9

The Italian Health System: Cost Containment, Mismanagement, and Politicization

Franca Maino

A year ago, assessing the health-care situation, Enza Caruso and Nerina Dirindin wrote: "The year 2007 can only be described as a positive one for health in terms of planning, given the great number of programs launched, commissions and councils put in place, and protocols of agreement signed by the Ministry for Health. Finance within the health sector was also notable for complying with the health pact and the rigorous control of public accounts backed up by deficit reduction plans, which regions under financial warning had to observe scrupulously or be put under compulsory administration."[1] The year 2008, however, began and then continued with a shocking series of health-care mismanagement cases, including the controversy over the appointment procedure for general managers and chief medical officers of health-care providers, the question of controlling health expenses, and the possible compulsory administration of regions that are unable to meet deficit reduction plans. This brought the issue of the relationship between health and politics—and the influence of the latter over the former—back into the public arena. Furthermore, 2008 was an unusual year for the Italian health system because it was the thirtieth anniversary of the passage of Law No. 833, which in 1978 had transformed health insurance into a national health service, the Servizio Sanitario Nazionale (SSN). Thus, especially at the end of the year, there have been many opportunities to reflect on and evaluate 30 years of health policy.[2]

Notes for this chapter begin on page 218.

After taking into account the relationship between health policy and welfare, referring to their reorganization at the ministerial level and the green paper on welfare, and after assessing the issues related to the control of health expenditure in connection with deficit reduction plans and, more generally, plans to introduce federalism, this chapter analyzes the principal episodes of health mismanagement in Italy and discusses the relationship between health care and the Mafia, as well as the appointment of general managers and chief medical officers of health-care providers. In the conclusion, we ask whether a "partyocracy" in the health sector may be making a comeback at a regional level rather than, or in addition to, the national level.

The New Minister and the Green Paper on Welfare

As a result of the collapse of the Prodi government and the early elections, the year 2008 was also characterized by the interruption of government action begun by Minister of Health Livia Turco in 2006. Following the victory of the coalition led by the Popolo della Libertà (PdL), the Ministry of Health was handed over to Maurizio Sacconi. This transfer also coincided with the establishment of a single Ministry for Work, Health, and Social Policy and hence, despite widespread criticism after the vote, the inclusion of health in this new ministry.[3]

A few months after the establishment of the new ministry, the "green paper on welfare" was introduced with the purpose of preparing—through a process of public consultation—the reorganization of all the main areas of social policy: social security, welfare, social benefits, and health care. The reality is that the green paper devotes only a few pages to health, and it does so in a manner that is not very organized or systematic. There is an analysis of the main problems of the SSN, but the suggested solutions are not articulated as a comprehensive reform plan for the health system. Rather, they are scattered throughout the document, often linked to the reorganization of other policy sectors.

Overall, the green paper seems to suggest three areas of strategic intervention: prevention, regional health promotion, and biomedical research. As regards finance, the document emphasizes the importance of setting up a second private tier to complement public health care, which would be put in place through the development of integrative health funds. It also advocates the implementation of fiscal federalism and an end to the allocation of financial resources at a regional level on the basis of past levels of expenditure. Finally, the

importance of evaluating and monitoring services is highlighted, suggesting the relaunch of the Agenzia Nazionale per i Servizi Sanitari Regionali (Age.Na.S., National Agency for Regional Health Services)[4] and the use of methods for monitoring services similar to those in the UK, following the adoption of the NICE (National Institute for Clinical Excellence). However, although it refers to these themes (particularly the relaunching of integrative health funds), the green paper does not clarify whether and in which way these measures could bring into question the principle of universalism (as feared by many).

Limiting Health Expenditure: Plans for Deficit Reduction and Federalism

In 2007 and 2008, the problem of health expenditure reared its head again. As shown in the annual government accounts, the level of debt of the Aziende Sanitarie Locali (ASL, local health authorities) and hospital trusts exceeded 51 billion euros compared to the previous year, growing by 11 percentage points. It should also be taken into account that health costs as part of overall regional expenses increased from 80 percent in 2005 to 83.5 percent in 2007.[5] Against this background, some regions—Lazio, Sicily, Campania, Abruzzo, and Molise—stand out as being constantly in the red in the last few years. In these regions, the level of debt recorded by health-care providers has continued to grow more than in others.

Until the beginning of 2000, patterns of regional expenditure were guided by expectations of central government deficit repayments. In the long term, this created a highly unbalanced situation, pitting a few well-organized regions, able to keep health expenses under control, against others under a heavy burden of accumulated debt. Taken as a whole, the SSN deficit can be seen as almost entirely due to a few regions with a high and persistent deficit level. The preferred solution to this situation has been the identification of selective measures directed specifically at disadvantaged regions rather than measures indiscriminately aimed at all regions.

