in 1984 that the federal government began imposing financial penalties on the provinces that did not respect these conditions and the additional provision for "equal access". This led to protest from the provinces, some of which were obliged to change their health care legislation to conform to the new Act.

There is considerable debate in Canada about the role of the federal government in "preserving" the principles of the health care system while allowing inter-provincial variation. A case in point is Quebec, which arguably created a distinct welfare state as part of its rapid modernization in the "Quiet Revolution" of the 1960s (Maioni 2016). From the start, health and social services were seen as an integral combination, leading to the creation of local community-based centers (*centres locaux de services communautaires*). Successive Quebec governments have all claimed to be governed exclusively by their own health legislation, not the Canada Health Act, although they have been among the most vocal in protesting cuts to federal transfers.

As in Italy, the direct provision of health care services to its citizens is not a responsibility of the central government in Canada. However, an important distinction in the Canadian Constitution is the federal responsibility for specific "populations", such as Indigenous peoples, immigrants/refugees, federal prisoners and the armed forces; this has led to a role for the federal government in health services for these populations, even if provided through provincial health plans (Butler and Tiedemann 2013). After the introduction of hospital and medical care, Indigenous Canadians could access health care services as provincial residents. Through their Indigenous status, they are also eligible for the federal government's "non-insured health benefits program". By the late 1980s, "self-government" began to be extended to health care funding in some Indigenous communities (Marchildon 2014). Nevertheless, in the absence of a targeted strategy in the development of health services for Indigenous peoples, the problems of access to, and appropriateness of, health care remained significant (Waldram et al. 1998). Thus, gaps in care have remained severe, and Indigenous peoples across Canada have suffered greater health problems and unmet needs, in both physical and mental health, and as a result of the traumas associated with their lived experiences.

Parsing out distinct roles for federal and provincial governments has also been put to the test in the area of public health. The federal government does have a key role in the regulation of food and drugs, and while public health measures fall primarily within provincial jurisdiction, the federal government has had to take on important roles in responding to public health threats. Indeed, the need for better intergovernmental cooperation, "a truly collaborative framework and ethos" (Naylor 2003, p. 12), was cited as a main lesson of the SARS crisis in 2002. By 2006, a federal Public Health Agency was established, which allowed for a coordinated response to the COVID-19 pandemic. Here, though, apart from mandates related to international travel and the procurement of vaccines, the provinces remained the primary players in establishing individual and institutional responses to the pandemic, including testing, distribution of vaccines and emergency mandates (Unruth et al. 2022). In contrast to Italy, no "national" state of emergency was declared in Canada, although several provinces implemented temporary "lockdowns" at the height of the pandemic.

Fiscal Federalism and Health Care in Canada

The term "national health insurance" is a misnomer in the Canadian context because, unlike the Italian case, the central government does not have a wide jurisdictional role in the domain of health, but rather exerts financial leverage through funding transfers. Furthermore, there is no "right to health" enumerated in the Constitution Act, as in the Italian Constitution of 1947, although legal scholars have argued that the fundamental rights of the Canadian Charter of Rights and Freedoms do in some sense "protect" Canadians' access to health care services (Jones Derek 2022). Nevertheless, the federal government has carved out policy-making capacity in health care, most notably through the Canada Health Act of 1984. Its principles are not "national standards" per se but rather federal conditions relative to the Canada Health Transfer, arguably to ensure a measure of "equality" of social rights for all Canadians regardless of province of residence. The glue that holds the "Canadian" health care system together, then, is the use of federal transfers in helping to finance provincial health care programs.

