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Public-Private Partnerships in a decentralised NHS: the case of Italy*

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Abstract

The paper analyzes the evolution of the Public Private Partnerships in Italy since their introduction in the 1990s, focusing on the "institutional PPPs", which may "involve the establishment of an entity held jointly by the public partner and the private partner" (EU Commission, 2004, p. 18). In the Italian case, several Regions converted public hospitals into institutional PPPs, creating "joint-stock companies" or "foundations". The majority of the boards of the new entities, which have private legal status, are controlled by the local health authorities, while the private partners are in charge of managing the hospitals.

The paper focuses on the PPP experience carried out in Emilia-Romagna and Lombardy, two important Regions ruled by governments with different political orientations. Institutional PPPs are set up with a different aim and play a different role in the two Regions. In Emilia-Romagna, institutional PPPs are aimed mainly at solving local planning problems in a "public" NHS, due to excessive bed capacity. In Lombardy, PPPs are part of a long-term strategy aimed at progressively privatising the provision and therefore they contribute to determine an "internal system change" (Wendt, Frisina and Rothgang, 2009) in the Regional Health Service.

Different PPP conceptions also emerge in the way the Regional governments dealt with the problems determined by the transition from the public NHS employment regulation to those adopted in the private healthcare sector: a shift, which is seen as crucial in order to ensure greater managerial flexibility to the PPPs. Within the institutional PPPs, the "old" public NHS employees enjoy rather different pay and working conditions from the "new" staff directly hired by the public-private entity. In the two Regions, the problem of managing a two-tier workforce found different solutions, which are consistent with the role and aims attributed to the PPPs.

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1. Introduction

In recent decades public-private partnerships (PPPs) attracted widespread interest both by the policy makers, with international institutions openly endorsing their adoption (IMF, 2006; World Bank, 2006; EU Commission, 2004), and in the academic debate about public sector reform. According to a famous definition, a PPP is a 'co-operation of some sort of durability between public and private actors in which they jointly develop products and services and share risks, costs and resources which are connected with these products' (Van Ham and Koppenjan, 2001, p. 598). Klijn et al. (2008, p. 258) define a PPP as "a cooperation between public and private actors in which actors develop mutual products and/or services and in which risk, costs and benefits are shared" [†]. Such definitions identify some characteristics considered as essential elements of a PPP and, at the same time, are not linked to specific forms of PPPs and to the context in which these forms have been developed, enabling international comparisons.

However, PPP remains an ambiguous concept (see Savas, 2000; Van Ham and Koppenjan, 2001; Hodge and Greve, 2005; Vrængbaek, 2008), while these and similar definitions have been criticised for their excessive inclusiveness, which risks making the concept useless. For example, allowing "for great variance across parameters such as time, closeness of cooperation, types of products/services, costs, complexity, level of institutionalization as well as number and type of actors involved" (Weihe, 2006, p. 3), Van Ham and Koppenjan's conceptualisation considers most forms of public-private collaboration as PPPs, including outsourcing, joint-ventures, the various financial arrangements in infrastructure projects such as DBO (design- build-operate), BOT (build-own-transfer) or BOOT (build-own-operate-transfer). As a consequence, the relevant differences among all these types of cooperative relationships risk being neglected or ignored (Weihe, 2006). PPP becomes "an umbrella term that covers different systems of public management without considering the variations they present" (Esteve and Ysa, 2010, p. 2).

In this broad context, the 2004 Green Paper on the PPPs released by the Commission of the European Communities provided a distinction between two fundamental types of PPPs, "based on the observation that the diversity of PPP practices encountered in the Member States can be traced to two major models" (EU Commission, 2004, p. 8). After having defined the PPPs as "forms of cooperation between public authorities and the world of business which aim to ensure the funding, construction, renovation, management or maintenance of an infrastructure or the provision of a service" (EU Commission 2004, p. 3), the Green Paper distinguishes between:

[†] In a previous work, Klijn and Teisman (2000) had used a very similar definition adding the element of the "durable character" of the cooperation.

1) purely contractual PPP, in which the partnership between the public and the private sector is based solely on contractual links. “It covers a variety of set-ups where one or more tasks of a greater or lesser magnitude are assigned to the private partner, and which can include the design, funding, execution, renovation or exploitation of a work or service” (EU Commission 2004, p. 8). One common example of contractual PPP is “the concessive model, where the private partner provides a service to the public, ‘in place of’, though under the control of the public partner and it is mainly remunerated by charges levied on the users of the service, although it can be subsidised by the public authorities”. Another example is represented by the cases in which “the private partner is called on to finance, carry out and administer infrastructures for the public authority (such as a school, a hospital, a penitential center or a transport infrastructure). The most typical example of this model is the PFI set-up. In this model, the remuneration for the private partner does not take the form of charges paid by the users of the works or of the service, but of regular payments by the public partner” (EU Commission 2004, p. 9).
2) institutionalised or institutional PPP, in which the cooperation between the public and the private takes place within a distinct entity, in charge of ensuring the delivery of a work or a service for the benefit of the public. “An institutionalised PPP can be put in place, either by creating an entity held jointly by the public sector and the private sector… or by the private sector taking control of an existing public undertaking” In both cases the new entity is jointly run by all the partners involved, according to the rules defined in the internal governance. Compared to the first type, the main advantage of an institutional PPP is that “direct cooperation between the public partner and the private partner in a forum with a legal personality allows the public partner, through its presence in the body of shareholders and in the decision-making bodies of the joint entity, to retain a relatively high degree of control over the development of the projects, which it can adapt over time in the light of circumstances”. Moreover it enables the public partner to develop its own experience in running a service while being supported by a private partner. Examples of institutional PPPs in the Member States are some structures used to administer public services at local level (such as water supply or waste collection services) at local level, named with different terminology and set up with different schemes, such as, for example, “the Kooperationsmodell, joint PPPs, Joint Ventures” (EU Commission 2004, p. 18).

