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Health care rationing in Italy: right to health vs. budget constraints in a regional-based health system

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Abstract

After the enactment of the 2001 Constitutional Reform Act, the Italian health system consists of as many as 21 regional health systems. The central government retains the public task of ensuring that all citizens, regardless of their territorial residence, may access the same universal and equitable health services and provisions.

After the economic crisis of 2007/2008, as has been the case in many other EU MSs, the Italian central government has decreased public expenditure on health care. Not only has such an approach undermined citizens' fundemental right to health. It has also triggered a fierce confrontation between regional governments and the State, which has also been the object of some rulings of the Italian Supreme Court.

Against this background, the paper aims to analyse the impacts that health care rationing has on the organisation of health and care services and on the evolution of social enterprises as health providers.

1. Introduction

The Italian national health system represents a good example of a long-lasting and sometimes controversial debate between market forces and State intervention. During the drafting of the Italian Constitution back in 1946 there were two main political options through which to organise the health care system. On the one side, there were those MPs who wanted to keep the role of public authorities as integrating the main action of private initiative. In contrast, on the other side, there were those MPs who supported the idea that protection of health would be far better ensured by robust and direct action on the part of public agencies. According to this latter approach, national and, later, regional authorities would take on responsibility for the organisation, management and supply of health care services.

At the end of the discussion in Parliament, the Constitution included a clear recognition of the right to health (s. 32), of the duty of public authorities to remove all the obstacles that may hinder such a right (s. 3) as well as the recognition of civil society and also business organisations to deliver health care services (sections 2, 38 and 41).

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The 2001 Constitutional Reform Act has provided for a regional-based health care system: currently, there are as many as 20 regional health care systems, corresponding to the regions of Italy.

The international economic and financial crisis that broke out in 2007/2008 also brought with it heavy health care rationing, which has inevitably had a major impact on the organisation of health care services and, accordingly, on the protection of the right to health.

Against this background, the Italian Supreme Court has had to strike a (difficult) balance between health budgets and individual rights. Not only has the Constitutional Court had to rule in a legal context in which health care activities are largely and solely entrusted to regional and local governments. It has also had to take into account the progressive pressure of European and international laws.

In the light of the foregoing, this paper is aimed at analysing how health care rationing has influenced the Italian health system and if it can somehow explain the development of social enterprises as health care providers.

2. A short description of the Italian national health system

Marketisation,[1] globalisation,[2] health budget constraints as well as the increase in the demand for health care services and the progressive ageing of the population appear to undermine individuals' right to health. Sometimes, it seems as though the obligation on the part of governments and public authorities to ensure citizens' fundamental rights is no longer an essential dimension of modern welfare states. There are also views of certain political and economic players who consider social (and perhaps also health) policies as a burden on growth and competitiveness.[3]

Added to this is the progressive and long-lasting devolution process of powers from central governments to regional and local levels,[4] which too may endanger the actual enforcement of the right to health. Such a condition is peculiar to

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1 See C. Newdick, 'From Hippocrates to commodities: three models of NHS governance', in *Medical Law Review*, Vol. 22, No. 2 (Spring 2014): 162-179.

2 Globalisation 'has significantly affected the law and economics approach, causing a re-thinking of the mechanisms of balance and un-balance between economic freedoms and individual rights. Accordingly, new systems of regulation are required to adequately and effectively match new social and economic needs.' M.A. Stefanelli, *Prefazione*, in M.A. Stefanelli (ed.), *Dopo la globalizzazione: sfide alla società e al diritto*, Giappichelli, Torino (2017):2.

3 B. Vanherke, S. Sabato and D. Bouget (eds.), Conclusions. Social policy in the EU: high hopes but low yields, Social policy in the European Union: state of play 2017, European Social Observatory (OSE):201.

4 See A. Rico, S. Leòn, Health care devolution in Europe: trends and prospects, Health Organisation Research Norway – Horn, Working paper (2005):1.

those legal and health systems, such as Italy, in which central and local governments share some provinces as to the organisation and supply of health care services. Whereas the central government retains the power of setting forth the general guidelines and principles of law, regional and local governments are entrusted with and are in charge of the organisation of health care services at the community level. In accomplishing this task, regional and local governments exhibit different models and patterns, which may even weaken the free, universal and fair access to health care services, which is to be ensured at the national level.