These selective measures were the result of agreements between the state and the regions[6] and a national legislative framework,[7] which established the criteria by which regions are entitled to integrative state funding and defined terms and conditions of deficit reduction. During 2007, the regions of Lazio, Campania, Abruzzo, Molise, Liguria, and Sicily signed agreements with the state that included plans for reducing their deficit. These plans, based over three years, 2007–2009, are aimed at re-establishing the economic and financial stability of

the six regions. By identifying and analyzing the underlying structural causes affecting the emergence of significant management deficits, they are intended to single out and selectively address the different problems faced by each region.

The plans take the form of a true restructuring program that will have an impact on those elements of expenditure that the regions have failed to control. Fiscal discipline measures related to deficit reduction plans envisage the following:

- an increase in tax rates to the maximum level established by current legislation and, where intermediate targets aimed at deficit reduction are not met, an increase in the IRAP (regional business tax) rates and a regional addition to the IRPEF (personal income tax) beyond the maximum legal levels until the missed targets are achieved. Conversely, where a region achieves better results than expected, there is the possibility of reducing tax rates by a corresponding amount;
- a temporary additional fund of 1,000 million euros for 2007, 850 million for 2008, and 700 for 2009;
- the allocation of 3,000 million euros to the health sector in regions affected by the deficit reduction plans and the adoption of additional fiscal measures on top of increasing the IRAP to the maximum amount and of imposing a regional addition to the IRPEF;
- a warning to regions failing to adopt structural measures to limit costs that they must fulfill deficit plan requirements. In case of persistent failure to comply, a commissioner is to be appointed;
- an audit of the amount of outstanding debt and its redemption.[8]

Between July and August 2008, the region of Lazio was put under central administration as a result of extreme delays in adopting the measures required by the plan. This also happened to the Abruzzo region, as a result of a delay in adopting the required measures and a critical situation as regards the finalizing of funding quotas for the health sector. At the beginning of November 2008, the undersecretary for welfare, Francesca Martini, announced new procedures of compulsory administration for regions still in deficit, in addition to the regions of Lazio and Abruzzo. In parallel, a parliamentary commission of inquiry was set up in the lower house to investigate health-care mismanagement and the causes of regional deficits.

The legal instrument on deficit reduction plans, agreed to by the central government, envisages a series of obligations that will inevitably result in heavy restrictions on regional governments. The latter are in some cases, such as Lazio, experiencing obvious difficulty in

managing the deficit reduction problem. Prescription charges are also one of the causes of conflict between the central government and the Lazio region, given the former's readiness to impose these charges as a means to reduce the level of debt, when it put the region under direct administration during the summer following its non-observance of deficit reduction commitments.

The case of Lazio raises more general questions regarding relations between the state and the regions in the new SSN framework. The procedures introduced for managing the deficit reduction plans, in fact, give the central government wide powers to direct and control the actions of regional governments, jeopardizing the latter's autonomy. At a time when the implementation of the Calderoli bill on federalism was being discussed, there was a risk of activating a process of recentralization that could potentially have powerful effects and would concern only the regions that were unable to meet the challenges posed by a highly decentralized system.[9] Deficit reduction plans underway, however, must run their course before any general evaluation can be made. It will then become possible to assess their structural impact, also with reference to the reorganization of regional procedures on planning and expenditure control, which are of strategic importance for any future management of regional health services.

Between July and August 2008, after several years of institutional collaboration, the issue of health costs and regional deficits re-exacerbated the conflict between central and regional government. Apart from the deficit reduction plans, tensions were heightened by the economic measures presented by the minister of economy and finance, Giulio Tremonti, at the beginning of July. The measures involved cuts in staff for health-care providers, reductions in hospital beds, and prescription charges even for exempted social groups in deficit regions. All regions, including those with their accounts in order and those governed by the center-right, formed a common front against these planned cuts. After all, the Health Agreement of 2006 envisaged an increase of 3 percent in the national health fund from 2008 to 2011 and additional funding to go toward the renewal of doctors' and paramedics' contracts and to cover charges for specialist and diagnostic prescriptions.[10]

It should also be taken into consideration that 2008 was the year of the Calderoli bill on fiscal federalism, which also widely affects national and regional health policy. This legislative decree states that the level of health expense must be determined according to "standard costs of essential levels of services fixed legally by the state, to be delivered on the basis of efficient and appropriate criteria across the national territory" (Article 6). It does not, however, specify what standard costs are, and on this issue there has been an as yet inconclusive debate.