As in Italy, the relationship between national and sub-national governments in Canada is affected by the "pendulum" of fiscal federalism. Initially, hospital and medical services were funded through two cost-shared programs put in place by the Hospital Insurance and Diagnostic Services Act of 1957 and the Medical Care Insurance Act of 1966. In each case, the federal government initially reimbursed the provinces for about half of their total expenditures in health care provision (Soderstrom 1978). By the mid-1970s, rising welfare state costs and inflation were of concern to governments across the so-called "industrialized" countries, including Canada and Italy. While Italy attempted to transform its health care system – and its funding mechanisms – during this time to create a more uniform system, in Canada fiscal arrangements began to devolve further. In 1977, the federal government replaced cost-shared financing with "block grants" to the provinces for health care and post-secondary education. Thus, instead of reimbursing provinces in an open-ended manner, the Established Programs Financing (EPF) Act distributed fixed sum of money on a per capita basis to each province and included both "cash" transfers and increased "tax points" (that is, giving provinces an increased share of federal income tax revenue). Ultimately, this made the provinces responsible for increases in health care expenditures. The EPF formula was initially calculated on the basis of gross national product (GNP) per capita growth but, as federal deficits mounted, this escalator was capped and eventually frozen. Thus, the actual contribution of the federal government to health care declined in real terms (Naylor et al. 2020).

The federal government became concerned that provinces were allowing non-public spending to increase as a way of controlling public expenditures. The response was to impose a cash penalty by way of a new legislation, the Canada Health Act of 1984, that linked five principles to the federal transfers. These, in particular the requirement for "equal access" to health services, prohibited such practices as imposition of user fees in hospitals or the toleration of extra-billing by physicians, on penalty of dollar-by-dollar deductions to EPF cash transfers.

Nevertheless, public expenditures continued to put pressure on federal deficits. In 1995, the federal government replaced the EPF, along with the existing cost-sharing program for social assistance (Canada Assistance Plan, or CAP), with a "super" block fund, the Canada Health and Social Transfer (CHST). The CHST substantially reduced the cash portion of federal transfers to the provinces, leading critics to point out that this threatened the federal government's presence in the health sector by undermining its ability to enforce existing standards in the Canada Health Act (Banting 1995). While estimates vary, provincial health expenditures from federal transfers declined from initial cost-sharing to about 30 per cent in the mid-1970s to 15 per cent by the mid-1990s, leading to provincial concerns about a serious vertical fiscal imbalance, given the increasing burden of health care relative to provincial fiscal capacity (Naylor et al. 2020).

The important changes to fiscal federalism introduced with the CHST were seen by many provincial governments (regardless of whether they felt there was too little or too much public money being spent on health care) as unilateral decisions to change the rules of the game, made to respond only to federal budget imperatives but seriously affecting provincial capacity to provide services. They also revealed a problem of accountability in federalism, since the transfer system does not "isolate" responsibility and makes it difficult for voters to "pin blame" on politicians (Richards 1996).

Political tensions between the federal government and the provinces, growing concerns in the medical community and public discontent over wait times led to proposals for reform and, in some provinces, calls for privatization and measures to increase revenue by other means. Electoral pressures also pushed the Liberal government to a new commitment to health care through a series of Health Accords and a new Canada Health Transfer. Through the "Ten Year Plan to Strengthen Health Care" in 2004, the federal government guaranteed multi-year funding with 6 per cent yearly increases. Designed to assuage public opinion, it was also a way to boost provincial fiscal capacity to provide health care services. In 2014, the Conservative government, recognizing the political salience of health care, kept the plan in place, albeit decreasing to a 3 per cent escalator. The other change was to replace the "mixed" formula with "pure" per capita transfer, despite raising concerns about regional variations in needs and capacity (Hajizadeh and Keays 2023).

Nevertheless, the Canada Health Transfer remains a source of conflict in intergovernmental relations, as provinces would prefer a guaranteed percentage of actual expenditures; the most recent negotiations by the Trudeau Liberal government have agreed a 5 per cent increase in funding over the next five years (Duong 2023). Furthermore, despite new initiatives to fill gaps in coverage, such as the federal government's commitment to a national pharmacare program, there is still no "rational benchmark" for health care cost-sharing with the provinces or an accepted "fair deal" in terms of the percentage of provincial health care costs that should be covered by the federal government (Naylor et al. 2020).