As already noticed (Esteve and Ysa, 2010; Cappellaro and Longo, 2011), research has mainly concentrated on contractual PPPs, and especially on PFI, either for country-specific experience or in comparative contributions. Little attention has been devoted to institutional PPPs, to their aims, organisational models and performance. “In particular, the question of the extent to which these

forms of stable partnership can ensure the sustainable provision of public services is still under investigated" (Cappellaro and Longo, 2011, p. 2).

As far as health care is concerned this last issue may be of great interest in a NHS, where full privatisation of the public providers could not be a politically viable option. In this case, the conversion of a public provider, typically a hospital, in an institutional PPP can be seen as a tool to obtain the benefits of private management and private regulation, while preserving the commitment to public goals through public ownership and control. In this sense, institutional PPP could be considered a way to go beyond the managerialisation of the public health care organisation carried out by NPM reforms, without fully privatising them.

In this paper we intend to explore if and how this idea was implemented in an empirical case, that of the Italian NHS. At the age of their introduction, between the second part of the 1990s and the beginning of the 2000s, institutional PPPs in Italy were considered, by public hospital managers, some policy makers and by some scholars, as a tool to enhance the ability of public hospitals to deliver efficient services. In particular hospital managers attributed great importance to the change in the employment relationships, where the shift from public to private regulation promoted by 1990s NPM reforms had been partial and incomplete, both in health care and in the public sector taken as a whole (Bordogna and Dell'Aringa, 2001). The conversion of a public provider into a PPP would make it possible the adoption of the employment collective agreements used by private healthcare organisations, which would substitute the NHS collective employment agreement. This would result in a shift in employment regulation which allows for higher flexibility in the management of the workforce, considered a precondition to enhance the level of efficiency in the services provided. The change in employment regulation would also affect industrial relations, substantially changing the balance of powers in favour of PPPs managers and penalising the unions.

This paper will deal with the issues of the shift in employment regulation into detail, which is substantially neglected by most of the literature, although hospital managers attribute it great relevance. The analysis will focus on the PPPs experience carried out in Emilia-Romagna and Lombardy, two important Regions ruled by political leaders with different ideologies. Literature has widely taken into account the national differences in PPP policy and implementation (see for example Osborne, 2000; Hodge and Greve, 2005). According to Petersen (2011), three different PPP national reform models can be identified within the EU context. Some governments (UK, Portugal, Spain and Ireland) "have enacted comprehensive policy and regulation frameworks and formed a substantial number of major projects over the last ten to fifteen years…Other countries, such as France, Germany, Italy, the Netherlands and Greece, have also developed relatively widespread policy and regulation frameworks, but signed a smaller number of actual PPP

projects"…Finally, in Scandinavian countries, Austria, Switzerland and Belgium and many former Communist countries so far "regulation initiatives have been modest and few projects have been signed" (Petersen, 2011, p. 4).

However, in the case of Italy national policy simply provided a very general framework, leaving Regions very large discretion in defining PPP regulation. This choice is consistent with the highly decentralised nature assumed by the Italian NHS after the 1990s and 2001 constitutional reform, which reserved most of the powers in the planning, organisation and management of the healthcare system to the 20 Regions (see for example, France and Taroni, 2005; Frisina Doetter and Goetze, 2011; Maino and Neri, 2011). As to PPPs, decentralisation resulted in some different Regional policies and implementation, which are well represented by the two cases examined in this contribution.

After a brief overview on PPPs regulation in Italy and in the two Regions under examination (sect. 2), we will describe aims attributed to PPPs in these areas, comparing expectations derived from literature with empirical evidence (sect. 3). Then we will analyse the issues related to the change in employment regulation (sect. 4); finally some brief conclusions concerning the role of PPPs in a decentralised NHS will be illustrated in the last section.

This paper is part of an ongoing research about institutional PPPs in the two Italian Regions. The research makes use of "traditional" methodologies such as the analysis of the regulations and available documents (Regional legislation and administrative acts, institutional PPPs acts, union agreements and any other document useful to this study). This is matched with semi-structured interviews carried out with Regional government officials and managers from local health authorities and public hospitals, as well as managers of the institutional PPPs, unions' members representatives and "experts" in this field. Quantitative information about PPPs are under elaboration, although so far only limited data were made available.

2. Public-private partnerships in the Italian NHS

In Italy institutional PPPs were legally introduced by reforms in 1992-93 (legislative decree no. 502/92 and no. 517/93), in the form of joint-provision-form-experiments (*sperimentazioni gestionali* - JPFE). JPFEs can assume many legal configurations, such as "public-private joint-stock companies", "private law foundations", "participation foundations" or "participation associations". All these organisational forms provide core health services, that is acute or rehabilitative hospital services, outpatient care or laboratory services. This feature distinguishes JPFEs from other types of

PPPs, where either the public sector contracted out the service to the private sector, or the involvement of the private sector is limited to the construction of the facilities and the management of ancillary services (see also Cappellaro and Longo, 2011).

JPFEs are subject to civil law, while the public health care providers, managed by the public Local Health Authorities (LHAs) or the public Autonomous Hospital Trusts (AHTs), are disciplined by public regulation. The public partners, usually a LHA or a AHT, sometimes also a municipality, must retain majority shareholding (51%) which can not be assumed by a private party. The private partners are typically private healthcare providers. In the JPFE internal governance, the public partners appoint the majority of the members of the Council of Administration, which has steering and monitoring powers, while the private partner appoints the chief executive in charge of the management of the services provided.

JPFEs are originally set up for a defined 3 (+3)-year period. At the end of that time an external evaluation committee should decide whether to make the public-private partnership a stable entity or to suppress it. In practice the experimental stage often lasts more than six years and it shows a tendency to become a permanent conditions.