Certainly, the aim of the legislative decree is to avoid resorting to past expenses as a criteria for deciding how resources should be allocated at the regional level. Many researchers have demonstrated that it is unrealistic to calculate the specific efficient costs of individual health services and to identify overall needs from the sum total of these costs. Therefore, it seems that the best way to calculate standard costs is to refer to per capita expenditure in one or more regions, which are, overall, considered more efficient. The problem is that regions that spend less (e.g., in the South) are not necessarily in a position to offer better quality services.[11]

The Problems of Health-Care Mismanagement

As far as Italian health care is concerned, the year 2008 started with press attention heavily focused on health-care mismanagement due to a death resulting from a dental abscess in Vibo Valentia and the immediate creation of a commission to evaluate the quality of health care in Calabria. At first sight, there seems to be a two-tier health-care system. There are more aberrant cases in the Center and the South, which are generally reported in the newspapers, and similarly in these regions a higher number of people suffer side effects from their stay in a health-care facility. The mismanagement of health care in these institutions is a particular problem for inhabitants of the South, as shown, following several investigations, by the results of Monitor Biomedico in the 2006 article "The Value of Proximity in Future Health Care."[12] In southern Italy and the Islands, 8.6 percent of the population stated that they had directly experienced poor health care, a figure considerably higher than the national average (equal to 6.2 percent) and over double the North-East (at 4.1 percent) and the North-West (at 3.6 percent). This is further confirmed by asking about side effects caused as a result of a hospital stay to people close to the interviewee: 34 percent of inhabitants of the South or the Islands referred to friends and family who were victims of health mismanagement, compared to 25 percent as a national average, 16 percent in the North-East, and 25.2 percent in the North-West.

However, the scandal of the Santa Rita nursing home in Milan, which arose in June 2008, showed that there are similar cases in the North. The Santa Rita clinic scandal (with similar instances being hypothesized in other private clinics in Lombardy) revealed a system in which doctors grew rich by taking advantage of patients, even carrying out unnecessary operations in order to obtain higher payments from the region.[13] Following an anonymous accusation sent to the police at the beginning of 2007, a picture emerged of a true "clinic of

horrors," with mounting evidence of fraud, blackmail, and ultimately the murder of elderly patients.

Roberto Formigoni, the president of the region, following events at the Santa Rita clinic, decided to suspend the accreditation contract for an indefinite period. The opposition in the regional council of Lombardy countered with a request for a revision of the accreditation system, referring, in addition to the arrests in the Santa Rita nursing home, to the abuse discovered at the same time at San Raffaele, at Multimedica, and at Humanitas. The opposition said that the Lombardy health model had inherent faults and suggested an extraordinary intervention in supervisory procedures, strengthening relationships with professional associations and setting up a commission with the objective of rethinking the credit system. The Milan Council's councilor for health, Gianpaolo Landi, emphasized the need to modernize the credit system and to revise the reimbursement system. To accomplish this, he suggested the creation of an authority made up of doctors and experts with consultative powers alongside, and in support of, regional control.

The legal response came at the end of 2008 with the approval of the first modifications to regulations for the control and accreditation of the private clinics. From now on, the accreditation process will have a fixed expiry date and will be entrusted to the ASL, as well as the region. Managing, medical, and social directors of public and private structures must be professionally registered, as general directors already are. Private organizations with over 250 beds, or which have an accident and emergency unit, now have to appoint a medical director.

After the summer break in 2008, the NAS (i.e., the Food Adulteration and Health Care Department of the Carabinieri, or national police force) made public its report on the SSN. It confirmed that fraud and corruption damaging the SSN (often with the complicity of medical staff) were widespread, costing the Italian people dearly. In the years since 2000, the cost to the public was equal to 233 million euros. To complete the picture and show how serious the situation was, during the same period 390 people were arrested, about 4,700 were reported to the authorities, and nearly 630,000 prescriptions were found to be falsified.

Health, Mafia, and Bribes

Health has been, and continues to be, a synonym for power, money, votes, and clients. There have been many cases in the newspapers demonstrating the perverse relationship between health and politics, particularly in regions such as Calabria, Campania, and Sicily. The chief prosecutor of the State Audit Court also sounded the alarm during the

inauguration of the judicial year 2008, drawing attention to widespread corruption in the public works sector, in public procurement, and in the health system.[14] Evidence that bribes are being paid out seems linked to stratagems and irregularities connected to various cases—from fraudulent modification of contracts to preferential treatment in procurement; from collusion with companies providing services to illicit contract awards and bids to provide supplies to public health-care providers; from falsified overbilling to false statements on the progress of improvements and the modernization of medical buildings. Also included are demands for excessive or unearned reimbursements to private medical organizations.