While health transfers to the provinces are, in effect, a way to address the "vertical" fiscal imbalance between the revenue-raising capacity of the federal government versus the provinces, there is also a "horizontal" imbalance between provinces of varying resources and wealth, which is addressed by equalization payments under the Federal–Provincial Fiscal Arrangements Act (Feehan 2020). Equalization can best be described as a "transfer of fiscal resources to and between subnational governments with the aim of mitigating regional differences in fiscal capacity and expenditure needs" (Dougherty and Forman 2021, p. 2). While equalization in Italy is a fairly recent experience (see below), in Canada it was first introduced in 1957, and is enshrined in the Canadian Constitution of 1982. Through a complex (and often politically contested) formula, equalization pools certain revenue categories from all the provinces; these are then in turn redistributed to provinces with "weaker" fiscal capacity so as to ensure the provision of comparable services to all Canadians[8] (Taylor et al. 2002). Given that health care now accounts on average for 40 per cent of provincial program spending (Canadian Institute for Health Information 2022), these payments are often deployed in the health care sector. In fact, health care has come to be seen as "crowding out" fiscal capacity across all the provinces.

With all of these tensions over money and decentralization, three missing elements in the province-based health care system in Canada stand out. There is insufficient emphasis on national outcome measures and quality indicators, and little relationship between system performance and funding priorities between levels of government. Similarly, federal transfers do not take into account population differences (age distribution, disease prevalence, etc.) that may be affecting the need for services and pressure on provincial spending, although additional funding for Indigenous health needs is now being recognized. This stands in contrast to Italy, where quality of care matters in terms of fiscal

federalism, as it does in most OECD countries that have such measures in place. The "integration" of the health care system remains weak – both within provincial health plans in the delivery of services (Toth 2021) and between provinces themselves and with the federal government, given the "fragmented budgetary architecture" that characterizes health care funding in Canada (Naylor et al. 2020).

More recently, the Liberal government in Canada has attempted to address some of these gaps. The 2023 Canadian Dental Care Plan is being introduced in stages to eventually provide benefits for all lower-income Canadians (Tasker 2023). And a national "pharmacare" plan – mimicking the "single-payer" system in place for hospital and medical care – is being developed, which would allow provinces to "opt in" to a national program with standards set and imposed through a Canadian drug agency and a national formulary (Health Canada 2019). Although yet to be legislated upon, this initiative would allow for considerable "centralizing" of drugs and drug costs and potential standardizing across the provinces.[9]

4. Italy: Health Care as a "Policy Wedge" for Federalization

Decentralization and the Development of the Italian Health Care System

Although the right to health was a highlight of the 1947 Italian Constitution, health care remained largely organized around a social insurance model based on employment (Vicarelli 2019). It was not until 1978 that Italy adopted a national health service (*Servizio Sanitario Nazionale* – SSN).[10] Known as Law 833/1978, this legislation transformed health care from a worker benefit to an entitlement of citizenship. In universalizing insurance coverage, access to publicly financed care became a function of residence and not the patients' contribution record. This established a new uniform structure for service provision based on the regions and local health units (*Unità Sanitarie Locali* – USL). The 1978 legislation also introduced a new model of administration based on three distinct tiers: central government (Ministry of Health), responsible for national planning and overall financing through compulsory contributions and taxes; regional governments, responsible for local planning and the organization of services within their jurisdictions; and local health units, responsible for the provision of services through their own structures (ambulatory care, hospitals) or through contracts with private providers. The USLs were to be run by management committees elected by general assemblies through the councils of local authorities. Finally, the law planned to eventually shift funding from social contributions to a tax-based financing system.

As in Canada, the question of health care funding has been a perennial problem in intergovernmental relations in Italy. Soon after its inception, the institutional framework of the Italian SSN revealed a serious shortcoming in the relationship between the central and regional governments: the lack of rational financial incentives.[11] This stemmed from the sharp distinction between financing responsibilities, assigned to the state, and spending responsibilities, assigned to the regions (and ultimately to the local health units). This led to an ongoing clash over the allocation of resources throughout the 1980s. As Ferrera (1996b) has illustrated, the typical scenario would include attempts by the central government to curb spending via budgetary ceilings; failure of the regions to respect these ceilings; financial borrowing by the regions to maintain services, coupled with declarations of "financial crisis"; and the eventual cover up of regional debts by the

central government with new attempts at cost containment through budgetary caps and higher user fees. Thus, since they did not have to raise revenues, regional and local politicians had little incentive to respect expenditure caps, and expected the central government to ultimately foot their bill (Ferrera 1996b).

