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Health Reform Monitor

Health decentralization at a dead-end: towards new recovery plans for Italian hospitals[☆]

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ABSTRACT

The recent introduction by the central government of recovery plans (RPs) for Italian hospitals provides useful insights into the recentralization tendencies that are being experienced within the country's decentralized, regional health system. The measure also contributes evidence to the debate on whether there is a long-term structural shift in national health strategy towards more centralized stewardship. The hospital RPs aim to improve the clinical, financial and managerial performance of public-hospitals, teaching-hospitals and research-hospitals through monitoring trends in individual hospitals' expenditure and tackling improvements in clinical care. As such they represent the central governments recognition of the weaknesses of the decentralization process in the health sector. The opponents of the reform argue that financial stability will be restored mainly through across-the-board reductions in hospital expenditure, personnel layoffs and closing of wards, with considerable negative effects on the most vulnerable groups of patients. While hospital RPs are comprehensive and complex, unresolved issues remain as to whether hospitals have the necessary managerial skills for the development of effective and achievable plans. Without also devising an overall plan to tackle the long-standing managerial weaknesses of public hospitals, the objectives of the hospital RPs will be undermined and the decentralization process in the health system will gradually reach a dead-end.

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1. Introduction

Over the past 40 years, in both developed and developing countries, health system organization has undergone a decentralization process from the national to regional and local levels, introducing a multi-level governance structure

[1–5]. The main aims of the devolution reforms have been two-fold: to increase efficiency and to improve the financial responsiveness of decentralized authorities [2,6,7]. However, during the early years of the 21st century, a re-centralization process in European health systems has been observed, even if this trend has been limited only to certain functions specifically related to political and fiscal competences, while legislative powers over health system organization have remained at the regional level. The adoption of these measures has mainly been due to policymakers' concerns about the financial sustainability of healthcare systems, equity problems relating to population health outcomes and accessibility to services, and wide interregional differences resulting from devolution poli-

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cies [5,8–12]. This re-centralization process has favoured the diffusion of theories on the reversal of decentralization trends, with some authors claiming that the “new long wave of re-centralization” is a long-term structural shift in national health strategy [5]. Conversely, other authors have identified in these policies only an attempt by policymakers to rapidly cut costs (consistent with EU austerity conditionalities), thus merely representing the adoption of a stronger stewardship approach in the management of highly decentralized health sectors [11,13].

The recent experiences of the Italian National Health Service (INHS) may provide useful evidence for the debate on the decentralization of healthcare. We describe the context of a new reform measure by the central government that introduces hospital recovery plans and discuss the expected benefits and potential issues that arise in their implementation. We also consider the arguments that have been advanced by proponents and opponents of the reform. The results may be useful to policymakers in considering the transferability of the approach to other countries.

2. Background

In Italy, the process of devolving healthcare from the central government to the regions began in 2001 with the transfer of major fiscal, financial and managerial responsibilities to the regional level, which was already responsible for the delivery of healthcare [14]. This process produced mixed results. Some regions implemented all the actions that they were capable of executing to meet the broad objectives of the reform, thus strengthening their systems. In contrast, regions that had weak managerial capacity and lower health service performance failed to reach the set goals [13,15–17]. A major consequence of the decentralization process to date is a significant imbalance in health expenditure levels among regions, resulting in considerable health budget deficits in 10 out of the 21 regional health systems. Since 2006, a re-centralization process has been underway, with a special focus on the weakest regions. Specifically, the central government has obliged those regions to adopt regional recovery plans (RRPs) with the aim of reducing healthcare expenditures in their own public spending. In the worst cases, the national government has appointed a Commissioner to pursue the central government's targets [9,13,15–17]. The overall effect of this regime has been a decrease in the annual level of over-spending. Indeed, in 2014, the public sector's total deficit was €864 billion, an 85% decline since 2006 (€6.010 billion) [18,19]. This decline suggests that RRPs are effective tools for improving economic and financial performance in the short term [9,13,16,18–20] with some limitations. Indeed, several authors have observed i) RRPs' limited efficacy in solving the structural causes of the deficits and ii) the lower quality of health prevention projects developed in Italian regions with financial deficits and recovery plans [9,16,21].

In light of the RRPs' positive results, in terms of both health system efficiency improvement and deficit reduction, and the Italian government's need to rebalance its finances, the Ministry of Health introduced hospital recovery plans in 2015 (Law No. 208/2015 art. 1 paragraphs

524–526) [22]. This article reports on these new financial instruments for Italian hospitals, which is the country's first experience of compulsory recovery plans for hospitals.

3. The new decree

3.1. The purpose and the content of the reform

Law No. 208/2015 introduced recovery plans for hospitals [22], with the draft decree being sent to the State-Regions Conference, Italy's inter-governmental body regulating the relations between the central government and the regions, in February 2016. This draft contained guidelines for improving the clinical, economic, financial and managerial performance of public hospitals (known as *Aziende Ospedaliere*, AO), teaching hospitals (*Aziende Ospedaliere Universitarie*, AOU) and research hospitals (*Istituti di ricovero e cura a carattere scientifico*, IRCCS) [23]. The endorsed decree, which was originally scheduled to be enacted in March 2016, was enforced in July 2016 [24].

Specifically, the new decree outlines the operational tools (recovery plans) for a) monitoring trends in individual hospitals' healthcare expenditure and b) implementing vigorous and effective interventions to improve the care provided and to ensure that all hospitals provide at a minimum, the services outlined in the “Essential Levels of Care” (LEAs), the basic benefits package that must be provided uniformly across the country. The main aim of this approach is to provide an effective tool for hospitals that is consistent with the growing demand for health services induced by demographic trends and epidemiological tendencies. The decree regulates two different types of recovery plans, both of which have a three-year horizon: Type A and Type B [23]. Type A plans deal with efficiency and are designed to ensure that hospitals develop strategies to balance their budgets. They apply to hospitals where the difference between costs that are recognized in the income statement and income that comes from healthcare “is greater than or equal to 5% or, in absolute terms, at least €10 (or 8) million”. Type B plans relate to clinical care and aim to identify measures that may improve care. They apply to hospitals that do not comply with the parameters concerning volume, quality and outcomes of care established by the central government. To draft the plans, hospitals must undertake several activities, as summarized in Table 1.

Each region must identify the health organizations within its jurisdiction that meet the above criteria and therefore are required to draft either one or both of the recovery plans. Each of the identified organizations has ninety days to present its three-year plan in accordance with the decree. The region must ensure that the actions outlined in the plan are implemented [23].

3.2. The stakeholder positions

The new decree will directly or indirectly involve a plurality of stakeholders, such as regional governments, hospital managers, personnel and citizens/patients [25]. In Fig. 1, we summarize stakeholders' influence in the policy

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