1992-93 legislation introduced JPFEs in a very limited way, stating that any JPFEs should be subject to a national procedure for authorization and monitoring and that no more than 9 authorizations could be released. Moreover, JPFEs regulation remained very ambiguous and scant. This feature allowed for an unpredictable use of this normative tool: the whole Lombardy quasi-market healthcare system introduced in 1997 (Brenna, 2011; Neri, 2011) was considered a JPFE, and therefore regularly authorised by the national procedure, in order to make it consistent and not in contrast with national legislation which in the second part of the 1990s increasingly limited competition in the NHS (see Neri 2011).

In 1999 legislative decree no. 229 provided additional regulations limited to public-private joint-stock companies, which became the only JPFE or institutional PPP model regulated by the national legislation. However, after 2001 constitutional reform and legislative decree 165/2001, Regions were given wide autonomy in PPP regulation. JPFE and, more generally, both contractual and institutional PPPs creation, authorization and monitoring was almost completely attributed to Regions.

After 1999 the institutional PPPs, labelled as JPFEs or simply as PPPs, had a wide diffusion, especially in the Northern and Centre-Northern Regions. According to the survey conducted by the National Commission on PPPs instituted in 2000 by the Ministry of Health, 65 contractual and institutional PPPs providing health care services had been implemented or simply promoted until 2002 (ASSR, 2003). No more recent data are available but it is presumable that more PPPs were set

up during the last decade, especially in the first half of the 2000s. Both contractual and institutional PPPs are concentrated mainly in Northern and Central Regions, with Lombardy having set up 18 PPPs.

The National Commission identified 36 joint-stock companies in 2002 over 65 PPPs and more recent regional or micro-level studies seem to confirm that this is the prevailing model of institutional PPPs in most Regions. Other institutional PPP models are the "civil law foundation" and the "participation foundation" which, for our purposes, can both be called foundations, promoted especially in Lombardy. Tuscany made a very different choice promoting mainly the "Health Society", a sort of public-public partnership between the LHAs and the municipalities, aimed at managing community care and long-term services.

Emilia-Romagna and Lombardy are two of the Regions where PPPs play a major role. The former, which is in the Centre-North of Italy, with a population of about 4,500,000 inhabitants, was the first Region to set up PPPs in the mid 1990s, creating some joint-stock companies either for the provision of health care services and ancillary services. Later, PPP recourse was limited to the provision of core health care services. No contractual PPP has ever been set up for providing this kind of service.

Table 1 reports the institutional PPPs operating in Emilia-Romagna during 2000, that is four joint-stock companies and one foundation managing a rehabilitation hospital. In that case the foundation model was preferred because, on legal grounds, it permitted including a municipality within the shareholders more easily than in the case of a joint-stock company. However in more recent years the foundation was suppressed and its hospital was re-incorporated within the Rimini LHA.

Table 1 – Institutional PPPs in Emilia-Romagna

Public partner	*Kind of PPP*	*PPP object*
Forlì LHA	Joint-stock company	Management of a new cancer centre
Imola (Bologna) LHA	Joint-stock company	Management of a highly specialised rehabilitation hospital created as the development of a LHA rehabilitation hospital
Modena LHA	Joint-stock company	Management of a new district general hospital and conversion of a small local hospital into outpatient services
Rimini LHA	Joint-stock company	Management of a new intensive rehabilitation ward within a LHA local hospital
Rimini LHA, a local municipality	Foundation (now suppressed)	Conversion of the small local LHA hospital into an intensive rehabilitation hospital

Most of the PPPs manage specialised hospital which are the result of the conversion of small local general hospital located in small towns (10-15,000 inhabitants). In Emilia-Romagna this is true except for the PPP located in the important industrial town of Sassuolo, near Modena, which

manages a new district general hospital serving an area of more than 100,000 inhabitants. In all the institutional PPPs the private partners are local private healthcare providers, except for the case of the suppressed foundation where the private partner was an important national provider based in Milan.

The conversion into a PPP often follows the refurbishment or, as in the case of Sassuolo, the building of a new hospital. In some cases, but not always, the refurbishment and infrastructure interventions were carried out through the constitution of contractual PPPs according to project finance models, but there is no link between these contractual PPPs and the institutional PPPs set up to manage the core health care services. Instead, private partners in the contractual PPPs can provide ancillary services within the refurbished or new hospitals.

Lombardy, which is in the North of Italy, is the biggest and most economically important Italian Region, with 9 millions inhabitants producing more of the 20% of Italian GDP. Lombardy has promoted PPPs since 1999, approving specific administrative acts in 1999 and 2004. These acts define a detailed regulation framework for the creation of both contractual and institutional PPPs. The Regional government made a significant investment in PPPs, including a specific regulation, approved in 2003, aimed at promoting private capital investment in infrastructure projects for public services, according to the British PFI model.

As reported in table 2, thirteen institutional PPPs can be identified in Lombardy. Ten of them were constituted as "associations in participation". The association in participation represents a specific contractual relationship between two partners, the "associate" (the local AHT) and the "associating partner" (a private provider). The associating partner provides the relevant services on behalf of the associate, according to the conditions included in the contract. These conditions also define the sharing of profits, losses and risks, in a way which should advantage the associate. It is evident that the association in participation is a contractual PPP but, according to Lombardy regulation, all the associations should be converted to joint-stock companies after three years. So far the conversion has not occurred yet, although in all the Lombard cases the associations in participation were set up not later than in 2005-6.

Apart from the associations in participation and the joint-stock companies, the Lombardy Region created two foundations, to which the Mantua AHT respectively transferred two hospitals in 2004-05. In both foundations three members of the Councils of Administration are appointed by the AHT, three by the municipalities of the hospital area and one by a private for-profit organisation directly involved in each foundation. As we will see in more detail, the involvement of local governments and of non-profit organizations was aimed at revitalising democracy in the healthcare organisations, following the example of the English foundation hospitals (Lewis and Hinton, 2005).