These clashes led to the intervention of the Constitutional Court, which ruled against the central government's attempts to make regions responsible for exceeding spending limits. The Court's declaration gave regions even less incentive to respect spending limits or to contain health costs. Given the impossibility of controlling regional health expenditure, the central government's response was to freeze employment, impose tight limits on capital spending and deliberately underfund the Italian SSN.[12]

During the 1980s, central and regional governments clashed permanently over allocating resources and responsibilities, the former accusing the latter of overspending and the latter of underfinancing (Maino 2001). In addition, regional differences widened greatly, producing different levels of efficiency and resources across the country. In this context, the annual Budget Law became the major instrument for controlling health care expenditure from the center (Maino and Razetti 2021). In turn, regions had difficulty controlling the local health units' health care provision and expenditure. And, since these units were under local councils, intergovernmental relationships were further complicated by the conflicts between regions and their municipalities.

5. Health Care Reforms in the 1990s

By the early 1990s, there was growing dissatisfaction in public opinion with the complex bureaucratic and administrative features of the Italian SSN, characterized by an unresponsive decision-making process, inefficient resource allocation and deficient audit mechanisms. External constraints, such as inflation, deficit and debts (especially with the perspective of the new European Union and the concomitant Maastricht criteria) and the financial crisis of September 1992, opened up the political opportunity for the Amato government to push through health reform in December 1992.

As France (1996) has pointed out, the 1992–1993 health reform had two major goals: the "de-integration" of the SSN to improve efficiency, responsiveness, choice and quality of care; and changes in intergovernmental powers and responsibilities in order to impose consistency in SSN's internal governance. The new health legislation confirmed the discretionary power of the regions on the expenditure side and matched this with an extension of powers and responsibilities on the revenue side (Maino 2001). The central state's contribution to funding health care was to be fixed prospectively through a per capita allowance (*quota capitaria*) sufficient to guarantee any citizen in any part of the country access to so-called "uniform levels of care". Any care not covered by the *quota capitaria* was to be paid by the regions, as well as any additional costs due to lower levels of efficiency than those assumed by the Ministry of Health in calculating the financial resources necessary to provide uniform levels. Within these limits, regions were thus given the power to increase contribution rates, to apply higher patient co-payments rates, to introduce co-payments for services so far exempt and to spend untied (general) revenues on health care.

In contrast to Canada, this reform of intergovernmental distribution of powers and responsibilities also meant that regions could take on the implementation and

administration of quasi-market initiatives (Maino 2001). The 1992–1993 legislation defined a broad framework for the adoption of managed competition aligned to regional situations, priorities and citizen preferences (Maino and Razetti 2021). To reduce bureaucratic complexity and improve management, the 660 local health units were transformed into 197 local health enterprises (*Aziende Sanitarie Locali* – ASL), administered by senior managers appointed by the region on performance-related salaries, with more operating autonomy, accounting procedures and performance auditing.[13] In addition, 88 large hospitals were transformed into hospital enterprises (*Aziende Ospedaliere* – AO), independent from the ASL and administered by contracted senior managers. The new ASLs were required to operate with balanced budgets; any surplus could be used for investments and staff incentives, while unjustified deficits could result in the loss of autonomy. This led to the emergence of 20 differentiated regional health care services (Maino 2001).

In 1999 a new comprehensive law reforming the SSN strengthened the operational autonomy of ASLs and hospitals, but also enhanced the powers of the central and regional governments in defining "essential" levels of care, determining accreditation criteria and regulating "supplementary health funds", i.e. private insurers and their tax treatment. Thus, the reform reasserted balanced planning based on the public sector as against open market logics, and increased the operational powers of the locally based ASLs.

The relationship between regional decentralization and health policy in the Italian context was more intense in this period than in Canada. Clashes over health care became synonymous with clashes over autonomy, and the struggle for more robust decentralization,[14] which in turn plagued the effectiveness of the SSN itself. The conflict was related to the allocation of resources between different levels of government, and to the lack of spending responsibility of the regions. The national legislation defined a broad framework within which each region was given the right to organize health provision as they wanted, distributing or centralizing the control on the ASLs, determining mechanisms for accrediting private providers and offering citizens additional services. This led to the emergence of different regional health care models.