In January 2008, Domenico Crea, a member of Parliament and a physician, and his son Antonio Crea, managing director of the Villa Anya nursing clinic in Melito Porto Salvo, which had an agreement with the regional health service in Calabria, were arrested, along with Antonio Iacopino, head of the political administration of Councilor Crea and also medical director of the clinic. The following were put under house arrest: Giuseppe Biamonte, interim director of the councilor's office for health; Pietro Morabito, ex-director of ASL 11 in Reggio Calabria and director of the provincial health board in Catanzaro; and Laura Autelitano, doctor and wife of Antonio Crea. Among those arrested were members of the Morabito clan and the Cordì clan, both of which are associated with the criminal 'Ndrangheta organization, accused, among other crimes, of the murder of Francesco Fortugno. Investigations revealing patronage between politics and the 'Ndrangheta led first to the commissioning of the ASL 9 in Locri and then to the inquiry into the "health mafia," which found that the murder of Fortugno in October 2005 took place to safeguard consolidated alliances and illicit agreements.[15] According to the charges, Councilor Crea was the lynchpin. He was the one suspected of favoring the interests of the 'Ndrangheta in exchange for votes, whereas the election of Fortugno would not have guaranteed the same level of profits as envisaged with Crea in the region. Crea had to be made head of the regional council in order to allocate contracts and jobs with the complicity of Pietro Morabito, director of the Catanzaro ASL, and Giuseppe Biamonte, proxy director of the health division of the region of Calabria. All this was in order to divert millions of euros toward clinics of friends or family members, or to appoint a cousin, a brother, or a neighbor to the various health boards.

Arrests in Abruzzo in July 2008 for medical mismanagement caused a scandal that again hit the health sector. The president of the region, Ottaviano Del Turco, was arrested, along with nine other people, and accused of criminal association involved in aggravated fraud, extortion, forgery, and abuse of office. The inquiry also investigated

the second conversion of sums owed by the Abruzzo ASL to private clinics into public authority debentures. It should be remembered that Abruzzo was among the regions with the worst budgetary problems and that in June 2008 it was Del Turco himself who presented a new deficit reduction plan to the unified conference of the state and regions, in order to avoid the appointment of a special commissioner and an increase in the rates of IRPEF and IRAP taxes.

The problem is that these scandals are the result of a widespread and long-standing type of behavior. Reviewing the last two decades, when the most significant SSN reforms were carried out, we can identify, along with measures to rationalize and reorganize the system, a series of events that show how widespread corruption and illegal payments are in this policy sector.[16]

More recently, in 2002, a scandal blew up and several arrests were made at the Molinette Hospital of Turin over defective Brazilian-made cardiac valves, which were implanted in many patients during the 1990s and caused several deaths. The investigation then extended from Turin to Padua. In February 2007, Michele Di Summa, a former chief medical officer at Molinette, was sentenced to nearly three years of imprisonment for bribery involving supplies of health equipment. In 2008, it was the turn of the ex-medical director of heart surgery in Padua, Dino Casarotto, who was sentenced to nearly six years for corruption, homicide, and grievous bodily harm to patients in whom he had implanted the defective heart valves.

Further investigations in 2007 focused on Rome. One of the main figures was Anna Giuseppina Iannuzzi (nicknamed "Lady ASL"), a businesswoman in the health sector who made statements to the authorities that uncovered a network of bribes, which, over the years, had caused a loss of about 80 million euros in the Lazio region's public health funds. "Lady ASL" confessed to having paid bribes to politicians, regional directors, and officials in order to obtain institutional accreditation and agreements, to cash unearned compensations by issuing false payment orders, and to receive EU funds for non-existent training courses.

The public and decision-makers end up having a schizophrenic relationship with the health sector, characterized by sudden outbursts in the media, widespread indignation among the public, and bitter political controversy. This means that the frenzy of the days following the sudden discovery of health mismanagement goes hand in hand with new initiatives and intervention programs, such as setting up ad hoc commissions responsible for uncovering problems and suggesting solutions. This burst of activity, however, soon gives way to widespread indifference. As a result, in the field of health service there is a

contrast between the experiences of the citizens, which vary substantially in terms of quality of and access to health care, wherein the ability of individuals to take advantage of different opportunities offered by medical structures is crucial, and the responsibility of political institutions, which are too preoccupied with issuing "announcements for effect" (almost always ineffectual) and with the difficult task of making accounts balance.[17]