But what are the reasons why powers in the health care sector have been and still are devolved from central to regional/local governments? What effects does such a devolution process have on health care provisions? Are we facing an era of re-centralisation of powers? Is there any way to make national and regional systems work together?

In health care, devolution constitutes the key governance mechanism mainly in tax-funded countries, where the public sector performs the roles of financing, purchasing and providing care. This means that in all European tax-funded health care systems devolution has been a key reform issue.[5] There are two main reasons for the devolution of powers, in general, and in health care in particular. The first reason has to do with policy: devolving powers from the central to local levels is expected to strengthen local democracy. This end is supposed to improve the capacity of welfare systems to respond more effectively to citizens' needs. Public policies and finances are then implemented to enhance building government capacity and service accountability at the local level. The second reason is fiscal accountability, that is, the financial risk is on the part of local governments, which are accordingly held responsible for public services. The combination of these two reasons in health care has forced national welfare systems to be divided into as many health regional systems as the national territories have been organised into. Such a division may cause some significant territorial inequalities or "patchwork quilt", since the actual enforcement of health care rights heavily depends on the organisation of the regional welfare systems. The rich areas would then tend to offer better and more effective health care services than the poor ones.[6]

These patterns, if any, changed dramatically after the outbreak of the international financial and economic crisis in 2007/2008. The crisis has reshaped

5 See Srinivasa Vittal Katikireddi, Katherine E. Smith, David Stuckler, Martin McKee, Devolution of power, revolution in public health? In *Journal of Public Health*, Volume 39, Issue 2 (1 June 2017):241–247.

6 In Italy, due to the great economic and social divide between the North and the South, there is a significant health tourism of patients moving from Sicily, Campania and Calabria to be treated in hospitals and clinics up north. It is noteworthy that such a movement is largely funded by the Southern local health authorities, which causes a rise in health expenditure.

the agenda of public policies regarding health and social care. National welfare systems have been confronting with a relatively new need, namely, to provide health care services with universal coverage but on a selective basis.[7] Such a turning point has been caused by the budget constraints that have progressively affected national and regional health policies. Doubtless, one of the challenges of modern welfare systems is to ensure citizens' fundamental rights *vis-a-vis* the financial sustainability of health care systems.[8]

To ensure citizens' right to health means that both central and regional governments have to come to terms with two different dimensions, namely, the programming and organisation function and the financial sustainability of their systems, respectively. The programming function implies the necessity of regarding the organisation of health care services as the positive answer by modern welfare states. They are responsible for both the quality of the services delivered and the organisational models that are considered to be the most adequate to supply those services. Whilst in the past, health care services used to be mainly supplied by public agencies, since late 1980s these services have also been delivered also by private organisations, especially non-profit. Both governments, at the central and also local level, as well as non-profit organisations are then entrusted with ensuring citizens' fundamental rights.

Through programming, the activities and actions are coordinated so as to accomplish public purposes. Planning and programming are essential functions in the health care sector given the importance of protecting and ensuring the right to health. First and foremost planning and programming imply the recognition of the major role that public institutions play in organising health care provisions. In this respect, the duty of solidarity and universal access to health care services ought to be interpreted according to an approach aimed at defining the scope and the extent of the intervention of public agencies in organising and supplying services of general interest.

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7 The so-called "selective universal health coverage" has been regarded as 'a contradiction in terms; rather an oxymoron'. See P. Carrozza, *Riforme istituzionali e sistemi di welfare*, in M. Campedelli, P. Carrozza, L. Pepino (ed.), *Diritto di welfare*, Bologna: [PUBLISHER???] (2010):220.

8 I do agree with those legal scholars who support the idea that 'a welfare system is necessary to modern societies, though it needs re-arranging and modernisation, especially to improve the quality of services provided.' G. Piperata, *Intervento pubblico, concorrenza e integrazione nel sistema delle prestazioni sanitarie e sociali*, in C. Bottari (ed.), *Terzo settore e servizi socio-sanitari: tra gare pubbliche e accreditamento*, Torino: Giappichelli (2013):90. On the same topic, see also L. Torchia, *Premessa*, in L. Torchia (ed.), *Welfare e federalismo*, Bologna: il Mulino (2005):8*ff*.