The Move toward Fiscal Federalism in Italy

Introduction of IRAP. One of the distinguishing features of the Canadian and Italian system stems from the relative autonomy of national and sub-national governments. As a federation, Canada allows provinces their own tax and spending mechanisms within their areas of jurisdiction, including health care. In Italy, meanwhile, mechanisms for SSN funding were modified through the introduction of IRAP (*Imposta Regionale sull'Attività Produttiva*), a regional tax on productive activities that entered into force in 1998. The IRAP links health care funding to GDP, gives more fiscal autonomy, management power and taxation control to regions, and substitutes a set of taxes, among which are the "health tax" (*tassa sulla salute*) and health contributions paid by employers, and a small share by employees. The tax rate was set by the central government at 4.25 per cent but regions could increase it by up to one percentage point.[15] With IRAP, regions gained more fiscal autonomy, management power and control over taxes.

This reform also introduced a "solidarity fund" (*Fondo di Solidarietà*) for regions unable to raise the necessary fiscal resources for health care services through the new regional tax. Although not as elaborate as Canada's provincial equalization payments, it is in effect an interregional equalization fund aimed at redistributing resources between richer and poorer regions. Like Canadian equalization, the *Fondo di Solidarità* is not an earmarked grant, although most of the revenue is indeed used in order to fund health services, from the net amount transferred from the central government to the regions through the National Health Fund (*Fondo Sanitario Nazionale* – FSN). Enterprises, entrepreneurs, craftsmen, tradesmen and anyone self-employed pays the IRAP. In order to ensure the uniformity of services throughout the national territory, the financing of the SSN depends on the per capita allowance guaranteed at the central level (as in Canada, where population is the basic criteria for the CHT). Therefore, if a region decides to increase the IRAP's tax rate, it does not receive an increase of its fiscal budget for health care since the tax base rise is compensated for by a reduction of the same amount of the public transfer.

Essentially, the aim of the IRAP was to accelerate the SSN's regionalization process by giving regions responsibility for revenues as well as expenses. But the IRAP went further, in practice, by allowing for a general increase of regional budgets and more autonomy in managing resources so as to avoid regional deficits. The shift from specific health contributions for the SSN to IRAP as the major source of financing also modified the share of direct taxpayer contributions, and widened the differences between regions.

Fiscal Federalism in Health Care. In 2000, Legislative Decree No. 56 on Fiscal Federalism marked a pivotal moment in the shift toward fiscal federalism. Its aim was to gradually transfer financial responsibilities from the national level to the regions. This was to be achieved by abolishing the National Health Fund over a three-year period and providing regions with new resources through a share of tax revenues. These resources included a regional surcharge on income tax, excise on petrol and VAT, which was expected to finance an equalization fund. This shift allowed regions to retain health care expenditure savings within their Regional Health Fund, thereby incentivizing efficient spending.

Despite these hallmarks of fiscal federalism, the responsibility for the definition of essential levels of care remains with the Italian state, in an effort to ensure some measure of equality in social rights. The use of the equalization fund is a key element in this regard, allowing a backstop for regions with less fiscal capacity. While regions could innovate, the central government retained policy-making capacity in health care, including monitoring, supervision and evaluation of the quality and the quantity of regional health care services. The national government also retained the major role in financing health research – an important facet of the Canadian government's contributions to the health sector. Still, an essential question raised by these reforms was which regions could afford fiscal federalism, a question that would dog future political debates and health reform.

The Push toward "Quasi-federalism". In this context, the IRAP reform became an important part of the "pro-federalism" stance promoted by center-right parties with strong support in northern regions throughout the 2000s. In this regard, "Fiscal Federalism Decrees" were introduced to accelerate regional fiscal autonomy, including health care (Maino and Ranzetti 2021). And the 2001 Constitutional Reform, a hallmark of the Berlusconi coalition, formally recognized a "quasi-federal" relationship, including a joint competency for the "right to health" (Maino 2019). Nevertheless, the central state retained the responsibility for defining "essential levels of care" (LEAs).