The Appointment of General Managers, Chief Medical Officers, and Assistant Medical Officers

Another aspect of the relationship between health and politics, which had already become apparent at the end of 2007, was the appointment of general managers for local health authorities and hospital trusts and of chief medical officers for the latter. This controversy began in December 2007 with the appointment of general managers in Lombardy. Of the 47 appointed by the center-right Lombardy Council, 44 came from the Casa delle Libertà (to be exact, 26 from Forza Italia, 10 from the Lega Nord, 6 from the Alleanza Nazionale, and 2 from the Unione dei Democratici Cristiani e di Centro), 1 came from the Partito Democratico, and only 2 were experts with no party allegiance.[18] Their appointment was preceded by the publication on the region's Web site of all 520 candidates who had put forward their candidacy, without making detailed curricula vitae available.

In the regions of Piedmont and Liguria during the same period, the appointment of chief medical officers in the main hospital trusts came under discussion. The current practice is that whoever wins the elections chooses the general manager of health boards under the spoils system. The general manager in turn decides who will cover the key positions in health-care facilities: chief medical officers, heads of departments, and lower-level managers. The recent history of health care in Piedmont shows how this system worked during the 10 years of center-right government in the region and how it was immediately replicated by the center-left government that followed. After a two-and-a-half year freeze on appointments, there was a race to fill vacant positions, which numbered 100, including chief medical officers, heads of departments, and managers of basic health providers across Piedmont. In general, problems arise from the right of the public authority to appoint chief medical officers, the frequency of job advertisements that attract only one or two applicants, the possibility of creating new head consultancies in addition to those in existence, and the fact that these appointments (like those for general managers) are closely linked to political competition.

On the subject of the link between politics and general managers, an inquiry held in January 2008,[19] carried out by the weekly publication *Il Sole 24 Ore Sanità*, stated that, following the regional election results in 2005, 62 percent of general managers of local health authorities and hospital trusts were connected to the center-left, 34 percent were associated with the center-right, 3 percent were from local lists, and only 1 percent (i.e., three general managers) were experts with no particular party affiliation (see table 9.1). This issue was considered so significant that the then health minister, Livia Turco, immediately proposed a reform aimed at the swift approval of new regulations on the choice of general managers and the appointment of chief medical officers, taking these regulations from the bill on the quality and safety of the SSN proposed in November 2007. The aim, according to Minister Turco, was to "give citizens the confidence that managers administering public funds and doctors wielding scalpels with power over their lives should be the best and most efficient at their job and not the most able to win the support of some politician or other."[20]

Above all, Minister Turco emphasized that there were two separate problems. One was the appointment of general managers, regarding which politics must continue to play a crucial role, albeit linked to transparent criteria for candidate selection. The selection of the other upper-level health officers and of doctors was another matter, because politicians should not be involved at all in the appointment process. It should, in fact, be the general managers' responsibility to choose, completely independently and in their capacity as managerial heads of the health authority, the best people to collaborate with, including chief medical officers.

Where general managers are appointed by the regional council, this must happen after a public announcement gives proper notice of the post available. Candidates should be selected by an expert committee, which then submits to the region a short list of the best applicants for final selection. Procedural transparency is ensured by publishing the decision-making process on the Internet, including curricula vitae and evaluations. In addition, the whole process must be assessed by an external non-regional body, namely, the National Agency for Regional Health Services.

Regarding the appointment of chief medical officers, under the current system candidate selection is limited to the identification of general suitability to fill the role. As a result, the majority, if not all, of the candidates often prove suitable. This means that ultimately the general manager has absolute discretion and might be influenced by external pressures in favor of a particular candidate. The Turco law, by contrast, introduces a proper candidate selection procedure, carried out by a commission that is largely made up of members taken from among

TABLE 9.1 *Political party affiliation of general managers of local health authorities and health-care providers by region*