Although at times there have been some attempts to reverse the current devolved health care systems,[9] it is difficult, if not impossible to some extent, to turn back the clock of recent history.[10] Citizens and patients seem to be quite satisfied with services and provisions that can access near their homes. Indeed, in some cases, citizens and local governments have struck back against the decisions of regional political powers to close down country hospitals, even if these are regarded as dangerous for public health or underperforming.

Are we therefore bound to live with regional and local health systems that are national-proof? Do we have to raise our hands in the face of progressive and apparently unstoppable social and health inequalities within the same national legal systems? Do we have to get used to fragmentation amongst services and territorial areas? Alternatively, is there any possibility of combining national guidelines with regional and local implementation of health care services?

In those legal systems, in which either Constitutions or statutes provide for a clear, though not always easy to perform, responsibility on the part of public authorities to ensure services of general interest, central governments retain some general regulatory and monitoring powers. Generally, Secretaries for Health Care exert their powers by getting regional and local governments involved in the decision-making process concerning important issues, such as migration, health risks, setting of quality standards and the like. Regional and county governments are then free to implement health policies according to their economic, social and demographic dimensions. In times of economic crisis, Supreme Courts may take action to compel regional governments to respect European financial and budget constraints, which then may serve as a kind of life-jacket to uphold central governments' powers.[11]

At any rate, except for a few cases in which the decisions and policies of regional governments can be appealed before national Supreme Courts, regional and county authorities are free to implement the actions and policies they consider more effective and sustainable for their own areas.[12] Such an approach can be harmonised through coordination meetings at the national level, in which regional and local governments share with central governments their

9 Some scholars have written that 'regional differentiation is by no means synonym of waste and inefficiencies.. See M. Bertolissi, *Tutela della salute: esigenze di eguaglianza e modelli organizzativi differenziati (con spunti di comparazione)*, in Tronconi (ed.), op. cit.:82.

10 On 4th December 2016, the majority of Italian citizens voted "No" in a referendum that, amongst other things, intended to re-centralise some powers, including health care services.

11 M. Belletti, *Percorsi di ricentralizzazione del regionalismo italiano nella giurisprudenza costituzionale, tra tutela di valori fondamentali, esigenze strategiche e di coordinamento della finanza pubblica*, Roma: Aracne (2012):124-125.

12 In this perspective, it is noteworthy that some regions belonging to neighbouring countries can also programme and plan cross-border health care services.

own views, projects and prospects. In their turn, central governments may propose to provide regional and local governments with funds, not according to their expenditure history, but according to standard costs incurred in providing health care services.

The right to health can be ensured and protected only by combining public policies that tend to promote solidarity, equality and financial sustainability. In this respect, regional and central governments are called upon to construe individuals' "health citizenship". In particular, the principal task of central governments is to co-ordinate and guide the actual implementation of the right to health at the regional and county levels. These levels should remain independent to some extent to better match individual's needs. Differences amongst regional systems do not necessarily imply negative consequences for the organisation and provision of health care services. Rather, if possible, devolution of powers brings about a higher level of responsibility and accountability of local health authorities. Responsibility and accountability serve then as prerequisites for striking a balance between de-centralisation of powers and the necessity of ensuring equal, universal and homogeneous rights to welfare and health care services. Any national health system faces such a "dilemma": how to recognise regional and territorial independence while the central governments take actions as to the financing of the services and their enforceability.

A way to overcome the difficulties of reconciling the national with the local levels of health care services could be to plan for "place-based" systems of care.[13] These systems, which consist of both public entities and private organisations, especially non-profit ones, represent the legal and institutional frameworks through which to deliver health care services and to ensure the enforcement of the right to health. Legal, territorial and organisational models all significantly affect the way health care services are managed and supplied, as well as the possibility of effectively enforcing the right to health.[14] In this perspective, new actors can be set up and some important changes in the organisation of traditional players can be introduced.[15]

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13 C. Ham, H. Alderwick, *Place-based systems of care. A way forward for the NHS in England*, The King's Fund (November 2015).

14 See R. Pessi, *Tornando su adeguatezza e solidarietà nel welfare*, in *Rivista del Diritto della Sicurezza Sociale*, Issue 4 (December 2016):594*ff*.; M. Cinelli, *L'"effettività delle tutele sociali tra utopia e prassi*, in *Rivista del Diritto della Sicurezza Sociale*, anno XVI, n. 1 (2016):21*ff*; L. Rampa, *Paternalismo, autonomia e diritti sociali: una rilettura in termini di analisi economica*, in *Politica del Diritto*, (3/2016), a. XLVII:305-336.