The "Health Pacts" that followed were based on controlling health expenditures by eliminating regional deficits and setting predictable three-year SSN funding cycles, but regions were now responsible for future deficits via stricter cost-control measures (Taroni 2015). Although implementation of the LEAs was slow, the monitoring report still showed a persistent gap between northern and southern regions' reforms.

While provisions set by the 2000 Fiscal Federalism Decree were never completely implemented (the National Health Fund, de facto, was not abolished), fiscal federalism issues re-emerged on the national political agenda under the third center-right cabinet led by Berlusconi, supported by a coalition including the Northern League (2008–2011). The government opted for a delegation law, through which Parliament had the power to issue a series of legislative decrees to further increase local and regional fiscal autonomy. The 2011 Decree on Fiscal Federalism was intended to increase regional fiscal autonomy and introduce a funding system of "standard healthcare costs", based on selected regional best practices.

Throughout the 2010s, the impact of the 2008 financial crisis, combined with the Berlusconi government attempts at "budget freezes", led to calls for more central control of regional budgets in health care. This resulted in further cuts in the SSN, including by the "technocratic" Monti government, acutely attuned to budgetary matters and EU pressures. Italy's tenuous fiscal scenarios at this point contrast sharply with the relative financial stability experienced by Canada; even with the aftershocks of the 2008 global crisis, Canadian federal governments – both Liberal and Conservative – continued to honor the fiscal federalism commitments to the provinces of the 2004 Heath Accords.

The evolution of fiscal federalism in Italy is still a controversial issue in relation to the recent proposal to introduce a so-called "differentiated regionalism". The center-right government led by Giorgia Meloni aims to grant greater autonomy to regions in accordance with Article 116 of the Constitution. The Draft Law on Differentiated Regionalism in Health Care, introduced in autumn 2022, provides for new legislative and administrative functions to be allocated in a differentiated manner as long as they remain compliant with LEAs. Critics have pointed to the possible consequences of such autonomy in increasing regional inequalities, exacerbating health mobility and potentially violating the constitutional principle of equality (Fondazione Gimbe 2023). Strengthening autonomy could increase inequalities in health services at the expense of central and southern regions, and generate fierce competition for health providers (Betti and Maino 2023).

6. Some Comparative Reflections: Federalism, Decentralization and Health Care Reform

The comparison of Canada and Italy leads to the basic observation that different polities, organized around different institutional settings, can nevertheless experience similar pressures and challenges in health care reform. In both cases, strong sub-national entities became the locus of health care organization and delivery, in Canada *because* of the overarching constitutional structure, but in Italy *despite* this. In both countries, we also see further devolution of spending responsibilities through fiscal federalism, although it could be argued that in Canada, this happened *despite* provincial concerns, while in Italy it occurred *because* of certain regional pressures. And, in both cases, a main concern has been how to guarantee a measure of uniformity in a cost-sharing system in which sub-national units have different levels of fiscal resources and institutional capacities, and are responsible not only for health care provision, but also its financing and cost containment.

Thus, even though Canada is a "constitutional" federation, in the area of health care it can be claimed that the federal government exerts a certain unifying force through the use of its fiscal powers. In this sense, as in Italy, the central government occupies an important political space by retaining some measure of control over the health policy-making agenda. In both Canada and Italy, central governments have used fiscal decentralization as a way of managing fiscal responsibilities more efficiently by obliging sub-national governments to take over the responsibility for health care cost control and deficits. These sub-national units, meanwhile, are confronted with a scenario in which they were now responsible for the costs of health care, but still bound by central norms on how to spend on it, effectively constraining the types of delivery or financing alternatives they could consider.

These constraints are de facto more binding in the Canadian federal landscape than in the Italian unitary polity. Even though provincial governments have jurisdiction in the design and administration of health care systems, they are constrained by the conditions set in the Canada Health Act in fiscal terms and subject to financial penalties through reductions in transfers. These are powerful constraints because, while the CHA does not dictate *how much* should be spent on health care, it does state in *what way* money should be spent. They are also powerful in terms of deterrence. Popular public sentiment toward the Canada Health Act, and the federal role in sustaining this favorable sentiment, reinforces the federal government's political influence in the health care sector, despite the fact that it has no formal jurisdictional power to direct health policy, even in concurrent terms.