Region	RC	DS	Margherita	SDI	Other center-left	Other center	Other center-right	FI	AN	LN	Other and experts
Val d'Aosta	—	—	—	—	—	—	—	—	—	—	1
Piemonte	1	7	6	—	1	—	—	4	—	—	3
Lombardy	—	—	—	—	1	2	—	21	9	11	—
Liguria	—	4	3	—	—	—	—	—	—	—	—
Veneto	—	—	—	—	—	—	—	20	1	2	—
Trento	—	—	—	—	—	—	—	—	—	—	1
Bolzano	—	—	—	—	—	—	—	—	—	—	1
Friuli-V.G.	—	4	5	—	—	—	—	—	—	—	—
Em.-Rom.	—	12	4	1	—	—	—	—	—	—	—
Tuscany	—	9	5	2	—	—	—	—	—	—	—
Umbria	1	3	2		—	—	—	—	—	—	—
Marche	—	6	10	1	—	—	—	—	—	—	—
Lazio	1	7	8	3	—	—	—	—	—	—	—
Abruzzo	—	3	3	—	—	—	—	—	—	—	—
Molise	—	—	—	—	—	—	—	1	—	—	—
Sardinia	—	6	3	—	—	—	—	—	—	—	1
Campania	—	9	8	2	—	4	—	—	—	—	—
Puglia	2	4	3	—	—	1	—	—	—	—	—
Basilicata	—	2	4	1	—	—	—	—	—	—	—
Calabria	—	3	5	—	—	—	—	—	—	—	—
Sicily	—	—	—	—	—	5	4	14	4	—	1
Total	5	79	69	10	2	12	4	60	14	13	8

Source: Calculated from data provided by a survey in *Il Sole 24 Ore Sanità,* no. 4 (2008): 4–5.

the chief medical officers of the same discipline at a regional or supra-regional level. This commission then provides the manager with a short list of three candidates. The general manager retains the power of appointment, but can choose only from among the three names given on the list provided by the experts, thus limiting the possibility that he or she is influenced or put under pressure by external factors. This whole procedure must also be published on the Internet to guarantee transparency and allow public scrutiny of the appointment process.

The early elections in 2008 interrupted discussions on this bill. However, the Berlusconi government has stated its intention to change the appointment system (particularly that of chief medical officers) and to banish politics from the selection procedure. The plan is to change the commission in charge of assessing candidates for top positions (former chief medical officers and assistant medical officers). Currently, the commission can be made up of people who work in the health-care facility or clinic where there is the job vacancy. If the current government's proposal is approved, the commission would instead consist of two external chief medical officers, chosen at random, and the managing director of the medical institution. The commission must provide the general manager with a short list of three candidates, in order of merit, based on their résumés, interview performance, scientific publications, and educational qualifications. A list of suitable people, which in practice includes all candidates, would no longer be drawn up. Under the new system, the general manager would also need to justify any choice other than the first person on the short list.

The issue of appointing general managers and chief medical officers, along with that of limiting health service costs, contributed to raising the level of conflict between the government and the regions, as the two took different positions. On one hand, the central government aimed to shield the appointment process from political meddling. On the other hand, the regions, which spend almost two-thirds of their budget on health care, were against a government initiative that would affect their autonomy with regard to the health sector. Clearly, there are two different views of health sector management. The basic premise of the regional point of view is that health-care policies must be linked to health-care management, and thus decisions on closing or opening medical facilities or the appointment of general managers or chief medical officers must be the responsibility of councilors or heads of councils. This does not exclude the need to identify and implement different selection methods from those currently in place. From this point of view, the proposal by Piero Marrazzo, president of the Lazio region, has a twofold purpose. Either the regional councils continue to appoint general managers, but from a list compiled by a

third party, or candidates for the presidency must state during their electoral campaign which professionals will occupy the top positions within regional health institutions. Thus, in this as in other areas of public administration, the issues of selection, evaluation, and responsibility remain the focus of a debate in which everyone agrees that the current situation is unsatisfactory, but a range of different positions regarding a possible reform of the system is expressed.

Conclusion: Toward a Regional Partyocracy in the Health-Care System?

Following this examination of the problems faced by the Italian health-care system, which finds itself caught between cost constraints, health mismanagement, and Mafia infiltration, it is worth drawing some general conclusions on how the (perverse) relationship between health care and politics has changed since the 1990s. In that time, the Italian health-care system has been the subject of many important reforms, which have redefined procedures and have decentralized to regions many responsibilities that were previously dealt with by the central government.

It is worth starting with Maurizio Ferrera's analysis to consider this issue. Over 10 years ago, he described the Italian health-care system from its initial constitution to the beginning of the 1990s.[21] How much of that analysis is still valid and can explain why, despite the changes made in the last 15 years, the influence of politics on the Italian health-care system is still so marked? The political exploitation of health care was started in the 1950s by the Christian Democrats and was perfected during the 1960s by the center-left governments. It reached its zenith in the 1970s and 1980s with the involvement of the Italian Communist Party and the extension of sharing-out practices from a national to a sub-national level, involving the regions, on one hand, and the local health boards, on the other. Political exploitation, therefore, took place at both a national and a sub-national level, in both a visible and in an invisible, hidden form.