15 On this issue, see IBM Institute for Business Value, *La sanità e l'assistenza sanitaria nel 2015. Evoluzione dei modelli di erogazione dei servizi sanitari.*

Given the complexity of the current social and health care systems, it is recommended that public regulation may offer a set of tools to govern processes whereby local welfare systems are enabled to match individuals' needs. Within a legal framework in which regional and local authorities are entrusted with organising health care services, the regional level is expected to outline guidelines that support local welfare actions and projects.[16] It is at the local level that coordination plays its own strategic role, since the different public responsibilities are challenged and compared locally. In this respect, the regional programming function is supposed to provide health authorities and local municipalities with integrated, efficient and effective responses, including health rationing and organisational re-arrangements.

3. Health care rationing and the right to health

In Italy, health care rationing is not an outcome deriving from the international and financial crisis of 2007/2008. In fact, it dates back to the early 1990s, when the Italian government started to inventory the health basket by connecting to it the necessary economic resources. In other words, the 1992 Health Reform Act attemped to ensure the protection of the right to health and to cap the resources that were intended to implement that right. This legal approach did not quite make it clear whether resources were to be regarded as constrained or as a proper objective to be achieved. Such a doubt was indeed the reason why many regional governments appealed to the Supreme Court against the Reform Act.[17]

The subsequent rulings of the Supreme Court, together with the 2001 Constitutional Reform Act, which has designed the regional health system as well as defined the duty of the central Government to ensure all citizens equal and universal access to health, have confirmed that financial rationing can by no means win the upper hand over the right to health. In other words, the Italian legal and health care systems do recognise that the right to health consists of an irreducible core.

Yet the recognition of the right to health has been heavily challenged by a recent Constitutional provision that provides for stringent and accurate financial constraints on the part of both central and local governments.[18] In this perspective, the Italian Constitution, which has been founded on a clear concept of the "Welfare State", no longer allows public authorities to go into debt. Such an obligation has triggered a fierce debate concerning the possibility of disregarding

16 See C. Ham, H. Alderwick, op. cit.
17 See ruling No. 355 of 1993.
18 See Section 81 of the Italian Constitution, as amended in 2012. On this issue, see C. Golino, Il principio del pareggio del bilancio. Evoluzione e prospettive, Padua: Cedam, 2013.

this provision when it comes to health care services, which are aimed at ensuring citizens' right to health.

In my opinion, the financial balance that Section 81 has introduced into the Italian legal and health care system should always be inconsistent with a constitutional setting according to which citizens, especially the most vulnerable people, are expected to be granted social and health rights only insofar as the economic or financial circumstances allow for them.

In other words, it is necessary to avoid financial and budget constraints being regarded as more important than the right to health.[19] Such a recognition is all the more significant in a contemporary context in which both European and national economic bonds seem to prevail over community solidarity and social cohesion.

4. Social enterprises as the result of health care rationing?

In many EU jurisdictions, social enterprises have long been engaged in the delivery of services of general interest, especially health care services. Their legal and organisational features largely depend on the individual Member States' legal systems. However, social enterprises may commonly be regarded as non-profit organisations whose social aims can be achieved through the carrying out of economic activities. In most welfare systems, social enterprises, along with public authorities, ensure citizens' right to health.

This implies a special role for social enterprises: they serve as adequate and effective legal forms through which to provide health care services.[20] Since social enterprises pursue the same goals as the services of general application and since they present specific legal and organisational patterns, not only are they suitable for delivering services of general interest;[21] in supplying health care services, they also actively contribute to ensuring citizens' right to health.

This role of social enterprises is consistent with the legal provisions included in the Charter of the Fundamental Rights of the European Union[22] that encompass the possibility for all EU citizens of accessing a relatively wide range of

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19 See E. Furno, *Pareggio di bilancio e diritti sociali: la ridefinizione dei confini nella recente giurisprudenza costituzionale in tema di diritto all'istruzione dei disabili*, in *Nomos* (1-2017):22.

20 Recital No. 71, Directive 123/2006.

21 See Recital No. 36 and Article 20 of Directive 2014/24/EU relating to public procurement and repealing Directive 2004/18/EC.