Due to retrenchment, concerns over cost containment, and the rise of right-wing parties, the Italian regions have pressured the central government for more fiscal autonomy. Decentralization in the health care sector has provided a "policy wedge" for the regions in Italy to engage in the process of "federalization". Specifically, regional governments are engaged in a struggle for autonomy in major policy sectors, the most important of which is health care. As in the Canadian case, the Italian state has shown itself favorable to fiscal decentralization in response to economic pressures, but has always maintained power over the health policy agenda. Over the past decades, the Italian government, having decentralized financial responsibilities to the regions, has allowed for extensive "experimentation" in health delivery and organization, but this has

also led to less power to enforce rules through the use of financial incentives, and more concern about interregional disparities. The central government can only impose minimum standards through its constitutional responsibility to set the health policy-making agenda. This brings it into direct conflict with the regions, which can claim that national policy, setting levels for co-payments, user fees and spending minimums hampers their ability to shape and maintain health care budgets.

Richer provinces and regions in both countries, particularly those governed by conservative governments, tend to be those that have pressed for more decentralization and, subsequently, have expressed most dissatisfaction with the results. In Italy, equalization between richer and poorer regions has been a long-standing issue of overt political contention. The 2000 Legislative Decree on Fiscal Federalism, with its explicit equalization provisions, can be seen as the last in a long history of attempts by the Italian state to ensure some measure of uniformity in services between residents of different regions. A "federalizing" polity like Italy would need a federal institution such as a "Chamber of Regions" in which conflicts over redistribution could be contained and resolved horizontally. In Canada, such mechanisms exist in the form of "executive federalism", particularly the First Ministers conferences, although these have fallen into relative disuse since the Trudeau government entered power in 2015. Still, even when they were more frequent, these were forums for bargaining and diplomacy, not to mention political grandstanding, rather than representational bodies. These mechanisms were successful in defusing conflict to some extent, although the polemic over redistribution and equalization still exists.

A comparison of health reform in Canada and Italy sheds light not only on issues of health care costs and access, but also tells us more about the impact of decentralization on both federal and quasi-federal arrangements. In Canada, a constitutional federal system, both levels of government have used institutionalized intergovernmental arrangements to further their political objectives: the federal government has attempted to control its public expenditures by reducing the growth in transfers to the provinces (such as in the mid-1990s), thus making them responsible for cost containment in expensive areas of social provision such as health care; by the same token, it has reinvested in health care in periods of relative economic growth (such as the mid-2000s). The provinces, meanwhile, have been able to use existing intergovernmental rules in order to extract fiscal resources, but at the cost of renouncing game-changing attempts to reorganize or redesign their health systems. This has meant that, despite the jurisdictional responsibility of the provinces for health care within the Canadian federation, there has been an overarching continuity of certain guarantees in publicly funded services regardless of the individual capacities of wealthier or less fiscally endowed provinces, and the more expensive services rendered in the territories. However, it has left the overall "system" in Canada with persistent gaps in care, frustrated patients and providers, and the stressful gamesmanship of intergovernmental conflict in providing adequate resources for ever-increasing health care costs.

In Italy, the distribution of powers between the central government and the regions and the long-lasting and growing process of decentralization – started with the reforms of the 1990s and continued with the state–regions agreements of the 2000s – leaves ample power to the regions in both the definition and management of public health and opening to private providers and generates an NHS which overall is highly differentiated from

region to region and at risk of inequality in access. Indeed, the debate on Italian health policy is still dominated by the attempt to manage conflictual relations between central government and the regions, largely connected to the increased regional responsibilities for health financing and spending and their incapacity to fully accommodate new rules, and the central government's interference in policy areas falling under regional responsibilities. In fact, regional governments have shown increasing frustration with existing rules and seem more interested in moving toward a "federal" arrangement through the process of health care reform. "Differentiated regionalism" will likely bring greater autonomy to individual regions, but further decentralization may lead to disparities in access to medical treatments and facilities across regions. With each region responsible for its own health care policies and regulations, there is a risk of varying quality standards, compromising patient safety and quality of care. These disparities might lead to "healthcare tourism", where patients travel to regions with better services to receive treatment, leading to strained resources and capacity in certain regions while leaving others underutilized. Differentiated regionalism can also affect the allocation of health care funding since wealthier regions are better equipped to generate revenue and allocate more resources to their health care systems. Finally, regional politics and differentiated priorities can influence health care decisions, potentially leading to the adoption of policies prioritizing political consensus over health care needs. For all these reasons, striking a balance between regional autonomy and national coordination remains a big challenge for the current Meloni government.