Table 2 – Institutional PPPs in Lombardy

Public partner	*Kind of PPP*	PPP object
Mantua AHT, local municipalities	Foundation	Property of a refurbished district general hospital
Mantua AHT, local municipalities	Foundation	Property of a refurbished local general hospital
S. Paolo AHT (Milan)	Joint-stock company	Management of a highly specialised dental center
S. Gerardo Monza AHT	Association in participation - Joint-stock company	Management of the Department of obstetrics-gynecology and pediatrics within an AHT hospitals
Seriate (Bergamo) AHT	Association in participation - Joint-stock company	Management of a highly specialised rehabilitation hospital
Seriate (Bergamo) AHT	Association in participation - Joint-stock company	Conversion of a small general hospital into a rehabilitation and long-term care hospital
Seriate (Bergamo) AHT	Association in participation - Joint-stock company	Development and management of a dialysis and nephrology unit within a small AHT hospital
Seriate (Bergamo) AHT	Association in participation - Joint-stock company	Management of a new center for Alzheimer treatment
Desenzano (Brescia) AHT	Association in participation - Joint-stock company	Conversion of a small general hospital into a rehabilitation and long-term care hospital
Desenzano (Brescia) AHT	Association in participation - Joint-stock company	Management of a new rehabilitation and Parkinson treatment unit within a AHT hospital
Desenzano (Brescia) AHT	Association in participation - Joint-stock company	Conversion of a small general hospital into rehabilitation and long-term care rewards with a private hospital
Melegnano (Milan) AHT	Association in participation - Joint-stock company	Management of a new psychiatric centre
S. Carlo Milan AHT	Association in participation - Joint-stock company	Management of a new centre for radiotherapy and neurological oncology

In the initial project the foundations were planned to directly manage the hospitals, as occurs for the joint-stock companies. However, both the foundations soon decided to contract out the management of the whole hospitals to two private health care providers. The contractual relationship follows the concession model (and therefore it can be considered a contractual PPP) and the contract duration is fifteen years.

The importance of the Mantua foundations goes beyond the two local hospital involved. In the Health and Social Plan 2002-04 approved in 2002, the Regional government clearly expressed the

intention of gradually converting all the AHTs, which in Lombardy (unlike the others Italian Regions) gather nearly all the public providers, into foundations regulated by civil law. However, the lack of a consensus on the privatisation of health care services, which according to periodical surveys is still a very unpopular idea, and the power of existing interests against privatisation has persuaded the Regional government to postpone the conversion of public hospitals into foundations regulated by civil law, apart from the two already created near Mantua. The intention of privatising public hospitals by means of this kind of PPP has been less clearly expressed, though not completely abandoned, in more recent Health and Social Plans or other regional acts.

Moreover Lombardy created four public hospital foundations, which result from the transformation of the national research hospitals (*IRCCS - Istituti di Ricovero e Cura di Carattere Scientifico*). These foundations were created implementing national legislative decree no. 288 approved in 2003, aimed at reforming a particular kind of research hospital, that is the above mentioned IRCCS. This decree was applied almost exclusively by Lombardy. The IRCCS foundations cannot be considered as PPPs because they do not involve private partners and, unlike the Mantua foundations, they are ruled by public law. However they enjoy a higher degree of autonomy in the asset management compared to public LHAs and AHTs.

Lombardy also promoted some contractual partnerships in healthcare through concession contracts and PFI-like projects. It is worth noting that, according to public statements, PFI legislation was introduced after a trip made to the UK in 2003 by the Chief Executive of the Lombard Department of Health. Lombard PFI regulation represents in many ways an adaption of the British regulation. On the contrary the influence is not so clear in the case of the foundation hospitals, which seem very different from the English model.

3. Why create a partnership? Institutional PPPs in theory and practice

In the Italian debate among a few groups of academics, hospital managers and different professionals (such as doctors and lawyers), several reasons have been suggested as grounds or supporting elements for the creation of PPPs in the health care sector (Fiorentini 2000; Bensa and Pellegrini 2002; Mapelli 2003; Cantù et al. 2005; Brugnoli and Zangrandi, 2009). For our purposes these reasons, which are often similar to those found in the international debate, can be summarized in three main points.

1) Private involvement can be justified by the need for large investments, e.g. buildings or costly technologies, for which financial resources beyond public grants are needed. This is often matched

with the acquisition of technical and managerial skills, essential in designing and realizing infrastructural works, which are believed to be insufficient in the public sector.

2) some forms of PPPs, foundations in particular, are thought capable of promoting greater involvement of the local communities in the strategic choices and the daily life of the healthcare organisations. Regionalisation would have made public hospitals and the other NHS providers too distant from the fundamental needs of the local population. These could find a new way to be represented through the presence of people appointed by municipalities or directly elected by local citizens within the governing bodies of the foundations. Unlike the England case, no mention has been made about the involvement and the representation of patients or workers in the foundations' internal governance.

3) PPPs are also expected to achieve a greater flexibility in internal organization and management compared to public healthcare organisations. By freeing the management from the constraints and hindrances of a public "bureaucratic" organisation, PPPs would be able to provide better quality and more efficient services. In particular, this would be possible thanks to PPP's higher flexibility and higher discretionary power in workforce management, compared to public providers, by shifting from the NHS employment regulation to that adopted by private healthcare providers.

The experience carried out in Emilia-Romagna and Lombardy only partially confirmed the expectations raised by the debate, while other important motivations emerged. The need to access additional financial resources as well as technical and managerial skills is prominent in the case of PFI-like and infrastructure projects involving private partners, so it is more relevant to contractual PPPs than it is to institutional ones. Although, as mentioned in the previous section, institutional PPPs are often associated to hospital building or refurbishing projects involving the private partners as investors.

Moreover, the private legal status of institutional PPPs can grant a much easier access to private capital, through debt and financial markets, than public healthcare organizations which are subject to several constraints. There is evidence that some LHAs used the creation of institutional PPPs, in order to exceed the debt limits imposed by national legislation (ASR Emilia-Romagna, 2003).