22 The Charter was adopted in December 2000 in the framework of the Treaty of Nice. See S. Peers, T. Hervey, J. Kenner, A. Ward (eds.), *The EUCharter of Fundamental Rights: A Commentary*, Oxford: Hart Publishing (2014):951-952.

services.[23] In this respect, Article 35 of the Charter provides for a general right to health, which all individuals are to benefit from.[24] The circumstance that the right to health falls under the broad definition of human rights, makes it part of EU policy and no longer the obligation of the single Member States only. EU law then provides for a general obligation not to violate fundamental rights (negative approach). At the same time, it also encourages both governments and non-profit organisations to be committed to promoting the implementation of those rights according to the European Charter (positive approach).[25] In this perspective, the right to health aims to enhance social equity and solidarity within the European national, public and universal social security systems.

The accomplishment of this aim is entrusted to a system of procedural rights, in which health authorities keep a certain degree of autonomy and power.[26] However, their power is subject to the scrutiny of the courts, which, in their turn, determine whether a decision taken by a public authority concerning the right to health is in accordance with national and EU laws.[27] This is the space in which social enterprises deliver their services and their public interest obligations. Within this legal framework social enterprises carry out their activities to fulfil the principles that are set forth in the EU Charter of Fundamental Rights. In this respect, social enterprises are regarded as essential partners in performing and implementing all those welfare services, including health care services, which are necessary to ensure that the right to health is fully accomplished. This task accounts for a different approach towards the supply of health care services. It has progressively shifted from a mere technical procedure whereby these services are outsourced through a regulatory framework according to which social enterprises deliver their services on the basis of their specific legal nature. However, social enterprises are not limited to this scope: local and health authorities also call upon them to take part in the programming of the services to be supplied.

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23 See, G.M. Caruso, *Diritti sociali, risorse e istituzioni: automatismi economici e determinismo politico di un sistema complesso*, in *www.federalismi.it*, (n. 4/2016):12. See also S. Gambino, *Livello di protezione dei diritti fondamentali (fra diritto dell'Unione, convenzioni internazionali, costituzioni degli Stati membri) e dialogo fra le Corti. Effetti politici nel costituzionalismo interno ed europeo*, in *www.federalismi.it*, (n. 13/2014, 25 giugno 2014):2.

24 'Everyone has the right of access to preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices. A high level of human health protection shall be ensured in the definition and implementation of all the Union's policies and activities.'

25 See. G. Palmisano (ed.), *Making the Charter of Fundamental Rights a Living Instrument*, Leiden-Boston: [PUBLISHER???] (2014).

26 See Article 41, para. 1 of the EU Charter of Fundamental Rights. See also Court of Justice of the European Union, case C-617/10, Åklagaren v Hans Åkerberg Fransson, 26 February 2013, especially para. 21.

27 C. Newdick, *Citizenship, Free Movement and Health Care: cementing individual rights by corroding social solidarity*, in *Common Market Law Review* (2006):43, 1653.

The legal and organisational structure of social enterprises, their specific goals, as well as their capacity for funding make these non-profit organisations particularly suitable to bridge the gap between citizens' needs and the lack of public resources. In times of austerity, in which it is all the more difficult for the MS's welfare systems to ensure equitable access to health care services, social enterprises are actually a legal and organisational tool which public authorities and citizens may count on to deliver health care services. Accordingly, social enterprises appear to be less the result of health care rationing than one of the responses to it. Due to their characters, social enterprises become "agents" of social innovation, whose action is consistent with the programming background of a given local community. Such a responsible engagement of social enterprises in the delivery of health care services seems to respect both public responsibilities and the ideal dimensions as well as their legal nature. Social enterprises also define social and health projects for the benefit of the community by contributing with their own financial resources.

5. Concluding remarks

The paper has endeavoured to prove that the right to health cannot be disregarded because of health care rationing. This needs to be balanced with the setting of priorities, which social enterprises can also be summoned and called upon to contribute to.

In this perspective, social enterprises are then engaged in the provision of health care services also "on behalf" of public authorities. This allows these organisations to propose new and innovative services, which are rightly needed with respect to citizens' health demands.

Since budget constraints on health care are not likely to decrease in the near future, the action and activities of social enterprises become all the more essential to the overall national health care system.

Ultimately, it is not a matter of the supremacy of public authorities or denial of the role of social enterprises. Rather, it is a question of how the health care system is arranged and organised: the more it is centred on co-operation and partnerships, the better.