The reforms of the 1990s gave rise to a process of regionalization and the creation of local entities, which, although intended to reduce the level of politicization, in fact shifted it toward the regions and the new local health authorities and health-care providers after 1994. But there are further differences compared to the pre-reform situation. As the recent scandals described earlier in this chapter demonstrate, the invisible exploitation of the health sector as a source of illegal, hidden funds was worse at the regional level and was often carried out by the health councilor and/or regional council.

All this has important implications for the measures aimed at rationalizing the health system. The cuts that were made possible at the beginning of the 1990s—thanks to a combination of national measures, often implemented by professionals, and increased regional responsibility—have become more difficult to implement, now that a significant proportion of resources is directly available at a regional level. In addition, some of the regional political personnel are still halfway between responsible behavior and a persistent "spending culture," according to which "the local partyocracy can continue their distributive games relatively undisturbed, claiming as a badge of honor their ability to secure funds from the center, to allocate resources at the local level, or to falsify accounts."[22]

Visible exploitation, a constant factor at the sub-national level, is closely connected to the increase in decisional, financial, and organizational regional autonomy that has resulted from health-care decentralization. Regions that have the power to do so seize the opportunity to appoint general managers and, in health-care facilities, health directors and chief medical officers who are politically close, so that, through them, the political exploitation of health care can continue, although within regional borders.

The "reform of reforms" of 1992–1993 attempted to block this practice, but these institutional barriers, which were largely effective when the party system was being destructured, seem less efficient now that there are signs of consolidation of the parties, above all as concerns their leadership at the local level. Once the health-care reforms of the 1990s were underway, the dynamics of political exploitation of health care shifted from a national to a sub-national level, which—contrary to expectations—brought forward "micro" rather than "meso" or "meta" interests.[23] In the long term, these interests, as shown by the scandals that emerged during 2008, successfully evaded the constraints on expenditure and the measures aimed at rationalizing the health system.

The constellation of interests in favor of change during the 1990s was anti-universalist and anti-statist. In recent years, however, there has not been an equal pressure against partyocracy. On the contrary, after going through a phase of partyocracy at the national level, health care now seems largely characterized by a variety of regional partyocracies that carve up increasingly scarce resources. Contrary to what seemed to be a reasonable expectation and hope at the time, from the second half of the 1990s, the whole debate has been heavily re-politicized (as shown by events when, from 1996 to 2000, Rosy Bindi was minister of health), with the result that health mismanagement has continued to spread and politics still influences the workings of the health system.

Notes

1. E. Caruso and N. Dirindin, "La sanità nel 2007: Tra piani e ripiani, un'immagine positiva," in *La finanza pubblica italiana: Rapporto 2008*, ed. M. C. Guerra and A. Zanardi (Bologna: Il Mulino, 2008), 69–91.
2. On this subject, see, among others, the volume by N. Falcinelli, G. F. Gensini, and M. Trabucchi, eds., *1978–2008: Trent'anni di Servizio sanitario nazionale e di Fondazione Smith Kline* (Bologna: Il Mulino, 2008).
3. The 2008 Finance Act (Law No. 247/2007) reconstituted 12 ministries as specified in the Bassanini law in 1999 (legislative Decree No. 300). As a result, the Ministry for Health was grouped with the new Ministry for Work, Health, and Social Policy. As stated, the second Berlusconi government repealed the Bassanini law in August 2001, creating two separate ministries—one for health and one for social policy.
4. On this, it should be noted that the Agenzia per i Servizi Sanitari Regionali (ASSR, Agency for Regional Health Services) changed its name following the 2008 Finance Act, becoming the Age.Na.S. The Berlusconi government, making use of the spoils system, proceeded to nominate a new director, Fulvio Moirano, in September 2008, and stated often that it was ready to develop the agency's role and functions.
5. Corte dei Conti, *Relazione sul rendiconto generale dello Stato: Esercizio finanziario 2007* (Rome: Corte dei Conti, 2008).
6. State-regional agreements of 3 August 2000 and 8 August 2001; state-regional agreements of 23 March 2005; Health Agreement, signed on 28 September 2006.
7. Laws No. 311/2004, No. 296/2006, No. 222/2007, and, more recently, legislative Decree No. 154/2008 are particularly significant.
8. On this subject, it became apparent that nearly all the regions affected by the plans had heavy health-related debts (many of these placed through the financial markets) and subject to particularly heavy financial conditions. The state had to anticipate a liquidity loan (equal to 9,100 million euros) to bring forward the reimbursement of these debts. The regions will have to reimburse these loans to the state within 30 years.
9. S. Neri, "Italia: La costruzione dei servizi sanitari regionali e la *governance* del sistema sanitario," *La rivista delle politiche sociali*, no. 3 (2008): 97–114.
10. The Health Agreement was signed in September 2006 between the Prodi government and the regions. It was intended to make up for the health deficit that had come into being between 2000 and 2006, combining an *ex ante* adjustment of funds available to the SSN with a package of measures aimed at reducing expenditures. Above all, controls on regional accounts were strengthened regarding coverage for unplanned expenses and automatic tax increases to be borne by the regions. It also separated the problems connected to the ordinary financing of the health system, to be linked to GIP (gross internal product), from the issue of the specific financing of debts incurred by regions in difficulty. A temporary three-year support fund was designated for this, subject to the regions' adoption of deficit reduction plans.
11. On this and the reasons making it complicated to calculate the standard cost, see the Dossier Nens, "Dottrina e prassi di un federalismo consapevole," November 2008, http://www.nens.it.
12. Monitor Biomedico, "Il valore della prossimità nella sanità del futuro," prepared by the Forum per la Ricerca Biomedica and by Censis, 2006.