The issue of the democratisation of healthcare organisations has been raised regarding foundations, even though it has never had the relevance it had in the case of UK foundation hospitals (see Day and Klein, 2005; Lewis and Hinton, 2005). In the statutes of Mantua foundations, citizens living in the area can register as foundation members and arrangements should have been made in order to allow for these citizens to be represented in foundation governance. However citizens' membership has never been activated and arrangements for citizens'

participation have never been established.

As to the enhancement of the level of managerial flexibility of the public healthcare providers, the issue will be treated in detail in the following sections. Here we underline that this was not the main motivation that lead policy-makers to promote the constitution of an institutional PPP and that this fundamental reason was different from those usually considered in the debate.

In many cases, Emilia-Romagna and Lombardy policy-makers saw the constitution of joint-stock companies as a preferable alternative to a hospital closure. Similar results emerged through research conducted in Veneto (Cappellaro and Longo, 2011). In the 1990s and in the 2000s cost containment and de-hospitalisation policies often pushed regional policy-makers to promote a re-organisation of the hospital services, involving a reduction of extra-bed capacity in acute hospitals present in a local area. Re-organisation brought about the closure of many small local acute hospitals, with fewer than 120 beds, as was recommended, if not compulsory, by national legislation. As happened in other countries, hospital closure became a very unpopular policy. In many cases hospital closure was avoided by converting the acute hospitals into highly intensive rehabilitation hospitals, refurbished and managed through the joint-stock company or the association in participation models. The conversion often responded to specific needs given that in many local areas there is a lack of intensive rehabilitation hospital beds.

As occurred for joint-stock companies, foundations created in Lombardy and Emilia-Romagna originated with the same purpose of preserving hospital activity in local areas where hospital capacity was seen as redundant. The choice of the foundation model is explained by the major role played by local municipalities in finding a solution aimed at keeping the local hospital open. As mentioned above, a foundation enables direct participation of the municipalities in the PPP more easily than the joint-stock company does.

In one famous case, the Sassuolo hospital in Emilia-Romagna, the interplay between the public and the private partners was quite different. Because of the ongoing building of a new LHA district general hospital, at the beginning of the 2000s the local LHA intended to stop purchasing health services from the local private hospital. The purchase would have been redundant thanks to the increased productivity of new public hospital; moreover, in the local area there was an extra-bed capacity which could be eliminated by excluding the private hospital from the NHS providers' network. Before implementing this decision, the LHA and the corporate group controlling the private hospital agreed to close the private hospital and to convert the new public hospital into a joint-stock company, which has the LHA and the corporate group as its shareholders. According to information collected in the interviews, the corporate group agreed to close its private hospital not only because, in some ways, it was forced to do that, but also because the involvement in the joint-

stock company was considered as a good opportunity to obtain a safe position within the local healthcare providers. The Sassuolo joint-stock company is controlled by the public LHA and it owns and manage a district general hospital serving a wide area; failure does not seem to be a realistic eventuality.

More generally, private partners are attracted by taking part into a PPP because they see it as a way to expand their business and profits. This is especially true in the case of the management of intensive rehabilitation or other highly specialised services, where an unsatisfied demand clearly exists. On this purpose, PPPs are often located near the borders with other Regions, in order to attract patients coming from these Regions.

This attempt has not always been successful. The only foundation set up in Emilia-Romagna was based in Cattolica, near Rimini, on the border with Marche. The conversion of the small local acute hospital into a rehabilitation centre had the clear purpose to attract patients from the Region of Marche and from Central Italy. However the foundation was not able to create its niche in the market and, as a result, it accumulated a relevant deficit in a few years. At the end the partners decide to suppress the foundation and the hospital was re-incorporated within the LHA.

Although most institutional PPPs were created for preserving hospital activities and preventing hospital closure, this does not mean that they could not permit PPP managers to enjoy a greater flexibility in the workforce management. The issue will be examined in the following section.

4. Employment relationships in the institutional PPPs

4.1 Employment relationship in the healthcare sector

Institutional PPPs offer the opportunity to obtain higher managerial flexibility because they are private entities operating according to civil law, although they are subject to public control. This status differentiates institutional PPPs from the public healthcare organisations such as LHAs and AHTs, which are still regulated by public law. Although managerialisation stimulated a convergence process between the public and the private sector, differences in regulation are still relevant. Employment regulation is one of the main areas in which relevant differences between the public and the private healthcare sector can be found.

In the Italian NHS managerialisation and reforms inspired to the NPM principles (Hood, 1991; Pollitt and Bouckaert, 2004) were first introduced in 1992-93. Employment and labour relations matters have been a crucial component of the NPM reform both in the NHS and in public administration as a whole. Since 1993, the employment relationship of most public employees has been no longer subject to administrative law and courts, as happened until that year, but it was

instead determined by collective bargaining, as it occurred to private workers. Pay and working conditions of NHS workers was no more regulated by legislation, though previously negotiated with unions, but by a national collective agreement, the NHS collective agreement. This was signed by unions and ARAN, the mandatory employers' bargaining agency created in 1993 to carry out national level negotiations on behalf of the public administrations. The first NHS national collective agreement was signed in 1998. In the national agreements clauses regulating working conditions had a duration of four years and pay clauses had a duration of two years. The structure of collective bargaining had a second level, with local agreements signed between each LHA/AHT and the local unions. Collective bargaining was expected to bring public sector employment relations in the public sector closer to those existing in the private sector. On the same purpose managers were empowered in personnel and employment relations matters, with increased autonomy from politicians and trade unions; they became also subject to stricter financial controls and tighter performance management.

In 1997-98 new reforms were introduced in the overall public sector, including the NHS, aimed at strengthening managerial authority and partially decentralising collective bargaining, following the private sector model. However these measures found many difficulties to be implemented and a significantly higher wage dynamic compared to the private sector was generated. In 2008 a third phase started, with the adoption of measures trying to strengthen the powers of public employers in labour relations matter. Managerial autonomy was emphasized but, at the same time, limited by regulating it through a number of legal, highly prescriptive rules (for more details on employment relationship reforms, see Bordogna and Neri, 2011).