This interaction between levels of government and the "entangled governance" in health policy is not easy to manage, as proved by recent disputes in these two cases. Under certain conditions, health care becomes a privileged field for clashes among different political worldviews, both ideological and institutional, due to its heavy financial commitments, and the considerable expectations of both its providers and users.

Notes

1. Article 32 of the Italian Constitution states, "The Republic protects health as a fundamental right of the individual and as a collective interest, and guarantees free medical care for the indigent".
2. Canada Health Act, R.S.C., 1985, c. C-6 (https://laws-lois.justice.gc.ca/eng/acts/c-6/page-1.html).
3. In Italy, the percentage of public total spending has decreased slightly over time, from 78 per cent in 2010 to 74 per cent in 2021. In Canada during the same period, the public share of spending was about 70 per cent until the pandemic, after which it rose to 74.5 per cent (Organization for Economic Co-operation and Development 2022).
4. See for example, on the Canadian case, Banting (1987); Maioni (1998); Tuohy (1999). For the Italian case, see for example Maino (2001); Toth (2021); Maino and Razetti (2022).
5. We take as our definition here the distinction of "federation" to refer to polities in which the formal division of powers is constitutionally delegated; while there are over two dozen such states across the world, the comparative literature tends to limit established federal democracies to the United States, Switzerland, Canada, Australia, Germany and India (see Fenna 2007).
6. In Canada these included former British colonies and, as has been noted more recently, Indigenous nations (that means First Nations, Inuit and Métis) through treaty rights recognized by the British Crown.
7. The OECD countries included in this definition incorporate both Italy and Canada, as well as the US, Mexico, Germany, Australia, Spain, Switzerland, Belgium, Austria and the UK (Greer et al. 2023, pp. 16–17).
8. These vary due to different revenues of the provinces over time: for example, strong resource revenues for a province such as Alberta, rich in oil and gas; strong economic performance in the industrial heartland of

Ontario; less capacity in the smaller maritime provinces of Nova Scotia, New Brunswick and Prince Edward Island. There is also political conflict around equalization toward Quebec, a perennial "receiver" of such payments which, when multiplied by its large population, amounts to a considerable sum of money.

9. Quebec already has a pharmacare program in place, since 1997, which allows for a hybrid public or private coverage (Morgan et al. 2017).
10. Italy was the first South European country to introduce a national health service, followed by Spain in 1986. Both countries reformed their social insurance-based health systems in order to establish national health services characterized by open and free access for all residents, standardized rules and organization, and tax-based financing (Ferrera 1996a).
11. A second but no less serious shortcoming produced by Law No. 833/1978 had to do with the over-politicization of health care (Ferrera 1995; Maino 2001, 2009). Management committees became arenas of party competition and spoils in the practice of *lottizzazione* (the allocation of control over public sector institutes and resources to parties in proportion to their strength).
12. These measures were labeled as the "axes of the three Cs", i.e. co-payments, ceilings and cuts (Vicarelli 1997).
13. The number of ASLs in Italy has gradually decreased to 109 in 2023. In addition to reducing the number of ASLs, some ASLs and AOs have merged, leading to mixed management between health services and hospitals.
14. For example, Article 117 of the Constitution contains a list of concurrent powers between the regions and national government, but they could not become operational until Parliament had delegated the necessary authority to the regions; the first major parliamentary delegation of power was passed in July 1975 (Zariski 1985). Furthermore, as regional finances were essentially based on central transfers, this financial dependency prevented regions from developing a strong technical bureaucracy needed for the direct management of public sector services (Dente 1997).
15. Regions could also introduce an additional flat rate tax on all income subject to national income tax (*addizionale IRPEF*) to compensate the abolition of health contributions charged to employees (equal to 1 per cent) and the health contribution of 0.9 per cent paid by pensioners.

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