13. Surgeons operating solely to increase the amount of refunds (and hence their salaries) were prevented from this by a police operation that resulted in jail sentences for the administrative officers and health directors of the private clinic. A total of 14 people were accused of offenses that varied from aggravated fraud to forgery of public documents and even, as in the case of the ex-medical director, Pier Paolo Brega Massone, and his assistant, Pietro Fabio Presicci, of causing grievous harm and willful murder "aggravated by particular cruelty."
14. Report by the attorney general of the State Audit Court, Furio Pasqualucci, at the inauguration of the legal year 2008, which took place on 5 February in Rome.
15. Annual report on the 'Ndrangheta, produced by the Parliamentary Commission of Inquiry into the organized crimes of the Mafia or groups of a similar nature, unanimously approved by the same commission on 19 February 2008.
16. During the era of Tangentopoli, one of the worst scandals involved the ex-health minister Francesco de Lorenzo, who was condemned in 1993 on appeal for bribes amounting to around 9 billion old lire that he had received from the pharmaceutical industries during his ministry, from 1989 to 1992. In May 1997, a series of arrests in Milan exposed the scandal linked to the management of the Center of Nuclear Medicine by Professor Giuseppe Poggi Longostrevi. Many services were never carried out, and in numerous cases other tests were added to prescriptions to increase SSN reimbursement. In addition, many of the most expensive tests were not even necessary.
17. See the report of the Forum per la Ricerca Biomedica and Censis, *Cittadini e sanità: Le opinioni degli italiani sulle istituzioni e le performance del Servizio sanitario: 2002–2006* (Rome: Censis, 2007).
18. F. Poletti, *La Stampa*, 23 January 2008.
19. The investigation by *Il Sole 24 Ore Sanità* examined all of the general managers for 279 health-care providers and the local health authorities in existence at the end of 2007 and looked at their political parties of reference. The definition of three general managers as professionals (i.e., without a political affiliation) is related to the fact that governments under different banners have reconfirmed the same general manager, even though some general managers with a particular party allegiance have been reconfirmed by a new council with different political leanings (three of Forza Italia in Piedmont and one of the Partito Democratico in Lombardy). The article does not specify whether the attribution of party allegiance was straightforward or in some way "forced." "This does not mean having a membership card in your pocket. Hardly any of them have this—nor to have to manage according to politics, but only to reflect … the ideas of regional government [with] reference to parties … which in any case are ready to back them [the general managers] up." These data are relevant, despite a few debatable statistical methods, especially in light of the wide use of the spoils system and the extensive changes in general managers following the elections. This is also confirmed by the concerned reactions of the minister and regional councilors for health.
20. Statement made by Turco at the Fiaso conference, "The Role of Health Boards in the Construction of the Managerial Classes," 24 January 2008.
21. M. Ferrera, "La partitocrazia della salute," in *Il gigante dai piedi di argilla*, ed. M. Cotta and P. Isernia (Bologna: Il Mulino, 1996), 53–72.
22. Ibid., 68.

23. Maurizio Cotta and Pierangelo Isernia introduce a distinction between the three levels on which political competition can be conducted to explain the gap between party lines and public policies. There are meta-policies, meso-policies, and micro-policies. The first refer to policy choices that are strongly linked to the political regime, and, for this reason, they are easily identified with highly ideological leanings. The second essentially correspond to "ordinary" policy innovations and the third to adjustments to already existent programs, often with specific goals. M. Cotta and P. Isernia, eds., *Il gigante dai piedi di argilla* (Bologna: Il Mulino, 1996).