NHS has been in the vanguard of implementation of the employment regulation reforms in the Italian public sector. However the level of flexibility and discretionary power in workforce management is often considered as being still limited and far from that enjoyed by private enterprises' managers. As it is emerged also in this research, many hospital managers think that the rules defined in the NHS collective agreements, and the related persistent interference of the unions in managerial matters, bring about a lack of flexibility and an inefficient workforce management. This problem could be, at least partially, solved by converting public organizations into institutional PPPs. Because of their private legal status, institutional PPPs could adopt the employment collective agreements used in the private healthcare sector, which would ensure greater flexibility. Similarly, the relationship with unions would veer towards those typical of the healthcare private sector, in which unions are weaker and play a minor role.

The private healthcare sector traditionally has a relevant role in the Italian healthcare system. Most of private providers work for the NHS, especially in the hospital sector. As a national average,

the share of hospital beds within private providers is about 20% of the whole (public or private) hospital beds available for NHS patients, even though but the share is much higher in some Central or Southern Regions such as Lazio or Sicily or much lower in Regions such as Tuscany or Veneto. Moreover the private sector is very strong in the rehabilitation and long-term care sector.

In the private healthcare sector there are three main agreements, respectively applied to private for-profit and not-profit providers, Church-owned or religious hospitals and other kinds of non-profit providers. Clauses in these agreements are quite similar. Compared to those include in the NHS collective agreement, they allow managers to reduce labour costs and to enjoy a higher discretionary power in using different components of the employment relationship such as wages, working hours and employment stability.

In the NHS the salary is higher, though not to a great extent, for the majority of the workforce. The basic pay is roughly equivalent but the difference is made by the negotiations for salary integrations at the LHA/AHT bargaining level, while, in the private health care sector, collective bargaining at company level is not carried out, except for major hospitals. However, in the private sector the salary gap can be balanced, individually, via *ad personam* bonuses, which are by their nature discretional and difficult to control and, therefore, frowned upon by unions. Individual remuneration of this kind can be used to attract professions which are more requested on the labour market, such as anaesthetists or radiologists. So, the creation of a PPP brings about the risk of poaching towards public healthcare organisations, as it was feared in the UK with the creation of foundation hospitals (Mohan, 2003).

Working hours regulation is more flexible in the private sector, for example in the work shift or overtime management. For some medium-high level professional groups weekly working hours is also longer in the private sector, compared to the NHS. Differences in favour of private employers concern also matters such as maternity leave coverage or sick leave calculations.

Finally, there are differences in terms of employment protection, at least for permanent workers, and in the possibility to adjust the number of workers according to the service demand. The hiring process for open-ended positions is very different, since all the public administrations must hire by public competitions, whose procedure can last many months or even years. A significant recourse to temporary or non-standard labour contracts helps to mitigate the problems raised by this situation. In the NHS the procedure for individual discharge is much more complex and offers more guarantees to the employee. In practice, as it is well-known, it is very difficult to dismiss a permanent worker in the NHS. Moreover, so far collective dismissals have never taken place, even though voluntary workplace or job mobility have been sometimes used as substitutes for that.

4.2 Shifting from public to private employment agreements

As the above discussion should have been made clear, the shift between NHS and private sector agreements is not weightless. So, in the case of conversion of a public hospital into a PPP, what happens to workers' employment relationship? How is the workers' transition to private employment agreements regulated? In the following pages, we will report some empirical evidence drawn from the case studies.

In Italian law, the transition of employees from LHAs and AHTs to new companies established as PPPs is constrained by the Civil Code regulating property transfer, disposal of companies or of company branches. This regulation defends employees providing for them to retain their previous employment conditions and related rights, as well as the enforcement of collective agreements in force before the transfer, until their expiry and unless replaced by other collective agreements applicable to the new employer's enterprise. Such provision is also valid when the employer is a public organisation and it is extended to cases where the legal status of the employer changes from public to private.

For employees who are not transferred from the converted public provider but are directly hired by the new PPPs, the employer can choose which collective agreement is to apply. In this respect, it is expected that the agreement being used for new hires is one typical of the private sector, such as the AIOP (*Associazione italiana ospedalità privata*) collective agreement, which is adopted by for-profit and not-for profit private healthcare providers.

Considering the regulatory framework described above, the issues of employment regulation within the PPPs were handled in partially different ways according to the Region analysed. In all cases studied in both Regions most of the transferred staff from the LHA or the AHT has maintained their employment with the public provider, even though they work under the direction of PPPs managers.

On this purpose. the "command", a specific juridical institute thought for provisional transfers between public administrations, was used in the joint-stock companies and in the associations in participation. The staff is still employed by the LHA or AHT but it is "commanded", i.e. under the management of the new institutional PPPs. This solution was favoured by the "temporary" nature of the new companies, which had to undergo a three-year experimentation before reaching a final decision on conversion. However, even in the hospitals which have been definitely converted into PPPs, most of the transferred workers have maintained the status of commanded staff, which became permanent. The employment with the LHA or AHT continues indefinitely, or rather as long as the employee keeps working at the PPP.

In the case of the Mantua foundations, where services have been contracted out to private providers, the command institute was not applicable. However, transferred workers maintained their employment with the public provider, that is the Mantua AHT, although they work within the privately managed hospitals. The private providers pay a compensation to the AHT for the services provided by its employees. In this case, in juridical terms the AHT acts as if it was a temporary work agency providing staff to the private organisations managing the hospitals.

On the contrary, new hires, who are directly employed by the PPPs, are subject to the private AIOP collective employment agreement. The same agreement is applied to staff who was already employed by the private providers and who was transferred to a PPP.

Therefore, the transition to PPPs seems to have inevitably determined disparities between staff from public providers and new hires, i.e. between groups of employees, possibly working on the same tasks, operating in the same wards. Sometimes, as in the case of Sassuolo, there is also the presence of staff transferred from other hospitals owned by the private partner.

The two-tier workforce derived from the dualism in contractual regimen which is applied within PPPs will expand in the next few years, then presumably dwindle and cease in favour of private-style employment regulation. Given the significant turnover rate within some professional groups, such as nurses and healthcare assistants, the growth of new hires has been fairly quick, especially since many structures undergoing experimentation are expanding their services, hiring new personnel with the private sector agreement.

Table 3 – Workers employed in the hospitals of Sassuolo and Suzzara

	At the moment of the PPP institution		2010		Difference (current -– PPP start)	
	PPP employees	LHA/AHT employees	PPP employees	LHA/AHT employees	PPP employees	LHA/AHT employees
Sassuolo	110 (26%)	318 (74%)	357 (56%)	280 (44%)	+247	-38
Suzzara	4 (2%)	237 (98%)	103 (39%)	192 (61%)	+ 99	-45

Source: elaborations from Suzzara Hospital and Sassuolo Hospital data.
Notes: 1) PPP institution refers to November 2004 for Suzzara and January 2005 for Sassuolo; 2) in the case of Suzzara "PPP employees" refers to employees by the private company, which was set up by the corporate group to manage the hospital.

Table 3 reports the number of employees of the hospitals of Sassuolo and Suzzara, one of the two Mantua foundation.

A distinction has been made between staff employed by the original public providers (LHA/AHT) and those directly employed by the joint-stock company, in the case of Sassuolo, or by the private company set up to manage the foundation hospital, in the case of Suzzara. This company was created by the corporate group to which the hospital was contracted out.

In Sassuolo, when the PPP was created (January 2005) there were 428 employees. 110 of them were employed by the PPP and then subject to the private sector collective agreement, whereas staff employed by the LHA with the NHS agreement amounted to 318. In 2010 the total employees were 637, due to the opening of new services. 357 of these (+247) were employed by the PPP and 280 (-38) were commanded from LHA. As shown in the table, proportion of the two groups has considerably changed in five years.

For Suzzara the data provided by the management show the total employees growing from 241, in November 2004 (start of the PPP) to 295 at the end of 2010. In November 2004 there were overall 4 employees by the private company and 237 "provided" by Mantua AHT. In 2010 private employees subject to the private sector collective agreement were 103 (+99) and public AHT employees were 192 (-45). The share of "public" AHT employees went from above 98% to 61% of the total in little more than 5 years, whereas employees of the private company grew by 39%.

On one hand, this process should lead the converted hospitals to the expected enhancement in managerial flexibility and to a labour cost reduction, on the other hand, it should have determined a worsening of employees' working conditions. However, consequences may be less dire than they seem on employees as a whole.

First of all, in order to attract the most sought-after professionals, both in Emilia-Romagna and in Lombardy some tools in the private agreement have been used, leading to an equal economic treatment between NHS and PPPs employees. From such perspective, a negative impact is having to affect mainly lower-level employees who have a lower professional profile and a weaker position on the job market.

Moreover, employment regulation derived from the same national private sector agreement showed many differences between PPPs created in Emilia-Romagna and in Lombardy. In Emilia-Romagna, the issue of the coexistence of employees with different contracts lead, perhaps unexpectedly, to make the treatment of the PPPs and the transferred NHS employees as close as possible. Workers directly employed by the PPPs have acquired the same treatment as LHA employees from the economical and, as far as possible given the different regulatory status, legal standpoint. Such conditions were reached by local collective agreements with the unions and also apply to newly hired employees.

This result was recommended or imposed by the Emilia-Romagna Regional government as binding condition for granting the authorization to proceed with the PPP. In the case of Sassuolo, it is worth noticing that the LHA's original project for establishing the joint-stock company generically provided for the employment of company staff to be "regulated by the law and reference

collective agreements in force", whereas the mandatory reference to the NHS collective agreement was enforced by the Region.

In Lombardy, on the contrary, within any PPP differences between staff transferred from the AHTs, employed with the NHS agreement, and staff employed by the PPPs with the private AIOP agreement are stronger. For this second group, that is new hires and workers transferred by other private healthcare organisations, PPPs managers simply applied the private collective agreement, with limited convergence with NHS employment regulation. Unions were not capable to promote any significant convergence towards the NHS collective agreement and, unlike in Emilia-Romagna, Lombardy Regional government did not make any pressure for that. This last point brings us to the issues dealth with the next section.

4.3 Unions and industrial relations in the PPPs

Healthcare unions usually opposes to the conversion of public providers into PPPs, fearing that the conversion will lead to full privatisation of the involved healthcare organisations. In a highly unionised sector (about 60-70% of the NHS workers in both Regions), their opposition has often been successful and affected the decision of the Lombard regional government to mitigate and postpone its original intention to convert all public hospitals into foundations. However, when the conversion looked inevitable, unions usually adopted a cooperative strategy in order to safeguard employment levels and working conditions.

In all studied cases, issues related to transferring public-providers personnel were tackled through talks and negotiations with unions, which led to the definition of "integrative" company level collective agreements governing several aspects of these transitions. The establishment of a framework of company level agreements, replacing those in force in the LHAs or HATs, seems to be a critical tool to manage the transition phase to the new entity. Quite often, the public counterparts themselves foster the involvement of unions in managing the dynamics which follow the transition from public to private status of the healthcare organizations converted into PPPs, in order to obtain the political and social consensus needed to ensure success for operations which are symbolically rather delicate, and quite complex in practice. This is especially evident in the case of the Emilia-Romagna, where the Regional government deliberately pushed LHA chief executives to manage the transition into PPPs with the unions.

In Emilia-Romagna the cooperative attitude of the Regional government was decisive in promoting a convergence process between the employment relationships of the staff with different legal status, towards NHS-like regulation. This was certainly affected by the left wing orientation of the Regional government but, as far as we know, the same attitude was proper of right-wing Regional governments such as that of Veneto.

On the contrary, the Lombardy government did not stimulate any convergence process, leaving the counterparts free to determine pay and working conditions of the new employees, strongly penalising the unions' action. However, even in Lombardy the Regional government was careful at ensuring that staff transferred by the public providers maintained the NHS employment regulation. Moreover it stimulated a joint government of the transition to the PPP, by unions and PPPs managers.

Such elements seem to endow relationships with unions within PPPs with a significant continuity to those in the public sector, but the final result of the transitions is still not clear and could be different in the two regions. Presently, relationships with unions seem to be still quite fluid, lacking a definite structure in many respects. In Emilia-Romagna, where there is an evident trend towards largely reproducing the relationship patterns within the NHS, such outcome is not to be taken for granted. The progressive replacement of public employees, bound by the NHS contract, with private ones, to which the AIOP contract applies, will certainly have consequences on the relationships with unions. It remains to be seen whether, in the long term, they will tend towards those established in private healthcare, or will instead assume original forms, reflecting a regulation of employment characterized by an ever deeper and ambivalent merging of public and private rules. In Lombardy, it is more likely that employment regulation in the PPP will reflect that adopted in the private sector.

5. Conclusions

As described above, in 2001 Regions were given significant autonomy in the promotion and regulation of both contractual and institutional PPPs. This choice was consistent with Italian NHS decentralisation, in which most of the powers in planning, organisation and management of the healthcare system are reserved to Regions. The analysis of the PPP experience carried out in Emilia-Romagna and Lombardy highlighted the fact institutional PPPs play a different role in the two Regions.

In Emilia-Romagna, traditionally the PPPs are aimed mainly at solving local planning problems in a "public" NHS: public acute hospitals are converted into PPP rehabilitation hospitals or public and private hospitals are forced to merge into a single entity, in order to prevent hospital closures. The creation of a public-private joint-stock company is seen as an alternative to the hospital closure, due to extra-bed capacity and cost-containment policy. Therefore it responds to the political need to prevent undertaking an unpopular policy which often finds strong opposition within the local communities.

Healthcare services are directly provided by the institutional PPPs, both in the case of the joint-stock companies and in the only foundation created in Emilia-Romagna. This helps LHAs keep the PPP productive choices and service provision under control, making them consistent or at least compatible with the public planning. In this traditionally "red" Region ruled by a centre-left government, the healthcare system is based on integrated networks of services, according to the "managed cooperation" model (Light, 1997). The networks include public and private providers as well as the institutional PPPs, which all provide the kinds and amount of services according to regional and local planning. The institutional PPPs often represent irreplaceable knots of the service networks, making the participation to the PPP profitable to private partners and minimizing the risk of failure. This is certainly true in the cases in which PPPs mainly provide services for the regional or local population, a "mission" which emphasize their public function, notwithstanding their private legal status. Instead, if the PPP provision is mainly addressed to patients who live outside the Region, the risk of failure is higher, as shown by the above mentioned case of the foundation created in Cattolica.

Therefore the creation of the institutional PPPs is not intended to privatise the public providers, but it is aimed to solve specific problems in the local planning and provision. This is also shown by the choice made in the employment regulation, characterised by a converging process between the NHS and private collective agreements towards that applied in the public sector. Therefore, on one hand, the PPP potential in terms of managerial flexibility risks not being exploited, on the other hand, the risk of worsening staff working conditions is strongly reduced or nullified.

In Lombardy, institutional PPPs often represent a solution to local planning problems. However, they are also part of a long-term strategy aimed at progressively privatising the healthcare provision, contributing to determine an "internal system change" (Wendt, Frisina and Rothgang, 2009) in the Lombard Regional Health Service. This strategy also includes the spread of contractual PPPs as well as the gradual increase of the healthcare contracted services provided by private organisations to the NHS. Privatisation of the healthcare providers is consistent with the ideal orientation of the Lombard government in power since 1995, which has based its action on the principles of horizontal subsidiarity, drawn from the social doctrine of the Catholic Church. This principle has been matched with that of market competition in health and social care, as well as in other welfare policies (Maino and Neri, 2011; Brenna, 2011). In this respect, the Lombard government frequently expressed its reliance on the ability of private for profit and, especially, not-for-profit organisations to provide healthcare services more efficiently than the public ones. Moreover, not-for-profit organisations are considered more responsive to population needs.

Privatisation strategy also explains the government attitude towards the employment regulation issued within the institutional PPPs, which permitted PPPs managers to adopt private collective agreement for the new hires, without any serious attempt to converge towards the NHS regulation. Unlike Emilia-Romagna, industrial relations are slowly evolving towards those practised in the private sector.

However, fears of the opposition raised by privatisation have pushed the Regional government to increase the role of private providers mainly by increasing the amount of contracted healthcare services provided by private hospitals and outpatient centres to the NHS. Except for the creation of four public law foundation hospitals, the conversion of public hospitals into foundations set up according to the model experimented in the Mantua foundation has been postponed, though not abandoned.

The different role played by the institutional PPPs, compared to Emilia-Romagna, emerges also by considering that in Lombardy the healthcare system regulation induces PPPs to enter into competition the public and private providers, instead of being integrated in service networks This remains true, although competition arrangements have been mitigated over the years (Neri, 2011).

So far the role attributed to PPPs in the other Regional healthcare systems seems to be more similar to that played in Emilia-Romagna than in Lombardy. Even Regions ruled by centre-right coalitions like Veneto used institutional PPPs and, in particular, joint-stock companies mainly to solve specific problems in local planning, without any purpose of privatising the service provision (Cappellaro and Longo, 2010).

However, the attitude of the other Regions towards institutional PPPs should become clearer in years to come, as the budget cuts and cost containment policies prompted by the public finance crisis will probably push several Regions, especially in Central and Southern Italy, to close several small hospitals in rural areas. As has already happened, the conversion of hospitals at risk of closing into PPPs could become a preferable solution, promoting a more generalised diffusion of the institutional PPPs.

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